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BUILDING VA'S FUTURE: CONFRONTING PERSISTENT CHALLENGES IN VA MAJOR CONSTRUCTION AND LEASE PROGRAMS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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CONTENTS

November 20, 2013

Page

Building VA's Future: Confronting Persistent Challenges In VA Major Construction And Lease Programs 1

OPENING STATEMENTS

Hon. Jeff Miller, Chairman, ... 1
Prepared Statement of Chairman Miller 27
Hon. Michael H. Michaud, Ranking Minority Member 2
Prepared Statement of Hon. Michaud 27
Hon. Corrine Brown, U.S. House of Representatives, Prepared Statement only 28

WITNESSES

Linda Halliday, Assistant Inspector General for Audits and Evaluations 2
Prepared Statement of Ms. Halliday 28
Accompanied by:
Maureen Regan, Counselor to the Inspector General, Office of the Inspector General, U.S. Department of Veterans Affairs
Llyod Caldwell, P.E., Director of Military Programs, U.S. Army Corps of Engineers 4
Prepared Statement of Mr. Caldwell 33
Glenn D. Haggstrom, Principal Executive Director, Office of Acquisitions, Logistics, and Construction, U.S. Department of Veterans Affairs 5
Prepared Statement of Mr. Haggstrom 36
Accompanied by:
Stella Fiotes, Executive Director, Office of Construction and Facilities Management, U.S. Department of Veterans' Affairs

STATEMENT FOR THE RECORD

Veterans of Foreign Wars 39
Disabled American Veterans 41
The American Legion 46

QUESTIONS FOR THE RECORD

Letter and Questions From: HVAC, To: VA 48
Responses From: VA, To: HVAC 51

BUILDING VA'S FUTURE: CONFRONTING PERSISTENT CHALLENGES IN VA MAJOR CONSTRUCTION AND LEASE PROGRAMS

Wednesday, November 20, 2013

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The Committee met, pursuant to notice, at 9:38 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [Chairman of the Committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Flores, Denham, Runyan, Benishek, Huelskamp, Coffman, Wenstrup, Cook, Walorski, Michaud, Brown, Brownley, Titus, Kirkpatrick, Ruiz, Negrete McLeod, Kuster, O'Rourke, and Walz.

Also present: Representative Mica.

OPENING STATEMENT OF CHAIRMAN MILLER

The CHAIRMAN. The Committee will now come to order. Welcome to today's Full Committee hearing, Building VA's Future: Confronting Persistent Challenges in VA's Major Construction and Lease Programs.

As some of you may know, in just about an hour we are going to recognize 33 Native American tribes and bestow the Congressional Gold Medal upon the heroic and selfless Native American Code Talkers who provided invaluable secure communication to Allied powers during World Wars I and II. Their courage, dedication, and honorable service enabled countless lives to be saved and victory to be done.

In the interest of conducting today's business in sufficient time to allow both Committee Members and members of the audience today to participate in honoring and celebrating these brave men and women, I will submit my opening statement for the record.

However, before I yield to the Ranking Member I do want to note that we have just authorized 27 major medical facility leases per the department's request for the fiscal years 2013 and 2014. At today's hearing we will address serious deficiencies in VA's planning, design, and construction of lease projects that were authorized in 2009. VA should be on notice that the approval of H.R. 3521 in no way holds the department harmless for the mismanagement of major construction and facility leases that continues today. Moving forward I expect the department to take immediate corrective actions to address the serious issues that have plagued the construction and the leasing programs so that the important projects that we have just authorized do not experience the same delays and cost overruns we have seen in the past. And now I yield to our Ranking

Member Mr. Michaud of Maine for any opening statements that he may have.

[THE PREPARED STATEMENT OF CHAIRMAN MILLER APPEARS IN THE APPENDIX]

OPENING STATEMENT OF HON. MICHAEL H. MICHAUD

Mr. MICHAUD. Thank you, Mr. Chairman. I would ask unanimous consent my opening remarks be submitted for the record.

[THE PREPARED STATEMENT OF HON. MICHAEL MICHAUD APPEARS IN THE APPENDIX]

The CHAIRMAN. Without objection.

Mr. MICHAUD. I yield back the balance of my time.

The CHAIRMAN. Thank you very much.

First I want to welcome our first and only panel of witnesses today. Thank you for coming. Joining us from the VA Inspector General is Linda Halliday. If you would, please come forward? The Assistant Inspector for Audits and Evaluations, Ms. Halliday is accompanied by Maureen Regan, Counselor to the Inspector General. We are also joined by Lloyd Caldwell, the Director of Military Programs, for the U.S. Army Corps of Engineers. From the VA we are joined by Glenn Haggstrom, the Principal Executive Director for the Office of Acquisitions, Logistics, and Construction. Mr. Haggstrom is accompanied by Stella Fiotes, the Executive Director of the Office of Construction and Facilities Management. Thank you all for being here today. Ms. Halliday, we will begin with you. You may proceed with your testimony. You are recognized for five minutes.

STATEMENTS OF LINDA HALLIDAY, ASSISTANT INSPECTOR GENERAL FOR AUDITS AND EVALUATIONS, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY MAUREEN REGAN, COUNSELOR TO THE INSPECTOR GENERAL, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; LLOYD CALDWELL, P.E., DIRECTOR OF MILITARY PROGRAMS, U.S. ARMY CORPS OF ENGINEERS; AND GLENN D. HAGGSTROM, PRINCIPAL EXECUTIVE DIRECTOR, OFFICE OF ACQUISITIONS, LOGISTICS AND CONSTRUCTION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY STELLA FIOTES, EXECUTIVE DIRECTOR, OFFICE OF CONSTRUCTION AND FACILITIES MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF LINDA HALLIDAY

Ms. HALLIDAY. Mr. Chairman and Members of the Committee, thank you for the opportunity to testify today on the results of VA Inspector General's work related to VA's construction and lease programs. With me today is Ms. Maureen Regan, the Counselor to the Inspector General and the Director of the IG's Office of Contract Review.

OIG reviews of VA's minor construction program, health care center leasing and activation process, and selected major construction process have disclosed a pattern of poor oversight, ineffective

planning, and mismanagement of capital assets in VA. We reported in 2012 that VA has not effectively managed the capital asset planning process to ensure minor construction projects are not changed significantly after approval, or that leased facilities are the right size and in the right location to ensure they are fully utilized. In our 2012 review of VA's minor construction program we found that VHA had integrated the design and construction of seven of 30 minor construction programs into three combined projects, which the exceeded the minor construction spending limitation of $10 million. Three other projects of the 30 we reviewed were inappropriately supplemented with medical facility funds, also known as nonrecurring maintenance funds.

These projects had little if any project planning or oversight. The improper mixing of minor construction with NRM funding was due to premature approval of poorly planned and inadequately developed contracts for medical facility design and construction.

To address the Committee's interest in the management of VA's health care center lease procurement process, our review found no health care centers had been built despite VA's original target completion of June, 2012. Congress authorized approximately $150 million for seven HCC facility activations. We also reported that VA could not provide accurate information on HCC spending into April, 2013 because central cost tracking was not in place to ensure the transparency or accuracy of reporting all HCC expenditures.

Further, the review of an anonymous complaint received in March, 2013 involving the lease for the Butler, Pennsylvania Healthcare Center led to the cancellation of the lease.

We noted instances where facilities were leased and constructed, and then stood empty and underutilized. And some of VA's construction projects, although they were properly authorized, were executed over budget and delivered well past their anticipated completion date.

To serve veterans in both New Orleans, Louisiana, and Orlando, Florida, VA is constructing two new medical centers. Our review of the financing and budgeting for the construction of the medical center in New Orleans found nothing substantially wrong. However, we noted excessive delays and slippage. Most of it was due to the delivery of the site from the City of New Orleans, and the need to remediate the hazardous substances identified after the site was transferred to and accepted by VA. To mitigate the construction delays VA was adjusting the construction activities to meet the completion deadline. In the VA Medical Center in Orlando, we reviewed the contract change orders amounting to over $9.6 million. After a thorough review we questioned about 30 percent of these costs. Lack of supporting documentation, inclusion of costs not associated in the work ordered, and overstatement of proposed costs were quickly brought to the attention of the VA contracting officer and negotiations were held to ensure VA was going to pay only what it was owed.

Our reports have motivated VA to review its minor construction policies and procedures. VA now ensures its construction programs managers better track and monitor project timeliness and cost as well as routinely compare approved designs with project scope to better manage changes. But given the practices in the past, such

as ineffectively monitoring projects, untimely executive of leases, and inaccurately calculating program costs and savings, VA is not recognizing the full potential of its construction program. VA needs better oversight, improved capital planning, and stricter asset management to gain assurance that it can address construction and lease challenges more effectively. With good management and stewardship there are opportunities to avoid cost increases and schedule delays.

Efforts to ensure the adequacy of its processes, especially the project management process and oversight, will help reduce the examples like the ones highlighted in our statement. Regardless, budget performance and schedule risks are inherent in any effort to deliver construction projects. Further planning and managing capital assets to align with veterans' health care needs and new medical treatment changing how and where care is provided is a challenge. Thus, risk management and mitigation must be effectively addressed throughout the life of construction projects.

Mr. Chairman, this concludes my statement today. Maureen Regan and I will be pleased to answer question on our respective work.

[THE PREPARED STATEMENT OF LINDA HALLIDAY APPEARS IN THE APPENDIX]

The CHAIRMAN. The Committee thanks you for your testimony. Mr. Caldwell, you are recognized for five minutes.

STATEMENT OF LLOYD CALDWELL

Mr. CALDWELL. Mr. Chairman and Members of the Committee, as the Director of Military Programs for the U.S. Army Corps of Engineers, I provide leadership for the Execution of the Corps' engineering and construction programs worldwide to include our support for other agencies. I am pleased to be with you today. And I will address our approach to delivering construction, specifically the construction of medical facilities.

The Department of Defense construction program uses designated construction agents, of which the Corps of Engineers is one. The construction agents procure and execute the delivery of DoD infrastructure. The Corps has a long history of executing some of the Nation's most challenging construction programs, both in our military missions as well as in our civil works responsibilities. We deliver a full range of medical facilities for the Department of Defense, to include hospitals.

Regardless of the nature of a facility, the Corps has developed and refined processes and capabilities for design and construction. We think of four fundamental elements to deliver successful projects. One, learning what is needed. In that case, early involvement by the Corps with the project's using agency to understand and assist the requirement's development, preferably in their planning and programming process. Two, planning the work. That is engaging stakeholders to align scope, budget, and schedule. Three, executing the procurement. A team effort that concerns all stakeholders from design through construction. And four, managing the execution. A governance approach that requires oversight from the job site to Corps leadership.

Throughout the process we manage scope, cost, and schedule objectives. We integrate actions and we evaluate issues and risks with our partners in the process to address and resolve them.

Budget and schedule risks are inherent in executing construction projects, and medical facilities are among the most complex facilities for which we manage design and construction. They require close, frequent coordination with a large number of stakeholders. They are subject to changing requirements during construction, often due to evolving medical technology. We maintain a medical center of expertise to assist the Office of Defense Health Affairs and to ensure unique medical functions are properly included in the larger project delivery process.

The Corps, as part of its interagency support, also has an established relationship with the Department of Veterans Affairs, providing support for a range of facility construction and maintenance requirements. The Economy Act and our 2007 Interagency Memorandum of Agreement provide authority and basis for the Corps and the VA's collaborative work. Our Corps headquarters works with the VA's Office of Construction and Facility Management. Our Corps regional offices have developed relationship with the 23 Veterans Integrated Service Network offices. In the past two years the Corps has managed work at 74 VA facilities.

We are currently assisting the VA to develop and implement an enterprise construction oversight capability, and we are collaborating with the VA to provide training opportunities.

We value our support to the VA and to the veterans of the Nation. We are pleased with the excellent working relationship that exists between our agencies.

Thank you, Mr. Chairman, for inviting the Corps to testify in this matter. I am pleased to answer your and the other Members' questions.

[THE PREPARED STATEMENT OF LLOYD CALDWELL APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Caldwell, for your testimony. Mr. Haggstrom, welcome and you are now recognized for your testimony for five minutes.

STATEMENT OF GLENN D. HAGGSTROM

Mr. HAGGSTROM. Chairman Miller, Ranking Member Michaud, distinguished Members of the Committee, I am pleased to appear here today to update the Committee on the Department of Veterans Affairs' continuing efforts to improve the management and timely execution of major construction and leased projects. Joining me this morning is Ms. Stella Fiotes, Executive Director of the Office of Construction and Facilities Management. I will provide a brief oral statement and request that my full statement be included in the record.

The CHAIRMAN. Without objection.

Mr. HAGGSTROM. The department's facility programs are an integral part of our ongoing mission to care for and memorialize our Nation's veterans. The department is committed to meeting our responsibility to design, build, and deliver quality facilities as tools to meet the demand for access to health care and benefits. VA con-

tinues to improve its real property portfolio, providing state of the art facilities that meet the needs of veterans, allowing for the highest standard of service. We have taken on the challenge of updating our aging infrastructure to meet increased workload demands, changing patient demographics, and services delivered closer to where veterans live.

In the past five years VA has delivered 75 major construction projects valued at over $3 billion that include the new medical center complex in Las Vegas, cemeteries, polytrauma facilities, spinal cord injury centers, a blind rehabilitation center, and community living centers. We continue work on 55 major construction projects valued at approximately $13 billion.

The department has also opened 180 leased medical facilities, 50 of which are considered major leases.

We have taken steps to improve the management and oversight of major construction projects which include implementing the recommendations from the Government Accountability Office, and the department's Construction Review Council. VA took aggressive action on the recommendations in the April, 2013 GAO report and all recommendations have since been closed.

Additionally, we have implemented actions addressing the four major challenge areas as identified by the Construction Review Council which is chaired by the Secretary of Veterans Affairs. These include recommendations to improve the development of requirements, design quality, funding, and program management and automation.

Unfortunately the department's major leasing program was not authorized by Congress for fiscal year 2013 as a result of the Congressional Budget Office's change in the budgetary treatment of the program. We are hopeful that for fiscal year 2014 authorization will be reinstated by Congress, permitting the department's current request for 27 projects that will serve the needs of approximately 340,000 to move forward.

In preparation of executing a future major leasing program should it be authorized, and to improve the current ongoing program, VA is in the process of addressing recommendations in the October, 2013 OIG report. These actions will be applied to future major leasing actions should authorization be restored.

VA has a strong history of delivering facilities to serve veterans. The way the Office of Construction and Facilities Management is doing business today has changed significantly since the Orlando, Denver, and New Orleans projects were undertaken. The recommendations made from previous reports have resulted in positive changes and are being applied to the entire program, including the next two proposed major medical center replacement projects located in Louisville, Kentucky and Omaha, Nebraska.

Our focus on ensuring well defined requirements and acquisition strategies that meet the project needs; assessing project risk; assuring timely project and contract administration; partnering with our construction and design contractors; early involvement of the medical equipment planning and procurement teams; applying the department's acquisition program management framework to our projects; and engaging in executive level onsite project reviews, along with monthly updates to the Committee on key projects, has

led to improvements and transparency in our program. All these actions will help to ensure the department's future capital program is delivered on time and within budget.

Thank you for the opportunity to testify before the Committee today. We look forward to answering any questions the Committee may have.

[THE PREPARED STATEMENT OF GLENN D. HAGGSTROM APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you much, Mr. Haggstrom, for your testimony on behalf of the department. We did just report favorably to the full House H.R. 3521, which does in fact authorize the 27 leases. Of course we have to have a full House vote, and then the Senate will have to act, but get ready. They are coming.

Mr. HAGGSTROM. Thank you very much, Mr. Chairman.

The CHAIRMAN. To the Corps of Engineers, what we are going to do, if we can, we are going to do two two-minute rounds so that we can try to get everybody in, including myself. So if you would start the clock?

Of the six Department of Defense leases, or medical facilities listed in your written statement as ongoing or as having been recently completed by the Corps, how many of the projects are currently or are completed on budget and on time?

Mr. CALDWELL. Mr. Chairman, your question is directed to the Corps and you are referring to leases? And——

The CHAIRMAN. No, no, I corrected. Facilities, take the lease, the word lease out. The Department of Defense medical facilities listed in your written statement, how many of those either are on time, on budget, or were completed on time or on budget?

Mr. CALDWELL. Sir, I can get you specific numbers. But virtually all of those are completed with some time growth and some cost growth. We generally——

The CHAIRMAN. That means they are not on time and they are not on budget?

Mr. CALDWELL. Sir it means that we anticipate and understand that there is risk associated and unknowns associated with construction. We anticipate a five percent cost growth on projects, including medical projects, and provide that in the programmed amount for the projects. And we endeavor to operate within that five percent. On the whole our experience is that we are operating within that five percent.

The CHAIRMAN. So you do plan on that five percent?

Mr. CALDWELL. Yes sir, we do.

The CHAIRMAN. Mr. Haggstrom, explain to us why four years after it was issued the department is still in the process of implementing recommendations by the GAO made in 2009 concerning VA's major construction programs?

Mr. HAGGSTROM. Mr. Chairman, to the best of my knowledge we have implemented the recommendations from the GAO report in 2009. And among them were the importance of doing a risk assessment for both the cost and schedule. And shortly after the report was issued in the future projects that we are undertaking that was one of the major changes that we work very closely now with our

architect and engineer firm of record on the project to accomplish that.

Subsequent to moving forward with the new projects we did go back and we started the process on older projects that we had started prior to the issuance of that report.

The CHAIRMAN. Thank you. Could I ask GAO if you concur with Mr. Haggstrom's statement in regards to VA fully responding?

Ms. HALLIDAY. Based on our reviews we would think that while they might be responding, the implementation has not been sufficient.

The CHAIRMAN. Thank you. Mr. Michaud? Ms. Brown?

Ms. BROWN. Thank you. Since I only have two minutes I am going to ask that my statement be placed in the record.

The CHAIRMAN. Always.

[THE PREPARED STATEMENT OF HON. CORRINE BROWN APPEARS IN THE APPENDIX]

Ms. BROWN. Thank you. Let me just say that this is, Ms. Halliday, you mentioned New Orleans that I am very familiar with, I have been there twice, and you mentioned Orlando. But I was not clear on your feedback as far as Orlando. Because I thought maybe you made a mistake and you were still talking about New Orleans when you should have been talking about Orlando. Would you take a look at that in your statement?

I have been, with the Chairman, to Orlando several times. This project is over 25 years old, and I have been here 21 years, and we are still working on it. I will be there. I asked my staff to drive by there and we do, and for the past, what, three months? We are still at 84 percent completion. I will be there Monday. I am going to not only drive by but I am going to stop. I want to know what is the problem? Why is it that we cannot complete the Orlando project? It is in my area. I was very instrumental in getting the authorization and the full funding.

Now I know everybody wants to go down and do the right thing. But I want to know why is it that we cannot go down and do the right thing, and help those veterans in Central Florida? Please?

Mr. HAGGSTROM. Ms. Brown, first of all I would like to make it very clear that we agree with you, that the project has taken too long to do. And there have been inherent problems which the VA has addressed in the past several years.

I do want to make it clear though to the Committee that in no case has any veteran who has been enrolled in the veterans health care system has gone untreated for any maladies or any issues that they have with regards to their health. The medical center director down there Tim Liezert has done an excellent job.

The CHAIRMAN. I think you might want, you are talking about Orlando area.

MR. HAGGSTROM. I am talking about Orlando, sir.

Ms. BROWN. Yes.

Mr. HAGGSTROM. Tim Liezert, who is the medical center director has done an excellent job in balancing the needs of what the veterans require. And we continue to do so.

With regards to the executive of this project there, it early on was inherent. We had some problems. And VA moved quickly to

address those problems. The issue here now is with contractor performance. And VA has taken every opportunity, as the Chairman has often asked me to do, to partner with our prime contractor in an effort to move this forward. But when you go down there and you look at the project, there are inherent problems with scheduling, the number of workers on the job to do this, the quality of the workmanship. And it goes on and on and on. And currently VA is taking every opportunity to exercise our rights to ensure that the contractor moves forward.

Ms. BROWN. Well can you tell me why it is that we have not had any advancement in the completion in the last three months? You know, I review the reports and it is stuck at 84 percent.

Anyway, Mr. Chairman, perhaps I can get the answers to my question in writing. But I will be there Monday.

The CHAIRMAN. Thank you very much, Ms. Brown. And if you would like to submit a question for the record I am sure Mr. Haggstrom would be glad to answer it. Dr. Roe?

Mr. ROE. Ms. Brown, I would recommend you go every Monday. I believe I would. We have been building major projects since the pyramids. And there is nothing magic about building this. I have been involved in building two hospitals from the ground up, and one a little bit, and several medical office buildings, schools, you name it as a public official. And you decide what you have, what your budget is, what you can pay for in the private sector, what you allocate or appropriate in the public sector. You get an architect, you design it, you bid it out, and as you stated there will be some cost adjustments, things you run across when you are building something you did not anticipate. Everybody understand that.

But we are reinventing the wheel here. And especially in hospitals, I get a little frustrated, and I certainly share Ms. Brown's frustration, is it, and I did this with schools. It is a great deal for architects when you redesign every school differently. And I realize every footpad is slightly different, the topography is a little different. But when you are building hospitals an operating room for the most part is an operating room, and a patient care room is basically a patient care room, and a laboratory is a laboratory. I have been in hundreds of them over my career. Why would you not cookie cutter, build something, basically why could you not do that? The VA is going to build a hospital, two more facilities. They are going to be redesigned from the ground up to look something different. You are going to pay a lot of money doing that. Why would there not be just a standard that you could change a little bit? And instead of going four floors, three floors, but essentially a layout like that instead of reinventing the wheel each time you do that?

Mr. HAGGSTROM. Mr. Roe, while the department does not have and use definitive designs, much like the Department of Defense does for many of their projects, we do have standardization across the department in terms of how we relate the various functions of a medical facility and so forth. I would ask Ms. Fiotes if she would to comment on that, as that is part of her responsibility in CFM, to work these standard module designs with our clients.

Mr. ROE. Well excuse me, not to interrupt but it is not working too well. Because we had the builders up here, what Mr. Chairman, a year ago, or something, and the contractors are begging for

mercy. I mean, things have been changed, and here, and they were asking us to help. I have never seen that in my life, where, the first time, only time in five years that I have been here that the contractor actually came up and asked for some help from Congress. I yield back my time, Mr. Chairman, I am over time.

The CHAIRMAN. Thank you. Ms. Fiotes, if you would take his question for the record we would appreciate that.

Ms. FIOTES. I will do that, Mr. Chairman.

The CHAIRMAN. Mr. Michaud?

Mr. MICHAUD. Thank you, Mr. Chairman. This is for the Inspector General. Repeatedly, the IG and the GAO has pointed out serious issues with mismanagement, overage, delays in construction within the VA system. What is your opinion regarding moving the authority for major construction from VA to the Corps of Engineers?

Ms. HALLIDAY. I would be concerned with the lack of control that VA would have. I think communications is most important in defining construction needs and marrying up what is actually being implemented as part of the project. At this point I understand that the processes are not well defined as to how that would operate, and who would have what responsibility. And I think that before you would make a move of that magnitude you have to look at that. A transfer of authority could entail creating some duplicity of capabilities within VA and render some of our workers nonproductive because the work transfers. We have had significant problems, although not with the Army Corps of Engineers, on the management of interagency agreements. The lack of control, the lack of transparency, the lack of ability to manage issues as they arise has been very problematic across VA. And this would be handled very similarly. So there are definitive risks that have to be managed. If communications breaks down between the Army Corps and VA then you know you are going to have problems with the construction site.

The CHAIRMAN. Dr. Benishek?

Mr. BENISHEK. Thank you, Mr. Chairman. Ms. Halliday, was there a, did you give us a number that there was like design changes in every single one of these projects that you described in your report?

Ms. HALLIDAY. The number I gave comes from a statistical sample of 30 projects that we looked at. So I did not quantify the number.

Mr. BENISHEK. I am kind of concerned about the idea of if you have a, you are planning for a five percent cost overrun from the very beginning it sounds like, Mr. Haggstrom. I mean I, I mean I have done some construction projects as well like Dr. Roe talked about and you know, we sort of like to hold our contractors' feet to the fire. You know? The contractors will say, well, you change the specifications, you know, halfway through the project it is going to cost you more. I have seen that. But I find it surprising that you are going to add five percent to the cost sort of automatically. I mean, how do you justify that?

Mr. HAGGSTROM. Mr. Benishek, I think you will find that is standard practice in the construction industry. And when you say exceed cost, when you look at the past five years when VA has de-

livered 75 major construction projects for the use of our veterans at over $3 billion, 95 percent of those were delivered within cost. Because when you look at the cost and how we do the programming for a major construction project we take into account as part of the appropriation and authorization request that there will be change orders associated with construction. That has been validated both by the Office of the Inspector General and the GAO.

Mr. BENISHEK. Well that sort of gets back to my question from the IG's. I mean, once you have a design you are supposed to stick to it. I mean, you have to have the design done first and not have excessive amounts of change orders. I mean, that is what I was sort of getting to——

Mr. HAGGSTROM. You are absolutely correct.

Mr. BENISHEK. —excessive change orders make things more expensive.

Mr. HAGGSTROM. And that is one of the things that the department has done in this past year as part of the forensics in looking at our program. Is that we found that when we had gone to Congress previously we did not have a well defined set of requirements and we have made major changes in that, in how we approach that. And the very fact that before we would approach Congress for either an authorization or appropriation we would achieve a 35 percent level of design. And I believe this is very similar to the way the Department of Defense, and the Corps of Engineers, and the Naval Facilities Engineering Command works in submission of their military construction program. So we are taking a close look at that and the best practices——

Mr. BENISHEK. Could you just forward the changes that you have made in your——

Mr. HAGGSTROM. Certainly, sir. We have provided to the Committee the report out from the Secretary's Construction Review Council. And that is available to the Committee. If you do not have it we will again forward it to you.

Mr. BENISHEK. Thank you. I am out of time.

The CHAIRMAN. For the members' information, GAO report says as of November, 2012 the cost increases for projects ranged from 59 percent to 144 percent, with a total increase of nearly $1.5 billion, and the average increase of approximately $366 million. The delays in these projects range from 14 to 74 months, resulting in an average delay of 35 months per project. Ms. Brownley?

Ms. BROWNLEY. Thank you, Mr. Chair. I actually wanted to follow up with your original line of questioning. And to the IG, so in answering the chair's question you said that you had not seen a marked improvement since you gave your report on the overall management of design and construction with the VA. So what do you suggest now? What would be your suggestions?

Ms. HALLIDAY. The reason I made that comment is the new control with regards to really defining and putting final stamp of approval on the project scope, have not been in place long enough to assess implementation of those controls. It is premature at this point. I think it is a good control. I think it is appropriate to look at construction contracts that way but I just do not have any evidence that the control will work as intended at this stage.

Ms. BROWNLEY. Thank you. And Mr. Haggstrom, you talked about 95 percent success. What is the percentage when you calculate the cost of change orders into your overall cost? How do you calculate that? What is the amount for change orders in an overall cost scheme?

Mr. HAGGSTROM. Just as Mr. Caldwell said the way the Corps calculates those contingency funds is, VA calculates them in a similar way accounting for approximately five percent of the cost of the project.

Ms. BROWNLEY. Well just the numbers do not seem to add up to me. But I do not understand why, and I think that is what we need to determine. I will yield back.

The CHAIRMAN. If again, and I apologize, but Mr. Haggstrom are you saying that all of your projects, major construction in particular, that every one of them has met the original budget?

Mr. HAGGSTROM. Of the 75 projects, sir, only four did we come back to Congress to ask for an increase in an authorization or an appropriation. All other projects were delivered within the appropriated amount, that is correct.

The CHAIRMAN. And the major projects that are existing now? How many have you come back asking for additional funds?

Mr. HAGGSTROM. With regards to Orlando, Denver, or New Orleans?

The CHAIRMAN. Correct.

Mr. HAGGSTROM. None.

The CHAIRMAN. Will you be?

Mr. HAGGSTROM. Not as far as I know.

The CHAIRMAN. Okay.

Mr. HAGGSTROM. Right now the way we look at it we are on track.

The CHAIRMAN. Thank you. Mr. Coffman?

Mr. COFFMAN. Thank you, Mr. Chairman. Mr. Caldwell, has the VA contacted the Army Corps of Engineers for assistance on the projects in Orlando, Aurora, or New Orleans?

Mr. CALDWELL. Sir, I am not aware of all of those projects. I can tell you that in Orlando, yes, we have provided support to them in terms of providing estimate evaluations as well as schedule evaluations, and providing advice regarding some of the contract administration matters that they are dealing with.

Mr. COFFMAN. Can you speak to some of the, I think the subject came up by the IG about interagency work. And I wonder if you could give examples of some other agencies outside of, say, the Department of Defense that you do work for?

Mr. CALDWELL. I have a list of probably 12 other Federal agencies that we provide support to. The total value of the support that we provided in fiscal year 2013 was about $1.3 billion spread across a number of Federal agencies. The Environmental Protection Agency, the Department of State, USAID, the Department of Transportation. So I could go on and name a number of those that we have done that. And that support, I should point out, ranges from consultation, where we have some technical expertise that we can advise them, all the way to actually managing the execution of projects.

Mr. COFFMAN. Okay. Could the Army Corps of Engineers aid and assist those projects if the VA requested help? The projects that the VA has?

Mr. CALDWELL. We would be pleased to work with the VA for anything they think that we could assist with. I should point out, when you say those projects, if what you are referring to is projects that are underway and have some challenges currently associated with them, there is some question there about whether we could step in and make a difference in that project. What we could do is to assess the conditions and provide some consultation to VA in that regard.

Mr. COFFMAN. Okay. But going forward you could do, you could do projects for the VA as you do for other agencies, could you not?

Mr. CALDWELL. Yes sir, we could do that in a support role, much like a construction agent role, yes.

Mr. COFFMAN. Thank you, Mr. Chairman. Just one final point, and that is that I think if we go back to the GAO report of April 30 of this year I think it stated that the Army Corps of Engineers projects were consistently within schedule, within budget, and that the VA projects were consistently not within schedule and not within the budget. I yield back.

The CHAIRMAN. Ms. Titus?

Ms. TITUS. Thank you, Mr. Chairman. I have some questions about how the VA deals with predictions of growth in populations that they serve. I represent an area in Southern Nevada that had unprecedented growth for over a decade and as we move away from the recession we see that growth coming back in Southern Nevada and across the Southwest with a large number of veterans moving to those areas. I wonder what the VA does to predict the movement of veterans when you are considering construction projects to be sure they are in line with future needs, not just at one snapshot in time? I would ask that to Mr. Haggstrom. And then Ms. Halliday, I would ask you if in terms of future construction has your office done any work to kind of look at whether the VA is effectively predicting and reacting to those potential demographic changes?

Mr. HAGGSTROM. With regards to how the department goes about developing the requirements, while I am not deeply involved in that there are many databases that both VHA and other offices within the department use that track veterans, track veterans' enrollments, and those kinds of things. Certainly I would be happy to take that question for the record and we can get you a more detailed answer.

Ms. TITUS. Thank you. Ms. Halliday?

Ms. HALLIDAY. My office has looked at the National Cemetery Administration, how they are approaching and planning for rural veterans to be served as well as urban veterans. I do not have a report at this time. I expect to issue a report shortly. And NCA has agreed essentially with the OIG to change its definitions so that there is a clear focus on rural veterans.

Ms. TITUS. Well that is fine for rural veterans. I am curious to see about if you have any plans or any ability to move resources or change construction goals? If someplace, say, is losing a population and someplace is gaining one? But if you all would look at

that and get back to me, I thank you, Mr. Chairman, and yield back.

The CHAIRMAN. Thank you, Ms. Titus. Ms. Kirkpatrick?

Mrs. KIRKPATRICK. First of all, I thank the Chairman and Ranking Member for continuing to have these hearings delving into the construction problems at the VA. And I applaud the VA for creating the Construction Review Council, that is a step in the right direction. But it has been exactly a year since they came up with their recommendations and Mr. Haggstrom I would like to know what your timeline is for implementing those recommendations? It is a little amazing to me that not only have they not been implemented by apparently there are not instructions to implement. So would you please address that?

Mr. HAGGSTROM. Congresswoman, all those recommendations have been implemented. We have briefed the Secretary on that earlier this year. We told him what we did. We laid out the program for him. He concurred with it. We moved forward. When——

Mrs. KIRKPATRICK. Well I am sorry to interrupt but apparently not——

Mr. HAGGSTROM. —the costing we did achieve that major milestone with the submission of the fiscal year 2013 program. We had design to 35 percent.

Mrs. KIRKPATRICK. Let me ask the Inspector General. In the report that we have in our record here it says those have not been implemented. Are you changing your report?

Ms. HALLIDAY. We have not provided oversight of that since it is such a new change. In preparation for this hearing I tried to get the decisions that came from the council to look at those clearly to see about the implementation and we were unable to do that.

Mrs. KIRKPATRICK. Can you tell us why?

Ms. HALLIDAY. There are briefing slides with regards to the Committee meeting to discuss the issues with construction. What we had a hard time doing was determining those decisions that were made based on those discussions so we could track the related implementation. We were certainly scheduling that for oversight.

Mrs. KIRKPATRICK. Okay. I yield back my time. But I am very concerned about the disconnect with that.

The CHAIRMAN. Mr. Ruiz+

Mr. RUIZ. Thank you, Mr. Chairman. Mr. Haggstrom, what are your internal data measures to measure your success in accomplishing your milestones?

Mr. HAGGSTROM. Mr. Ruiz, we are very focused on metrics in how we look at our program with regards to cost, schedule, and performance, and quality of what our contractors are putting in place?

Mr. RUIZ. Can you give me three of your top examples of data driven measurements of success that you follow? Your top three priorities?

Mr. HAGGSTROM. Cost, schedule, and performance. Those are our top three. Those——

Mr. RUIZ. So how do you measure, how do you measure performance?

Mr. HAGGSTROM. We measure performance against a schedule.

Mr. RUIZ. If it is done on schedule?

Mr. HAGGSTROM. If it is done in accordance with what we call the master schedule.

Mr. RUIZ. Okay.

Mr. HAGGSTROM. That is applied against all major construction programs.

Mr. RUIZ. So that is one. Can you give me two other very specific examples of how you measure success?

Mr. HAGGSTROM. The cost. Are we remaining within the authorization and the appropriated cost. As we go through the project we look at that through earned value management. And when we, again, we look at schedule. Is the contractor complying with the schedule that they provide us at the onset? And we look at performance in terms of quality, and the number of workers on the job, and is that job being accomplished as it should be to meet the standards of the VA? Mr. RUIZ. What are your top two poorest performing construction projects right now?

Mr. HAGGSTROM. Right now we are having a great deal of difficulty with the contractor in Orlando. And quite frankly with the other projects we are still within the acceptable limitations that we have set for ourselves. Orlando is the major project with regards to schedule.

Mr. RUIZ. Okay. And so what are those obstacles? What are those problems? And what are you doing to mitigate them?

Mr. HAGGSTROM. When you look at in the future what we have put in place from the Construction Review Council I go back to the whole essence of a successful construction program is predicated on a clear definition of what the requirements are. And taking those requirements and translating them into a design that we can move forward with and have the assurances that at that point in the design there should be little to few changes in the future as we go forward with it. At that point in time we have developed a schedule for the execution of the program and also a very, very accurate cost in terms of what the overall cost of the program would be.

Mr. RUIZ. If you fail in achieving your data driven measurements for success what are your plans to correct that?

Mr. HAGGSTROM. We work very closely with the contractor. We find ways to bring them back on schedule. How can we do that? How can we support them? We can look at value engineering in terms if costs start to exceed what they are. Are there things that we can do within the scope of the project that could potentially save money?

Mr. RUIZ. And how are you informing your veterans regarding whether or not you are achieving those successes, that are reliant on that facility to open? Are you being transparent with your——

Mr. HAGGSTROM. I believe we are. I know the medical centers have very robust programs at their respective locations where we have ongoing construction that continually meet with the veterans service organizations and the veterans in the area to keep them informed on the status of the project and where we are going.

Mr. RUIZ. Thank you.

The CHAIRMAN. Thank you, Mr. Ruiz. Ms. Negrete McLeod?

Mrs. NEGRETE MCLEOD. Thank you, Mr. Chair. To Mr. Haggstrom, thank you for attending today's hearing. The VA hospital at Loma Linda is the main hospital where veterans from, you

have four Members on this Committee that get serviced by that. Mr. Cook, Mr. Takano, Mr. Ruiz, and myself, that is where they all seek treatment. In the OIG report the health center lease for Loma Linda was not awarded until a few months ago. What were the issues at Loma Linda that led to the lease not being finalized until this year when it was authorized in 2009?

Mr. HAGGSTROM. Congresswoman, when you look at these leases and the execution of the leases I will say very up front that there was a very aggressive timeline when these leases were submitted to Congress. As part of the OIG report we were charged with developing a reasonable timeline to achieve these leases and in doing so we worked closely with our client. So when you look at a major lease in terms of these seven HCC leases, and the process that we go through to secure the land and then the developer, we are looking at a life cycle acquisition time of approximately 61 months.

When you take a look at the Loma Linda lease specifically there was a 46-month duration from the time it was authorized to the time that we signed the lease with the developer. However, when you look at that and you take into account things that were beyond the VA's control, there were 21 months within that whole process where we were going through negotiations with the city and the developer that took the excessive amount of time.

So if you start to normalize these leases, these seven leases, you will come back to the fact that taking out those things that VA had no control of we were very much within the timeline of what we would say is approximately 26 months from the time we were soliciting an offer for land to the time we signed a lease with the developer.

The CHAIRMAN. Mr. O'Rourke?

Mr. O'ROURKE. Thank you, Mr. Chair. And I want to thank you and the Ranking Member for keeping this Committee focused on performance and accountability at the VA. I really appreciate that.

And for Mr. Haggstrom, it was interesting to read the VFW's statement for today's hearing, where they note that we will need to invest over $23 billion over the next ten years to complete our SCIP projects. At current requested funding levels it will take more than 67 years to complete our ten-year plan. The proposed veterans hospital in El Paso is number 79 on the list so I have got some deep concerns, given everything that we heard today, given past reports by the GAO and the OIG. What can, to cut to the quick, what can we do to move ourselves up on that list? What is the essential core criteria used to determine where a proposed hospital ranks on that list?

Mr. HAGGSTROM. Mr. O'Rourke, the department uses the strategic capital investment planning process as part of helping to define what the most urgent and pressing needs of the department are. I would ask Ms. Fiotes if she would comment. She is part of the SCIP board that reviews these projects.

Mr. O'ROURKE. Great. And before you do, let me add something to the questions and remarks made by Ms. Titus. In El Paso you have more than 80,000 veterans who are underserved by the existing clinic. You have had Fort Bliss, which has gone from 8,000 active duty soldiers six years ago perhaps when these lists were first made, to 33,000 active duty soldiers. And you also have an under-

utilization of the current VA because it is inadequate. And sometimes that underutilization is used as an argument for our placement on the list. So with that in mind, what can we do to make a better case to you and other members of the SCIP board?

Ms. FIOTES. Congressman, the SCIP board reviews projects that are scored in a very data driven way based on a lot of the things that you mentioned.

Mr. O'ROURKE. Is utilization a part of that?

MS. FIOTES. Utilization is part of it. The movement of populations, the projected workloads, the existing infrastructure, all these things come into bear. And ultimately the projects are scored using the basic criteria of ensuring safety and security at our facilities, meeting department initiatives, fixing what we have, right sizing the inventory, providing value of our investment, and finally increasing access. Those are major criteria. They have several subcriteria. It is very data driven. It is very objective. And when those projects get presented to the SCIP board the medical centers and the Veterans Integrated Service Networks have the opportunity to argue their case, if you will, or plead their case. It is very objective, very data driven. I would say that the numbers fall out where they fall out.

Mr. O'ROURKE. Before I yield back, would you commit to meeting with me to discuss that issue of utilization and make sure that you all have all the data as you make these objective, data driven decisions?

MS. FIOTES. And I would ask in that case to also be accompanied by my colleague who actually runs the SCIP from a different office from our office. I participate on the board but——

Mr. O'ROURKE. Thank you. I look forward to doing that. Mr. Chair, I yield back.

The CHAIRMAN. Thank you very much. Also Members, Dr. Roe has said that he will stay and continue to chair this for those who may want to stay and have second round of questions. Mr. Walz, you are recognized.

Mr. WALZ. Thank you Chairman and Ranking Member. And I encourage you to continue to ride herd on this issue because it is a challenge and great points have been brought up. Ms. Halliday, I would just like to comment since I have come to Congress I have been an unabashed fan of the IG's office and the work you do never ceases to impress. I am grateful for that. It helps us do our job better and it helps your partners in VA do their job better. So thank you for that.

Again, I think Mr. O'Rourke brought up a good point, Mr. Haggstrom. This is a big undertaking. The independent budget he was speaking of estimates that we provided about 25 percent of the funding. But I have to be honest with you, I would be hard pressed to provide more right now under the circumstances where we are having some of these challenges. I am absolutely convinced the VA does things, many things, incredibly well, world class level. I have yet to be convinced that building hospitals is one of them. And that is a challenge for me because I know how important they are.

And just one specific question. And I like Dr. Ruiz getting at some of the specifics in this. Each VA officials who manages a

major construction project, what are their defined roles and responsibilities in the change order process? How does that work?

Mr. HAGGSTROM. Congressman, we have taken the change order process very seriously as a result of the GAO report and issues we have dealt with our contractor in Denver. I would ask Ms. Fiotes, she has been leading the initiative to look at how we do change orders, streamline that process, and be more effective in our ways that we do them.

Ms. FIOTES. Congressman, there are several parties involved in reviews of change orders. And change orders fall into three basic categories. They are usually errors or omissions in the design, they are unforeseen conditions, or they are owner requested changes. And it is part of the nature of construction, that change orders will arise in all three areas.

Involved parties, the resident engineers who review the change orders for technical merit; our architect, engineer, and construction management consultants who review for cost validity and help us come up with our cost estimate; and ultimately the contracting officer who then negotiates the proposed change order with the contractor who submitted it. Many times it goes back and forth several times. Those are the parties and the key roles and responsibilities, if you will.

We did assess that our change order process, while there was guidance in several places it was not really consistent and consolidated in one place. We have proceeded since then to issue a handbook for our project managers and project executives so that they all follow a consistent process. We have inserted timelines to ensure the timeliness of the review of the change orders. We found that some change orders, either because the contractor was not pushing or because they just were not as critical, just fell by the wayside and were stale.

Mr. WALZ. Okay. My time is going to be up. But I cannot help get a really, really strong feeling that we are being told everything seems pretty good and on track and going in pretty much the norm, and the numbers, as one of my colleagues said, I am having a hard time matching these up. So I may wait around for another round. Thank you.

The CHAIRMAN. Thank you, Mr. Walz. Members, we have been joined by Mr. Mica from the east coast of Florida, who many of his veterans are in fact served by the hospital that is being constructed in Orlando. And I would like to ask unanimous consent that he be allowed to participate in the questions. Without objection, so ordered. And Mr. Mica is recognized for a round of questions. And Dr. Roe, if you would take the chair?

Mr. MICA. Thank you, Mr. Chairman, and thank you this Committee for its continued vigilance and pursuit particularly on the construction side of VA hospitals and medical facilities. Looking at some of the delays and problems we have had, as you know we have had some serious problems in Orlando. And I think it was cited in the testimony that I heard that that is one of the roughest.

We had sent from Central Florida delegation a letter regarding payments. Part of the problem we have in Orlando is the VA has kept changing the design, some of the requirements, and vendors are not being paid. When the vendors are not being paid we have

had at least one go under and we have had others that are in serious financial situations because tens of millions of dollars has not been paid. Can anyone respond to what we are doing? Is that Mr., I cannot see without my classes, Mr. Haggstrom?

Mr. HAGGSTROM. Yes. Mr. Mica, that was the case initially back in 2012, early 2012. At that point in time the VA sat down with both the contractor and the AE firms and addressed many of the issues that the contractor had brought forth. We had asked the contractor to prioritize those issues, where in the design and the construction drawings did they have questions that they felt they needed additional information?

Mr. MICA. Well some were pretty simple. I mean, I was in the development business, built nothing as big as the VA but a simple, well it sounds simple, but if you have a toilet and it is floor mounted and you change the specs to wall mount it after you have put the plumbing in the floor and you have to change it to the wall, and support that, the plumber actually took me and showed me what had been drawn and then what was the new requirement and was having trouble getting paid for it. I mean, these are simple things where we need to get a quick resolution. You are telling me now that that has been the case?

Mr. HAGGSTROM. When we execute a change order with the contractor, the contractor may come to us with a proposal. The government will then pursue looking at an independent——

Mr. MICA. Well just look at that one. Let us——

Mr. HAGGSTROM. —we will always provide a level——

Mr. MICA. Look at that one and get back with me, if you can, and tell me if that contractor has been made whole? I do not have too much time, I know, this clock goes pretty fast here. You are going to open the nursing home, 120-bed facility next month?

Mr. HAGGSTROM. That is correct, sir.

Mr. MICA. What about the domiciliary, 60-bed unit?

Mr. HAGGSTROM. I believe the domiciliary is scheduled to open in either January or February.

Mr. MICA. Okay. And it looks like, what can you tell the Committee as to the time of opening the hospital itself?

Mr. HAGGSTROM. Currently the legal extended completion date on the hospital was this past August. We issued Brasfield and Gorrie a show cause notice——

Mr. MICA. No I——

Mr. HAGGSTROM. —which they then provided us a recovery schedule and they told us April of 2014.

Mr. MICA. And you think we can hold to that?

Mr. HAGGSTROM. Brasfield and Gorrie, every month when they have submitted us an updated schedule has continued to slip the hospital and currently they are now projecting they would not be complete until September of 2014.

Mr. MICA. September of 2014? Okay. And part of that I heard is issues with the electrical contractor. Can you get back to me or the Committee and for the record what the issues are? I want them in the record. Do you leave this open for a week or ten days? Whatever? And let us know what the issues are so I have some record of what you are telling me, and what they are telling us, is the issue right now. Can you do that?

Mr. HAGGSTROM. We would be pleased to do that.

Mr. MICA. Okay. Thank you. There are other questions. And if you would, I chair an Investigative Oversight Subcommittee, Government Operations Subcommittee. I would like a listing of all of your current VA properties that are vacant or underutilized. That is facilities vacant, buildings, we will get the specifics to you. And if you could provide it to the Committee, and also a copy to me? Because we are looking across the entire spectrum of the Federal government for underutilized buildings, facilities, properties, assets that we are sitting on. Thank you and I yield back.

Mr. ROE. [Presiding] Thank you, Mr. Mica. I now yield three minutes to Mr. O'Rourke.

Mr. O'ROURKE. Thank you, Mr. Chair. I want to join Mr. Walz in commending the work of the OIG. In addition to holding monthly town hall meetings I hold a quarterly town hall meeting just for veterans in El Paso. And we will get anywhere from 200 to 300 veterans who attend those meetings. And my entire presentation is driven from OIG findings in seven key areas. And one of them that we look at is access. And right now the score for the El Paso VHA is 39 percent. And that is below the VISN, it is below the national average. And it is part of what I was bringing to the attention of Mr. Haggstrom, is that we have an access problem. We are very far down on the list to have it addressed in any meaningful, comprehensive way. I fear that one of the criteria that is being used right now in terms of utilization is perhaps being misscored and not taking into account the broader picture. From your experience in the OIG's office, can you provide any direction to me in my office and how we pursue that? Or to the VA and how they can improve their scoring to take into account issues like those brought up by Ms. Titus and myself, and other underutilized and underserved areas?

Ms. HALLIDAY. At this point we would have to spend more oversight on that. It becomes a little bit subjective with how you score projects. Our focus had been on the rural health veterans and were they getting served appropriately and looking at how rural health veterans were defined made a big difference between that and the general population. And I see that the National Cemetery is agreeing to start applying a methodology that we have actually presented to them so that they can ensure they do not have gaps in service delivery. The next step, of course, is to look at the bigger picture of access to VA medical care. But I do not have specific answers for you right now.

Mr. O'ROURKE. I would love to have the opportunity to speak with you about that and see if that is something that the OIG has either data on already or would be interested in pursuing in the future. And as I said earlier, one of the things that we would ask that you perhaps consider or look at is when our community historically has approached the VA about the need for a full service hospital we are met with this underutilization argument, that not enough of your veterans are registered with or are using that. And we see that as a circular argument, in that the care has been insufficient and so veterans are opting not the take that. So I appreciate that and I will yield back to the chair.

Mr. ROE. I thank the gentleman for yielding. Mr. Coffman?

Mr. COFFMAN. Thank you, Mr. Chairman. Let me just say first that I think that the VA has, the Veterans Administration, has a comparative advantage when it comes to running cemeteries over the Department of the Army. And I think that the Department of the Army's Corps of Engineers, the Army Corps of Engineers, has a comparative advantage when it comes to doing construction projects. So maybe we can switch these functions around to which organization does a better job in a given area.

Mr. Haggstrom, according to the testimony of Mr. Caldwell of the Army Corps the VA has the authority to work with the Army Corps on construction projects. Has the VA formally worked with the Corps on the current major projects in Orlando, Aurora, and New Orleans?

Mr. HAGGSTROM. Mr. Coffman, I do know we have a partnership with the Corps. We have, as Mr. Caldwell said, worked extensively with them on the Orlando project with regard to accessing some of their expertise when it came to looking at cost and scheduling.

I also believe that as we entered into the Denver and New Orleans project we tapped into the Corps' expertise with regards to the type of contract we were using, an integrated design and construct contract. Since it was relatively new acquisition vehicle to the department we did ask the Corps to come take a look at the contract and do an assessment and provide us some feedback on that.

Mr. COFFMAN. Given the fact that according to a GAO study on April 30 of this year the Aurora project is I believe 144 percent over budget and in fact is more so than any other project that you are working on, why have you not been more, shown more initiative in terms of reaching out to the Army Corps of Engineers to help assist on the Aurora project?

Mr. HAGGSTROM. With regards to the GAO report, VA disagreed and it is in our response to the GAO in the way they calculated those costs. They looked at the cost from the inception when it was in the infancy and planning stages to ultimately what it was appropriately and authorized for. And they have taken all that and they said that is a cost growth. When we look at it what we are working on, we requested $800 million in authorization and appropriation from the Congress, they provided that, and we are within that authorization and appropriation in executing this project.

Mr. COFFMAN. Where are you at right now, I understand that the general contractor or the prime contractor is appealing the cost. And your cost estimate I believe is $604 million for the Aurora project and the contractor is saying that it is going to cost over $1 billion to build the project. Where is that at? I understand there is a dispute resolution going on right now on that?

Mr. HAGGSTROM. There is, Mr. Coffman. Currently it is in the Civilian Contract Board of Appeals. There is a series of meetings that will take place over the course of I believe the next seven to eight months where the Contracting Board will look at both the submissions from the contractor and the department and make a decision.

Mr. COFFMAN. Thank you, Mr. Chairman. I yield back.

Mr. ROE. Thank the gentleman. Ms. Brownley, you are recognized.

Ms. BROWNLEY. Thank you, Mr. Chair. I wanted to ask Ms. Halliday, it seems in this hearing that the chair's data points with

regards to projects and cost overruns and timeliness does not add up to VA's testimony with regards to such a large percentage is on time and on cost. Can you help me and the Committee to understand the differences here and how we reconcile this?

Ms. HALLIDAY. In most of our oversight we have problems actually getting assurance that we have full costing through the projects. I think I am on record as saying that there is a problem with not being able to track the full expenditures for the health care systems, for example, the seven HCCs that VA was trying to do. This is systemic. It goes across the department in the inability to really track all expenditures. So you definitely are going to have variables between what was originally estimated and what the actual costs were. Maureen Regan, who handles our contract oversight, looked specifically at the Orlando Medical Center and had found that almost 30 percent of the expenditures she looked at on change orders could not be validated or appeared inappropriate charges and claims from the contractor. I think that is something that happens in the normal course of business but with good processes and tracking of expenditures you can sort this out. Unfortunately VA does not have those systems to really track expenditures on a per project basis and ensure it gets all of its expenditures accounted for.

Ms. BROWNLEY. And does the Army Corps have a way to track costs?

Mr. CALDWELL. Ma'am, we do. And it is important to understand that especially with medical facilities you may have sources of funds which are from different appropriations that come together. So when Mr. Haggstrom talks about the cost of a facility as I think of that I am thinking of what amount has been authorized by Congress for that project. There may be other funds that are required for the initial outfitting of the contents of the facility as well. And so, when someone looks at a facility to try to sort out what the cost is, the question becomes which numbers are they looking at and for what purposes?

Ms. BROWNLEY. I understand. I just think it is certainly frustrating from my perspective that, at least what the IG is saying is, that there is really not a way within the VA to fully track the costs of a project. And that seems to be fundamentally problematic to me, that the scope and size of the projects that we are trying to undertake here, the importance of these facilities to our veterans, and our inability really to be able to track these costs. I mean, it just seems really honestly unbelievable to me in a way. And I think that it is something that we need to fully understand. And I understand large agencies have systemic problems. I understand that. But we must address the issue. And I think it must be fixed. I mean, this is fundamental to any major construction project is that we should be able to track the costs. And our job partially is in oversight. And if it cannot be done then I do not know how we will ever get our arms around some of these issues. Thank you, Mr. Chair.

Mr. ROE. Thank you for yielding. Ms. McLeod, you are recognized for three minutes.

Mrs. NEGRETE MCLEOD. Thank you, Mr. Chair. For Mr. Haggstrom, what office was responsible for the management of the

seven health care center leases that have failed to come to fruition? It is hard for me to believe that the prospectus were allowed to be published in the budget books. Someone should have known that the timeline was unrealistic. Would you please walk me through the process as it existed then and as it exists now? Thank you.

Mr. HAGGSTROM. Congresswoman, this is a joint effort between the Veterans Health Administration and Ms. Fiotes' office, the Office of Construction and Facilities Management. If I could ask Ms. Fiotes to comment on that. Well, let me take that. Better yet, when we look at this the VHA looks at the databases that the department has in terms of the needs of the veterans, where they are, what type of health care needs are there. They will then come forward now through the SCIP process that was effective in 2013 to put this requirement as part of the overall portfolio needs of the department in moving forward of what the health care requirements are.

These seven projects were undertaken prior to the SCIP process, including the large leased projects. So they come to us with a requirement in terms of size, location, those types of things. We then work with them to put a package together that we normally do what we call a two-step procurement. Step one being putting a solicitation for offer out to the area for landholders who may be interested in selling their land to a developer for future development. Once we look at that we come to an understanding of is it in the defined area that we are asking for? And also very importantly we do due diligence with respect to Federal requirements and environmental requirements at looking at that land to ensure that there is no contamination on it.

We then enter into negotiations with that landholder and we reach what we call an assignable title. That assignable title is never taken in VA's name. All it is is an agreement to the purchase price of that land and then once a developer is brought on board the developer will take title and pay the landowner.

Step two is to find a developer who will actually do the final design and construction and potentially hold the lease on that facility into the future.

Mrs. NEGRETE MCLEOD. I yield back.

Mr. ROE. Thank you for yielding. First of all I want to, I will ask just a couple of questions, yield myself a few minutes. In some levity the Coliseum in Rome was built in eight years. Admittedly they did not have the EPA and a few things they have now, but they did get that construction project done from the ground up in eight years. It looks like that is far going to surpass Orlando if it ever gets done. So I know that you are here. I appreciate what you are doing. I know that folks are trying to get the right thing done and get these projects done for veterans. Because the goal, as Mr. O'Rourke clearly pointed out, is to take care of veterans. I mean, that is the only reason for us to be here. And we need to do that in the most efficient way we can because there is not an endless, bottomless pit of money.

And I can assure you, and Ms. Brownley brought this up, these cost overruns, the last project that I dealt with myself personally was a $20-something million office building we built, our practice built. I can assure you there were not cost overruns because I

signed my name to a note at a bank. It was me they were going to come after if we had those cost overruns. And I can assure you we got in under budget and on time. And I can assure you that the people involved in paying that note back were paying attention. And Mr. O'Rourke pointed out, and I think he is absolutely correct, is that we need to pay more attention here on the VA Committee if we do not have systems in place that pay attention. And again, I am trying to get my arms around what the Chairman read out just a minute ago before he left, what the GAO found were costs substantially increased and schedules were delayed. It sounds like, when I listen to the testimony, that everything is going along fine. But then I read this, as of November, 2012 the cost increases for these projects, that is Denver, Colorado, Las Vegas, Nevada, New Orleans, Louisiana, and Orlando, Florida, the cost increases of these projects range from 59 to 144 percent, which is a lot, with a total cost increase of nearly $1.5 billion. So we just appropriated more money which then kept you within the budget. So I guess you can say that those projects were on budget. And an average increase of approximately $366 million, these delays were 14 months to 74 months, and an average of 35 months, and so on. He has read that before.

I guess what I am going to ask you all is are, and the IG, are the metrics in place now to prevent an Orlando or a New Orleans or a Denver again? Are the metrics there so it will not happen? I know this would not have happened and did not happen in any of the projects that I have been involved in, numerous projects, that I was keeping my eye on the project, too.

Ms. HALLIDAY. Dr. Roe, we believe that the metrics are in place but I think there are other factors that really cone into play. And one is the reliance that both the Army Corps of Engineers and VA will have to contract to get these facilities stood up. So I would like to give Maureen Regan an opportunity here to speak on her review of Orlando. Because many of the problems that came about in Orlando were a direct result of the performance of the primary contractor.

Mr. ROE. Okay.

Ms. REGAN. Thank you. I will first say we have not published anything on Orlando. We did get complaints from a lot of subcontractors who said they were not paid and I think some of the names actually came from the Committee for people for me to call. And I talked to all of them. And we do want to look at that issue, that a lot of them did not get paid. They did go under. I think I heard 15 companies went bankrupt because they were not paid. We had difficulty finding some of them.

But one of the issues I learned was a lot of them were not direct subcontractors to Brasfield and Gorrie. Some were subs to subs to subs. When I talked, in at least one case, with one particular type of service, I did talk to the actual sub. And he said he got paid everything, and he paid his subs. We do intend to go in and look at it. But we had determined that the first thing was to get the building built. And if we are in there, asking for records, interviewing people, and taking up people's time, that is going to delay the project even more. Because at this point we were not even sure in

talking to the subs whether or not the change orders had been submitted to VA for payment.

So a lot of issues come up in these projects that you do not exactly anticipate at the time. And one of them in this case was a lot of the subs walked off the job because they were not getting paid. Then you have to get new subs to come in. We did review two change orders in Orlando that Brasfield and Gorrie had submitted. And I can say we had a difficult time getting the review of those change orders done because we could not get the records we needed from Brasfield and Gorrie and one of their large subs to do the review. And that is the reviews we found about a 30 percent overcharge.

Mr. ROE. I think that is perfectly acceptable behavior. If I am a sub and the only thing I have got to sell are my skills and time that I walk off the job if nobody is paying me for it. I mean, I think that is perfectly reasonable for them to do that. Because they have lost that time they cannot get back, and their equipment and all that they have used, they have lost.

So I, hopefully this is an isolated situation. And what I would like to see going forward is a white paper, maybe from the IG, a one-pager so that we on the Committee here can have an idea going forward, and this, maybe the VA can help us out with this, going forward what those metrics are. And I know we hired a project manager for any project that the City did, that we hired as our person on the site to be there everyday looking at that project to be sure it was going along as advertised. And there are penalties in there, in most contracts, that if you get done early, you get a reward. If you are late, there are penalties. And that is a incentive to get the project done on time and on schedule. But you cannot completely come in, like he said, and pull a toilet out of the wall, and say that you have plumbed it into the floor, and now you want it in the wall for whatever reason. I cannot imagine why that was important. But anyway, it was, and here is this poor guy who is not getting paid.

So I want to ask if Mr. O'Rourke has any closing comments?

Mr. O'ROURKE. Mr. Chair, just briefly I want to thank the Office of the OIG, the Corps, and the VA for being here. And I think that it is the nature of these hearings that we are going to focus on where we have problems. And I know that there are so many things that you do well. And I would be remiss if I did not thank you on behalf of the veterans that I serve for the facilities that we do have that are working, and the projects that you have executed successfully.

But the urgency from me, and I think you are hearing it from many other members, is that we have the projects that we focused on today that are taking far too long, almost ten years in the case of Denver. And you think about those veterans whose care we are deferring, for example in El Paso, number 79 on the list. If we cannot execute these, what does it mean for their hopes or their, you know, do not know how long it is going to take us, their children's or their grandchildren's hopes that we are going to have adequate access in VA care in El Paso.

So I look forward to working with you constructively in a partnership to find out how we do a better job in exercising oversight

and managing the resources and are authorized and appropriated. And then also holding you accountable and working collaboratively, and in some cases creatively, to find other ways, maybe better ways, to do these projects in the future.

So I thank you for your participation, I thank the chair for yielding, and I will yield back.

Mr. ROE. I thank the gentleman for yielding. And I want to thank you all, both on the oversight and investigation part and on the VA part, for trying to get these facilities done, and the Corps of Engineers for getting these done in a timely fashion so we can take care of veterans. That is our purpose, our only reason for being here. Thank you all the Committee, I appreciate your time, and this hearing with no further comment is adjourned.

[Whereupon, at 11:02 a.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Jeff Miller, Chairman

Good morning, and welcome to today's Full Committee hearing, "Building VA's Future: Confronting Persistent Challenges in VA Major Construction and Lease Programs."

Today's hearing is the fifth oversight hearing this Committee has conducted in the last three years concerning serious issues with the Department of Veterans Affairs' (VA's) real property capital asset program - particularly the many failures and deficiencies that have plagued VA's major medical facility construction and leasing initiatives and led to significant cost increases and substantial delays in many important medical center projects.

Though the Department claims to be aware of the many problems plaguing its construction and capital asset programs and taking initial steps to correct many of the issues we have identified, cause for serious concern remains.

In a report released earlier this year on VA construction, the Government Accountability Office (GAO) found that, though VA has made some improvements, VA's major medical facility projects continue to experience cost increases and schedule delays similar to those that GAO had identified in 2009.

Similarly alarming, the VA Inspector General is going to testify this morning that they have seen a persistent "pattern of ineffective VA capital planning and asset management" over the past several years.

As I have said before, today's plans and projects are tomorrow's hospitals and clinics, and - whether it is by building the new, renovating the old, or leasing the existing – our allegiance must always be to the veterans who rely on VA to provide the benefits and services they need to lead healthy, productive lives.

We cannot continue to keep them waiting.

Thank you.

Prepared Statement of Hon. Michael H. Michaud

Thank you, Mr. Chairman, for holding this hearing today.

Providing veterans timely, quality health care in a safe environment is a focus of this Committee and one I stand firmly behind.

We have authorized and appropriated billions of dollars for the Department of Veterans Affairs construction programs over the past decade. It is important that we provide vigilant oversight on the resulting process of building and leasing of VA facilities.

Just this year, we have held three hearings on the VA's construction program and processes. In May, a Subcommittee on Oversight and Investigations hearing examined the VA's construction policy. In June, the Full Committee examined VA's capital investment options. And today, we are examining the persistent challenges VA faces in their Major Medical Facility and Lease Programs.

As you know, there have been multiple reviews conducted by the Office of Inspector General, the Government Accountability Office, and this Committee, on VA's ability to manage a construction portfolio efficiently and effectively.

Unfortunately, most of those reviews have repeatedly pointed out serious issues of mismanagement, lack of oversight, overages on expenditures, delays in construction, and multiple instances of insufficient guidance.

In efforts to manage their construction programs, VA deployed the Capital Asset Realignment for Enhanced Services, or CARES process, more than a decade ago. Most recently, the Strategic Capital Investment Plan, or SCIP, was introduced to formulate VA's construction budget for Fiscal Year 2012. SCIP is a 10 year plan that integrates all capital investment planning across the three administrations.

It seems, however, that even though VA has a plan, they struggle to execute it.

For example, in October of this year, the Inspector General released a report on VA's management of the seven Health Care Center Leases that were authorized in P.L. 111–82.

We were told by VA that these Health Centers would be up and running by 2012. To date, according to the VA IG report, only three of the seven leases have been awarded and none are operational. Additionally, I understand that cost overruns and delays have plagued the process.

Mr. Chairman, I am very concerned. First, I am concerned that the Committee is not getting accurate information from the onset, and so I have to question for what are we authorizing these funds?

Secondly, the veteran community is constantly being let down when a promised facility is not delivered on time.

I consider it a major disservice to the veterans who rely on VA to provide needed and very important health care services.

I hope we hear today from VA what they are going to do to address past problems and delays, how they are going to get things back on track, and what can be done to avoid similar problems in the future.

Thank you Mr. Chairman and I yield back my time.

Prepared Statement of Hon. Corrine Brown

Thank you, Mr. Chairman and Mr. Ranking Member, for calling this hearing today.

When the process started to authorize a new Medical Center for the region, Central Florida had been waiting for a hospital for over 25 years. I first started representing this area in Congress 21 years ago. I brought Jesse Brown, then Secretary for Veterans Affairs to the area and to show him how important this is. This facility will increase the treatment options for Central Florida veterans.

I did not think it would take so long to finish the facility. I have looked at the fact sheets the VA has sent out for the last three months and the facility has been stuck at 84% percent complete. July-84%; August-84%; September 84%.

I don't understand what could be taking so long that there has been no advancement in the completion of the facility for the last 3 months.

I have my staff drive by there every so often and it appears there is no work going on.

The veterans of the Central Florida cannot wait any longer for a full Medical Center to be built. Once again we are having a Full Committee hearing on construction. I am surprised, to say the least, that after we had the first hearing in March of last year, we are having yet another hearing on the same facility.

This is not about politics anymore. We must build this facility for the veterans of Central Florida.

Prepared Statement of Linda A. Halliday

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify on the results of the Office of Inspector General's (OIG) work related to the Department of Veterans Affairs (VA) construction and lease programs. Our focus will be on a recently released OIG report on health care centers, including issues related to a health care center in Butler, Pennsylvania, and a facility in Cleveland, Ohio, as well as OIG reports over the past 2 years related to the Veterans Health Administration's (VHA) management of its Minor Construction Program, VA's execution and utilization of capital assets in Marion County, Florida, and information regarding the new VA medical centers (VAMCs) under construction in New Orleans, Louisiana, and Orlando, Florida. I am accompanied today by Ms. Maureen Regan, Counselor to the Inspector General.

BACKGROUND

VA uses a Strategic Capital Investment Plan (SCIP) to prioritize its major construction, minor construction, non-recurring maintenance, and lease projects. SCIP's objective is to produce an annual consolidated list of capital projects that significantly reduce identified performance gaps in veterans' access, workload and utilization, safety, space, and facility conditions over a 10-year period. SCIP is used to ensure that VA's strategic performance planning efforts address the needs of VA's three Administrations, VHA, the Veterans Benefits Administration, and the National Cemetery Administration.

The OIG has completed reviews that disclosed a pattern of ineffective VA capital planning and asset management. Our reporting has shown that VA has not effectively managed the capital asset planning process to ensure that minor construction projects are not combined or otherwise significantly changed after approval, or that leased facilities are of the right size and in the right location to ensure they are fully utilized. In addition, VA has not effectively executed authorized construction and lease projects to ensure they are completed timely and within budget. Until these issues are addressed, VA will not have assurance that it is timely and cost-effectively acquiring health care facilities to serve the needs of its veteran population.

HEALTH CARE CENTER LEASE MANAGEMENT

In October 2013, we reported that VA's management of timeliness and costs in the Health Care Center (HCC) lease procurement process was ineffective.[1] As of August 2013, only four of seven leases had been awarded and no HCCs had been built, despite VA's target completion date of June 2012. Congress authorized approximately $150 million for the HCC facility activations.

We found the following deficiencies:

- Lack of Guidance – VA did not meet the aggressive milestones it set for HCC activation and occupancy due to a lack of specific guidance for this new initiative. The existing VA handbook did not cover lease projects with such high annual costs as those of the new HCCs.
- Inaccurate Milestones – VA used identical milestones for completing the seven HCCs even though the projects varied in size and budget. VA planned 32 total months for completing the seven HCCs, with annual lease costs ranging from $3.8 million to $16.2 million. Also, VA used a two-step process that separated land acquisition and contractor selection into different phases and should have lengthened each overall lease acquisition by 8 to 9 months.
- Lack of Documentation – Documentation was unavailable to support whether VA adequately assessed the feasibility of accomplishing the HCCs in the aggressive 32-month time frame promised. Given the lack of progress to date and the inadequate planning documentation, it will take far more time than Congress anticipated for VA to award and activate the seven leases.
- Lack of Central Tracking – VA could not provide accurate information on HCC spending into April 2013. According to VA officials, central cost tracking was not in place to ensure transparency and accurate reporting on all HCC expenditures. During our audit work, VA officials provided various estimates, ranging from about $4.6 million to $5.1 million, on the costs to prepare for HCC lease awards, but we could not gain reasonable assurance that this figure represents a complete accounting of HCC costs.[2] Until effective central cost tracking is instituted, expenditures to acquire the HCC leases will remain unclear.

We made recommendations to the Principal Executive Director, Office of Acquisition, Logistics, and Construction (OALC), and the Under Secretary for Health to:

- Establish adequate guidance for management of the procurement process of large-scale build-to-lease facilities.
- Provide realistic and justifiable timelines for HCC completion.
- Ensure HCC project analyses and key decisions are supported and documented.
- Establish central cost tracking to ensure transparency and accurate reporting on HCC expenditures.

They both concurred with our recommendations. We consider the corrective action plans submitted to be acceptable and we will follow up on their implementation.

Butler, Pennsylvania Health Care Center Lease

In response to an anonymous complaint received in late March 2013, the OIG's Office of Contract Review conducted a review of the proposal submitted by Westar Development Company, LLC, for the contract of the lease to develop an HCC in Butler, Pennsylvania. The complainant alleged that Westar was actually conducting business for entities created and controlled by Mr. Michael Forlani who was suspended from doing business with VA in December 2011. In 2012, he pled guilty to bribery and racketeering charges, and on April 1, 2013, was sentenced to 97 months in Federal prison.

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[1] *Review of Management of Health Care Center Leases,* October 22, 2013.

[2] These costs include architecture-engineer services, due diligence services such as environmental studies and title verification, and land options contracts.

On May 31, 2012, VA awarded a 20-year lease to Westar for the Butler, PA, HCC. The total value of the lease was $151 million. Mr. Robert J. Berryhill submitted the proposal as the Senior Vice President of Westar and listed Mr. Samuel E. Calabrese as the President of Westar. On April 3, 2013, a criminal information was filed in the U.S. District Court for the Northern District of Ohio against Mr. Berryhill charging him with five counts of mail fraud, two counts of wire fraud, one count of false impersonation of a Federal officer, and one count of aggravated identity theft. On April 23, 2013, he pleaded guilty and on July 30, 2013, Mr. Berryhill was sentenced to more than 6 years in prison.

Our review substantiated the initial allegation. The land proposed by Westar had been purchased by or through individuals and entities affiliated with Mr. Forlani. In addition, Mr. Calabrese was currently employed by one of the suspended entities and provided consulting services to another. We also determined that the proposal submitted by Westar was replete with false and misleading representations that were relied on by VA when evaluating the proposal and making the award. These false representations resulted in points being awarded to Westar during the technical evaluation. We found:

- Westar was not a veteran-owned business as claimed.
- Westar grossly misrepresented its past performance and experience and that of its team members.
- Westar did not have an agreement with the general contractor identified in the proposal.
- Westar identified team members with whom there was no formal arrangement.

On June 13, 2013, we issued a Management Advisory Memorandum to OALC. In response, VA issued a stop work order and on August 9, 2013, terminated the contract for cause. In addition, VA has proposed the debarment of Westar, Mr. Berryhill, Mr. Calabrese, VA Butler Partners, LLC, and VA Butler Partners Holdings, LLC.

At the request of OALC's Executive Director, we have continued our review to determine who, if anyone, should be held accountable within VA. We expect to issue the results of that review in December 2013.

Brecksville, Ohio, Enhanced Use Lease

In December 2011, the OIG's Office of Contract Review initiated a review of the Enhanced Use Lease (EUL) between VA's Office of Asset Management and Veterans Development, LLC (VetDev). The EUL was entered into as part of VA's consolidation of the Cleveland, Ohio, campuses located in Brecksville and the Wade Park area of Cleveland, Ohio. VA's EUL authority allows VA to lease underutilized property to private developers. Under the EUL with VetDev, VA leased the Brecksville campus to VetDev for a one-time cash payment of $2 million and in-kind consideration of not less than $4 million. The "in-kind" consideration was space provided at no cost to VA in an administrative building and a parking garage that VetDev constructed adjacent to the Wade Park campus and leased back to VA. The package also included payment to VetDev for care provided to veterans in a domiciliary that VetDev built adjacent to the Wade Park campus. Payments for the space and domiciliary care are paid under service agreements entered into as part of the EUL.

We determined that the decision to completely vacate and close the Brecksville campus and consolidate to the Wade Park campus was not in VA's best interest because:

- There was insufficient space at Wade Park to transfer all services provided at Brecksville which resulted in increased costs to VA to lease off-campus space.
- The estimated reported cost savings associated with the consolidation were not supported.
- VA is overpaying VetDev for space and services at Wade Park.
- There is an increase in security risk to VA employees and patients at the leased space at Wade Park.

We concluded that the service agreements associated with the EUL were used to circumvent the leasing procurement process. The use of a service agreement for the domiciliary was of particular concern because it did not include any "in-kind" consideration for the EUL and included patient care services provided by a subcontractor, Volunteers of America, which was reimbursed on a per patient per day basis, not as a lease for space. Contracting out domiciliary services is inconsistent with VA policy.

As previously noted, the criminal charges against Mr. Forlani included bribes made to obtain an interest in the property adjacent to the Wade Park campus on which the two buildings and garage were constructed as well as preferential tax

breaks. In addition, interactions between Mr. Forlani and the Director of the Cleveland Health Care System at the time, Mr. William Montague, resulted in criminal charges filed against Mr. Montague in June of this year.

VHA'S MINOR CONSTRUCTION PROGRAM

In response to a request from the Committee on Appropriations, U.S. House of Representatives, we reviewed the organizational structure, procedures, and financial controls VHA used to manage its minor construction projects.[3] We reported that VHA's Minor Construction Program lacked adequate internal controls for oversight of individual projects as a means of ensuring proper use of minor construction funds. We found that VHA did not ensure that medical facility funding was consistently used to supplement minor construction projects. In addition, VHA did not ensure adequate monitoring of minor construction project schedules and expenditures.

Proper Use of Minor Construction Funding

VHA integrated design and construction work for 7 of 30 minor construction projects into 3 combined projects that exceeded the $10 million minor construction spending limit. As a result, we reported that VHA violated the Anti-Deficiency Act in five of seven projects. We also found that 3 of 30 projects were inappropriately supplemented with medical facility funds and project monitoring was ineffective. A third combined project was in the process of being awarded; however, when the OIG notified VHA of a potential Anti-Deficiency Act violation, VHA suspended these projects during the award process.

This improper use of minor construction funding occurred because Office of Capital Asset Management and Support (OCAMS) and Veterans Integrated Service Network (VISN) officials did not effectively oversee project execution and OCAMS fully funded individual projects prior to medical facilities developing contract solicitations for design and construction. Once funding was provided to medical facilities, OCAMS and VISNs were dependent on the facilities to self-report changes in project scope during the contract solicitation process. This resulted in OCAMS and VISNs not being fully aware of project scope changes in the contract solicitation process for design and construction.

According to an OCAMS official, VHA was strongly encouraged to outsource design and construction contract management to the U.S. Army Corps of Engineers (USACE) at medical facilities where contracting resources were scarce. USACE managed 13 of the 30 projects we reviewed. Typically, after OCAMS officials approved minor construction projects, USACE managed project execution. USACE was responsible for integrating the design and construction of five of the seven minor construction projects we identified as being improperly combined into two major construction projects.

According to VHA officials, OCAMS maintained no control over project scope once funding was allotted and did not even review the construction contract solicitation prepared by the USACE's contracting officer. Further, at one VA medical facility, project engineers responsible for the facility's minor construction projects did not have copies of the USACE contracts signed on the medical facility's behalf. This condition heightened construction risks and limited oversight and control of construction costs and change orders.

Medical Facility Funding and Minor Construction Projects

Our report also disclosed that 3 of the 30 minor construction projects we reviewed were supplemented with medical facility funding. These three projects received $24.4 million in minor construction and $14.6 million from medical facility funds. When adding funding from both appropriations together, two of the three projects exceeded the $10 million spending limit for minor construction projects.

VA medical facilities did not follow non-recurring maintenance (NRM) policy limiting the use of medical facility funding to supplement minor construction projects and limiting renovation projects to $500,000. OCAMS provided guidance in September 2008 and again in September 2010 to VA medical facilities on the allowable uses of minor construction and NRM funds based on draft Handbooks that had not been officially issued. These draft Handbooks defined the limits of minor construction projects and expanded NRM to include projects that renovated and modernized existing facility square footage between $500,000 and $10 million.

Monitoring of Minor Construction Projects

OCAMS and VISN officials did not routinely monitor minor construction project schedules and financial performance. Rather, OCAMS assigned responsibility to VA

[3] *Review of VHA's Minor Construction Program,* December 17, 2012.

medical facility project engineers to monitor the projects and notify OCAMS if significant changes occurred or additional project funding was required. The draft minor construction program Handbook required OCAMS to create Minor Program Review Teams to perform quarterly reviews of project schedules and financial performance at selected sites. However, we found no evidence that the Minor Program Review Teams were formed and instead that internal program reviews were performed. As a result, VHA lacked the ability to effectively identify projects with cost overruns, significant schedule slippages, or significant construction scope changes in a timely manner and take corrective actions when necessary.

Recommendations

To address these issues, we recommended the Under Secretary for Health publish Minor Construction Program policy, develop procedures to ensure projects are executed within their approved scope, and determine whether other combined minor construction projects violated the Anti-Deficiency Act. VHA also needed to implement a mechanism to ensure medical facility funding is not used to supplement minor construction projects, ensure program reviews are performed, and strengthen project tracking reports. The Under Secretary for Health concurred with our findings and recommendations, and provided action plans to address our recommendations. In November 2012, VHA finalized and published policy for the Minor Construction Program. VHA has new procedures requiring that design documents be compared to approved project scopes prior to funding transactions being performed. As of today, one of the six recommendations remains open.

The Villages Outpatient Clinic, Marion County, Florida

In August 2012, we reviewed allegations received through the OIG Hotline that The Villages Outpatient Clinic (OPC) was underutilized during the first 18 months the facility was open.[4] The 53,000-square-foot, multi-specialty facility opened in October 2010 and was expected to provide up to 120,000 primary care, mental health, and specialty care visits per year. Congress approved funding of about $1.5 million per year for the next 20 years.

Our review disclosed that The Villages OPC was not used to provide primary care, mental health, and specialty care as planned. In particular, The Villages OPC did not use the surgical suite between the time the facility opened in October 2010 and August 2012. The surgical suite consisted of four fully equipped operating rooms and three gastrointestinal procedure rooms. The surgical suite and procedure rooms shared a common, eight-bed surgical recovery area, which was also fully equipped but hardly ever used. We determined The Villages OPC was likely to achieve only 41 percent of primary care, 34 percent of mental health care, and 24 percent of specialty care visits planned for FY 2012.

Underutilization of The Villages OPC occurred because of a lack of oversight over the planning and operations of the facility. Specifically, VISN 8 did not adequately monitor it on an ongoing basis as required by VHA policy to determine whether the facility was meeting the business purposes, goals, and objectives presented in the project proposal. North Florida/South Georgia Veterans Health System (the Health System) officials did not effectively determine the overall demand for medical care or the types of specialty services needed most in the geographical area where The Villages OPC was located. Health System officials also could not document that the demand justified the size of the OPC, or that the specific health care needs of local veterans justified each of the 13 specialty services planned in the proposal.

As a result, the Health System spent almost $2 million inefficiently on facility and equipment costs as well as on staff salaries and benefits. We conservatively estimated that between October 2010 and April 2012, the Health System incurred about $1 million in costs for equipment, approximately $668,000 in salaries and benefits for three surgeons, and about $263,000 for facility space that was not fully utilized. These funds represented a lost opportunity to provide veterans with additional access to medical care in an underserved geographic area.

We recommended that the VA Sunshine Healthcare Network Director conduct a thorough utilization review of The Villages Outpatient Clinic to ensure facility resources efficiently target the medical needs of the most underserved veterans. Further, the Network Director should determine whether to relocate the unused nuclear medicine machine to another VA medical facility. The VA Sunshine Healthcare Network Director agreed with our finding and recommendations. The Villages OPC began phasing in use of the operating room suite in June 2012. In addition, the North Florida/South Georgia Veterans Health System has finalized plans to move

[4] *Review of Alleged Mismanagement of The Villages Outpatient Clinic, Marion County,* Florida, August 7, 2012.

the Single Photon Emission Computed Tomography machine to Gainesville, Florida, to improve utilization. We closed the recommendations in our report in August 2013.

CONSTRUCTION OF THE NEW ORLEANS VA MEDICAL CENTER

According to VA officials, this project is the largest single construction project currently underway in the Department. In December 2011, the then Chairman of the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives, requested that the OIG provide information related to construction of the New Orleans VAMC to include reviewing the financing and budgeting of construction for the New Orleans VAMC and to examine plans to remove fuel tanks buried at the construction site.

Our review of VA's expenditures did not identify substantive issues with VA's stewardship of the project. At the time of our review (February 2012), VA had obligated $359 million (36 percent) and expended $105 million (11 percent) of the $995 million appropriated for the New Orleans VAMC. This was due to delays in the City of New Orleans delivering the site to VA and a need for additional VA remediation of hazardous substances that was identified after site transfer in April 2011.[5] VA has preliminary plans to mitigate delays by adjusting construction activities and if necessary compensating contractors negatively impacted by delays outside of their control in the construction phase of the project.

CONSTRUCTION OF THE ORLANDO VA MEDICAL CENTER

At the request of VA acquisition officials and pursuant to VA Acquisition Regulations, the OIG's Office of Contract Review completed reviews of two construction change orders related to the Orlando VAMC construction project. The change orders were from contractors and subcontractors seeking compensation from VA for $9.6 million. Our reviews questioned $2.9 million (30 percent).

For the first change order valued at $4.46 million, we questioned $1.8 million due to differences between proposed versus actual costs, lack of supporting documentation for proposed costs, and the inclusion of costs for specific individuals whose efforts were unrelated to the scope of the change order. The second change order was valued at $5.15 million and we questioned $1.1 million related to an overstatement of the proposed costs, the inclusion of costs unrelated to the change order, and lack of supporting documentation for the proposed costs. We reported these questioned costs to the VA contracting officer for use in negotiating payment with the contractors and subcontractors.

CONCLUSION

Without effective capital asset management, VA officials have not been able to ensure authorized leased projects are completed timely and within budget, minor construction projects are not combined or otherwise significantly changed after approval, leased facilities are the right size and the right location to ensure they are fully utilized once completed, or authorized lease projects are completed timely and within budget. Until these issues are addressed, VA will continue to lack assurance that it is timely and cost-effectively acquiring health care facilities to serve the needs of veterans.

Mr. Chairman, and Members of the Committee, this concludes my statement today. We will be pleased to answer any questions you may have.

Prepared Statement of Lloyd C. Caldwell

Mr. Chairman and Members of the Committee, I am Lloyd Caldwell, Director of Military Programs for the U.S. Army Corps of Engineers (Corps). I provide leadership for execution of the Corps' engineering and construction programs in support of the Department of Defense (DOD), other agencies of the Federal Government in the United States and around the globe. Lieutenant General Thomas Bostick, Chief of Engineers, leads the Corps. Thank you for the opportunity to testify here today.

The Corps fully recognizes the importance of the service of members of the armed forces, the support of their families, and the service of our veterans, in sustaining the strength of our Nation. We understand the vital link between the goals of their service and missions and the technical capabilities we provide, from consultation to delivery of infrastructure. Members of our team have had the opportunity these past several months to engage some of your staff members as they have conducted fact-

[5] Delays totaled approximately 26 months. VA officials attributed 17 months due to the delay in transferring the site and 9 months for the unanticipated need for additional remediation of hazardous substances identified after site transfer.

finding on the Corps' construction capabilities and experience with delivering medical facilities. Today we have been asked by the committee to address our approach to delivering construction; more specifically construction of medical facilities.

DOD's construction program utilizes designated construction agents, of which the Corps is one; who procure and execute design and construction of projects to deliver the Department's infrastructure requirements authorized by law. All construction is acquired by contracting with the private sector. The Corps is also known for the Civil Works mission it provides for the Nation, and the Corps' capabilities are perhaps uniquely developed to fulfill both military and civil engineering responsibilities. Interagency collaboration is an important element of the Corps' work, and the Corps provides interagency support as a part of its service to the Nation.

My testimony will address the Corps' project delivery process, with specific attention to medical facility construction and the interagency relationship with the Department of Veterans Affairs (VA). First, I will provide an overview of the principles and processes our teams use as they plan and execute the projects that we undertake. That will be followed by a discussion of the relationship the Corps has with the VA and how we support their mission through the work we do on their behalf across the Nation.

CONSTRUCTION PROCESS

The Corps has a long history of executing some of the Nation's most challenging construction projects and programs, whether through our military missions or Civil Works responsibilities. The past 12 years have been especially demanding as we have simultaneously provided support to operations in Iraq, Afghanistan and to DOD as it transforms and realigns. During this period, the Corps completed 2,165 military construction projects with a value of $50.3 billion. The Corps has delivered, or is in the process of designing and constructing, a full range of medical facilities for DOD, to include very large hospitals valued near a billion dollars, and capable of delivering world-class medical services. A summary of some of the recently completed and ongoing Corps work of significant medical facilities follows.

Location	Description	Delivery	Authorization
Fort Belvoir, VA	New Hospital completed	2011	$1.03 billion
Fort Sam Houston, TX	Hospital Addition completed	2011	$802 million
Fort Riley, KS	New Hospital under construction	2014*	$404 million*
Fort Benning, GA	New Hospital under construction	2014*	$350 million*
Fort Bliss, TX	New Hospital under construction	2016*	$966 million*
Rhine Ordnance Barracks, Germany	New Hospital under construction	2021*	$990 million*

* Planned or scheduled as of November 1, 2013

The Corps has long sought to lead, adapt, and apply important lessons of design and construction in conjunction with our industry partners to obtain economical and quality facilities meeting the requirements of DOD in a disciplined manner. For example, we applied concepts of Evidence Based Design with the DOD Office of Health Affairs to guide development of world-class medical facilities, and with the DOD Education Activity (DODEA) we developed design concepts for 21st Century school facilities.

Regardless of the nature of the facility, the Corps has developed and implemented processes and capabilities for design and construction, which have been refined over many years. Our project management business process brings together the range of diverse professionals and activities required of a successful project, which includes our design, construction, acquisition, and project management professionals. Success depends upon early involvement to understand the overall project objectives and to plan the approach to execute the project from design through construction. We think of four fundamental elements to deliver successful projects:

1. Learning what is needed;
2. Planning the work;
3. Executing the procurement; and
4. Managing the execution.

Each of these elements represents unique skills, involving multi-disciplined teams who account for project scope, delivery schedule, and ultimate cost as team members

work collaboratively with one another. These basics must be managed concurrently, in a continuous cycle that occurs throughout the life of a project.

The responsibility for programming and budgeting for construction projects rests with the service or agency requiring the facility. However, the ultimate success of a project depends upon early development of the scope and acquisition plans of action, including validation of the scope and cost estimates. Learning about a project requires early involvement by the Corps with the project–"Using Agency" to understand and assist with development of their requirements. We have found the sooner our professionals are involved, the greater our ability to deliver a successful project and minimize cost or time growth.

Planning work begins as requirements are being developed. It engages all stakeholders and involves more than facility design. We also define and align requirements that may compete for cost, scope, or schedule objectives. Plans for acquisition, work phasing, and project delivery are agreed upon early, and before construction. We will determine the project acquisition processes, which will influence the design process and development of the solicitation. For medical facilities, the medical equipment requirements may be extensive, so decisions are made among the team for the manner of acquisition of medical equipment.

Execution is a team effort from design through construction to include clinicians and medical service personnel of the Using Agency for medical facilities. During construction, we partner with the prime contractor and the government management team. Frequent, periodic meetings ensure open lines of communication to enable clear understanding of what all parties need throughout the project's life.

A governance approach that involves oversight from the job site to Corps leadership ensures early recognition, leadership awareness, and decision-maker involvement in resolving problems. A series of structured control processes, implemented throughout the organization, are designed to identify and evaluate issues with our partners as they arise and minimize the time it takes to address and resolve them.

Training is also a vital component in maintaining professional standards and keeping up to date on current practices. We maintain educational courses and require or encourage professional credentialing in the processes and disciplines required for our mission. We provide specialized technical training across a broad range of subjects, providing continuous learning, essential to maintain the highest levels of expertise in engineering and construction throughout the Corps. We also draw heavily from the Defense Acquisition University, its certification and continuing educations programs to maintain contracting competencies.

Budget and schedule risk is inherent in executing any construction projects, and medical facilities are among the most complex facilities we construct and deliver on behalf of DOD. They require close, frequent coordination with a large number of stakeholders, often with divergent interests and requirements. They require exacting technical design and construction standards, both of which must be carefully managed. Moreover, they are subject to changing requirements due to evolving medical technology – even during construction. We manage the challenges posed by those risks, and we seek to minimize the cost and time growth risk which complex medical facility construction may face.

To assure the standards and criteria of the Defense Health Agency, and to assist in their planning, we established specialized medical infrastructure capabilities and employ them across the enterprise to assist us in delivering medical projects. Our Medical Center of Expertise at Fort Belvoir, Virginia, applies current specialized knowledge to address demanding health care facility requirements. It provides a full range of medical facility design, construction, outfitting, commissioning, and medical maintenance capabilities that support the Defense Health Agency. The Center's staff includes subject matter experts in medical facility design and construction, serve as technical consultants, and draw on architect-engineer firms experienced in medical facility design. They participate in every phase of project delivery, from requirements development to project close out, and ensure we meet the full range of health care facility standards.

The Corps has broad experience across its enterprise in construction and delivery of medical facilities. Of our forty-three local district offices, seventeen of them (40 percent) have significant experience in medical facility design, construction, outfitting, repair, and maintenance. They have demonstrated the ability to deliver this demanding work on time and on budget.

THE CORPS' RELATIONSHIP WITH THE DEPARTMENT OF VETERANS AFFAIRS

The Corps, as part of its interagency capabilities, has an established relationship with the Department of Veterans Affairs (VA), providing support for a broad range of facility construction and maintenance requirements. Authority for the Corps'

work with VA is based on the Economy Act, which, coupled with an interagency agreement, provides us with sufficient authorities to work collaboratively. During 2007, the Corps of Engineers and the VA formalized its relationship through a Memorandum of Agreement (MOA) for the Corps to provide the VA support in the execution of their minor construction and non-recurring maintenance needs.

As veterans started returning home from service in recent conflicts, and increased funds to support facilities became available, VA leadership drew on this MOA, increasingly asking the Corps to assist with its construction needs. Prior to fiscal year 2007, Corps execution support to VA was at or below $2 million annually for work for the Veterans National Cemetery Administration. In 2007, the workload grew to $7 million and quickly began to rise as follows:

Fiscal Year	Execution Amount ($ millions)
2008	14
2009	108
2010	348
2011	377
2012	340
2013	239

As execution funds have grown over the years so has the collaborative relationship between the Corps and VA. Corps Headquarters has a good and stable relationship with the VA's Office of Construction and Facility Maintenance. Our regional and local offices have also developed relationships with each of the 23 Veterans Integrated Service Network (VISN) offices around the country; in the most recent two years, the Corps managed work at 74 different VA facilities nationwide. Whether and how a VISN incorporates the Corps services into its projects is at the discretion of each VISN.

One example of our efforts is the recently completed 30,000 square foot expansion of the Grand Junction, Colorado VA Medical Clinic. We added a third floor surgery facility to an active facility, including operating rooms, intensive care units, and sterile processing areas. The project demonstrated our ability to work closely and collaboratively. Much of the work was accomplished at night, to minimize impacts to the operations. The local VA public affairs office provided project related information to the staff – establishing expectations and minimizing impacts. When issues arose, VA and Corps leaders worked through them, never allowing an impasse to divert from their collective goal – completing a vital facility to serve our veterans.

Our relationship is growing; we are currently working together to assist VA develop and implement an enterprise construction governance capability; we expect to begin this effort within two months. We've also collaborated with the VA to provide training opportunities using a variety of instructional modes. We expect to assist with construction project quality management, schedule analysis and management, and project management automated information systems familiarization – all within the next four months.

The Corps plays a unique role in service to the Nation as a subordinate command of the Army with expertise in both civil works and military infrastructure; we possess unique capabilities and have a long history of successfully solving demanding engineering challenges. We also acknowledge the solemn duty to care for our veterans and will continue to support those efforts with our most capable teams as we continue to develop our support and assistance relationships with the VA.

Mr. Chairman, this concludes my statement. Thank you for allowing me to be here today to discuss the Corps' construction capabilities. I would be happy to answer any questions you or other Members may have.

Prepared Statement of Mr. Glenn D. Haggstrom

Chairman Miller, Ranking Member Michaud, distinguished Members of the Committee, we are pleased to appear here this morning to update the Committee on the Department of Veterans Affairs' (VA) continuing efforts to improve construction pro-

cedures and planning processes resulting in the timely execution of major construction and leasing projects. Joining me this morning is Ms. Stella Fiotes, Executive Director, Office of Construction and Facilities Management.

The Department's infrastructure programs, which include major and minor construction, non-recurring maintenance (NRM), and leasing, are part of our ongoing mission to care for and memorialize our Nation's Veterans. The Department is committed to meeting our responsibility to design, build, and deliver quality facilities as tools to meet the demand for access to health care and benefits.

VA continues to improve its real property capital asset portfolio, providing state-of- the-art facilities that meet the needs of Veterans, allowing for the highest standard of service. We have taken on the challenge of updating our aging infrastructure to allow for flexibility to meet increased workload demands; changing Veteran patient demographics; advances in medical technology; new complex treatment protocols and advanced procedures; patient-centered care and services delivered closer to where Veterans live; and evolving Federal requirements.

The focus of our testimony today is on VA's major construction and leasing program – specifically efforts to improve program execution and – to provide you a perspective of how we are delivering VA's important major construction projects.

Program Execution

VA has taken several steps to improve the management and oversight of its major construction and lease projects. In 2009, the VA Facility Management (VAFM) transformation initiative was established to improve planning processes; integrate construction and facility operations; and standardize the construction process. Our accomplishments include:

1. Integrated master planning - VA has adopted an enterprise approach to integrated master planning as our business process standard. Consistent master planning will standardize requirements development, which will minimize design changes.

2. Systems for project management - VA procured a collaborative project management software system in 2012 and is completing phase one fielding and will complete fielding in 2014. This software supports leases, major construction, and minor construction as well as NRM.

3. Post occupancy evaluations (POE) - The POE program, piloted in 2012, is now the business process standard for the major construction program, and will expand to the minor construction program in fiscal year (FY) 2014. POE evaluates the completed construction to assure closure of all gaps and deficiencies noted in the approved project scope.

Further, VA has implemented the findings of the December 2009 Government Accountability Office's (GAO) report on "VA Construction: VA is Working to Improve Estimates, but Should Analyze Cost and Schedule Risks" and now performs risk analysis for potential cost and schedule delays as part of the project design process. VA has also implemented and recommended closure of all of the recommendations in the May 2013 GAO report "VA Construction: VA Additional Actions Needed to Decrease Delays and Lower Cost of Major Medical-Facility Projects." These include: adding medical planners to the major construction programs to support integration of medical equipment into the construction process; consolidating change management guidance for construction contracts into an updated, handbook for staff; hiring additional staff attorneys to facilitate faster legal reviews of change order documents; and hiring additional resident engineers and contracting officers to reduce processing time for change orders.

In April 2012, as a follow on to the VA Facility Management (VAFM) initiative, the Secretary of Veterans Affairs established the Construction Review Council (CRC) to serve as the single point of oversight and performance accountability for the planning, budgeting, execution, and management of the Department's real property capital asset program. Chaired by the Secretary, the CRC identified challenges in four major areas, and through deliberate process improvements VA has addressed the following:

1. Development of Requirements - VA now includes planners in the requirements development phase of the project, resulting in full requirements development before design commences. Design must advance to 35 percent completion prior to requesting major construction funds. This assures that full requirements are identified early and are designed, estimated, and managed through the construction cycle to yield more accurate cost estimates and scopes for VA's budget submissions.

2. Design Quality - VA policy now requires constructability reviews as part of every design review. These reviews identify potential design errors and omissions prior to construction, allowing the design to be corrected, and thereby reducing changes during construction.

3. Activation - VA has implemented an integrated approach to quantify the full activation costs associated with each project in order to assure the project construction program is coordinated with the development of the information technology (IT) and medical equipment budgets and plans. This prioritizes the funding and planning necessary for the procurement of medical equipment and IT infrastructure, in an effort to synchronize major equipment delivery and installation with the construction schedule.

4. Program Management and Automation - VA has increased the education and certification requirements of project managers and has deployed collaborative tools for project management to ensure project cost, scope, and schedule growth are controlled. VA has also increased staffing for the oversight and execution of our construction project contracts in response to the size of the current construction program.

Additionally, we will incorporate the Department's acquisition program management framework into the project's acquisition life-cycle. This will ensure that acquisition decision milestones identified during the design and construction phases of the project are reviewed by the acquisition decision authority in determining if the project is in compliance with meeting the identified requirements, cost and scope before moving on to the next phase.

Through the CRC and continual review through the acquisition life-cycle, VA will continue to drive improvements in the management of VA's real property capital programs.

Another key component of our portfolio includes the major leasing program. VA is in the process of addressing recommendations in the October 2013 OIG report, "Review of Management of Health Care Center Leases." OALC and VHA are working together to implement corrective actions that will provide project managers additional guidance on acquiring build-to-lease facilities; establishing a reasonable timeline to award, construct and activate leases; ensuring key decisions and supporting analysis is documented; and improving the accuracy of expenditures associated with a project.

Major Project Update

VA bears the responsibility to manage all projects efficiently and to be good stewards of the resources entrusted to us by Congress and the American people.

The new Orlando medical center will include 134 inpatient beds, an outpatient clinic, a 120-bed community living center, a 60-bed domiciliary, parking garages, and support facilities all located on a new site. VA expects to serve nearly 113,000 Veteran enrollees through these facilities. The construction project is 85 percent complete. Currently, the prime contractor is projecting a completion date of September 2014, which is a slippage from the April 2014 date the contractor provided to VA in response to the Show Cause letter VA issued in January 2013. VA sent a Supplemental Agreement to the contractor to document the April 2014 date; however, the contractor declined to sign. While the contractor's performance does not meet our expectations, VA continues to work with the contractor as the best way to deliver this project to ensure a quality project is delivered to meet the needs of Veterans and their families.

The Denver replacement hospital will include 182 inpatient beds, an outpatient clinic, a 30-bed community living center, 30-bed spinal cord injury center, and 4-bed blind rehabilitation unit. VA expects to serve nearly 66,000 Veteran enrollees through these facilities. The construction project is approximately 30 percent complete. VA is now in litigation with the contractor regarding the integrated design and construction contract. Accordingly, I ask the Chairman's and the Committees' understanding that VA will not be able to respond to the matters at issue in the litigation as it may compromise the governments' legal position. However, the construction is ongoing, and VA continues to work with the contractor.

The New Orleans replacement hospital will include 200 inpatient beds, an outpatient clinic, and research, parking, and support facilities. VA expects to serve nearly 72,000 Veteran enrollees through these facilities. The construction project is approximately 34 percent complete. We are working closely with the contractor to arrive at a firm-fixed price for the construction.

VA will continue to apply lessons learned from our current medical center projects toward future construction. The next two proposed medical center replacement

projects are located in Louisville, Kentucky, and Omaha, Nebraska where both projects are in the early stages of design.

The Louisville project is planned to include a new 108 bed medical center, a Veterans Benefits Administration Regional Office, structured parking, and associated campus infrastructure improvements. Schematic design solutions are being developed, concurrent with National Environmental Protection Act (NEPA) documentation on the 34 acre Brownsboro Road site in Louisville.

The Omaha project is scoped to replace most of the existing campus, including a new surgical suite, intensive care unit, bed tower, diagnostic and administrative services, energy center and parking garages. This project is further in development, having completed all required NEPA documentation, and has entered into the Design Development phase.

Conclusion

In FY 2012 and FY 2013, VA delivered over $1.4 billion in facilities and continues work on 55 major construction projects valued at nearly $13 billion to provide the much needed facilities for our Veterans and their families. VA has a strong history of delivering facilities to accomplish its mission to serve Veterans. To help ensure previous challenges are not repeated and to lead to improvements in the management and execution of our capital program as we move forward we will focus on:

- ensuring well defined requirements and acquisition strategies that meet the project needs;
- assigning additional staff to assure timely project and contract administration;
- partnering sessions that include VA, the construction, and design contractors;
- early involvement of the medical equipment planning and procurement teams;
- applying the acquisition program management framework to our projects; and
- engaging in executive level on-site project reviews.

We continually seek innovative ways to further improve our ability to design and construct state-of-the-art facilities for Veterans and their families and we regularly engage in forums composed of both the private and public sectors that discuss best practices and challenges in today's construction industry.

As we have done this past year we will continue to meet with Congressional delegations to discuss their projects, brief the House and Senate Veterans' Affairs Staff to keep them apprised of the major construction program and provide regular updates to the Congressional Committees to ensure they are fully informed on the progress of these medical centers. Thank you for the opportunity to testify before the committee today. We look forward to answering any questions the Committee has regarding these issues.

Statements For The Record

VETERANS OF FOREIGN WARS OF THE UNITED STATES

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, thank you for the opportunity to submit our views regarding the Department of Veterans Affairs (VA) major construction and capital leasing projects.

The vastness of VA's capital infrastructure is rarely fully visualized or understood. VA currently manages and maintains more than 5,600 buildings and almost 34,000 acres of land. Although VA has decreased the number of critical infrastructure gaps, there remain more than 3,900 gaps that will cost between $54 and $66 billion to close, including $10 billion in activation costs.[1]

Major Construction

Decades of underfunding has led to a major construction backlog that has reached between $19 billion and $ 23.3 billion. There are currently 21 Veterans Health Administration (VHA) major construction projects that have been partially funded dating back to 2007. In the Administration's budget request for FY 2014, VA requested funding for only one project.[2] The total unobligated amount for all currently budg-

[1] Department of Veterans Affairs, FY 2013 Budget Submission Construction and 10 year Capital Plan, Vol. 4 of 4, February 2012, p. 8.1–1.

[2] Ibid. p. 8.2–12

eted major construction projects exceeds $2.9 billion.[3] Yet, the total budget proposal for FY 2014 major construction accounts was less than $342 million.

To finish existing projects and to close current and future gaps, VA will need to invest at least $23.2 billion over the next 10 years.[4] At current requested funding levels, it will take more than 67 years to complete VA's 10-year plan.

Of VA's 49 current major medical facility construction projects on which there is data, 23 are over their initial cost estimate, 21 are at cost and five are under cost. These 49 facilities have a total cost overrun of $2.9 billion. Some of the changes in cost can be attributed to a change in the size of the facility or the scope of care it will deliver, but many of these cost overruns are a result of poor communication with the general contractors. In addition to cost overruns, 24 of the 29 projects that have been initiated have gone past their initial estimated completion date, while only five have been delivered on time.

Many of these delays are a result of poor communication between VA and the general contractors. Not having defined roles and responsibilities for each VA official that manages portions of major construction projects, particularly within the change order process, causes contractors to get permission from one VA employee only later to be denied by a different employee. Failing to place medical equipment planners at each major construction site has also led to construction errors and change orders that would not have been necessary if the planner would have been on site. The lack of a project management plan makes it difficult to keep both the contractor and VA on the same page during the construction phase.

The VFW believes VA could improve its major construction projects by changing to an architect-led design-build process. VA currently employs two project delivery methods: Design-bid-build and design-build. Design-bid-build project delivery is appropriate for all project types. Design-build is generally more effective when the project is of a low complexity level. It is critical to evaluate the complexity of the project prior to selection of a method of project delivery.

Design-bid-build is the most common method of project design and construction. In this method, an architect is engaged to design the project. At the end of the design phase, that same architect prepares a complete set of construction documents. Based on these documents, contractors are invited to submit a bid for construction of the project. A contractor is selected based on this bid and the project is constructed. With the design-bid-build process, the architect is involved in all phases of the project to insure that the design intent and quality of the project is reflected in the delivered facility. In this project delivery model, the architect is an advocate for the owner.

The design-build project delivery method attempts to combine the design and construction schedules in order to streamline the traditional design-bid-build method of project delivery. The goal is to minimize the risk to VA and reduce the project delivery schedule. Design-build, as used by VA, is broken into two phases. During the first phase, an architect is contracted by VA to provide the initial design phases of the project, usually through the schematic design phase. After the schematic design is completed, VA contracts with a contractor to complete the remaining phases of the project. This places the contractor as the design builder.

One particular method of project delivery under the design-build model is called contractor-led design-build. Under the contractor-led design-build process, the contractor is given a great deal of control over how the project is designed and completed. In this method, as used by VA, a second architect and design professionals are hired by the contractor to complete the remaining design phases and the construction documents for the project. With the architect as a subordinate to the contractor, rather than an advocate for VA, the contractor may sacrifice the quality of material and systems in order to add to his own profits at the expense of VA. In addition, much of the research and user interface may be omitted, resulting in a facility that does not best suit the needs of the patients and staff.

Use of contractor-led design-build has several inherent problems. A shortcut design process reduces the time available to provide a complete design. This provides those responsible for project oversight inadequate time to review completed plans and specifications. In addition, the construction documents often do not provide adequate scope for the project, leaving out important details regarding the workmanship and/or other desired attributes of the project. This makes it difficult to hold the builder accountable for the desired level of quality. As a result, a project is often designed as it is being built, compromising VA's design standards. Contractor-led design-build forces VA to rely on the contractor to properly design a facility that meets its needs. In the event that the finished project is not satisfactory, VA may

[3] Ibid. p. 2–49
[4] Ibid. p. 1–4

have no means to insist on correction of work done improperly unless the contractor agrees with VA's assessment. This may force VA to go to some form of formal dispute resolution, such as litigation or arbitration.

An alternative method of design-build project delivery is architect-led design-build. This model places the architect as the project lead rather than the builder. This has many benefits to VA, such as ensuring the quality of the project, since the architect reports directly to VA. A second benefit to VA is the ability to provide tight control over the project budget throughout all stages of the project by a single entity. As a result, the architect is able to access pricing options during the design process and develop the design accordingly.

Another advantage of architect-led design-build is in the procurement process. Since the design and construction team is determined before the design of the project commences, the request-for-proposal process is streamlined. As a result, the project can be delivered faster than the traditional design-bid-build process. Finally, the architect-led design-build model reduces the number of project claims and disputes. It prevents the contractor from "low-balling," a process in which a contractor submits a very low bid in order to win a project and then attempts to make up the deficit by negotiating VA change orders along the way.

Health Care Center Leasing

VA has also fallen behind on awarding the seven health care center leases that were authorized by Congress in 2009. Currently, four of the seven leases have been awarded, but none of the facilities are operational. This has occurred because VA lacks the guidance on how to manage the purchase process of projects of this size. Before these leases were authorized, VA only had guidance for projects that were much smaller in scope. However, they used this guidance to plan the site selection and award the contract.

On October 22, 2013, the VA Office of the Inspector General (IG) found that site selection alone should have taken an average of 2.5 times the length of time as the guidance they were using recommended. Additionally, VA could not accurately account for how much has been spent to date on the health care center projects, and VA will not be able to fully account for costs until an effective central cost tracker is put in place.

The IG provided VA with four recommendations to improve the timeliness and cost management issues that resulted from the lack of guidance for lease projects of this size. The VA has concurred with the recommendations and is in the process of developing the appropriate guidance and transparency for future health care center leases.

The VA has taken steps to improve their major construction and health care center leasing projects, but small improvements over a long period of time will not be sufficient. If VA cannot drastically improve its major construction operations, it may be time for VA to ask for and receive assistance from outside its own agency to get its construction projects on track. VA and the Department of the Army (DA) currently have an Interagency Agreement (IAA) that allows VA to request assistance from DA on capital planning, design, engineering, and construction management services. It is unclear to what extent VA and DA have worked together under this IAA, but it seems it could be central in developing and maintaining VA's major construction programs in the future.

Mr. Chairman, this concludes my testimony and I look forward to any questions you or the Committee may have.

Disabled American Veterans

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to present testimony for the record on the views of DAV (Disabled American Veterans) concerning the Department of Veterans Affairs (VA) and its capital investment programs, including the necessity for Congress to authorize important leases for VA community-based outpatient clinics and other necessary facilities, and to address other capital asset and construction policy issues. This is a very important hearing on a vital subject that in many ways has languished for years. We appreciate your conducting it today.

Mr. Chairman, the Committee titled this hearing, "Building VA's Future – Confronting Persistent Challenges in VA Major Construction and Lease Programs." While this title may seem meaningful, newsworthy or topical to the Committee, DAV would differ on your characterization of its focus. We believe that, for years, VA's path on capital needs, including its proposed leases, has been crystal clear, and

only seems "challenging" now because VA persistently has been obstructed by the Office of Management and Budget (irrespective of which party controlled the Administration) and Congress—including the Budget and Appropriations Committees in both chambers—in actually securing the resources VA has consistently and clearly identified as necessary to keep VA's capital plants and facilities in proper, safe and modern condition for the care and treatment of veterans, including members of our organization, DAV.

Over the years, VA has used a variety of techniques and approaches to identify and justify necessary capital resources, to sharpen these estimates, and to address the doubts and skeptics of VA's true needs. Nevertheless, any perfunctory review of the end results of these annual efforts would show massive gaps between what was identified by VA professionals in the beginning of the process, what the Administration asked for, and what was ultimately provided by Congress.

In plain language, to remain a viable health care system for the veterans who need VA today and will unquestionably need it in the future, we believe VA now needs a reasonable and sustained flow of billions of dollars in major medical facility construction, minor construction and maintenance and repair funds.

The latest projection (based on VA's "Strategic Capital Investment Planning" (SCIP) process, demonstrates that VA could easily spend over $50 billion or more over the next decade in all infrastructure accounts to modernize, renovate and replace health care facilities. Some of VA's facilities are over 100 years old, and the facility average age is over 60 years. We estimate that VA's current "ten year plan" for modernization of capital facilities under the SCIP approach would require 67 years or even longer to achieve its goals if Congressional funding for these purposes continues at its recently observed pace. We are unsure why, even facetiously, VA would entitle the current plan a "ten year plan," given this outlandish prospect.

As a partner organization of the *Independent Budget*, DAV has regularly endorsed and recommended annual appropriations for major and minor medical capital facility improvements well in excess of what Administrations have requested, or that Congresses have provided in appropriations. Typically, over this decade, Congress has provided about one-fourth, more or less, of the amounts identified by our estimates. We believe that, absent sufficient funding, situations such as embraced by the title of this hearing are inevitable now, and will be repeated well into the future.

Mr. Chairman, it is no secret that that the IB veterans service organizations have always relied on VA's internal estimates in making our infrastructure funding recommendations to both the Administration and Congress, because we believe professional staff in these VA offices and facilities know their programs better than anyone, and are making estimates based on intimate knowledge of the system and its needs, professional principles associated with capital improvements, and known construction standards and costs. If these internal needs are overblown or inflated, are the "experts" in the Office of Management and Budget (OMB) or on Capitol Hill justifying their decisions to gut VA's estimates and to fund these programs at lesser levels? How is it that VA develops a solid, professional and defensible budget for infrastructure, only to have it reduced without any justification or explanation? DAV believes this is also an oversight question worth the Committee's efforts, to determine how these decisions are made, and by whom.

Leased Facilities

One of VA's cornerstones in capital planning is leasing. Leasing community-based facilities is a proven, cost-effective way for VA to extend access and provide services without the need to build expensive government-owned facilities. Such leased facilities are an important element in the future of VA health care, discussed further in this testimony, and we appreciate the hoped-for resolution of the paralysis that has suspended this key program for over a year. VA's current leasing plan calls for a little over $2 billion to be committed to leases over the next 10 years. VA leases properties to use for each administration within VA, ranging from community-based outpatient clinics (CBOC) and a variety of health care centers, to research, warehouse space and other valuable uses. The cost of these leases does not fall under VA construction accounts, but is accommodated from within each administration's or other VA offices' operating accounts. [1]

Well known to this Committee, in a 2012 policy shift, the Congressional Budget Office (CBO) changed its accounting practices on how major facility leases are to be funded, effectively halting Congressional authorization of future VA leases. Currently, there are 28 major capital leases, totaling nearly $247 million, for which VA had requested Congressional authorization. These leases have been in limbo. This

[1] FY 2012 Budget Submission, Construction and 10 Year Capital Plan, February 2011, Vol. 4 of 4, p. 8.2–85.

backlog of leases will only grow as existing leases expire. Lack of reauthorization could result in closures of current VA clinics, and newly proposed clinics cannot be activated without authorization. Inaction will lead to increased costs associated with longer travel times or the need to authorize fee-basis care that otherwise would be provided through such leased CBOCs. Access to care will also decline as veterans will be forced to travel farther and wait longer for the care they need.

We sincerely compliment the Committee and your professional staff in working to resolve the lingering dispute of the past year that delayed VA in opening new community-based clinics through the well-established and popular leasing program that has been used to extend VA care to hundreds of communities over the past 25 or more years. Over that period, Congress improved VA health care access and patient satisfaction by authorizing and funding nearly 900 VA community-based outpatient clinics, the vast majority having been in leased space rather than government-owned facilities. These clinics have provided local, convenient and cost-effective primary care for millions of veterans.

While we take no position on which specific community clinics and other VA facilities should be authorized in the new draft bill the Committee is considering today, we support the bill developed by the Chairman and urge its positive consideration by the Committee and the full House at the earliest possible date, so that the Senate can act on it this year. Millions of veterans already benefit from the cost-effective and commonsense approach of VA's leasing facilities, and we appreciate the hard work of your professional staff in negotiating a potential resolution of what appeared only days ago to be an insoluble problem, that pitted the CBO against the OMB in a seemingly endless dispute about how these clinics should be treated in the budget.

VA "Challenges," or Loss of Talent?

Another concern you articulated in your invitation letter is VA's "persistent challenge" in managing the construction of several new VA medical centers. It is true that until these new facilities were authorized, VA had not completed construction of a new VA medical center since 1994. In all probability, hundreds of talented architects, engineers and other key staff in VA Central Office and facilities who had worked within VA in years previous to 1994 to build those facilities (Minneapolis, Portland, Baltimore, Richmond, West Palm Beach) departed their VA employment, because Congress in its wisdom determined not to authorize further VA major medical facilities as replacements for VA's aging facilities. We do not blame those professionals or VA for these significant resignations and the subsequent loss of talent; but we have little doubt that the departures of these professionals affected VA's ability to design, manage and build VA's newest facilities. They certainly did.

Mr. Chairman, one of your predecessors as Chairman in effect accurately predicted the current situation about six years ago, and based his concern on his view that so many of VA's staff who had been involved in managing new construction in the 1980's and 1990's had departed that he doubted VA would be successful in building new facilities that Congress was considering to authorize at that time (Denver, Las Vegas, New Orleans and Orlando were specifically identified as among his concerns). It is no surprise to DAV today that VA has been experiencing difficulties in managing the projects now identified by this Committee as being of concern because of poor execution and cost overruns. However, we believe VA is making an honest and straightforward effort to learn from its past mistakes, and will in fact surmount the problems that have surfaced in recent times. The suggestion you made in your invitation letter that the Army Corps of Engineers or another federal agency could step in and improve this complex VA program is an unproven theory, and an unlikely scenario in our judgment.

Considering the example of the Corps, the recently completed construction of the Fort Belvoir Army Community Hospital, the Army's newest facility and one of the world's most expensive hospitals, was managed by the Army Corps of Engineers. That $1.3 billion construction project was roundly criticized by outside reviewers for both delays and excessive costs, similar to the types of criticisms levied at VA over cost overruns at the Orlando and Denver facilities. We do not envision an Army Corps of Engineers takeover of VA construction to be in the best interests of veterans, or of VA's capital programs. We know of no other federal agency with the expertise to build hospitals or other types of health care facilities suitable for veterans' care.

Mr. Chairman, it is important to remember that VA facilities are the primary places where our veterans receive their care, and these facilities are just as important entities as the physicians, nurses and myriad technicians who actually deliver their care. Every effort must be made to ensure these facilities remain safe and sufficient environments to deliver care to veterans. A VA budget that does not ade-

quately identify and fund facility maintenance and construction reduces the timeliness and quality of care for veterans.

As indicated above, VA's most recent iteration of facility planning mechanisms is SCIP. SCIP is described by VA as a tool to help VA make more informed decisions on its competing capital investment needs, in a severely constrained funding environment. One key element that appears to be missing from the SCIP criteria is a comprehensive assessment of the resources that exist outside of the VA through existing contracts and sharing agreements, and how those arrangements may affect VA's need for VA-managed facilities. Unlike VA-built and leased space, contracts can be amended, cancelled or situated differently to respond to demographic changes and needs of veterans. VA-owned facilities are more static and inflexible. This is especially relevant and important to VHA because VA, Congress and the IBVSOs have increasingly supported leveraging community resources to provide accessible care to veterans in rural, remote and underserved areas where VA simply cannot justify government construction. Without an unambiguous understanding of the health care resources that exist outside of VA, the Department is greatly challenged to make sound decisions on capital investments and right-sizing its inventory for the near-, mid- and long-term planning vistas. Another apparent flaw of SCIP is the lack of transparency on the costs of VA's future real property priorities that hinders VA's ability to make informed decisions. This was among the findings in a report that the Government Accountability Office (GAO) issued on January 31, 2011, entitled VA Real Property: Realignment Progressing, but Greater Transparency about Future Priorities is Needed.

The IBVSOs fully support the GAO's recommendation to enhance transparency by requiring VA to submit an annual report to Congress on the results of the SCIP process, subsequent capital planning efforts, and details on the costs of future projects. Mr. Chairman, your draft bill's inclusion of a new reporting requirement is consistent with the need for greater transparency in leased facilities, and we agree with the sentiment expressed in the bill. We believe a similar detailed annual reporting requirement should be imposed on all VA SCIP-prioritized projects.

The IBVSOs also support the inclusion of new criteria that considers resources that are available to VHA through existing contracts and sharing agreements. We urge a more rigorous analysis by VA that informs the priority list of projects in SCIP.

Quality, accessible health care continues to be the focus for DAV and the IBVSOs. To achieve and sustain that goal, large capital investments must be made, and should not be avoided or obscured with partial funding as is the present case. Presenting a well-articulated, transparent capital building plan is important, and a feat that VA has actually accomplished fairly consistently, but funding that plan at nearly half of the prior year's appropriated level and at a level that is only 25 percent of what is needed to close the access, utilization and safety gaps is not responsive, and in fact impedes VA's mission to care for veterans.

As indicated above, decades of underfunding by one Administration and Congress after another have created a major medical facility construction crisis that has reached a scope of $19-$23.3 billion in unmet needs. Currently, 21 VHA major construction projects have been partially funded by Congress dating back to 2007. In the Administration's budget request for the current year (FY 2014, still to be enacted by Congress almost two months into the year), VA requested funding for only one new project.[2] The total unobligated amount for all currently-budgeted major construction projects exceeds $2.9 billion.[3] Yet the total budget proposal for FY 2014 major construction accounts was less than $342 million, a small fraction of needed funds.

As summarized earlier, to complete existing approved projects and to close current and future gaps, VA needs to invest at least $23.2 billion[4] over the next 10 years. At current requested funding levels, it will take more than 67 years to complete VA's "10-year plan." In the short term, VA must begin requesting and Congress must begin providing funding for major construction at levels that at least begin to address this backlog, such as a level of $1 billion or more in major construction funding in FY 2015 as a modest down payment on the backlog. A funding level of this magnitude would enable VA to close the most severe safety gaps and complete funding on the longest-standing and previously approved major projects.

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[2] Ibid. p. 8.2–12
[3] Ibid. p. 2–49
[4] Ibid. p. 1–4

Minor Construction Accounts

To close all the minor construction gaps within a 10-year timeline, VA would need to invest between $6.8 billion and $8.3 billion.[5] For several years, VA minor construction was funded at a level to actually meet its 10-year goal, and we appreciated that commitment by Congress. However, over the past two years (2012–2013), Congress has acceded to the Administration's drastic funding reductions in minor construction requests. However, VA proposed $715 million in this account for FY 2014, an amount that comes close to the level needed annually to close all gaps within ten years.

The IBVSOs believe that minor construction accounts can be brought back on track by investing approximately $831 million per year over the next decade to close existing gaps and prevent an unmanageable situation.

Another unmet and significant challenge for VA in infrastructure is associated with VA's national Medical and Prosthetic Research Program. An independent analysis commissioned by VA at the behest of the House Appropriations Committee, published in 2012 after an unconscionable delay, clearly showed a need for VA to invest almost $800 million in upgrades, renovations and outright replacements of VA research laboratories and associated research facilities. While we realize these funds will not materialize immediately given VA's other needs as outlined in this testimony, we urge Congress to begin to address needs in VA's research program by appropriating new funding for both major and minor construction projects, and for additional maintenance, at minimum to address the most serious deficiencies identified in the research infrastructure report.

Nonrecurring Maintenance Accounts

Even though non-recurring maintenance (NRM) is funded through VA's Medical Facilities Appropriation account, and not through a construction appropriation, it, too, is critical to maintenance of VA's capital infrastructure. NRM embodies the many small projects that together provide for the long-term sustainability and utility of VA facilities. NRM projects are one-time repairs, such as modernizing mechanical or electrical systems, replacing windows and equipment, and preserving or replacing roofs and floors, among other routine maintenance needs. Nonrecurring maintenance is a necessary component of the care and stewardship of a facility. When managed responsibly, these relatively small, periodic investments ensure that the more substantial investments of major and minor construction provide real value to taxpayers and to veterans as well.

With ever-shrinking requests from the Administration and compliant appropriations from Congress in recent years, VA finds itself slipping farther behind in addressing a slew of recognized safety, utilization, and access deficits associated with infrastructure. To simply maintain VA infrastructure in its current (and often substandard) form, VA's NRM appropriations account could easily justify $1.35 billion per year, based on the estimated plant replacement value the IBVSOs have calculated. The account is currently being funded at $712 million, about half of what is needed. Even more funds will be needed to prevent the current documented NRM backlog of $19 billion to $23.3 billion from growing to more staggering levels. Also, to close the gaps in safety, access and utilization, VA will need to invest between $27 and $33 billion more in major and minor construction, and $2 billion or more in leasing.

Plant Replacement Value

The vastness of VA's capital infrastructure is rarely fully visualized or understood. VA currently manages and maintains more than 5,600 buildings and almost 34,000 acres of land with a plant replacement value (PRV) of approximately $45 billion. Although VA has worked to reduce the number of critical infrastructure deficits, there remain more than 3,900 gaps that will cost between $54 and $66 billion to close, including $10 billion in activation costs for new facilities that will be needed downstream.[6]

VA is falling behind in closing current NRM safety, utilization and access gaps. Just to maintain what VA manages, in the condition that it is in, VA's NRM account should be funded at $1.35 billion per year, based on the IBVSO estimated PRV. It is currently being funded at about one-half of need, at $712 million per year. More

[5] Ibid. p. 1–4

[6] Department of Veterans Affairs, FY 2013 Budget Submission Construction and 10 year Capital Plan, Vol. 4 of 4, February 2012, p. 8.1–1.

funds will need to be invested to prevent the $22.4 billion NRM backlog[7] from growing even larger.

The IBVSOs believe VA should develop a PRV schedule and publish its results. Adding the PRV to the SCIP will allow VA to more accurately determine the appropriate amount to request for NRM and objectively determine when a facility becomes more costly to maintain than to replace. Using PRV as a tool, VA can more accurately determine the annual funding levels needed for NRM by facility, allowing for the reduction in the NRM backlog and fully funding future needs in a way that would be the most cost effective. The industry goal for NRM is around two percent of the PRV. At that rate, facilities can operate for 50 years or more without outspending what it would cost to replace them. Knowing what percentage of the PRV is being spent will allow Congress and VA to take a longer view of capital planning, and to visualize when a facility will need to be replaced.

In Conclusion

Mr. Chairman, in summary, if Administrations and Congresses properly fund VA's infrastructure needs into the future, in cognizance of this testimony that the work of the IBVSOs represents, and if VA adopts some of the important recommendations in the *Independent Budget*, we believe much of VA's deficit in capital infrastructure can be addressed, and its methods can be improved. However, due to the decades of underfunding that has occurred in addressing VA's capital needs, we see no "quick fix" to solve VA's current capital crisis. Years of benign neglect must be replaced with years of dedicated and predictable investments in infrastructure, if Congress intends to ensure that VA remains a viable provider of health care services in the future.

Mr. Chairman and Members of the Committee, this completes DAV's testimony, and we appreciate the opportunity to present it for the Committee's consideration.

The American Legion

Chairman Miller, Ranking Member Michaud, and distinguished Members of the Committee;

Building a hospital is no easy task – neither is running one for that matter. The Department of Veteran Affairs (VA) owns and operates more than 1,700 hospitals around the country, with 32 hospitals being recognized as "Top performers" by The Joint Commission, a not-for-profit organization that ensures the quality of U.S. health care by its intensive evaluation of more than 20,000 health care organizations.

On behalf of our National Commander and the two and a half million members of The American Legion, thank you for inviting us to share our views on the VA's major facilities construction program.

When American Legion National Commander Dellinger testified before a joint session of Congress on September 10th 2013, Congressman Coffman referred to the Commander's construction background and asked Commander Dellinger if he would please offer his comments, based on his personal experience in the construction industry, about construction challenges that VA was facing in Colorado and other areas. Commander's Dellinger's responded "Maybe the VA should get out of the construction business, and do what they do best – take care of our veterans"

Since September, American Legion leaders and staff have been researching and reviewing possible policy changes regarding VA's major construction and leasing programs, and will be presenting our findings and recommendations to our voting members during our upcoming meeting in March 2014. It will be at this meeting that The American Legion will decide whether or not to develop and pass a resolution regarding the VA construction program.

As part of our research and investigation, The American Legion met with senior officials from The Army Corps of Engineers, The VA Office of Acquisition, Logistic & Construction (OALC), and the VA Office of Construction and Facilities Management to assess the viability of diversifying VA's construction management responsibilities.

During our evaluation, we found that;

The Army Corps of Engineers

[7] Department of Veterans Affairs, FY 2013 Budget Submission Construction and 10 year Capital Plan, Vol. 4 of 4, February 2012, p. 1–4.

➢ Is adequately suited to undertake the long-term mission of managing VA's construction portfolio
➢ Has a track record that is equal to or better than the federal industry standard regarding on-time, on-budget construction projects
➢ Would report directly to VA and not replace OALC
➢ Has worked on VA construction projects in the past
➢ Routinely builds hospitals for the Department of Defense

The Corps is not without its criticisms, however most of the criticisms suffered by the Army Corps of Engineers involve their Civil Construction arm and the amount of money Congress has dedicated to disaster relief, beach erosion and other civil engineering projects, not their construction projects. One note regarding this organization is that, there is more transparency and ready access to information regarding overhead expenses and actual costs than with private firms as the Government Accounting Office has an entire collection of assessments and evaluations of The Army Corps of Engineers ready for public review. Information about Army Corps can also be found at the Congressional Budget Office, The Congressional Research Service, as well as other federal research activities and offices.

It is also important to note that inserting the Army Corps of Engineers into the VA construction program would not reduce VA's authority or oversight in any way, as VA would always maintain the roll of "customer" in any future relationship. Another advantage is the advocacy role that Army Corps assumes on behalf of VA. In the event of cost overruns not covered by the reserve fund, Army Corps takes on the responsibility of representing VA before Congress to request additional appropriated funds needed to complete the project.

Based on our initial research, we don't believe that Army Corps would be adequate solutions to interject into the troubled projects currently in progress, but would have the flexibility and ability to be retained as a consultant to help evaluate paths to completion, if requested, and their value to VA on future construction projects will be the subject of our pending resolutions and recommendations. That said; it is also true that the Army Corps of Engineers is routinely relied on to offer oversight and advice when federal projects are not performing as planned, thus giving Army Corps the reputation of expert in the construction management industry.

While reviewing VA's construction program we found that the VA initiated a Construction Review Council (CRC) in April 2012 to serve as the single point of oversight and performance accountability for the planning, budgeting, execution, and delivery of the VA real property capital asset program. It was further explained that the CRC undertook a complete review of the Department's real property capital asset program life cycle to ensure the phases of the life cycle were properly identified and the inputs and outputs of the respective phases were achieved to ensure the successful completion of the capital program.

The council made four recommendations:

➢ Requirements - Complete 35 percent of design prior to submitting project for construction funding. Define processes for capturing origin requirements, approving requirements, and approving changes to the requirements once project development has started. Conduct master planning of all VISNs (include all VBA and NCA facilities) and integrate plans into the SCIP 10-year plan. Master plans will include major projects, leases, minor projects, and non-reoccurring maintenance (NRM) construction for all Administrations.
➢ Design Quality - Identify and implement steps to reduce design related issues that increase cost and/or delay construction. Improve peer review process by including assessment of constructability, using construction management firms to augment Architectural/Engineering (A/E) technical peer review.
➢ Funding - Coordinate SCIP process with budget to assure alignment with services and related initiatives. Consider a dedicated design fund to allow design to proceed seamlessly from start to finish. Recognize and include OI&T costs and activities as part of project cost and effort. Consider a separate fund for historic preservation activities.
➢ Program Management & Automation - Adhere to common leading indicator metrics for construction. Implement new construction management software tool. Streamline processes and procedures for change orders. Increase professional certifications for program/project managers. Link medical equipment procurement to specific construction to ensure synchronization.

Since no new projects have been initiated since the implementation of these recommendations, it is not possible to gage what impact, if any the recommendations will have on VA's construction program.

VA has developed a change order handbook since the original one was not consistently applied across project sites. In addition, change orders below $250,000 will not be submitted to VA Central Office for approval which should speed up change orders on the local level.

While The American Legion is not prepared to make any specific recommendations to Congress at this time, we are confident our Veteran's Affairs and Rehabilitation Commission, who has oversight of this issue, will present their findings and recommendations to The American Legion during our Winter Conference, and will then make copies of our work, and any future approved resolutions available to this committee.

In conclusion, should this Committee consider any changes to the current procurement process of VA construction, The American Legion would insist that language be included into any bill that requires any contracting agency participating in VA construction activities be required to adhere to VA's Vets First contracting policies in accordance with Public Law 109–461, and all applicable VA procurement policies regarding veteran small business procurement priorities.

Thank you again for inviting The American's Legion to share our views on this important matter.

For additional information regarding this testimony, please contact Mr. Louis Celli at The American Legion's Legislative Division, (202) 861–2700 or lcelli@legion.org.

Questions For The Record

LETTER AND QUESTIONS FROM: HVAC, TO: VA

January 10, 2014

The Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

In reference to our Full Committee hearing entitled, "Building VA's Future Confronting Persistent Challenges in VA Major Construction and Lease Programs" that took place on November 20, 2013. I would appreciate it if you could answer the enclosed hearing questions by the close of business on February 28, 2014.

Committee practice permits the hearing record to remain open to permit Members to submit additional questions to the witnesses. Attached are additional questions directed to you.

In preparing your answers to these questions, please provide your answers consecutively and single-spaced and include the full text of the question you are addressing in bold font. To facilitate the printing of the hearing record, please e-mail your response in a Word document, to *Carol Murray at Carol.Murray@mail.house.gov* by the close of business on February 28, 2014. If you have any questions please contact her at 202–225–9756.

Sincerely,

MICHAEL H. MICHAUD
Ranking Member

MHM:cm

Questions Submitted by Ranking Member Michaud:

1. The VA Office of Inspector General released a report on October 22, 2013 titled "Review of Management of Health Care Center Leases" (VAOIG Report). This report states that "VA could not provide complete financial information on the seven HCCs. VHA delegates funds tracking to project-level management at the Veterans Integrated Service Networks (VISNs) and RPS. VHA's former Chief Financial Officer said VHA headquarters would need to request HCC information from this level to compile a complete picture of costs. Although project-level management at the VISNs and RPS tracked HCC financial information, neither could provide complete data and support regarding total costs incurred to procure HCC leases."

a. Please provide the Committee with the specific steps taken or proposed to be taken by VA to improve its ability to identify and track costs associated with the leasing program.

2. The VAOIG Report states that the VAOIG "could not identify a common fund code across VISNs for each HCC so costs could be systematically extracted from VA's Financial Management System. Further, RPS personnel could not readily provide complete financial information for all HCC expenses. RPS is responsible for the day-to-day management of all lease procurement activities from project initiation to lease award, including tracking associated expenses."

a. What steps, if any, has VA taken to address this concern and provide more accurate and complete cost information regarding HCCs and other VA construction and lease projects.

3. In regards to the project-level management of VA construction and lease projects:

a. Please provide the Committee with a detailed explanation regarding the project-level management process used at VA, including the titles and detailed job descriptions of the project-level management.

b. Please provide the Committee with an explanation of any changes that have recently been made or are planned to be made to this process in order to provide improved function, control, and transparency to the process.

4. In regards to VA's overall construction and lease program:

a. Please provide the Committee with updated schematics of the Office of Construction and Facilities Management, the Real Property Service, and the Office of Acquisition and Logistics. Include the position titles and incumbent names for all senior-level positions.

b. Are there any statutory barriers presently in place that VA feels unduly hinders its ability to operate a construction and leasing program?

c. In VA's view, are the problems with VA's construction and lease operation that have been identified over the last several years caused by too much centralization of this operation, or too little?

d. Please provide the Committee with a detailed discussion of what VA believes to be the advantages, as well as any identified disadvantages, to the VA of operating an in-house construction program.

5. The VAOIG Report states that "[a]s part of its FY 2008 Asset Management Plan, VHA commissioned studies to assess the feasibility of leasing facilities in lieu of major construction. VA determined that leasing major outpatient clinics, or HCCs, would provide the flexibility to increase veterans' accessibility to services and address critical outpatient needs without the need for additional major construction funding."

a. Please provide the Committee with copies of the studies referenced.

6. The VAOIG Report recommended that "the Under Secretary for Health, in coordination with the Executive in Charge of the Office of Acquisition, Logistics, and Construction, provide realistic and justifiable timelines for award, construction, and activation of the Health Care Center leases."

VA's response stated that "[t]he Integrated Master Schedules for all major lease procurements, including the Health Care Centers (HCCs), are scheduled to be implemented in November 2013. **Estimated completion date: December 2013**" (emphasis in original).

a. Have these schedules been implemented? If so, when were they implemented?

b. Please provide a copy of the Integrated Master Schedules.

c. In VA's view, what specific factors led to not meeting the milestones contained in the FY 2010 budget submission for the completion of the HCCs?

d. What were the reasons underlying the decision to establish "identical milestone dates for all seven HCC projects outlined in the prospectuses submitted to Congress even though the projects varied in size?"

e. Will VA adjust the milestones contained in the Integrated Master Schedules to accommodate projects that are larger or more complex that the average schedules as shown in the Integrated Master Schedules?

f. Were there specific factors relating to HCCs that caused the process to not meet milestones as compared to the then-existing process and guidance regarding CBOCs, including larger CBOCs?

g. Please provide me with a detailed explanation of the planning process, including an estimated timeline, in regards to CBOCs within the current SCIP process.

7. In regards to the VA's Health Care Projection Model (HCPM):

a. Is information generated by the (HCPM) used within the SCIP Process?

b. If so, please provide the Committee a detailed explanation of the types of information provided by the HCPM and at what stage of the SCIP process this information is utilized.

c. In terms of the final decision regarding a project, how much weight is accorded information derived from the HCPM?

8. In previous testimony provided to the Committee, VA stated that Vet Centers are placed in locations based upon proximity and population.

a. Are Vet Centers included in the SCIP planning process?

b. Please describe how proximity and population are determined and utilized within the planning process.

c. Please provide a detailed description of the planning process as it relates to determining the need for, and location of, Vet Centers.

9. VA's written testimony states that it has "procured a collaborative project management software system in 2012 and is completing phase one fielding and will complete fielding in 2014."

a. Please provide a detailed description of this software, as well as a detailed timeline regarding actions taken with regards to this software since procurement in 2012.

b. Please describe to the Committee lessons learned by the VA during initial fielding, and how these lessons will be used to better manage projects once the software is deployed and fully operational.

c. Please provide a specific date in 2014 when VA believes that this software will be deployed and fully operational.

Rep. Kirkpatrick:

1. According to the April 2013, GAO Report VA CONSTRUCTION – Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Project, (600–13–302), VA has not yet developed specific guidance or instructions on how to implement recommendations set forth by the Construction Management Review Council. In his testimony, Mr. Haggstrom indicated that all recommendations have been implemented:

a. Please provide the committee with a side-by-side list of the recommendations and how/when they were addressed by VA?

b. If there is a recommendation yet to be implemented, please provide a timeline for when it will be completed.

Rep. Brown

1. In regards to The Orlando VA Medical Center: The last update received says the Medical Center will open in August of 2014. What is the specific date the facility will open?

2. Please explain the lack of any progress over the summer of 2013 on this project? Reference the 84% percent completion rate of the facility over the three months of July, August and September.

3. In previous meetings and briefings, one of the issues brought up was that there wasn't enough VA staff on site to oversee the project. Has this concern been addressed?

4. The previous project manager was removed for not following VA instructions. How is the new manager working out? Has there been any advancement on finishing this project?

5. Many concerns regarding this project have involved a large number of change orders that have been submitted. To date, how many change orders have been sub-

mitted for the project? Have those leveled off? Are there still changes being made to the design of the facility at this late date? What are the implications on costs, schedule and delivery of these late changes?

6. Can this facility be opened in stages? The outlying buildings are almost complete, except for the landscaping and the food service. What can we do to get veterans help tomorrow?

Rep. Negrete McLeod

1. How many months of delay in awarding the lease for the Loma Linda Health Care Center come from finding property owners willing to sell?

2. How many property owners owned the land currently being developed for the Loma Linda Health Care Center?

3. What role did VHA Women Veterans Health Committees and Women Veteran Program Managers contribute to the design of the 7 Health Care Centers to ensure that they complied with women veteran patient privacy standards as stated in VA regulations?

RESPONSES FROM: VA, TO: HVAC

Questions for the Record from Ranking Member Michaud

Question 1: I would like to hear from VA why they believe they are the best agency to handle the construction process for their facilities?

VA Response: The Department of Veterans Affairs (VA) has a strong history of delivering facilities to serve Veterans. In the past 5 years, VA has delivered 75 major construction projects valued at over $3 billion that includes the new medical center complex in Las Vegas; cemeteries; polytrauma rehabilitation centers; spinal cord injury centers; a blind rehabilitation center; and community living centers. The Department also opened 180 leased medical facilities, 50 of which are considered major leases.

VA has a robust training program that provides Federal Acquisition Certification in accordance with Federal standards for its Program/Project Managers, including those managing VA's major construction projects. VA has provided additional training and invested in a two-year project manager coaching program to further supplement the skills and develop project leaders to assure success in the major construction program. VA's construction site staff supervisors are required to have Federal Acquisition Certification in Contracting (FAC–C). The same or equivalent training and certifications are required by other Federal agencies such as General Services Administration, the U.S. Army Corps of Engineers and Naval Facilities Engineering Command's project managers and construction site leaders.

In 2009, with the establishment of the Office of Acquisition, Logistics and Construction, VA initiated a construction best practice review as part of its VA Facilities Management Transformation Initiative. VA studied best practices in the U.S. Army Corps of Engineers, General Service Administration, the Canadian Health Care System, Kaiser Permanente, Sutter Health, and others. These studies resulted in several initiatives such as the development and fielding of an integrated master planning program; reestablishment of the post occupancy evaluations; revisions to project execution planning process; and the establishment of regional offices to improve project execution and customer support. A significant best practice adopted from the Department of Defense is the development of designs through concept (or 35%) before announcing the construction budget, requesting funds and timeline for execution. VA continues to learn and share with its Federal partners and private industry.

The way we do business today has changed and will continue to be refined as necessary to deliver timely, high- quality facilities. The recommendations made from previous reports have resulted in positive changes that are being applied to the entire capital program. Additionally, Secretary Shinseki's establishment of a Construction Review Council (CRC) demonstrates the Department's commitment to continued stewardship and delivery of high-quality facilities in support of our Nation's Veterans.

As VA continues to develop one of the most patient-centered and innovative care delivery models currently in use anywhere, it needs to be able to coordinate and refine facility design in conjunction with clinical operations in a seamless manner. Outsourcing contracting, design, and construction administration would impose new barriers between clinical care delivery and construction project planning, design and construction. VA is the best organization to execute its construction program as VA's

construction project managers and construction managers understand VA's mission to deliver the best facilities to an ever evolving and advancing medical mission.

Question 2: What office was responsible for the management of the 7 Health Care Center Leases that have failed to come to fruition? It is hard for me to believe that the prospectuses were allowed to be published in the budget books. Someone should have known that the timeline was unrealistic. Please walk me through the process as it existed then and as it exists now.

VA Response: VA's Office of Acquisition, Logistics, and Construction (OALC) is responsible for the procurement of the Health Care Center leases, along with all of VA's major medical leases. While the process for procuring these large-scale leases is essentially the same (i.e., VA follows the relevant parts of the Federal Acquisition Regulation, General Services Acquisition Regulation, VA Acquisition Regulation, and all laws and Executive Orders pertaining to leases), VA is refining various tools and internal procedures regarding major lease procurements.

For example, VA has refined and clarified the internal roles and responsibilities among the various VA offices involved in VA's leasing program. OALC has also rebaselined VA's lease procurement estimates to reflect improved timeframes for performance. These timeframes have been validated against actual projects. OALC is also currently revising the leasing handbook that provides guidance, standards, and processes to ensure lease projects are reported and administered consistently across the Department.

In order to ensure consistency in the planning process, all leases, including Health Care Center leases, are now submitted and reviewed through VA's Strategic Capital Investment Planning (SCIP) process, to ensure each initiative fulfills medical center gaps for access, utilization, and/or space. The SCIP process requires an analysis of alternatives for each project proposed for budget consideration, and documentation of key decisions.

Question 3: Your testimony is replete with all of the changes and improvements VA has made to the lease and construction processes yet we still have failures like the 7 Health Care Center leases. Please explain to the Committee why you believe that these changes are tangible and have actually improved the process? Why shouldn't we look to another agency, such as Corps of Engineers, to build our hospitals for us?

VA Response: In the past 5 years, OALC has successfully completed 50 major facility leases. VA does not consider its execution of these seven Health Care Center (HCC) leases as failures. The Department set an extremely aggressive timeline to deliver these projects. Unforeseen challenges were encountered during the procurements (i.e., changes in the real estate markets, inquiries from interests external to VA, bid protests, and difficulty securing suitable property). To date, VA has awarded contracts for six of the seven leases, with the seventh lease in re-procurement.

VA's latest process improvements were introduced too late to impact these seven HCCs. However, these improvements will have an immediate impact on new projects through more effective roles and responsibilities, processes, and timelines for delivery. Efforts to improve upon these areas will continue, particularly through OALC's internal reviews and the CRC.

With regard to using the Army Corps of Engineers (COE), VA evaluates the delivery method for each lease and construction project on its merits. One of the delivery strategies includes the utilization of the COE when unique health care mission expertise is not required. When VA determines that unique health care mission expertise is not integral, and the best delivery strategy is to employ another agency, such as the COE, this strategy is executed. VA has utilized COE to deliver a number of minor construction projects and engaged them in supporting VA in the construction of the Orlando, New Orleans, and Denver major medical center projects. Additionally, VA is working closely with the COE to streamline VA's processes.

Question 4: If you could design a construction and lease process for the Department of Veterans Affairs, what would it look like? Do you believe that the big tertiary care facilities are going to be needed in the future given the advancements in technology and care delivery?

VA Response: It is necessary to have a process that is streamlined/nimble enough such that implementation of the construction plan is executed, before changes in technology and care have occurred, that make initial design features obsolete. In addition, the underlying designs must be as flexible and creative as possible to allow for evolutionary changes that minimize future costs. VA is continu-

ously reviewing and re-validating all aspects of its construction and leasing programs.

VA has initiated the following:

- Increased the number of planners and defined their role in developing requirements based on established gaps in service.
- Increased the technical ability to review designs, thru stronger peer review and constructability reviews.
- Established the SCIP process to help prioritize VA's capital investment needs and projects and ensure that the underlying capital programs meet facility needs.
- Requested authority to expand the Department's enhanced use lease authority, and supported the President's proposed Civilian Property Realignment Act (CPRA), to add to its toolkit for reducing unneeded assets.

There is a dynamic bi-directional approach to the deployment of resources involving tertiary care centers in the Veterans Health Administration's (VHA) future. Tertiary care centers will still be necessary. 'Cutting edge' technology actually drives use of tertiary type facilities, due to heavy support service for technology and the need for a critical mass of patients for uncommon medical conditions/treatments, such that practitioners have sufficient case numbers to be maximally proficient. As certain established technologies mature, movement to secondary level facilities from tertiary care facilities does occur. The use of tele-health technologies, however, can disseminate the cognitive component of care to primary and secondary care level facilities in a virtual manner, which diminishes the drive to place tertiary care to lower level facilities. These dynamics will continue to re-balance the placement of new technologies over time.

Question 5: In a recent OIG Report on Health Care Centers, it was recommended that the Under Secretary for Health, in coordination with Executive in Charge of the Office of Acquisition, Logistics, and Construction, ensure supporting analyses and key decision regarding the Health Care Center leases are supported and documented. VHA concurred and stated that "all leases, including Health Care Center leases, will be submitted and reviewed through the Department of Veterans Affairs (VA) Strategic Capital Investment Planning (SCIP) process to ensure each initiative fulfills medical center gaps for access, utilization, and/or space. However, the FY 2012 10 YR Capital Plan already included the seven HCCs in the SCIP process. What caused the SCIP process to fail the first time?

VA Response: The seven HCCs were included in the fiscal year (FY) 2010 budget submission, prior to the development of the SCIP process. The SCIP process was initiated with the FY 2012 budget formulation process, to prioritize all new capital investments (e.g., major construction, minor construction, leases, and non-recurring maintenance projects) based on identified mission needs. As a result of the SCIP process, VA has a total picture of need and a prioritized integrated list of capital investments.

All leases since the initiation of SCIP in FY 2012, including any proposed HCCs, are submitted and reviewed through VA's SCIP process.

Question 6: Are Vet Centers included in the SCIP planning process? In previous testimony the VA stated that a Vet Center is placed in a location based on proximity and population. Can you outline for the committee how proximity and population are calculated and the stages of the planning process for a Vet Center?

VA Response:

The SCIP planning process involves two phases – the validation that a proposed capital project will successfully and cost-effectively close an identified SCIP gap, and the prioritization of all validated projects so that the most necessary projects are pursued first within limited resources. All VA leases, including VetCenters, are included in the validation phase, which requires an approved SCIP business case for any action being proposed. When a VetCenter lease changes location, even within the same geographic area, there are many factors taken into consideration in the business plan, including Veteran proximity and population, cost, access to mass transit, parking, etc. However, the VetCenters are not included in the prioritization phase of the SCIP planning process. VA's Readjustment Counseling Service (RCS), which administers the Vet Centers, does not compete for any capital asset funding, as all RCS leases are funded through the RCS Specific Purpose funding process.

In addition to the business case requirements imposed by the SCIP process, any new proposed Vet Centers beyond the existing 300 would be submitted via an Executive Decision Memorandum to the Under Secretary for Health for concurrence and ultimately to the Secretary for his review and approval. All Veteran population data that are utilized in this decision-making process are obtained directly from the Veteran Population Projection Model (currently VetPop 2011), which is publically available at www.va.gov/vetdata/. The overall living Veteran population by county is the best available data source, since currently no data are available from any approved source that shows Veterans who served in a combat zone or area of hostility.

Question 7: How is a Veteran Service Area (VSA) defined? How is it calculated?

VA Response: We do not define nor calculate Veteran Service Areas (VSA), and we no longer use this terminology. VHA's health care operations are organized into 21 Veterans Integrated Service Networks (VISN) which are further broken down into 81 Markets. Each market consists of a set of contiguous counties that usually contain at least one, and possibly multiple, VA medical centers (VAMC), and their associated clinics, which are designed to operate as independent health care system. Our strategic planning process is based at the market level. Planners, based on the current and projected future health care needs of the Veteran population residing within the market, develop the appropriate level and location of resources to best meet Veteran needs.

Question 8: It is the committee's understanding that before the SCIP process, the criteria for developing a new CBOC were, among other things, space deficits at the parent facility, market penetration, population density, medically underserved, etc. What if any criteria have changed since the SCIP process was initiated?

VA Response: The criteria for developing a new Community-Based Outpatient Clinic (CBOC) are largely unchanged. Identifying appropriate locations to establish VA health care facilities requires extensive analysis of multiple factors, including but not limited to:

- Veteran enrollee population;
- Health care demand projections;
- Access guidelines (e.g., drive-time);
- Market penetration;
- Cost-effectiveness;
- Waiting times; and
- Critical space needs.

Much of the same data and information (access, utilization, space, cost-effectiveness) are used to justify and appropriately size projects (including CBOCs) in the SCIP process. All SCIP capital projects (major construction, minor construction, leases and non-recurring maintenance projects) are reviewed, scored, and approved through the VA governance process.

The six SCIP major decision criteria are:

1) Improve safety and security
2) Departmental initiatives
3) Fixing what we have
4) Increasing access
5) Right-sizing inventory
6) Ensure value of investment

This SCIP process results in a prioritized listing of capital projects that is used to inform the annual capital budget request. The SCIP decision criteria, priority weights, and the integrated, prioritized list are provided to the Secretary for approval each year.

Question 9: In VA testimony in 2009 to the House Subcommittee on Health of the Committee on Veterans' Affairs VA outlined the time from the planning stage to setting up a CBOC to the time patients are served. It is our understanding that this time frame was before the current SCIP process. Under the current SCIP process what is the current time frame from planning to clinic activation, can you outline to the committee the various planning phases?

VA Response: VHA's Access Expansion Planning (AEP) process is the first stage or phase for establishing CBOCs. Through the AEP process, VISNs detail plans - including establishing CBOCs - to meet the projected demand and to improve geo-

graphic access to primary care and mental health services for Veteran enrollees. The AEP process, from the call for AEP submissions to Under Secretary for Health's endorsement of new sites of care for SCIP process consideration, takes approximately four months.

In a typical year, the SCIP Action Plan Call is sent out within the Department in late November/early December, submissions are due late January/early February. The Business Case call goes out in March with the Final Business Cases due in May/June. The Department submits its budget request to OMB in September, and the President's Budget is typically released in February, approximately 14 months after the initial SCIP Action Plan Call.

Once authorization and funds have been received, the schedule includes 26 months to lease award, 26–30 months for build-out, and 3–6 months for activation. This timeline does not include unforeseen challenges, for example, changes in the real estate markets, political interest in site location, bid protests, litigation, and difficulty securing suitable property.

Question 10: In the recent OIG report on HCC's; a HCC is defined as "a large scale outpatient clinic positioned to provide all the medical services of a hospital, excluding inpatient beds." Using this definition, is it true that any of your larger CBOCs, are in fact, HCCs? What was different about these leases that caused them to be so mismanaged? Are they not like any of the other VA Major Medical Facility Leases? Please explain.

VA Response: VA does not consider its execution of these seven HCC leases as mismanagement. VA's position is that these leases were not inherently different from other large-scale, build-to-suit leased facilities. All leases of this size can face unforeseen challenges, for example, changes in the real estate markets, bid protests, litigation, inquiries from interests external to VA interest in site location, and difficulty securing suitable property. To date, VA has awarded contracts for six of the seven HCC leases, with the seventh lease in re-procurement.

The VA Office of Inspector General report referenced in question 10 above, was generated prior to the issuance of the VHA Site Classifications and Definitions Handbook (VHA Handbook 1006.02) on December 30, 2013. In accordance with this new Handbook, "A Community-Based Outpatient Clinic (CBOC) is a VA-operated, VA-funded, or VA-reimbursed site of care, which is located separate from a VA medical center. A CBOC can provide primary, specialty, subspecialty, mental health, or any combination of health care delivery services that can be appropriately provided in an outpatient setting." In accordance with this new Handbook, a HCC is defined as: "A VA-owned, VA-leased, contract, or shared clinic operated at least 5 days per week that provides primary care, mental health care, on-site specialty services, and performs ambulatory surgery and/or invasive procedures which may require moderate sedation or general anesthesia." The services provided by an HCC exceed those of a CBOC by performing "ambulatory surgery and/or invasive procedures which may require moderate sedation or general anesthesia." A small number of currently open outpatient facilities, initially classified as CBOCs, will soon be reclassified as HCCs based on the new classification standards.

Question 11: Can you outline how the Health Care Planning Model (HCPM) inputs into the SCIP process? And provide us a copy of this year's HCPM?

VA Response: The HCPM provides a standard 10-step planning tool used to proactively evaluate the comprehensive health care needs of Veterans within VISN markets and develop strategies to meet those needs. The HCPM uses a web-based portal for systematic data analysis. Appropriate data sources are built into the portal to maximize the time VISNs spend in analysis versus data gathering. Many of the data elements that are built-in to the HCPM to project Veteran health care (such as access, utilization, and space needs) are the same data elements that VISNs use to build their SCIP Action PlansBecause the HCPM is a web-based planning tool, it is not possible to provide a copy of it.

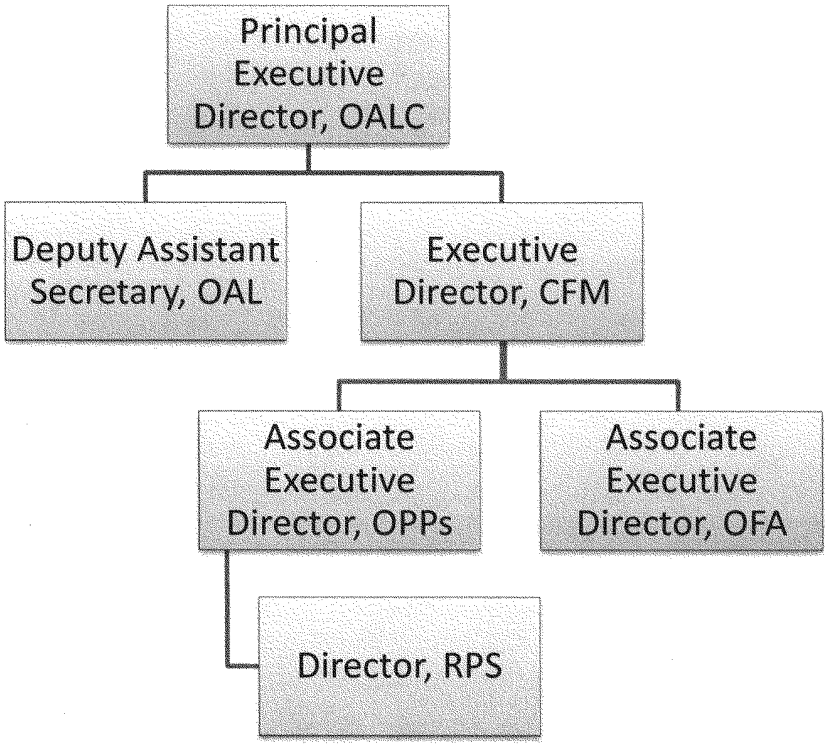
Question 12: Please provide the Committee with an updated schematic of the Office of Construction and Facilities Management; the Real Property Service or RPS; and the Office of Acquisition and Logistics. Please include in the schematic a full and detailed description of how these offices work together to ensure that the lease and construction process is moving forward. Please also include the Veterans Health Administration's construction offices that are part of the construction process and have responsibility for the construction and lease programs for VHA.

VA Response: The Office of Construction and Facilities Management (CFM), Real Property Service (RPS), and the Office of Acquisition and Logistics (OAL) all fall under the Office of Acquisition, Logistics and Construction (OALC). OAL, as identified in the question, has no role in the execution of the Department's construction and leasing programs.

As part of its overall responsibilities relating to VA's real property portfolio, RPS oversees the administration of VA's "medical facility" lease acquisitions, VA's "general purpose" lease acquisitions (specifically, those not exceeding a 2,500 square feet of space threshold, per a delegation from GSA), and provides support for VA space acquisitions conducted through the General Services Administration (GSA). RPS, as a part of the Office of Operations, works closely with the Office of Facilities Acquisition (OFA) to make VA lease awards. OFA develops guidelines and provides technical support to properly oversee lease and major construction contracting and architect/engineer selection. Both offices report to the Executive Director, CFM, who in turn, reports to the Principal Executive Director, OALC. CFM executes VA's major construction, leasing, real property management, and other capital asset services in support of VA's mission, and manages VA's major construction and leasing programs. CFM's Executive Director serves as the primary advisor to the Principal Executive Director, OALC, and the Secretary of Veterans Affairs regarding issues concerning VA's construction, leasing, and real property programs.

In addition to daily interaction between the offices within CFM, CFM and its stakeholders (e.g., VA Administrations and Staff Offices) work closely together as appropriate throughout the acquisition life cycle of the project. Certain stakeholders (e.g., VHA, VBA, and NCA) are required to identify their proposed projects and underlying requirements, which are then included in the SCIP process for evaluation, and potentially, in a subsequent VA budget. CFM's role is in the execution of Major Construction projects and leases. CFM also assists stakeholders during the planning process to refine the requirements of a project.

Below is a chart indicating the relations between the OALC offices mentioned above:



The Office of Capital Asset Management Engineering and Support (OCAMES) falls under VHA's Assistant Deputy Under Secretary for Health for Administrative Operations (ADUSHAO). OCAMES provides the policy, funding, budget documentation, and oversight for execution and policy compliance for the upfront planning of Major Construction projects and Leases and for all aspects of Minor Construction and Non-Recurring Maintenance projects. OCAMES collaborates with CFM and the medical centers on the execution of Major Construction projects and leases to ensure they remain within the approved scope of the project and lease as well as meet the needs of a dynamic, modern healthcare environment.

Question 13: Are you aware of the Building Information Model, or BIM, that the Corps uses to simulate designs?

VA Response: Yes, VA is aware of the Building Information Model (BIM). On April 3, 2008, CFM issued a design alert requiring the BIM be used on all VA Major projects starting with FY 2009. CFM also released a BIM Guide in April 2010, which is being used throughout VA. OALC is aware that its BIM guide has also been adopted by the Commonwealth of Massachusetts, and the countries of Singapore and Australia.

Question 14: You mention in testimony that you have procured a collaborative project management software system and should be done fielding it in 2014. The software supports leases, major construction, and minor construction as well as non recurring maintenance. During the test phase of this system, what were the lessons learned and how has it enhanced your ability to manage projects?

VA Response: The pilot of the collaborative project management software, TRIRIGA, validated that a commercial off-the-shelf product could be deployed and used effectively to manage VA construction projects. During the pilot phase, VA learned the best method for migrating projects from the current software. VA also identified the training requirements for VA, contractor, and designer staff to utilize the collaborative elements. The software improves accountability for project issues and requests for information and submittals, while enhancing information sharing between VA and its contractors resulting in better outcomes.

Question for the Record from Representative Kirkpatrick

Question 1: According to the April 2013 GAO report, VA has not yet developed specific guidance or instructions on how to implement recommendations set forth by the Construction Management Review Council. During Mr. Haggstrom's testimony today, he indicated that all recommendations have been implemented. Could you please provide a side-by-side list of the recommendations and how/when they were implemented by VA? If there is a tactic yet to be implemented, please provide a timeline for when it will be completed.

VA Response: As of August 2013, the Construction Review Council (CRC) recommendations were considered closed with ongoing activities. VA's construction program review is an iterative process that will continue as VA strives to deliver first-class facilities on time and within budget. The table below describes CRC findings and recommendations:

CRC Major Finding	Action (s) Taken
Requirements	The recommendation adopted included achievement of the requirement for 35 percent design completion for complex medical facilities prior to requesting construction dollars. This policy was initiated with the FY 2013 budget submission..
Design Quality	The peer review process has been augmented to include constructability reviews by professional construction management firms. The first project to conduct a constructability review was the Orlando SimLearn Center. This is now a standard practice for construction projects and is monitored by OALC to ensure it is completed prior to award..
Funding	SCIP process is aligned with the budget process. The development of integrated master schedules allows the projection of activation funding for medical and IT needs to be forecast. This forecasting allows coordination of funding at all levels..

CRC Major Finding	Action (s) Taken
Project Management	Contracting officers have been assigned on site for hospital replacement projects and other large major programs. Additional attorneys have been hired and assigned to support major construction. The increased staff reduces the delays and backlogs experienced. Local change order thresholds for General Counsel review have been raised on projects with experienced contracting officers. A change order handbook was developed and fielded to ensure consistent processing..

In addition to the activities described above, VA reviews modifications to identify recurring issues and revises the specifications for use on future projects. This allows for improvement on future designs. The Acquisition Program Management Framework is being applied to construction projects to ensure executive level review and approval of projects advancing in design. The review will look at the quality of the design and all comments will be reviewed to ensure designs are correct for construction.

Questions for the Record from Representative Brown

You talk in your testimony about costs and change orders, but I really only have one concern with this hearing. The Orlando VA Medical Center.

Question 1: The last update I have received says the Medical Center will open in August of 2014. What is the date the facility will open?

VA Response: As of December 2013, schedule updates from the Department of Veterans Affairs (VA) prime contractor, Brasfield and Gorrie (B&G), show a projected construction estimated completion date of December 2014. This schedule has continued to slip from the April 2014 date provided by B&G in their response to VA's Show Cause letter. Once construction is complete, the Medical Center will initiate a 3-phase activation plan that begins with outpatient services and moves inpatients in the final phase. The first patients will be seen 120 days after final turnover of the entire building to VA.

Question 2: Please explain the lack of any progress over the summer on this project? I refer to the 84% percent completion rate of the facility over the three months of July, August and September.

VA Response: Completed work did not progress significantly due to the contractors' lack of productivity and synchronization of trades, leading to overall inefficiencies of effort. Although the VA meets regularly with the contractor to discuss observations on performance and progress, and has consistently provided recommendations regarding sequencing of work and staff, the responsibility for "means and methods" of completing the work remains with the contractor.

VA is utilizing the current provisions under the Federal Acquisition Regulation (FAR) to monitor the contractor, and taking the following steps to protect the Government's interest in project completion:

- Continue to retain funds for performance delays, Davis-Bacon wage violations, and work deficiencies;
- No reimbursement for indirect costs beyond May 12, 2013, based upon VA Acquisition Regulations; and
- Notify contractor of intent to withhold liquidated damages assessed after extended contract completion date of August 8, 2013..

Question 3: In previous meetings and briefings, one of the issues brought up was that there was not enough VA staff on site to oversee the project. How have you addressed this issue?

VA Response: VA has increased the number of resident engineers, as well as added full-time construction management and architect/engineer personnel on site in Orlando. These staffing actions occurred over a year ago, and OALC's perspective is there is no staffing issue.

Question 4: The previous project manager was removed due to not following the VA instructions. How is the new manager working out? Has there been any advancement on finishing this project?

VA Response: OALC has seen improvements with the change of the contractor's personnel. Although the new superintendent's oversight has yielded advancements

in certain areas, it appears that the contractor's insufficient workforce level makes it challenging to achieve significant progress in more areas concurrently.

Question 5: One of the concerns in this project is the large number of change orders that have been submitted. Have those leveled off? Are there still changes being made to the design of the facility at this late date?

VA Response: As with any project of this size, scope, and complexity, changes continue to be identified but have tapered off dramatically, as expected. In the past 7 months, there have been, on average, only 13 changes initiated by either VA or the contractor a month, each with an average value of only $5,100. In each successive month during this period, the number of changes has progressively decreased. Additionally, since the design of the facility is complete, changes at this stage do not impact the design but are changes primarily associated with utility connections or field conditions.

Question 6: Can this facility be opened in stages? I know the outlying buildings are almost complete, except for the landscaping and the food service. What can we do to get veterans help tomorrow?

VA Response: Currently health care services are provided to Veterans in East Central Florida through six existing CBOCs in Lake Baldwin, Viera, Daytona Beach, Kissimmee, Leesburg, and Clermont. Complex outpatient and inpatient services are provided at the Tampa VA Medical Center (VAMC), Gainesville VAMC, or local community hospital. When construction of the new Orlando facility is complete, most of these complex outpatient services and inpatient services will be provided at the new facility.

The Orlando construction project includes the development of a medical complex on 65 acres in Lake Nona. The project is being executed through seven individual and unique contracts. As each of these contracts is completed, and space is turned over to VA, the space is activated. For instance, the Community Living Center (120-bed Nursing Home) was activated in early December. The 60-bed Residential Rehabilitation Treatment Program was activated in February. The remaining hospital, clinic, diagnostic and therapeutic facility is currently being completed under a contract with an estimated completion date in December 2014. Once space is turned over to VA by the contractor, the activation plan for this space is planned in 3 phases. VA has a comprehensive plan to use space quickly and safely as soon as the contractor completes the contractual requirements and releases the space to VA. In the meantime, VA is providing health care services for Veterans at our CBOCs, VA facilities in Tampa or Gainesville; or at one of the area community partners.

Questions for the Record from Representative McLeod

Question 1: How many months of delay in awarding the lease for the Loma Linda Health Care Center come from finding property owners willing to sell?

VA Response: VA experienced delays for several reasons, including difficulty in locating and securing a preferred site that met the advertised criteria; site owners who became unwilling or unable to sell their property; and valuation issues where VA and the site owners could not reach agreement on a fair market value purchase price for the property. Three site surveys were held and multiple sites reviewed before a preferred site was secured through an assignable option to purchase. The process took approximately 27 months, including about 21 months of delays as explained above.

Question 2: How many property owners owned the land currently being developed for the Loma Linda Health Care Center?

VA Response: The Loma Linda Health Care Center is currently being developed on land from one owner.

Question 3: What role did VHA Women Veterans Health Committees and Women Veteran Program Managers contribute to the design of the seven Health Care Centers to ensure that they complied with women veteran patient privacy standards as stated in VA regulations?

VA Response: The Veterans Health Administration's (VHA) design standards for women's clinics were developed in collaboration between OALC's Office of Construction and Facilities Management and VHA's Women's Health Services. This collaboration in part ensured specific women's privacy requirements were fully incorporated into the latest design standards to provide a safe environment for women Veterans. During the design of each Health Care Center, medical center staff and

contracted Architect/Engineering firms were required to use VA's design standards and requirements as the foundation for developing the design documents.

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