VA CONSTRUCTION POLICY: FAILED PLANS RESULT IN PLANS THAT FAIL

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

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U.S. HOUSE OF REPRESENTATIVES

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VA CONSTRUCTION POLICY: FAILED PLANS RESULT IN PLANS THAT FAIL

Tuesday, May 7, 2013

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 2:00 p.m., in Room 334, Cannon House Office Building, Hon. Mike Coffman [Chairman of the Subcommittee] presiding.

Present: Representatives Coffman, Huelskamp, Benishek, Walorski, Kirkpatrick, Kuster, and O'Rourke.

OPENING STATEMENT OF CHAIRMAN COFFMAN

Mr. COFFMAN. Good afternoon. I would like to welcome everyone to today's hearing titled "VA Construction Policy: Failed Plans Result in Plans That Fail."

I ask unanimous consent that several of our colleagues from the Committee join us at the dais today to hear about construction developments affecting facilities that serve their constituents. Hearing no objection, so ordered.

Providing veterans medical care is a core function of the VA. When the VA does health care right, it can be second to none. However, the process VA employs to build its health care facilities is abysmal and the results lead to delays for much-needed care to veterans.

The Government Accountability Office's recent report noted that VA's four largest medical center construction projects have had an average of cost increase of $366 million and an average delay of 35 months. One of the most distressing items in the VA report is that VA failed to learn from its mistakes as it went from project to project. I must add that many of these same issues have been identified by GAO in the past, and we seem to be no closer to a better result.

Ultimately, it is not just major facilities that epitomize why VA's construction policy is a debacle. A little more than a year, ago this Subcommittee held a hearing on VA's failure to perform due diligence and failure to inform Congress of project increases regarding the proposed clinic in Savannah, Georgia. Based on subsequent correspondence with VA over the past year, I am not quite certain VA is getting the message that its construction program is dysfunctional and not in keeping with industry best practices or veterans' expectations.

Not only is VA building facilities over budget and late, but it is also failing to pay the contractors for the work in a timely manner. While ensuring taxpayer dollars are properly spent is of utmost im-

portance, VA must pay its bills on time. Last week, I visited the Denver project and spoke directly with VA about prompt payment to contractors and subcontractors and was alarmed by VA's response in the issue, and I will monitor their commitment to improving the process.

Under the Prompt Payment Act and OMB's guidance, a Federal agency is expected to, quote, "to ensure that prime contractors disburse the funds that they receive from the Federal Government to their small business subcontractors in a prompt manner," unquote. The Prompt Payment Act also requires that the contractor certify that his or her subcontractors are receiving payment commensurate with the work performed. But as evidence shows, some contractors and subcontractors in these four projects have been waiting for months to be paid.

Moreover, the Small Business Act explains that it is, quote, "the policy of the United States that prime contractors establish procedures to ensure the timely payment of amounts due pursuant to the terms of their subcontracts with small business concerns," unquote. VA's failure to abide by the laws governing payment to its contractors is unacceptable and is a problem in need of an immediate fix.

Given the number and variety of facilities VA has built over the last several years, it is disturbing to me that VA continues to employ policies and techniques that have repeatedly fallen short. I look forward to hearing from today's witnesses regarding VA's construction policies and how we can move forward to effectively and efficiently build medical facilities for our veterans.

Mr. COFFMAN. I now yield to Ranking Member Kirkpatrick for her opening statement.

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

OPENING STATEMENT OF HON. ANN KIRKPATRICK

Mrs. KIRKPATRICK. Thank you, Mr. Chairman, for holding this hearing.

The focus on the construction program of the Department of Veterans Affairs is one that needs to remain a top priority for this Subcommittee and necessary to ensure that veterans' needs are being met. Hundreds of millions of dollars are authorized and appropriated every fiscal year to ensure that veterans are cared for in the safest, most state-of-the-art buildings to be built. The other priority, of course, is that, along with the building, there is in place quality and timely health care delivery to those who have earned it.

Today's hearing focuses on a recently released Government Accountability report on construction that is very concerning. GAO reports that some of the biggest construction projects have increased in cost by over 140 percent, while others have experienced delays in construction for up to 74 months. While I may understand the reasons for some of this, clearly there is a need for VA to scrutinize their construction program processes and make improvements where it may be necessary to do so.

I understand that just a few years ago, the VA put in place the Strategic Capital Investment Process, or SCIP. I look forward to hearing from the VA about how this process is working. Additionally, the Subcommittee has been informed that the Secretary, in an effort to improve the construction process, created a Construction Review Council 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. I look forward to hearing from the VA on how this Council's report has been beneficial to the VA.

This Committee has held numerous hearings on the VA's construction process, and efforts have been made to improve and streamline construction projects. Having said that, I also believe the VA still struggles to effectively manage the program. From the Capital Asset Realignment for Enhanced Services to the recently implemented SCIP, problems and challenges remain.

Mr. Chairman, I stand ready to work with my colleagues and with the VA as we tackle these issues in front of us today.

Thank you, and I yield back.

Mr. COFFMAN. Thank you, Ranking Member Kirkpatrick.

I would now like to welcome the panel to the witness table, which you are there. On this panel we will hear from Lorelei, did I say that right, St. James, Director of Physical Infrastructure Issues for the Government Accountability Office; Raymond Kelley, Director of Legislative Services for the Veterans of Foreign Wars; Mr. Glenn Haggstrom, Principal Executive Director, Office of Acquisition, Logistics, and Construction for the Department of Veterans Affairs; and accompanying Mr. Haggstrom, Ms. Stella Fiotes, Executive Director, Construction and Facilities Management, Office of Acquisition, Logistics, and Construction, for the Department of Veterans Affairs.

Ms. St. James, you are now recognized for 5 minutes.

STATEMENTS OF LORELEI ST. JAMES, DIRECTOR OF PHYSICAL INFRASTRUCTURE ISSUES, GOVERNMENT ACCOUNTABILITY OFFICE; RAYMOND KELLEY, DIRECTOR OF LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; AND GLENN D. HAGGSTROM, PRINCIPAL EXECUTIVE DIRECTOR, OFFICE OF ACQUISITION, LOGISTICS, AND CONSTRUCTION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY STELLA FIOTES, EXECUTIVE DIRECTOR, CONSTRUCTION AND FACILITIES MANAGEMENT, OFFICE OF ACQUISITION, LOGISTICS, AND CONSTRUCTION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF LORELEI ST. JAMES

Ms. ST. JAMES. Chairman Coffman, Ranking Member Kirkpatrick, and Members of the Subcommittee, I am pleased to be here today to discuss VA's construction of major medical facilities and actions it should take to decrease the time and cost of these projects. My testimony today is based on our report published a few days ago.

VA has an important mission of caring for over 6 million veterans. Right now, VA has 50 major medical facilities that it is ei-

ther building or renovating, at a cost of more than $12 billion. This is a huge undertaking. Since before the Las Vegas facility was constructed, VA had not built a project of this size in over 15 years.

GAO has reviewed VA's approach to planning and building major medical facilities. These are facilities that cost over $10 million. VA, however, has struggled to match its aging infrastructure with the changing needs of veterans. It must also contend with a wide array of stakeholders, including Congress and veterans organizations.

In our report, we found problems around two fundamental construction issues: time and money. But to be fair, most construction projects, private or public, change from design to opening day, and events, sometimes beyond anyone's control, can easily add time and money. Even given this, for the VA facilities we reviewed, we remain concerned about the amount of time and the amount of cost increases from the time projects are to be finished and the time they are expected to be completed. Why is it taking so long to complete these facilities and why have costs increased so much?

These answers are important. Over the next 10 years, VA plans to construct or renovate projects that have an estimated value of over $21 billion.

Of the 50 projects in our review, we reviewed in detail four major medical facilities, in Denver, Orlando, New Orleans, and Las Vegas. So far, Denver is 18 percent complete, but it has taken 10-1/2 years from the selection of the design firm to VA's recent estimated completion date. It also experienced a 144 percent cost increase from the initial cost estimate. In Las Vegas, the project took slightly more than 10 years. In contrast to VA, we found that the Naval Facilities Engineering Command, who builds similar medical facilities under similar regulations, designs and builds such facilities in about 4 years. Similar to Denver, Orlando has experienced a 143 percent cost increase, and New Orleans a 59 percent increase.

While each facility has unique circumstances, we found several reasons for these increases, including some that were beyond VA's control. For example, due to Hurricane Katrina, construction costs in Las Vegas skyrocketed. In Denver and New Orleans, political pressure, including pressure from some veterans groups, moved VA to change from shared facilities to stand-alone facilities. In Orlando, the site changed three times from 2004 to 2010, once because VA didn't move quick enough to secure needed land. Lastly, unanticipated events, such as undetected underground storage tanks, as we saw in New Orleans, can impact estimates.

In VA's November 2012 Construction Review Council report it acknowledged several management problems and stated that, among other actions, it would submit initial designs to Congress that were 35 percent complete, beginning with its 2014 budget submission. These estimates are important. Congress uses them to make funding decisions and veterans use them to measure when medical services will be available.

Lastly, in VA's management of all major facilities, we recommended that VA issue guidance on when to use medical equipment planners and they should issue procedures to clarify to contractors the roles and responsibilities of all VA personnel involved

in projects. They should also streamline its change order process. VA and contractor officials all cited this as a fundamental management problem. VA agreed with our recommendations, and we are encouraged by its planned actions, but believe these actions should be implemented and monitored to ensure that real change occurs.

Mr. Chairman, this concludes my statement. I am happy to answer any questions that you have.

[THE PREPARED STATEMENT OF LORELEI ST. JAMES APPEARS IN THE APPENDIX]

Mr. COFFMAN. Ms. St. James, thank you so much for your testimony.

And I am going to go ahead and recess the Committee for votes and then we will reconvene right after voting.

[Recess]

Mr. COFFMAN. The Committee is called to order.

Mr. Kelley, you are now recognized for 5 minutes.

STATEMENT OF RAYMOND KELLEY

Mr. KELLEY. Mr. Chairman, Ranking Member, Members of the Subcommittee, on behalf of the 2 million members of the Veterans of Foreign Wars and our auxiliaries, thank you for the opportunity to testify today.

I know everyone has heard these statistics, but they are worth repeating. VA's infrastructure is, on average, 60 years old. Utilization has risen from 80 percent to 121 percent in a matter of 6 years. In that same time period, the facilities have eroded, the conditions of those facilities have eroded from 81 percent to 71 percent. The VA currently holds 50 major construction contracts and has identified a total of 130 major construction projects that need to be addressed, all at a cost of about $25 billion. VA has a monumental task of expanding and replacing its medical facilities, and they must maximize every dollar and implement processes that will expedite the construction process.

The VFW has identified four major areas that need to be addressed to ensure the construction projects are done in a more efficient and cost-effective manner. First, VA must fully integrate the Electronic Contracts Management System. Second, VA needs to stop using the design-bid-build contracting practice. Third, VA must adopt a comprehensive facility master plan. And fourth, they should use medical equipment planners during the construction of all medical facilities.

Due to time constraints, I will limit my remarks to just two of these areas of concern.

VA has historically relied on the design-bid-build project delivery system when entering into contracts to build major facility projects. Of the 50 current VA major facility projects, 43 of them are design-bid-build. With this model, an architect is selected to design the facility, the design documents are used to secure the bid, and then the successful contract bid-holder builds the facility. Design-bid-build projects often encounter disputes between the consumer—in this case VA—and the construction contractor. Because these contracts are generally firm fixed price based on the completed design, the construction contractor is usually responsible for cost overruns

unless VA and the contractor agree on any needed or proposed changes that occur with change of scope, unforeseen site condition changes, or design error. VA and the contractor negotiate these changes through change orders. This process can become adversarial because neither party wants to absorb the costs associated with the change and each change order can add months to the project completion date.

The flaws of design-bid-build projects have become apparent, highlighted by the delays in Orlando, Florida, with the new medical facility that has been delayed 39 months, due in part to change order disputes. This contract must be followed through to completion, but VA must use this as a lessons learned and change their contracting model to an architect-led design build model. A design-build project teams the architect and the construction contractor under one contract. This method can save VA up to 6 months of time by putting the design phase of the construction and the construction performance metric together. Placing the architect as the lead from the start to finish and having the construction contractor work side by side with the architect, allows the architect to be an advocate for VA. Also, the architect and the construction contractor can work together early on the design phase to reduce the number of design errors, and it also allows them to identify and modify the building plans throughout the project.

The VFW also believes VA would benefit from the use of medical equipment planners. Using these planners, which is an industry practice used by the Army Corps of Engineers and other Federal agencies, places an experienced medical equipment expert at the disposal of the architect and the construction contractor. When used properly, the medical equipment planner can work with the architect during the design phase and then the construction contractor during the build phase to ensure that needed space, physical structure, and electrical support are adequate for the purchased medical equipment, reducing change orders, work stoppages, and the demolition of newly built sections of a facility. Using the Orlando facility as an example again, issues with the purchase of medical equipment caused cost overruns of more than $10 million and construction had to be suspended until these issues were resolved.

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

[THE PREPARED STATEMENT OF RAYMOND KELLEY APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you, Mr. Kelley.

Mr. Haggstrom, you are now recognized and have 5 minutes, please.

STATEMENT OF GLENN D. HAGGSTROM

Mr. HAGGSTROM. Thank you, Mr. Chairman.

Chairman Coffman, Ranking Member Kirkpatrick, distinguished Members of the Committee, I am pleased to appear here this afternoon to update the Committee on the Department of Veterans Affairs' continuing efforts to improve construction procedures and planning processes to ensure timely execution of major construction

projects. Joining me this afternoon from the Office of Acquisition, Logistics, and Construction's Office of Construction and Facilities Management is Ms. Stella Fiotes, the Executive Director. I will provide a brief oral statement and request that my full statement be included in the record.

Through the Department's capital-asset programs, which include major and minor construction, nonrecurring maintenance, and leasing, we are delivering the infrastructures necessary to fulfill our mission to care for and memorialize our Nation's veterans. Our continuing goal in the Office of Acquisition, Logistics, and Construction is to improve construction procedures and planning processes to ensure timely execution of major construction and leasing projects to provide state-of-the-art facilities for our veterans.

VA continues to make significant improvements in its real property capital-asset portfolio. Implemented with the fiscal year 2012 budget, the Strategic Capital Investment Planning process, or SCIP, is a Department-wide planning process to track and prioritize the Department's capital investment needs. Using this approach, VA has visibility across its entire property portfolio and is able to synchronize the projects we undertake in our major infrastructure programs to address our most critical needs.

Some of the steps that we have taken to improve the management and oversight of major construction projects include implementing the recommendations of the 2009 GAO report and undertaking the VA Facilities Management transformation initiative, or VAFM, which works to improve planning processes, integrate construction and facility operations, and standardize the construction process.

Last April, as a follow-on to the VAFM, Secretary Shinseki established a Construction Review Council 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 Construction Review Council identified four major findings to improve performance. Actions have been identified and are currently being implemented to address these findings.

Finally, we are in the process of reviewing the GAO final report, which was released on May 3, 2013, and plan to take immediate actions to implement their recommendations.

In the past 5 years, VA has also accomplished and delivered a significant number of projects for veterans. Most recently, in fiscal year 2012 and 2013 to date, VA has delivered nearly $1 billion worth of facilities. This includes 16 medical facilities, including the new Las Vegas hospital, and five new cemeteries or cemetery expansions, the vast majority of which were delivered without construction delay and within the appropriated funds. VA continues to work to complete 52 major construction projects to provide the much-needed facilities for our veterans and their families.

I am pleased to update you that since I last appeared before the Committee to brief you on the construction of the new VA medical center in Orlando, the project has advanced from approximately 50 percent completion to approximately 80 percent completion today. After issuing Brasfield & Gorrie a show cause notice in February of 2013, the Department has notified them that they will continue

as the contractor on the project. They have provided to VA a completion date of April 2014. We will continue to work closely with Brasfield & Gorrie to ensure they adhere to their projected timeline.

The lessons we have learned from Orlando and other past major construction projects is guiding us in our management of the Denver and New Orleans replacement hospitals and future projects.

In closing, VA has a strong history of delivering facilities to accomplish our mission to serve veterans, and we are committed to meeting our responsibility to design, build, and deliver quality facilities to meet the demand for access to health care and benefits. The lessons that we have learned from our past projects will continue to lead to improvements in the management and execution of our capital program as we move forward.

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

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

Mr. COFFMAN. Thank you, Mr. Haggstrom.

Mr. Haggstrom, the VA has 11 projects with a range of cost increases from 4 to 59 percent. In all but two of these projects the cost increases are over 10 percent. Has VA officially informed Congress regarding all of these increases?

Mr. HAGGSTROM. Mr. Chairman, I don't know specifically which projects you are referencing. But to the best of my knowledge, we are very diligent in notifying the Congress if there are cost overruns, and the amount of those costs, we must notify Congress. If you would provide me a list of those projects, I would be happy to supply the record for those.

Mr. COFFMAN. It is the projects that are listed in the GAO report, the 11 projects listed in the GAO report. Do you need us to go over those?

Mr. HAGGSTROM. No, I don't. I am in receipt of the GAO report. And we will certainly look at those and will reply to the Committee.

Mr. COFFMAN. So to the best of your knowledge, you don't know whether or not Congress was informed?

Mr. HAGGSTROM. To the best of my knowledge, we have fulfilled all our requirements in the notification of process.

Mr. COFFMAN. So Congress was informed?

Mr. HAGGSTROM. As far as I know, sir.

Mr. COFFMAN. Mr. Haggstrom, does VA believe that their obligations for payment of construction completed extends only to the prime contractor?

Mr. HAGGSTROM. Mr. Chairman, our contractual relationship is with the prime contractor and only the prime contractor. We do not have privity of contract with the subcontractors. However, as you had mentioned in your openings remarks, that we do require certification of the prime contractor to the VA to ensure that they are paying their subcontractors.

When you look at what we do, go through the change order process, the pay application process, all those things are to be resolved

with the prime contractor in terms of what payments they are due and the payments that they would subsequently make to their subcontractors.

I would like to add that the Miller Act, which was passed in 1935, if you will, is really a safety net for subcontractors. The Miller Act specifically requires that for Federal projects over $150,000, that there is both a performance bond and a payment bond that is held by the prime contractor so that in the event if the prime contractor has a contractual relationship with that subcontractor for a certain amount, the subcontractor performs the portion of the project for that amount and the prime contractor does not pay that subcontractor, the subcontractor has recourse against the prime contractor through Federal court.

Mr. COFFMAN. But doesn't current law go above that, go beyond that in the Prompt Payment Act in terms of defining VA's responsibilities to ensure that subcontractors are paid?

Mr. HAGGSTROM. Absolutely. And we adhere to that as closely as we can. Once a month, we have what we call a pay application review with our prime contractor. And during this, the prime contractor will provide to VA the portions of the projects that have been executed between the last pay application meeting and the current pay application meeting. It is our goal and requirement that once we receive that information, to process that and make payment within 15 days to the prime contractor.

Mr. COFFMAN. Let me just say that I think all of you referred to the VA facility that is being constructed in Denver, and I think that is well within the boundaries of the city of Aurora, which is in my congressional district. I think there has been a history of those subcontractors not being paid, and that is of concern to me.

Ms. St. James, did contractors submit excessive or unwarranted change orders to drive up costs or cause delay?

Ms. ST. JAMES. That wasn't a central focus of our review. We understood that the Committee was looking into that. But in Orlando, we did hear of instances like that, and we are aware of the show cause notice. But we did not verify independently whether or not any of those charges were excessive or unwarranted.

Mr. COFFMAN. Ranking Member Kirkpatrick.

Mrs. KIRKPATRICK. Thank you, Mr. Chairman.

Ms. St. James, in our briefing book, we have four major hospitals: Las Vegas, Orlando, Denver, and New Orleans? And staff just gave me a list of just the Orlando problems with the contracting officer, with cure notices, show cause notices that really have delayed the project. Did you find that that was the case with the other three facilities?

Ms. ST. JAMES. I think out of the four that we looked at, it was that the relationship between VA and the prime contractor was not as favorable, let's say, as the other contracts that were out there. There seemed to be more problems in Orlando with the prime contractor than we saw in the other sites.

Mrs. KIRKPATRICK. Thank you. Do you agree with Mr. Kelley's recommendation that they go to an architect-design-build rather than just a regular design-build model?

Ms. ST. JAMES. We looked at the different kinds of contracts, as you just mentioned, and quite frankly, if you have your require-

ments set up and agreed to and you have a contractor and you have a good relationship with that contractor, it doesn't really matter the vehicle that you choose. A lot of it depends upon the relationships, requirements being defined, and the relationship between the sub and the prime as well.

Mrs. KIRKPATRICK. So why is that relationship a problem at the VA?

Ms. ST. JAMES. In Orlando?

Mrs. KIRKPATRICK. In Orlando.

Ms. ST. JAMES. It is a big project. There are lots of change orders. When subcontractors put in for the change orders, we saw that the prime would agree with those change orders, but VA would not agree with them, and therefore you have a disagreement. And when you have a very large project, you have lots of change orders. It is just natural to the construction. So we found that that was a major problem in Orlando, was the difference views of the cost information being provided in the change orders. Neither VA or the contractor agreed.

Mrs. KIRKPATRICK. Thank you.

Mr. Haggstrom, on these projects do you have somebody on the site who can review change orders who has the authority to approve them rapidly at each one of these facilities?

Mr. HAGGSTROM. Yes, Congresswoman, we do. We have a resident engineering staff, we have a project executive, we have contracting officers assigned to all of these projects to help facilitate and move the change order process along.

Mrs. KIRKPATRICK. So how would you explain the bad relationship that apparently exists between the contractor and the VA that ends up with these show cause hearings and orders to cure?

Mr. HAGGSTROM. Well, if I could, the show cause and cure notices do not necessarily delay a project. Those are two contracting vehicles that the Federal Government uses as part of the procurement process to ensure our rights are protected with regard to the contract that was consummated between ourselves and the prime contractor and oversight and fiduciary responsibility for the money that you have provided us to construct these particular facilities.

With regards to the Orlando project, early on in my previous testimony before the Committee, clearly VA had some problems in terms of errors and omissions when we started this project. Those errors and omissions were corrected through working with our AE and with our contractor. Those drawings were corrected and put back into place approximately a year ago, and we moved forward on those.

There is a continuing, I think, discussion and issue with the prime contractor over the cost of these things. Whether or not perhaps the cost that they estimated were underestimated with regards to the subcontractors performing this work, again, I don't know. But these are all possibilities that drive the relationship between ourselves and that prime contractor.

Mrs. KIRKPATRICK. My time is almost expired, but I want to ask one other question, and that is, where does the CRC then fit in the whole scheme of things? You have somebody on site who can approve the change orders and then you have got the CRC. So what

is their role in terms of direct review and oversight of the construction on the site?

Mr. HAGGSTROM. The Secretary has made it very clear when we formed the CRC that certain elements of the project would have to come before the CRC and himself in terms of any change orders, significant change orders that would drastically affect the cost or the schedule of completion.

Mrs. KIRKPATRICK. My time is almost up. Does that delay then the decision on the change order?

Mr. HAGGSTROM. It does not.

Mrs. KIRKPATRICK. I yield back my time, but I would like another round of questioning if we have time.

Mr. COFFMAN. We will have a second round.

Mr. Huelskamp.

Mr. HUELSKAMP. Thank you, Mr. Chairman. I am going to read what you have read once already from the GAO report. And I am quoting here. It notes: "Cost increases for these projects range from 59 percent to 144 percent, representing a total cost increase of nearly $1.5 billion and an average increase of approximately $366 million per project. The schedule delays range from 14 to 74 months, with an average delay of 35 months per project."

And I have a question for Mr. Haggstrom, if I might. The GAO's report makes clear that for a number of years—and you referenced the 2009 report—VA's construction arm has not been doing a good job. Yet according to records I have, in 2009 you received a $20,470 bonus, in 2010 you received an $18,022 bonus, and in 2011 you received a $16,300 bonus, all on top of your base pay. Given this GAO report and what we have heard here, do you really think you deserved these bonuses?

Mr. HAGGSTROM. Congressman, those bonuses were not determined by myself. Those bonuses were determined by my supervisors in the senior leadership at VA. And with all due respect, I would ask you to take that up with them.

Mr. HUELSKAMP. My question is with you. Do you think you deserve those bonuses in light of these GAO reports and these cost overruns and delays in construction?

Mr. HAGGSTROM. Congressman, I believe I have answered your question.

Mr. HUELSKAMP. Sir, let me re-ask it. Do you believe you deserved these bonuses? It is either yes or no or I refuse to answer the question.

Mr. HAGGSTROM. I will answer one more time. Those bonuses were not by my own doing. Those were from my superiors.

Mr. HUELSKAMP. Did they indicate to you, Mr. Haggstrom, why you deserved these bonuses when they gave them to you?

Mr. HAGGSTROM. Congressman, I have answered as far as I can answer.

Mr. HUELSKAMP. Did they indicate to you why you deserved these bonuses? Surely they told you. They didn't tell you at all why you were given a $20,000 bonus in 2009, an $18,000 bonus? They didn't tell you why you were given a bonus?

Mr. HAGGSTROM. Those bonuses, I presume, were based on my performance plan and my performance that they viewed and how I did my job during those particular years.

Mr. HUELSKAMP. I wish you would answer that question. Apparently they didn't tell you, then, why you deserved a bonus?

Mr. HAGGSTROM. No. The bonus came down in my paycheck.

Mr. HUELSKAMP. Just magically appeared, I guess, for no reason. And I would appreciate perhaps you might visit with your superiors, in light of the GAO report. I mean, we are talking about $1.5 billion of cost overruns on four projects. Are you proud of these particular projects?

Mr. HAGGSTROM. I am not, but I think you need to put those cost overruns in context.

Mr. HUELSKAMP. I am putting it in a bonus context.

Mr. HAGGSTROM. No, I am putting it in the fact that when you looked or when VA looked at these projects and they costed them out, many of these projects started out as nothing more than large health care centers when we started the requirements definition process. Those matured sometimes into full-fledged inpatient medical facilities, based on emerging needs. So you have got to look at ultimately what the VA planned to build as opposed, in the end, to what they started to build in the beginning.

Mr. HUELSKAMP. Mr. Haggstrom, the VA for here is you.

Mr. HAGGSTROM. Pardon me?

Mr. HUELSKAMP. The VA today is you. It wasn't somebody else, some other agency determined what they should be. It was based on your estimates, what you described to Congress of the money you needed for this project. And they come in at an average of $366 million per project cost overrun. And you can't blame it on the DoD made you do these. I mean, these are the VA estimates coming out of the GAO report. And that is what we have here.

Mr. HAGGSTROM. These are VA estimates based on what we started with.

Mr. HUELSKAMP. Did you have any—

Mr. HAGGSTROM. When you move from a health care facility of several hundred thousand square feet to build a full-fledged medical inpatient care facility at sometimes 1.5 million square feet, you are going to have a change in the cost of that project.

Mr. HUELSKAMP. Absolutely. Obviously, we were wrong on the first estimate. Obviously, you are going to have a massive change because you made a mistake at the beginning. And what bothers me is you are in charge of these, you are the gentleman sent here to represent why this wasn't too bad, and these same folks give you a very, very big bonus, multiple years in a row, in light of these GAO reports, and you claim not to know why you got a bonus.

That to me, Mr. Chairman, is very disappointing. Bonuses are not given just because. They are given for performance. And if I was giving a bonus here, we would actually dock your pay. And that is what most of my constituents say.

One last thing I want to note, and you might indicate to your superiors as well. I have sent multiple letters to the VA that they have ignored on other budgetary issues. In particular, I sent a letter on September 23, 226 days ago, and the VA just says we don't care what Congress thinks. And that is why you wonder why we get upset when you have cost overruns and you try to explain to us that your estimates initially were wrong and then you get massive bonuses. This is not a proper way to run an agency.

And I yield back, Mr. Chairman.

Mr. COFFMAN. Thank you, Mr. Huelskamp.

Ms. Kuster.

Ms. KUSTER. Thank you very much.

Mr. Haggstrom, my question is with regard to the change in scope of these projects. What were the factors that led to the change to a more complex facility? Did it have to do with the number of veterans that were coming back from Iraq and Afghanistan and the complexity of their issues? And where in the Veterans Administration is that type of decision-making made?

Mr. HAGGSTROM. Certainly. When you look at the requirements, the requirements that we work to in construction and facilities management are determined by the administrations. Principally, we build for Veterans Health Administration, the medical facilities, and the National Cemetery Administration, our national cemeteries. Those are the folks who provide to us, the engineers, what they require in order to be built. They use multiple factors. They use the demographics. We use the databases that VA has maintained through the year. And all those things are subject to change.

Let's take a look, if you will, just at the Denver facility as an example. As we talked before, Denver started out as an outpatient community health center when we started to build that. Then through the years we went back and forth at the senior level in VA to decide is it going to be that or is it going to be an inpatient facility with bed towers or are we going to use shared facilities with the University of Colorado to handle our inpatient loads.

Ms. KUSTER. Excuse me for interrupting, but was the Congress kept apprised as these decisions were made?

Mr. HAGGSTROM. I am sorry, I can't answer that. I was not a part of VA when those major decisions were being made. When Secretary Shinseki came in, one of the first things he directed as the Secretary of Veterans Affairs is directing us to build a full inpatient medical facility. And that is where I essentially pick up.

All those things previous, though, until those decisions are made, you can't design a facility. You may be able to look at pieces of it, but in terms of designing a full medical complex, the relationship of how all these clinics work, the inpatient, the diagnostic and treatment, all those can't be completed until a decision is made on what is going to be the final scope of this facility.

Ms. KUSTER. Thank you. I wanted to say I had a tour during our district work period of the VA facility in White River Junction, Vermont, New Hampshire being the only State that doesn't have a full-service VA hospital, but my constituents go to Vermont. And I was very impressed, actually, and I understood the complexity, given the age of the building. But one of the things that was particularly impressive was the opening of a new women's health facility. And I just would love to have you comment on the changing types of issues that you are dealing with and some of these issues that are coming back from the Iraq and Afghanistan war in particular.

Mr. HAGGSTROM. Certainly. And while I am not a clinician, our involvement in working with the VA staff, the emerging requirements in health care today are so different from what our veterans faced from World War II and Korea and even Vietnam. When you

look at today, I believe almost 15 percent of our armed forces are women. And so years ago, when you walked into a VA hospital you would probably not find very many facilities that were equipped to handle women veterans and the special needs they have. These are all things that the Department is making very focused attention on in terms of modifying and modernizing our facilities to cope with these new requirements—traumatic brain injury, mental health, post-traumatic stress syndrome.

All of those things are, if you will, perhaps they were present in previous conflicts. It is only now during our last two engagements that these are really coming to the surface and having the clinicians look at how we can better treat our veterans to help overcome these disabilities.

Ms. KUSTER. Thank you. And just one quick question—my time is almost up—for Ms. St. James.

How do you believe the VA can better communicate within their own organization and with contractors to improve upon this process so that we are not facing cost overruns and delays?

Ms. ST. JAMES. In this regard, we noted that in the Council, the VA's Council, Construction Review, that they plan to take action on this. And basically what is needed is a matrix which indicates who in VA has responsibility for what, so that the contractor knows the direction that they should follow. We did find in Orlando there was confusion there, and the contractor was directed in one case to go ahead and build a room, a part of the facility, and then was later directed, redesign it.

So it is really common sense when you have a project that is as large and complex as these are, we are talking over a million square feet in some of these and 31 acres in some of these facilities, you absolutely must have clear communication.

Ms. KUSTER. Thank you very much.

I yield back the balance, which I do not have.

Mr. COFFMAN. Mr. O'Rourke.

Mr. O'Rourke. Thank you, Mr. Chairman.

I am interested in the context of the projects that have been highlighted today within the SCIP list, or the Strategic Capital Investment Planning list. And my understanding is there are 3,900 projects that have been identified on that capital list that need to be at some point built in order to fill the gaps in service to our veterans.

When these projects go over these many months or these many dollars, what does it do to the projects behind them?

Mr. HAGGSTROM. In terms of the time, it has no effect. When you look at—when you say "cost overruns," what are we talking about in terms of a cost overrun? When you look at the projects that are under construction today, we are within the appropriated amounts that Congress has provided to us to construct those facilities, and so if a cost overrun could have two different meanings, the cost overrun vis-&-vis what the original project was bid at and—

Mr. O'ROURKE. That is what I am trying to get at. So, if you are spending $366 million more than you originally budgeted, where is that money coming from if not from projects that would have been funded further down the list, or did you have a contingency of $366 million for that project?

Mr. HAGGSTROM. No, there is not a contingency of $366 million. Conceivably, under what you are talking about, if those cost overruns were in fact correct, it would, of course, push the program out to the right and projects would not be funded as quickly as perhaps we would have liked them to be.

Mr. O'ROURKE. And I see, you know, I am obviously most concerned about El Paso, the community I represent and the veterans there, who today have to go to Albuquerque for the nearest full service veterans hospital, which is a 10-hour roundtrip, and these are veterans, whose service extends as far back to World War II, going for cortisone treatment, for example. And so we desperately, in my opinion, need a full service VA hospital in El Paso, and I see we are number 79 in that list, and the 2014 request is zero dollars. A few projects up, there are dollar requests for those projects.

So I can't help but read into this that, but for these overruns or whatever the term of art is for spending more than we originally anticipated, we would have been able to get to these projects sooner.

I don't know, Ms. St. James, if in your analysis of the VA's construction projects you were able to correlate, you know, these overruns in time and dollars to what it did to our ability to construct other projects further down the list.

Ms. ST. JAMES. No, we really did not look at that. I would hope, though, that VA's implementation of providing better estimates where the design is 35 percent complete at the time they submit it to you, that you would have a better idea of what the project would cost and that is what we would hope to see.

When VA comes back to you for money, with having 35 percent complete done at the initial asking, you should have a better idea and a better knowledge of how much more it could actually increase. But a lot of things happened that are unanticipated as well, but we are aware of the SCIP process. It is relatively new, and we have looked at that in the past and within the last couple of years.

Mr. O'ROURKE. And I guess, for Mr. Haggstrom again, in El Paso, it seems like we have a number of opportunities for a new VA facility, full service VA hospital. One is to co-locate it with the new William Beaumont, the DoD active duty hospital, which is moving forward now. Another is to find a partner within the public health community with Texas Tech, for example. What do those opportunities do in shortening construction time and reducing costs when we are co-locating with other facilities? Does that offer a community like El Paso an opportunity to jump up a little bit on the list since we have a partner with whom we can construct that facility with?

Mr. HAGGSTROM. Congressman, with all due honesty, that is a very difficult question to answer with regards to how you put it because there are so many other factors that are taken into consideration when we look at the SCIP process and the planning and programming, and many of that goes to the demographics of the areas, what the needs of those veterans are and how they can be best served.

If you would like to, for me to take that back as a question, I will certainly be more than happy to do that and try to provide that for the record.

Mr. O'ROURKE. I appreciate that. Thank you.

Thank you, Mr. Chairman.

Mr. COFFMAN. Thank you, Mr. O'Rourke.

Ms. St. James, when we talk about say the facility in Aurora, Colorado, and the cost overrun issue and the time delay, it did start out as a—or I think there was discussion at least of being a joint facility and then it was a standalone facility, VA facility. How much did that contribute to the cost overruns or to the—that delay? But I understand, obviously, when it went to bid, it was sent out to bid as a standalone facility. I don't think it was sent out to bid as a joint facility, so I don't know how you can contribute that as it was contributed to the cost overruns.

Ms. ST. JAMES. That is actually a good question. There are four cycles from beginning to end for a construction project, and we look at it from the very beginning, from the planning aspect, and so we felt that if you do not include that planning aspect in looking at how long it takes, then you are not really looking at the full picture of how VA manages this entire process, and in our report, we know that VA really wanted us to look at from the construction point on, but I think you have to realize that that—the risk is on the contractor from that point. Prior to that point, the risk is on VA. So, I think their estimates for these projects done decades ago were not done as well as they could have been, which is why they are looking at doing the 35 percent design to be complete in submitting it to you in the very beginning.

Mr. COFFMAN. Is that normal to have a certain percentage of the design done before they go out to bid, because I know that is their practice. Is that also the practice in say the private sector?

Ms. ST. JAMES. What we found in VA actually had an industry forum and the industry recommended to VA that they have a 35 percent design complete.

Mr. COFFMAN. Okay. Mr. Haggstrom, what is—now, I understand, first of all, I just want to commend you on putting—in our visit to Aurora, Colorado last week, at the facility, I think you or somebody associated with you has said that you-all, 2 months ago, put more resources in terms of personnel to process the change orders so that the prime gets paid and hopefully the subcontractors get paid in a more timely manner. And I will certainly be monitoring them, but I want to commend you on that. But obviously not having adequate resources on the ground has contributed to these delays, and so where—where—do the other facilities have the same problems that Aurora, Colorado, has in terms of the delay—a delay in payments and problems with subcontractors?

Mr. HAGGSTROM. We experienced that with Orlando, Mr. Chairman, and we took the same steps to remedy that by putting additional resident engineers on staff and construction management support. I believe we certainly have taken our lessons learned from both Orlando and Denver in that we are staffing our project in New Orleans, which is currently on cost and schedule, to make sure that those same issues are not encountered.

Mr. COFFMAN. Ms. St. James, other facilities of the Federal Government, I think, are managed by the GSA. Should that be the same case with the VA? Are their practices better? I mean, would the taxpayers and the veterans be better served if in fact the proc-

ess of constructing facilities like health care facilities were managed by the GSA instead of the VA?

Ms. ST. JAMES. That is a good question. We actually have not looked at, GSA doing that, but I know that VA has reached out to GSA in terms of some of its management issues in the report that we have been referring to that they put out November 2012. But I can say that when you look at these four facilities, it really doesn't matter the type of contract you have. The relationship that exists between a contractor, the prime or the subcontractor, taking 8 to 10 years to build a facility, at the end of the line is the veteran, and that is where our concern also is.

Mr. COFFMAN.—And, I just want to say as a Gulf War veteran and Iraq War veteran, I am very disappointed and I think that when there are delays in these projects and these projects are designed to meet the capacity needs of our veteran population, then I believe, and maybe let me refer to Mr. Kelley, I believe that care is ultimately delayed. Mr. Kelley.

Mr. KELLEY. I agree with your statement that care is delayed. I want to commend VA for using the SCIP process. It really does outline what the needs are. They need to put processes in place to be able to achieve those. They understand that demographics change. If they were to use a master planning in the Las Vegas facility, they would have known that adding onto Nellis wasn't going to cut it. They knew the demographics had changed. They knew the medical equipment and the processes that took place needed to change, and they needed a larger facility.

So I think having a full master plan at each facility early on would provide them the insight to know, when we start this planning process, what do we really need, and then you don't have a small facility turning into a large facility and you get quicker access to the veterans.

Mr. COFFMAN. Ms. Kirkpatrick.

Mrs. KIRKPATRICK. Thank you, Mr. Chairman.

Mr. Haggstrom, I have over 20 years experience as a health care hospital attorney. In that time period, we completely remodeled the hospital, project started and completed, then we built a huge new addition. That project was started and completed. Then we built a cancer center, and that project was started and completed.

In all fairness to you, can you identify differences in your procedure between the private sector and the VA that would explain these huge delays in construction?

Mr. HAGGSTROM. Congresswoman, I have never served in the private sector construction industry. My entire, almost 40 years in public service has been with Air Force civil engineering. I was a civil engineer for 28 years in the Air Force and subsequently with the Department of Agriculture here and VA. So, in all honesty, I am not that familiar with private sector developments and how they go about it, but I will tell you that there are different requirements when you deal with Federal contracting in terms of the contracting process, in terms of the due diligence, in terms of how we do our design and construction laws that have to be applied, perhaps like Davis-Bacon, the Miller Act, all those kinds of things. Those are not necessarily applied in the private sector.

When you look at it, I believe, when you look at the Federal sector and how we complete construction projects, we exercise significantly greater oversight in terms of what our contractors are doing, the quality of what they are doing, and the fact of the matter is, just because they tell us there is additional money required to finish this out does not necessarily mean that we will agree with those contractors. And we do our due diligence to ensure that what they are claiming is in fact the truth and the fact that they deserve payment. So there are a lot of—

Mrs. KIRKPATRICK. Well, let me just interrupt you there. I can tell you, in the private sector, we do due diligence also and it doesn't cause these kinds of delays, so I have a big concern about that. But let me switch to a different line of questioning. You mention that one of the reasons the Denver project took so long is that—the needs of the veterans were changing and you had to change the scope of the project and the design, but are you looking down the road at new delivery systems in health care, for instance, using technology. Do we still need these large medical facilities when we are entering an age of telemedicine?

Mr. HAGGSTROM. I think that is an excellent point, and Dr. Petzel, who heads Veterans Health Administration, clearly is looking at the various ways of delivery and not necessarily sticking to infrastructure or bricks and mortar, if you will, in terms of care for veterans. Telemedicine, home telehelp, in-home health care, all those kinds of things I know are on the VHA's plate in order to do better delivery and provide better care for our veterans.

Mrs. KIRKPATRICK. One last question, and I direct this to Mr. Kelley. You know, it seems to me that when you have a 10-year delay in a completion of a project, by the time that project is complete, it is already obsolete. Do you see that in what you have investigated? Do you see the VA trying to come back to Congress asking for authorization to then remodel these facilities that have been 10 years in the construction?

Mr. KELLEY. I don't know the facility becomes obsolete. I do know that the demographics change, that veterans have an expectation when VA comes out into the community and says, we are going to build a facility, this is what we are going to build, and here is the timeline we are going to build it. Now the veterans are invested in this, they are waiting, they have marked their calendar. And when that doesn't come through, they start getting very, very anxious: Are we not going to get our hospital? Is it going to have the full services that we were promised? Where am I going to get my medical care? Now that the population has grown, the wait lines are getting longer where I am at. I have to travel further to receive this care. I have to do contract care with a doctor I don't know. So, there are a lot of implications. I don't know if it necessarily makes a facility obsolete, but it—quicker delivery would provide better care to our servicemembers and vets.

Mrs. KIRKPATRICK. No question about it. You know, delayed care is denied care. I thank the panel. I thank the Chairman for having this hearing.

Mr. COFFMAN. Thank you.

Ms. Kuster.

Ms. KUSTER. Thank you very much, Mr. Chairman, and I, too, thank you for having this hearing. I think it is an important topic, anything that we can do to meet the needs of the veterans, but I also can appreciate the complexity in the health care delivery model throughout. And my experience, 25 years in the private sector on the legal side with health care delivery is that it is far more complex now than it certainly was.

My question is along the lines of Representative O'Rourke in terms of those who are waiting for facilities, and I am looking at much, much smaller facilities. I don't represent an urban area. I represent a very rural area in New Hampshire. We also have long distances to travel, mountains and weather and such, and so what we are looking at is a much smaller clinic model, and I am just wondering, this is just a question as to how you build facilities, do these big projects hold up a small clinic in a rural area?

Mr. HAGGSTROM. I don't believe so because the way the appropriation is structured and the way you provide us resources comes down in two different programs. Well, actually several different programs, but the two that focus on construction is the Major Construction Program, which are facilities at $10 million or greater.

Ms. KUSTER. Right.

Mr. HAGGSTROM. Those are line item appropriations where it very specifically says we will build X at Y. When you look at the Minor Construction Program, that is an appropriation. It is not a line item appropriation, and so it is much more flexible in terms of responding to the needs of our veterans and where those monies are placed to meet those critical needs.

When you look at the third scenario and one that we have relied on very heavily, and that is usually with our community-based outpatient clinics and our health care facilities, we use a build-to-suit model, and there are several break points in that leasing process, if you will. The clear break point being that if we have an annual rent in excess of $1 million, we must attain approval from the Committee to move forward with that. For less than a million dollars on service rent during the course of a year, the Secretary has the authority to make those decisions for those facilities.

So when you look at it, because when we do a build-to-suit model in putting these facilities on the ground, those leasing costs are borne by the medical facilities accounts or through the annual appropriations process.

Ms. KUSTER. Trust me, where I am talking about, the rent will be significantly less that be a million dollars, so—and my other question, and if you have this information or if not, if you could get back to the Committee, I am very focused on serving women veterans, and in particular, those who have experienced military sexual trauma or assault. And I was so impressed by this White River Junction facility with a separate facility for women, separate entrance, very, very well thought through with a task force that included veterans in the planning and the architecture and the design to make women feel safer when they come to the hospital for treatment. Do you know, or any of the panel members, the number of facilities or the percentage of facilities nationwide that are now equipped to deal with the increasing numbers of women veterans separately from being mixed in the general population?

Mr. HAGGSTROM. Right off the top of my head, I don't, but I would be happy to take that question and get the answer for you as a matter of record.

Ms. KUSTER. Yeah, I would be very interested, and also, just as my time runs down, just for planning purposes, looking forward, whether that is something that is being included in the planning, and I see you nodding your head, if you would like to respond.

Ms. FIOTES. Yes, it is, Congresswoman. I recently attended my first SCIP board meeting and was introduced to the process, and among the very many large number of projects and plans that were presented by the various medical centers and veterans integrated service networks, there was specific reference in several cases, in numerous cases, to the specific needs of women veterans, and they are considering that, and they are planning it in their programming going forward.

Ms. KUSTER. Excellent. Thank you very much.

I yield back my 2 seconds.

Mr. COFFMAN. Mr. O'Rourke.

Mr. O'ROURKE. Thank you. Mr. Kelley offered some suggestions to address some of the findings made by Ms. St. James and the GAO, and I wonder, Mr. Haggstrom, if you could give us your thoughts or your reaction to his suggestions.

Mr. HAGGSTROM. Certainly. I fully agree that medical planners are a crucial part of these large projects, and we have already taken steps to include professional medical planners on both the Denver and the New Orleans project, so we are moving forward with that.

With regards to eCMS. ECMS is a contract writing system.

Mr. O'ROURKE. Right.

Mr. HAGGSTROM. It is not a program management system, so we are in the process of fielding a new program management system which is specifically tailored to manage construction projects. What we will do, though, is look to interface the contract writing system with the program management system so that we do have a seamless process for contractual record and all the change orders or what goes on, on a project.

When you look at an AE-led design build, to be honest with you, I have never been involved in a project with an AE design build, but when we looked at it and we talked about it because we did see that you mentioned it, we will take a look at it, but one of our initial reactions was bonding capacity of the AE firms. So, that could be somewhat problematic in terms of who is the lead, the bonding capacity that that particular firm may be able to attain, where typically you would probably see a much larger bonding capacity on the construction side as opposed to on the AE, but these are all things that we will certainly take a look at.

Mr. O'ROURKE. I appreciate that. We in our office would be interested in hearing your answers to the specific recommendations made by Mr. Kelley.

And then I want to follow up on something that Congresswoman Kuster brought up and I tried to address in my earlier questions, but essentially learning from what has gone less than ideally, I guess, in some of these projects that have been highlighted in this report, what can communities like ours who need new facilities and

need investment from the VA to serve veterans who currently are not able to get service in our communities and have to travel for that service, what can we do to improve that process, whether it is through a co-location, I talked about DoD, or through a university system, whether it is providing land and leasing opportunities, give us some guidance in El Paso on how we can partner with you to be able to service these veterans who aren't getting that service today.

Mr. HAGGSTROM. I think the things that you said are very relative to looking at the future needs. I know VHA, we are in many, many communities across the United States, sit down, talk with your medical center directors, talk about the requirements that you need in your community, make sure they are aware of those things, and those things can be put forth as we go into the planning and programming process. They can come up through the SCIP process, all those kinds of things.

So, I think you are on the right track. I will tell you, as you noted, the number of projects that are in the queue as requirements, there is a substantial list, and certainly as part of the SCIP process, we do our best to ensure that the most critical needs that serve our veterans are first in the queue to make sure that they happen.

Mr. O'ROURKE. And are the criteria you use to determine ranking within that SCIP process, are those published along with—

Mr. HAGGSTROM. They would. In fact, I would like to ask Ms. Fiotes if she can go through that, having just—

Mr. O'ROURKE. That would be great.

Mr. HAGGSTROM.—been on the SCIP process. She is a board member, so she participates in that planning process.

Ms. FIOTES. Thank you for the opportunity.

Actually, the criteria are very well defined, and the entire process is very deliberative, comprehensive and integrated, and it starts with a 10-year planning horizon where all the VISNs, the networks, present their gaps and their proposals how to address these gaps, and by the way, in many cases, they also talk about non-capital ways to address the gaps, which goes to the Congresswoman's question earlier about other, other than just building facilities, solutions.

Mr. O'ROURKE. And those come from the local VHA directors or the regional?

Ms. FIOTES. They come from what we call the Veterans Integrated Service Networks, there are 23, I believe, across the country, and they—those plans are presented to the SCIP board. Along with this 10-year planning horizon, we then do, subject matter experts then do a review of the proposed projects and the business cases for those projects, and this forms the basis for the annual budget request.

So we go from the 10-year horizon to what should we be looking at for the upcoming year. The criteria, to get to your initial question, again, are defined and are used for the ranking, it includes improving safety and security, fixing what we already have, increasing access to veterans, right sizing the inventory, ensuring the value of the investment, then, of course, the department's initiatives, so they've —and each criterion has sub-criteria that, again,

the entire process is data driven to allow us to do the most objective assessment and prioritization.

Mr. O'ROURKE. Thank you. Appreciate that.

Thank you, Mr. Chairman.

Mr. COFFMAN. We will do one last round for anybody that has any clean-up questions.

Mr. Haggstrom, I think you mentioned the electronic contract management system, and tell me what that is supposed to do again.

Mr. HAGGSTROM. The eCMS or Electronic Contract Management System is a contract writing tool that we use in VA to put in place the various contracts, whether they be service contracts, construction contracts or commodity contracts. They are used by the contracting workforce to do this, and what it does is, it is an electronic repository for the contract files in terms of what the terms and conditions are, the standard clauses are, what the costs are, when it is gone out to bid, what those bids were, all those kinds of things. It is the electronic file for contracts.

Mr. COFFMAN. Is it designed to make the system more efficient?

Mr. HAGGSTROM. It is designed to make the contracting workforce more productive. It gets us out of the paper business. It is transportable so that multiple contracting officers can use the same file at different times. We can do our risk assessments electronically as opposed to having to go out to the contracting offices and look at the paper copies. So it is what we are moving to in the department in terms of our contracting records.

Mr. COFFMAN. Ms. St. James, is that system being utilized by VA?

Ms. ST. JAMES. I am sorry. Say again.

Mr. COFFMAN. Is the Electronic Contract Management System being currently utilized, to your knowledge?

Ms. ST. JAMES. That is a recommendation that again is coming out of their report, and I would wholeheartedly push VA to do that. Particularly when we were asking questions about the change orders and how long things were taking, they couldn't really tell us. There was no system to do that. So for accountability and for tracking and for metrics, it certainly is something that I think needs to be done.

Mr. COFFMAN. So it is not being currently used?

Ms. ST. JAMES. Not that I am aware of.

Mr. HAGGSTROM. Well, it is being used. When you look at the contracts that we are putting in place, the vast majority of—all the new contracts are in fact going through the Electronic Contracting System and into the Federal Procurement Data System.

Ms. ST. JAMES. For the four that we looked at as well?

Mr. HAGGSTROM. Yes.

Ms. ST. JAMES. Okay. We just know that for the change orders, we couldn't get that information easily. There was no real good system in order to give that to us.

Mr. COFFMAN. Mr. Haggstrom, how long has this system been in place and been used? Apparently, there was a mandate in 2007.

Mr. HAGGSTROM. That is correct.

Mr. COFFMAN.—for this system. How long has it been utilized now?

Mr. HAGGSTROM. I believe the system was established, it was prior to my arriving there, back around 2006 or so. It was not well received. Our OIG did an audit on the usage of the system. At that particular time, it was down in the low 40s, the percentage, even lower than that. Through the years, this is one of the metrics that we track internally to the goal, and I believe we are now up in the high 70s to mid 80 percent usage of electronic contract writings.

Mr. COFFMAN. Is this a mandate by Congress? I mean, is it the law?

Mr. HAGGSTROM. No, it is a mandate of the department, sir.

Mr. COFFMAN. It is a mandate by the—and you put out a memo two years ago for everybody to use it and not everybody is using it now?

Mr. HAGGSTROM. There are pockets of folks that still have not fully developed their contracts within the system. We go through, we find those. We provide education. We provide learning engagements to those folks.

Mr. COFFMAN. Well, I mean, you were in the United States Air Force. If you gave out a mandate—I mean, you should put a memo, we have got a copy of the memo 2 years ago that said everybody has got to use this system, and you are saying now people decide whether or not they want to use it. That is under your leadership? You are saying that that is the way things work?

Mr. HAGGSTROM. There are cases where people have not used the system to the full capability that they should be using it to. We go out, we do audit reviews, we find those, we talk with the heads of the contracting agency. There is a hierarchy within the department from me as the acting chief acquisition officer to the heads of contracting authority within the various administrations and/or staff offices. These are the people that need to enforce through their leadership the use of these. I do not have administrative authority over all of the people who do contracting in the department. I just have functional authority.

Mr. COFFMAN. Well, it sounds like you have got a real organizational problem. If you have got a system that is designed—you know, if you are—the problem is, you have got delays; you have got cost overruns; the system isn't working; you are not utilizing the system that is designed to make it work; you are not able, in your position, to get people to use the very system that Congress mandated in 2007. I think that is problematic.

Mr. Haggstrom, on another issue. Is VA requiring surety bonds of construction contracts currently?

Mr. HAGGSTROM. Yes, they do.

Mr. COFFMAN. Okay. Why is the VA making what appears to be arbitrary last minute cuts to monthly payments to the prime contractor, who then passes the cuts down to subcontractors?

Mr. HAGGSTROM. It would be helpful to have a specific issue that that surrounds, but that could range from the work was not performed—

Mr. COFFMAN. Specifically to Aurora, Colorado.

Mr. HAGGSTROM. In those particular cases, we have encountered areas where the work was in fact not performed but was being asked payment for. We found that, in some cases, the work was

performed years prior, and the time for the request for those change orders and payments had been exceeded.

And we have also found that, in Colorado, there is a request for payment above what the budgeted cost, but what that is absent of is any rationale of why it was budgeted at X dollars and now why it is at Y dollars.

The contract that we have in place is not a cost-plus contract. It is a firm target price contract, where the contractor is to adhere to those budgeted amounts. In the case where there is clearly a reason, such as a change in scope or complexity or something like that, they are well within their rights to submit those changes to the VA, and we will respond to them. And if they are due additional payments, we will make those, based on what our government cost estimate is.

Mr. COFFMAN. Why is the VA pushing the prime in subcontractors—in what project would this be? In Aurora, Colorado, to complete work without an approved change order?

Mr. HAGGSTROM. Congressman, we, over the past two months, we just sat down with Kiewit Turner and worked to resolve 111 change orders that Kiewit Turner provided to us as the greatest needs to come to resolution on. That was completed back in mid April. As a result of that, VA has issued to Kewitt Turner $4 million in change orders that Kiewit Turner can now invoice the VA for, for payment.

Mr. COFFMAN. I will take a look at that.

Mr. Kelley, does the VFW conduct any field work to evaluate VA's construction program?

Mr. KELLEY. No, we do not.

Mr. COFFMAN. Very well. Mrs. Kirkpatrick.

Mrs. KIRKPATRICK. Thank you, Mr. Chairman.

I want to follow up on your line of questioning regarding the change orders. It appears that the CRC made a recommendation, actually looked at the process for change orders, and they made a recommendation that the VA examine the authority levels of contracting officers in the field to execute change orders without additional reviews and that the VA consider support for hiring three additional attorneys to review change orders.

Mr. Haggstrom, where are we in terms of those recommendations?

Mr. HAGGSTROM. The authority for the change or the change orders for the contracting officers in the field has been increased from $100,000 to $250,000 per change order. That is in effect, and we are working with our general counsel to hire four additional attorneys that we—would be dedicated to helping us manage the contractual requirements required by these large contracts.

Mrs. KIRKPATRICK. My last question is, does SCIP apply to these four major projects that we are looking at in Las Vegas, Denver, Orlando and New Orleans?

Mr. HAGGSTROM. They do not. This is pre-SCIP.

Mrs. KIRKPATRICK. And why is that?

Mr. HAGGSTROM. SCIP was not, I guess, not envisioned when we started the planning and programming and ultimately requesting funds for these projects. It was not until fiscal year 2012 that the

SCIP came into being. All these projects were developed and appropriations requested prior to that.

Mrs. KIRKPATRICK. Mr. Kelley, would the processes in SCIP help speed up completion of these projects?

Mr. KELLEY. Appropriations at a level that would fund these would speed up the process. I don't—I think SCIP can be used for part of the planning, but as soon as the contract is written, then that is where the delays begin, in my opinion. There is some delay in the planning of that because I think there is some long-term master planning that needs to happen that would allow them to have a better understanding prior to planning, but SCIP, SCIP lays out some of that. I think they can go in a little deeper, but I don't think that—SCIP, in the process of determining need, affects the way the contracts are—in the end, are done or completed.

Mrs. KIRKPATRICK. Ms. St. James, could you prioritize for us the top three changes that you think the VA needs to make to speed up completion of these projects?

Ms. ST. JAMES. Well, we made three recommendations in our report that really were ran or systematic—systemic issues throughout, and one of them was on the medical planners. You absolutely need the medical planners to be involved up front and to have guidance on when they should be used and particularly in these very large complex medical facilities. The communication, that needs to be clearly laid out so that you don't have delays in what the contractor understands that they need to do. And then the change order process, that change order process was really systemic throughout. And when you have delays, sometimes up to 6 months, it doesn't work well, and if they don't get the process changed with the change orders and streamline that, then you are going to continue to see delays, and that is within the construction.

VA needs to get their planning to go away from, and I understand that they are, from rough orders of magnitude and giving Congress what they think they need. They need to put that planning effort up front, which I believe they are trying to do, and then to manage that construction process, including correcting the change order.

Mrs. KIRKPATRICK. Thank you.

I yield back.

Mr. COFFMAN. Thank you. My thanks to the panel. You are now excused.

The obstacles facing VA construction are disheartening, but I look forward to working with the VA to improve its construction practices and to create a system that is both fair to the veterans who have served this country and to the taxpayers who foot the bill.

With that, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material.

Without objection, so ordered.

I want to thank all Members and witnesses for their participation in today's hearing. This hearing is now adjourned.

[Whereupon, at 4:12 p.m., the Subcommittee was adjourned.]

APPENDIX

Prepared Statement of Hon. Mike Coffman, Chairman

Good afternoon. I would like to welcome everyone to today's hearing titled "VA Construction Policy: Failed Plans Result in Plans That Fail."

Providing veterans medical care is a core function of VA. When VA does health care right, it can be second to none. However, the process VA employs to build its health care facilities is abysmal and the result leads to delays for much needed care to veterans

The Government Accountability Office's recent report noted that VA's four largest medical-center construction projects have had an average cost increase of $366 million dollars and an average delay of thirty-five months. One of the most distressing items in the GAO report is that VA failed to learn from its mistakes as it went from project to project. I must add that many of these same issues have been identified by GAO in the past and we seem to be no closer to a better result.

Unfortunately, it is not just major facilities that epitomize why VA's construction policy is a debacle. A little more than a year ago, this Subcommittee held a hearing on VA's failure to perform due diligence and failure to inform Congress of project increases regarding the proposed clinic in Savannah, Georgia. Based on subsequent correspondence with VA over the past year, I am not quite certain VA is getting the message that its construction program is dysfunctional and not in keeping with industry best practices or veterans' expectations.

Not only is VA building facilities over budget and late, but it is also failing to pay the contractors for their work in a timely manner. While ensuring taxpayer dollars are properly spent is of the utmost importance, VA must pay its bills on time. Last week, I visited the Denver project and spoke directly with VA about prompt payment to contractors and subcontractors and was alarmed by VA's response to the issue. Under the Prompt Payment Act, and OMB's guidance, a Federal agency is expected "to ensure that prime contractors disburse the funds that they receive from the Federal Government to their small business subcontractor in a prompt manner." The Prompt Payment Act also requires that the contractor certify that his sub-contractors are receiving payment commensurate with the work performed. But as evidence shows, some contractors and subcontractors in these four projects have been waiting for months to be paid.

Moreover, the Small Business Act explains that it is "the policy of the United States that its prime contractors establish procedures to ensure the timely payment of amounts due pursuant to the terms of their subcontracts with small business concerns." VA's failure to abide by the laws governing payment to its contractors is unacceptable and is a problem in need of an immediate fix.

Given the number and variety of facilities VA has built over the last several years, it is disturbing to me that VA continues to employ policies and techniques that have repeatedly fallen short.

I look forward to hearing from today's witnesses regarding VA's construction policy and how we can move forward to effectively and efficiently build medical facilities for our veterans.

Prepared Statement of Hon. Jackie Walorski

Mr. Chairman and Ranking Member, it's an honor to serve on this Committee.

I thank you for holding this hearing on such an important issue for our veterans and the future of veteran health care.

The Department of Veterans Affairs (VA) oversees an impressive health care delivery system comprised of 152 hospitals and 821 community-based outpatient clin-

ics (CBOCs) in addition to close to 300 veteran centers.[1] These facilities have a reputation for providing quality care specific to veteran needs; however, many of these facilities are in desperate need of repair and modifications to accommodate the influx of new veterans as well as a veteran population composed of approximately 43 percent who are 65 or older.[2]

There is an obvious greater need for state-of-the-art facilities that can address the unique needs of all veterans. This is why I am determined to ensure the replacement CBOC proposed for South Bend remains on schedule to open in 2015. The approximately 53,000 veterans in Indiana's Second Congressional District have earned access to the primary care and mental health services promised with this new facility.[3]

The delays and significant cost increases for other VA medical center projects are disturbing. This is an issue which necessitates immediate action from the VA.

I look forward to working with my colleagues and our panelists to establish a plan of action for the Department of Veterans Affairs which eliminates redundancies and streamlines processes that promote greater efficiency in the construction of major medical-facility projects.

Thank you.

Prepared Statement of Lorelei St. James

Chairman Coffman, Ranking Member Kirkpatrick, and Members of the Subcommittee:

I am pleased to be here today to discuss our recent work examining cost increases and schedule delays at the Department of Veterans Affairs' (VA) major medical-facility construction projects.[1] According to VA's fiscal year 2013 budget submission to Congress, the Veterans Health Administration's (VHA) existing infrastructure does not fully align with the current health care needs of the veteran population.[2] To help address this situation, VA has 50 major medical-facility projects[3] under way, including new construction and the renovation of existing medical facilities, at a cost of more than $12 billion. Although VA has taken steps to improve its process for managing these construction projects, opportunities exist for VA to improve its efforts.

This testimony discusses VA construction management issues, specifically (1) the extent to which the cost, schedule, and scope for selected new medical-facility projects have changed since they were submitted to Congress and the reasons for these changes, (2) actions VA has taken to improve its construction management practices, and (3) the opportunities that exist for VA to further improve its management of the costs, schedule, and scope of these construction projects. This testimony is based on our April 2013 report. In that report, we discuss VA's current 50 major medical-facility projects, including the original cost estimates and completion dates and the projects' current status according to November 2012 data.[4] To understand issues involving costs estimates and completion dates, we took a more detailed review of four VA medical-facility projects in Las Vegas, Orlando, New Orleans and Denver. We also reviewed and analyzed construction documents, VA's Strategic Plan Fiscal Years 2011 to 2015, and other relevant documents. We interviewed officials from VA; veterans support organizations; architectural and engineering firms; gen-

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[1] Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, "Department of Veterans Affairs Statistics at a Glance," Updated 4 February 2013. *http://www.va.gov/vetdata/docs/Quickfacts/Winter—13—sharepoint.pdf.*

[2] *Ibid.*

[3] There are an estimated 53,318 veterans in IN–02. This data was compiled on 09/30/2012, based on the district lines from the 112th Congress. *http://www.va.gov/vetdata/Veteran—Population.asp.*

[1] GAO, VA Construction: Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects, GAO-13-302 (Washington, D.C.: April 4, 2013).

[2] U.S. Department of Veterans Affairs, Fiscal Year 2013 Budget Request. Construction IV (Washington, D.C.: 2012).

[3] The term "major medical-facility project" means a project for the construction, alteration, or acquisition of a medical facility involving the total expenditure of more than $10 million. See 38 U.S.C. § 8104. These projects cost at least $10 million, some in the hundreds of millions of dollars. The project types include new construction, renovation of existing structures, expansion, or a combination of types. The total number of major VA medical-facility projects is based on agency data from November 2012.

[4] We identified reasons for selected facilities' overall cost and schedule changes, but were not able to identify the extent to which specific reasons changed these costs and schedules, unless specifically noted.

eral contractor construction firms; and construction management firms. The work on which this statement is based was conducted from April 2012 to April 2013 in accordance with generally accepted government auditing standards. For a more detailed explanation of our scope and methodology, see the April 2013 report.

In summary, we recognize that some cost increases and schedule delays result from factors beyond VA's control; however, our review of VA's largest projects indicated weaknesses in VA's construction management processes also contributed to cost increases and schedule delays. Given that VA is currently involved in 50 major medical-facility construction projects, including four large medical centers, VA should take further action to improve its management of costs, schedule, and scope of these projects.

Cost Increases and Schedule Delays at the Four Largest Projects Occurred for a Variety of Reasons

Cost Increases and Schedule Delays

Costs increased and schedules were delayed considerably for VA's four largest medical-facility construction projects, when comparing November 2012 construction project data with the cost and schedule estimates first submitted to Congress. Cost increases ranged from 59 percent to 144 percent,[5] representing a total cost increase of nearly $1.5 billion and an average increase of approximately $366 million per project. The schedule delays ranged from 14 to 74 months with an average delay of 35 months per project (see table 1).

Table 1: Veterans Affairs Major Medical-Facility Projects Cost Increases and Schedule Delays, as of November 2012

Project location	Initial total estimated costs	Total estimated costs	Percentage increase	Initial estimated completion date	Current estimated completion date	Number of months extended	Total estimated years to complete[a]
Las Vegas	$325 million	$585 million	80	April 2009	June 2014	74	10.25
Orlando	$254 million	$616 million	143	April 2010	July 2013[b]	39	8.5
Denver	$328 million	$800 million	144	February 2014	April 2015	14	10.5
New Orleans	$625 million	$995 million	59	December 2014	February 2016	14	8.5

Source: GAO Analysis of VA data.

a - The column titled "total estimated years to complete" is reported to the nearest quarter year and is calculated from the time VA approved the architecture and engineering firm to the current estimated completion date. We calculated the "number of months extended" column by counting the months from the initial estimated completion date to the current estimated completion date, as reported by VA. According to VA, the dates in the initial estimated completion dates are from the initial budget prospectus, which assumed receipt of full construction funding within 1 to 2 years after the budget submission. In some cases, construction funding was phased over several years and the final funding was received several years later. Naval Facilities Engineering Command officials we spoke with told us that historically, their medical facility projects take approximately 4 years from design to completion. We calculated the percentage change in cost by using the initial total estimated costs and total estimated costs, as reported by VA.

b - VA provided time extensions to the Orlando, Florida contractor extending the contract completion date to July 2013. Because of an ongoing dispute between VA and the general contractor regarding performance of the contract in Orlando, VA issued a "show-cause" notice to the contractor on January 31, 2013. The show-cause notice provides the contractor an opportunity to present any facts relevant to the dispute. As of the publication of this testimony, VA has yet to determine the next steps to resolve this matter. July 2013 is considered the current completion date provided to us by VA officials. However, the general contractor disagrees with this date and has estimated that it will be spring 2014.

Of the remaining 46 major medical-facility projects, 26 are under construction or were recently completed. Of these 26, half have experienced cost increases, but the other half experienced either no change in costs or a decrease in costs. Nineteen of

[5] According to the Office of Management and Budget (OMB), federal agencies should keep a contingency fund of 10 to 30 percent above total estimated costs to address increased costs on construction projects. However, this guidance applies after construction has begun, and many of the cost increases we observed occurred before that time. The construction contractor is generally responsible for cost increases and schedule overruns under the terms of the fixed-price contract. OMB Circular No. A–11, Appendix 8 (2012).

24 construction projects currently under construction or recently completed have experienced schedule delays.[6]

In commenting on a draft of our April 2013 report, VA contends that using the initial completion date from the construction contract would be more accurate than using the initial completion date provided to Congress; however, using the initial completion date from the construction contract would not account for how VA managed these projects prior to the award of the construction contract. Cost estimates at this earlier stage should be as accurate and credible as possible because Congress uses these initial estimates to consider authorizations and make appropriations decisions. We used a similar methodology to estimate changes to cost and schedule of construction projects in a previous report issued in 2009 on VA construction projects. We believe that the methodology we used in our April 2013 and December 2009 report on VA construction provides an accurate depiction of how cost and schedules for construction projects can change from the time they are first submitted to Congress.[7] It is at this time that expectations are set among stakeholders, including the veterans' community, for when projects will be completed and at what cost.

Reasons for Cost Increases and Schedule Delays at VA's Four Largest Projects and Related Scope Changes

At each of the four locations we reviewed, different factors contributed to cost increases and schedule delays:

- **Changing health care needs of the local veteran population changed the scope of the Las Vegas project.** VA officials told us that the Las Vegas Medical Center was initially planned as an expanded clinic co-located with Nellis Air Force Base. However, VA later determined that a much larger medical center was needed in Las Vegas after it became clear that an inpatient medical center shared with the Air Force would be inadequate to serve the medical needs of local veterans.
- **Decisions to change plans from a shared university/VA medical center to a stand-alone VA medical center affected plans in Denver and New Orleans.** For Denver and New Orleans, VA revised its original plans for shared facilities with local universities to stand-alone facilities after proposals for a shared facility could not be finalized.
- **Changes to the site location by VA delayed efforts in Orlando.** In Orlando, VA's site location changed three times from 2004 to 2010. It first changed because VA, in renovating the existing VA hospital in Orlando, realized the facility site was too small to include needed services. However, before VA could finalize the purchase of a new larger site, the land owner sold half of the land to another buyer, and the remaining site was again too small.
- **Unanticipated events in Las Vegas, New Orleans, and Denver also led to delays.** For example, VA officials at the Denver project site discovered they needed to eradicate asbestos and replace faulty electrical systems from pre-existing buildings. They also discovered and removed a buried swimming pool and found a mineral-laden underground spring that forced them to continually treat and pump the water from the site.

VA Has Taken Steps to Improve Its Construction Management Practices

VA has made improvements in its management of major medical-facility construction projects, including creating a construction-management review council. In April 2012, the Secretary of Veterans Affairs established the Construction Review Council to serve as the single point of oversight and performance accountability for the planning, budgeting, executing, and delivering of VA's real property capital-asset program.[8] The council issued an internal report in November 2012 that contained findings and recommendations that resulted from meetings it held from April to July 2012.[9] The report revealed that the challenges identified on a project-by-project basis were not isolated incidents but were indicative of systemic problems facing VA, and made several recommendations to address these problems. But VA has not

[6] VA did not provide schedule data for both initial estimated completion date and current estimated completion date for two projects under construction.

[7] GAO, VA Construction: VA is Working to Improve Initial Project Cost Estimates, but Should Analyze Cost and Schedule Risks, GAO–10–189 (Washington, D.C.: Dec. 14, 2009).

[8] The Construction Review Council was comprised of officials from the VA, including the secretary, deputy secretary, chief of staff, under secretaries, and assistant secretaries, as well as key leaders across the department. The Secretary of VA chaired nine meetings from April 18 through June 15, 2012, to review the VA construction program and identify challenges that led to changes in scope, cost over-runs, and scheduling delays of major projects.

[9] VA, The Construction Review Council Activity Report (Washington, D.C.: November 2012).

yet developed specific guidance or instructions for how to implement the recommendations.

VA has taken some other actions to improve construction project management. For example, VA has collaborated with other federal agencies involved in medical facilities construction to tap their experience, and convened a construction industry forum to communicate about ways to improve medical facilities construction practices. In addition, VA has taken steps to involve construction contractors earlier in some projects to allow coordination with the architectural and engineering firms in designing and planning a project.

Opportunities Exist for VA to Further Improve Its Construction Management Practices

Although VA has made improvements in its management of major medical-facility construction projects, many of these projects continue to experience cost increases and schedule delays. We recognize that some cost increases and schedule delays result from factors beyond VA's control; however, our review of VA's four largest projects indicates that weaknesses in VA's construction management processes–in particular, those listed below—also contributed to cost increases and schedule delays:

Using Medical Equipment Planners

VA officials have emphasized that they need the flexibility to change their heath care processes in response to the development of new technologies, equipment, and advances in medicine.[10] Given the complexity and sometimes rapidly evolving nature of medical technology, many health care organizations employ medical equipment planners to help match the medical equipment needed in the facility to the construction of the facility. Federal and private sector stakeholders during our review reported that medical equipment planners have helped avoid schedule delays. VA officials told us that they sometimes hire a medical equipment planner as part of the architectural and engineering firm services to address medical equipment planning. However, we found that for costly and complex facilities, VA does not have guidance for how to involve medical equipment planners during each construction stage of a major hospital and has sometimes relied on local VHA staff with limited experience in procuring medical equipment to make medical-equipment- planning decisions. In Orlando, medical equipment specifications changed several times and led to cost increases of at least $14 million in addition to schedule delays, as these issues forced VA to suspend construction until the issues were resolved. In our April 2013 report, we recommended that the Secretary of VA develop and implement agency guidance to assign of medical equipment planners to major medical construction projects. VA agreed and said it planned to address this recommendation.

Sharing Information on the Roles and Responsibilities of VA's Construction-Management Staff

Construction of large medical facilities involves numerous staff from multiple VA organizations. Officials from the Office of Construction and Facilities Management (CFM) stated that during the construction process, effective communication is essential and must be continuous and involve an open exchange of information among VA staff and other key stakeholders.[11] However, we found that the roles and responsibilities of CFM and VHA staff are not always well communicated and that it is not always clear to general contracting firms which VA officials hold the authority for making construction decisions. This can cause confusion for contractors and architectural and engineering firms, ultimately affecting the relationship between VA and the general contractor. For example, contractor officials at one site said that VA's project manager directed them to defer the design of specific rooms until medical equipment was selected for the facility; however, VA's central office then directed the contractor to proceed with designing the rooms. This conflicting direction from VA could require the contractor to redesign the space, further expending project resources. Participants from VA's 2011 industry forum also reported that VA roles and responsibilities for contracting officials were not always clear and made several recommendations to VA to address this issue. In April 2013, we recommended that the Secretary of VA develop and disseminate procedures for communicating—to contractors—clearly defined roles and responsibilities of the VA officials who manage major medical-facility projects, particularly those in the change-order process. VA agreed and stated they had actions underway to improve communication involving roles and responsibilities.

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[10] VA, Strategic Plan Refresh: FY2011–FY2015, (Washington, D.C).

[11] VA, Construction Primer (Washington, D.C.: January 2013).

Managing the Change- Order Process

Most construction projects require, to varying degrees, changes to the facility design as the project progresses, and organizations typically have a process to initiate and implement these changes through change orders. Federal regulations [12] and agency guidance [13] state that change orders must be made promptly, and that there be sufficient time allotted for the government and contractor to agree on an equitable contract adjustment. VA officials at the sites we visited stated that change orders that take more than a month from when they are initiated to when they are approved can result in schedule delays, and officials at two federal agencies that also construct large medical projects told us that it should not take more than a few weeks to a month to issue most change orders. [14] However, officials at two sites, New Orleans and Orlando, said that it was common for VA to take 6 months to process a change order, even though VA has directed its staff to eliminate or minimize delays. [15] Processing delays may be caused by the difficulty involved in VA's and contractors' coming to agreement on the costs of changes and the multiple levels of review required for many of VA's change orders. In April 2013, we recommended that the Secretary of VA issue and take steps to implement guidance on streamlining the change-order process based on the findings and recommendations of the Construction Review Council. [16] VA concurred with our recommendation and was reviewing the options proposed by the Construction Review Council to streamline the change-order process.

We provided a draft of our April 2013 report for VA for review and comment. In its written comments, VA concurred with our recommendations.

Chairman Coffman and Ranking Member Kirkpatrick, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

Contacts and Acknowledgments

If you have any questions about this testimony, please contact Lorelei St. James at (202) 512–2834 or stjamesl@gao.gov. Other key contributors to this testimony include are Ed Laughlin (Assistant Director), Nelsie Alcoser, George Depaoli, Raymond Griffith, Joshua Ormond, Amy Rosewarne, James Russell, Sandra Sokol, and Crystal Wesco.

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[12] 48 C.F.R. § 43.201

[13] VA, VA Resident Engineer Handbook, "Chapter 3: Major Construction: Contract Changes" (3.24) (Washington, D.C.)

[14] Specifically, we interviewed the U.S. Army Corps of Engineers and Naval Facilities Engineering Command. We recognize that the Department of Veterans Affairs serve different populations in the defense community—active duty military personnel and veterans, respectively. However, these organizations construct similar medical facilities, in addition to abiding by federal government regulations for construction projects.

[15] Although officials at one of these sites said that VA's timeliness of the change order process has improved, they noted that a change order still takes an average of 2 to 3 months, indicating to them that further improvement is needed.

[16] GAO-13-302.

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Prepared Statement of Raymond C. Kelley

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the nearly 2 million men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, I would like to thank you for the opportunity to testify today regarding VA construction policy.

As the Department of Veterans Affairs (VA) strives to improve the quality and delivery of care for our wounded, ill and injured veterans, the facilities that provide that care continue to erode. With buildings that have an average age of 60 years, VA has a monumental task of replacing or expanding the existing medical facilities. From 2004 to 2010, utilization of VA health care facilities grew from 80 percent to 121 percent, while the conditions of these facilities declined from 81 percent to 71 percent over the same period of time.

In 2010, VA adopted the Strategic Capital Investment Planning (SCIP) process to identify current and future infrastructure needs. Based on this process, VA identified 130 major construction projects that need to be completed by 2021 to eliminate the current and future gaps in utilization and safety. The price tag to close these major construction gaps is between $21 billion and $25 billion. To even come close to accomplishing these projects, VA must maximize every dollar and implement processes that will expedite the construction process.

The VFW has identified four major areas that need to be addressed to ensure that construction projects are done in a more efficient and cost effective manner. First, VA must use the electronic Contract Management System (eCMS) to its fullest potential; second, VA needs to change from using the design-bid-build practice; third, VA must adopt a comprehensive facility master plan; and forth, VA should being using medical equipment planners on all major construction projects.

eCMS is VA's centralized electronic contract writing and management platform that is intended to replace the current contract writer. eCMS is designed to reduce costs, standardize the acquisition process, reduce workload and improve communication for any contract valued at $25,000 or more.

Roll-out and utilization of eCMS has been slow. By VA's own account, usage has gone from 17 percent in 2008, to 77 percent in 2012. The VA Office of Acquisitions and Logistics and Construction (OALC) has mandated that all contracts costing more than $25,000 must be processed through eCMS. However, design flaws within eCMS prevent it from being an effective tool in contract management and fiscal oversight, and causes contract officers who use the program to also write the contract through the National Acquisition Center's Contract Management system.

Therefore, eCMS's information is incomplete and cannot be relied upon for making sound procurement decisions and causes contract officers to duplicate their effort, which results in inefficient use of time and resources.

VA projects that system upgrades to eCMS will be completed in 2014. Congress must ensure that the resources that are needed to complete these upgrades are available and they must provide oversight to confirm eCMS is being utilized. While the system is improving, OALC must follow through with its mandate to write contracts in eCMS, so OALC can consistently capture data, allowing them to make better acquisition decisions.

VA has historically relied on the design-bid-build project delivery system when entering into contracts to build major medical facility projects. Of the 50 current VA major medical facility projects, 43 of them are design-bid-build. With this model, an architect is selected to design a facility, the design documents are used to secure a bid, and then the successful contract bid holder builds the facility.

Design-bid-build projects often encounter disputes between the costumer – VA in this case – and the construction contractor. Because these contracts are generally firm-fixed-price, based on the completed design, the construction contractor is usually responsible for cost overruns, unless VA and the contractor agree on any needed or proposed changes that occur with a change of scope, unforeseen site condition changes or design errors. VA and the contractor negotiate these changes through change orders. This process can become adversarial, because neither party wants to absorb the cost associated with the change, and each change order can add months to the project completion date.

The flaws of design-bid-build projects have become very apparent, highlighted by the delays in Orlando, Florida, where a new medical facility has been delayed by 39 months due mostly to change order disputes. This contract must be followed through to completion, but VA must use this as a lessons-learned and change their contracting model to an Architect-led design-build model.

A design-build project teams the architectural/engineering company and the construction contractor under one contract. This method can save VA up to six months of time by putting the design phase and the construction performance metric together. Placing the architect as the lead from start to finish, and having the construction contractor work side-by-side with the architect, allows the architect to be an advocate for VA. Also, the architect and the construction contractor can work together early on in the design phase to reduce the number of design errors, and it also allows them to identify and modify the building plans throughout the project.

VA must also use master planning at all of its facilities. Master planning will allow VA to examine and project potential changes in technology, patient care practices and changes in veteran demographics. The new Las Vegas Medical Center is an example of not knowing the trend in the veteran population, causing the project to be delayed while the scope of the project was changed. Early on, VA only planned to expand an existing facility, later realizing that a much larger facility was needed to meet the needs of the veterans in the community. Having a thorough master plan could have eliminated some the 74-month delay in the construction of this facility.

The last area the VFW would like to discuss that has been identified as causing delays in medical facility construction is the purchase of medical equipment. VA wants to equip its facilities with the most up-to-date equipment. However, procuring medical equipment after the design of the facility inevitably causes building delays while the designs are redrawn, and in some cases some demolition of recently constructed areas must take place to accommodate the newly purchased medical equipment.

The VFW believes that VA would benefit from the use of medical equipment planners. Using these planners, which is an industry practice used by the Army Corps of Engineers and other federal agencies, places an experienced medical equipment expert at the disposal of the architect and construction contractor. When used properly, a medical equipment planner can work with the architect during the design phase and then the construction contractor during the build phase to ensure needed space, physical structure and electrical support are adequate for the purchased medical equipment, reducing change orders, work stoppages, and the demolition of newly built sections of a facility.

Using a medical equipment planner can reduce schedule delays and cost overruns. Using the Orlando facility as an example again, issues with the purchase of medical equipment caused cost overruns of more than $10 million and construction had to be suspended until the issues were resolved.

It is important for VA to become more efficient at constructing facilities. Veterans have expectations that medical facilities will be available when VA first states what the completion date will be. It is obvious by looking at the number of delays and cost overruns that the contracting and building procedures that VA currently uses

are antiquated and are costing VA millions of dollars more for each project and causing five to six year delays in much needed medical facilities. By implementing these four initiatives, future major construction projects will have better oversight, cost controls and more efficient procedures for unforeseen changes in the construction of facilities.

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

Information Required by Rule XI2(g)(4) of the House of Representatives

Pursuant to Rule XI2(g)(4) of the House of Representatives, VFW has not received any federal grants in Fiscal Year 2013, nor has it received any federal grants in the two previous Fiscal Years.

Prepared Statement of Glenn D. Haggstrom

Chairman Coffman, ranking member Kirkpatrick, distinguished members of the subcommittee, I am pleased to appear here this afternoon to update the subcommittee on the Department of Veterans Affairs' (VA) continuing efforts to improve construction procedures and planning processes to ensure timely execution of major construction projects. Joining me this afternoon is Stella Fiotes, Executive Director, Construction and Facilities Management, OALC.

The Department's infrastructure programs which include major and minor construction, non-recurring maintenance, and leasing are part of our ongoing mission to care for and memorialize our Nation's Veterans. We are 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 has made significant improvements in its real property capital asset portfolio to provide state of the art facilities to 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 management of increased workload demands; changing Veteran patient demographics; advances in medical technology; new complex treatment protocols and advanced procedures; delivering patient-centered care and services closer to where Veterans live; and evolving Federal requirements.

The focus of my testimony today is on VA's major construction program – our program identification, process improvements and challenges, and accomplishments. This will provide you a perspective of how we deliver VA's major construction projects.

Program Identification

The Strategic Capital Investment Planning (SCIP) process was implemented with the fiscal year (FY) 2012 budget. This Department-wide planning process prioritizes the Department's future capital investment needs to strategically target VA's limited resources to most effectively improve the delivery of services and benefits to Veterans, their families and survivors by addressing VA's most critical infrastructure needs and performance gaps and investing wisely in VA's future. Using this approach, VA has visibility across its entire real property portfolio and is able to synchronize the projects we undertake in our major infrastructure programs to address our most critical needs. As part of this, VA has identified critical milestones for review in the life-cycle of a project from the planning and programming stages to the disposition of a facility when it is no longer functional for its purpose or needed to fulfill the mission.

Process Improvements

VA has taken several steps to improve the management and oversight of major construction 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. VAFM identified a need for the following:

1. An enterprise approach to integrated master planning - Plans were piloted in 2011 and are moving to full operation;

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, minor construction as well as non-recurring maintenance (NRM), and;

3. Post occupancy evaluations (POE) - The POE program, piloted in 2012, is now standard practice for the major construction program and is expanding to the minor construction program. POE evaluates the completed construction to assure closure of all gaps and deficiencies noted in the approved project scope.

In April 2012, as a follow on to the 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 findings to improve performance in four major areas:

1. Development of requirements - Add rigor to the requirements development phase of the project and complete 35 percent of a project's design prior to requesting major construction funds. This assures that full requirements are identified early, designed, costed and managed through the construction cycle which results in more complete cost estimates and scopes in VA's budget submissions.

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

3. Funding - VA is implementing an integrated approach to activation and funding to assure the project construction program is coordinated with information technology (IT) and medical equipment budgets and plans. This identifies the funding and planning for the procurement of medical equipment and IT infrastructure, and incorporating major equipment delivery and installation into the master construction schedule.

4. Program Management and Automation - VA continues to educate and certify project managers and deploy modern collaborative tools for project management to ensure project cost, scope, and schedule growth is controlled.

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. The recommendations in the May 2013 GAO report on "VA Construction: VA Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects" are improvements that were also previously identified and are currently being addressed.

Challenges and Accomplishments

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.

Last year we briefed the House Veterans Affairs Committee on the construction of the new VA medical center in Orlando. The Orlando project includes 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. The construction project has advanced from approximately 50% completion a year ago to approximately 80 percent today. While the project has been challenged by design errors and omissions, medical equipment coordination, and contractor performance, VA remains committed to working with our contractor to ensure a quality project is delivered to meet the needs of Veterans and their families.

The lessons learned from Orlando and past major construction projects are guiding us in our management of the Denver and New Orleans replacement hospitals. Both complexes will be full-service tertiary care medical centers that include specialty care; outpatient clinics; inpatient services; central energy plant and parking structures; as well as other support services. Both facilities are under construction with completion dates of 2015 and 2016 respectively. Lessons learned have resulted in increased staff to assure timely project and contract administration; partnering sessions that include VA and the construction and design contractors; early involvement of the medical equipment planning and procurement teams; and engagement in executive level on-site project reviews. VA will continue to provide regular updates to the Congressional Committees to ensure you are fully informed on the progress of these medical centers.

While VA's major construction program has encountered challenges, it has also completed and delivered significant projects for Veterans in the past five years. In

FY 2012 and FY 2013 to date, VA has delivered nearly $1 billion worth of facilities. This includes 16 medical facilities, including the new Las Vegas hospital, and five new cemeteries or cemetery expansions, the vast majority of which were delivered without construction delay and within the appropriated funds. VA continues work to complete 52 major construction projects to provide the much needed facilities for our Veterans and their families.

Conclusion

VA has a strong history of delivering facilities to accomplish our mission to serve Veterans. 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. The lessons learned from our past construction projects will continue to lead to improvements in the management and execution of our capital program as we move forward. Thank you for the opportunity to testify before the committee today. I look forward to answering any questions the Committee has regarding these issues.

Questions For The Record

Letter and Question Submitted by Rep. Beto O'Rourke, To: VA

May 10, 2013

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 Subcommittee on Oversight & Investigations hearing entitled, "VA Construction Policy: Failed Plans Result in Plans That Fail," that took place on May 7, 2013, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 10, 2013.

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 Jian Zapata at jian.zapata@mail.house.gov by the close of business on June 10, 2013. If you have any questions please contact her at 202–225–9756.

Sincerely,

MICHAEL H. MICHAUD
Ranking Member

CW:jz

Questions Submitted by Representative Beto O'Rourke

Mr. Glenn D. Haggstrom

1. Please identify the factors that go into determining the Strategic Capital Investment Planning (SCIP) priority for a facility that is co-located with either a U.S. Department of Defense (DoD) facility or a private or public medical center.

VA Response to Questions Submitted by Rep. Beto O'Rourke

Question Submitted by Representative Beto O'Rourke

Question: Please identify the factors that go into determining the Strategic Capital Investment Planning (SCIP) priority for a facility that is co-located with either a U.S. Department of Defense (DoD) facility or a private or public medical center.

VA Response: The Department of Veterans Affairs (VA) Strategic Capital Investment Planning (SCIP) process provides an innovative and methodologically-rigorous approach to providing a single, integrated list of its prioritized capital investment projects. To identify projects that best meet the Department's critical needs, SCIP relies on a data-driven approach that includes the use of gap analysis, strategic capital assessment, and long-term capital planning.

For the President's 2014 Budget proposal, VA ranked each capital project according to how well each addressed six major criterion it identified as critical for addressing the Department's and Veteran-s' needs. Criteria include improving safety and security for Veterans and VA staff; fixing and extending the useful life of current infrastructure; increasing access; right-sizing inventory; maximizing value; and the degree to which the project addresses mission critical initiatives that are outlined in the Department's strategic plan. SCIP criteria also includes collaboration with the Department of Defense (DoD). Projects that have a VA/DoD component are given priority points that factor into the project's overall prioritization score. Once a recommendation is made, the integrated list is reviewed by VA leadership for approval and inclusion in the annual budget request. It should be noted that DoD's Capital Investment Decision Model (CIDM) also contains a scoring component in its criteria that awards incentive points for collaborative proposals that support both Departments.

VA and DoD have a long list of collaborating in the provision of medical care to their respective beneficiaries. Support of capital construction collaborations with DoD comports with Departmental initiatives. The VA/DoD Joint Executive Council established a Construction Planning Committee (CPC) to facilitate collaboration between the Departments and ensure an integrated approach to planning, design, construction (major and minor), leasing and other real property-related initiatives for shared medical facilities. This integration enhances service delivery and assures projects that are mutually beneficial to both Departments. In order to enhance existing capital asset management planning processes, the CPC developed a common approach to identify and to share common data elements and to improve communication. In 2012, the CPC shared point-of-contact information with both VA and DoD planners as well as three data points: population, workload, and purchased care, for utilization in each Department's capital planning processes. In 2013, the CPC added two additional data elements: access and available space, to aid in the early identification of potential joint construction and leasing opportunities at the field level.

While supportive of collaboration, VA does not have statutory authority to construct or lease joint VA/DoD facilities. This is a significant impediment to the Department's ability to collaborate effectively with DoD. To address this issue, VA and DoD have both proposed legislation in fiscal year 2014 that would alleviate existing roadblocks to planning and funding future joint medical facility projects.

Additional Questions & Answers to VA from the Committee Members

1. VA previously stated that it concurred with GAO's recommendations for improving VA's construction management practices. As such, please provide an overview of what actions VA is taking to address these recommendations.

VA Response: Included in GAO's report, Appendix IV, are Comments of the Department of Veterans Affairs (VA). VA intends to address the report recommendations as follows:

Recommendation 1: Develop and implement agency guidance for assignment of medical equipment planner to major medical construction projects.

VA Comment: Concur. VA concurs that medical equipment planning is critical to mitigating project cost and schedule risks.

In coordination with the Veterans Health Administration (VHA), the Office of Acquisition, Logistics, and Construction (OALC) is evaluating criteria for the assignment of medical equipment planners to major construction projects, as well as medical equipment planner project roles and responsibilities, and will develop and implement the appropriate VA guidance. Additionally, VA has ensured that medical equipment planners are incorporated into the Denver and New Orleans major construction project teams.

Recommendation 2: Develop and disseminate procedures for communicating to contractors clearly defined roles and responsibilities of VA officials that manage major medical facility projects, particularly the change order process.

VA Comment: Concur. VA concurs with the importance of establishing and communicating clearly defined roles and responsibilities, particularly with respect to the change order process.

VA currently addresses the roles and responsibilities under the contract with the designer at the design kickoff meetings and with construction contractors at the preconstruction conference. Roles and responsibilities relative to changes are discussed in detail and followed in writing. The contracting officer provides a letter specifically naming individuals with the authority to execute changes and the limits of their authority. The contractor is required to sign the letter, acknowledging understanding of the stipulated authorities and limits.

VA's project management plan (PMP) template requires the creation of a communications plan and matrix to assure clear and consistent communications with all parties. The communications plan must address the following:

a. generation, collection, dissemination, and storage of project information;

b. regular project communication, such as meetings and in-progress reviews;

c. frequency and method of communication (e.g., e-mail, phone); and

d. stakeholder roles and responsibilities. An appendix to the plan provides more specific information on the development of the plan and provides a sample of a typical communications plan matrix. VA will continue to review and define these communications plans and develop procedures to ensure distribution to all the stakeholders.

VA has also added a Construction Peer Excellence Review to assure effective communication and collaboration are incorporated on projects during construction. This program is an adaptation of the General Services Administration (GSA) program. VA has GSA staff on loan to stand up the program and perform the initial reviews. The program involves industry leaders visiting the site and assessing individual and "team" effectiveness.

Recommendation 3: Issue and take steps to implement guidance on streamlining the change order process based on the findings and recommendations of the Construction Review Council.

VA Comment: Concur. VA is developing and will implement guidance to streamline the change order process to reduce review time and increase proactive action. These strategic activities include:

a. Establishing time goals for processing change orders and modifications to the contract. These time goals for processing will clearly convey to the staff the acceptable performance level. These time goals will be benchmarked with other Federal agencies to assure VA incorporates best practice initiatives; and

b. Standing up a metrics program that will allow leadership to monitor change order processing time in order to affect resources to bring the change order processing time within acceptable standards.

In order to immediately streamline the process, VA has placed contracting staff on-site in New Orleans, Orlando, Denver, Manhattan, and Palo Alto and has additional contracting officers available to deploy to any site requiring support to shorten review and processing time. Additionally, VA has hired four additional attorneys dedicated to the major construction program. These attorneys are being integrated into the project teams to assure timely counsel and review of actions.

2. In response to GAO's recommendation to develop and disseminate procedures for communicating to contractor's clearly defined roles and responsibilities of VA officials responsible for managing major medical-facility projects, VA states that it will develop procedures to ensure distribution to all stakeholders. Please explain what these procedures might include to ensure all stakeholders are made aware of these roles and responsibilities.

VA Response: Please refer to response to Question 1, Recommendation 2.

3. In response to VA's concerns with GAO's methodology, VA recommends using an alternative methodology such as calculating the estimated completion date from when the construction contract was awarded, rather than when the project was first submitted to Congress. Can you please explain this methodology and why you think it is better model to use?

VA Response: To clarify, VA did not recommend an alternative methodology. Rather, VA requested GAO to consider and include additional cost and schedule information that provides a more comprehensive perspective regarding changes to con-

struction requirements and their impact on initial cost and schedule estimates. VA detailed this request in its March 27, 2013 response to the draft GAO report, and provides the same explanation below.

VA has significant concerns with Tables 3 and 5 of the GAO report regarding the calculation of cost increases and schedule delays. Designs, initial cost estimates, and schedule completion dates are developed years prospectively, well before Congress appropriates funding and the contract to construct is awarded, which determines initial cost and ultimate completion date of the construction project. For example, GAO referenced numerous cost increases in the Denver project, which in some cases were driven by a change in requirements; however, they failed to mention that during the mid-2000s (i.e., 2004–2008), the construction market was experiencing extremely high cost escalation which greatly contributed to the project's overall cost increases. This was highlighted in the prospectus submitted for the fiscal year 2008 budget.

As another example, Orlando indicated a completion date of April 2010 in the first prospectus included in the budget (referred to throughout the report as "Initial Estimated Completion Date"). However, Orlando did not receive its final funding for the main hospital building until fiscal year 2010, making it impossible to complete the project any time during that fiscal year.

As a result, VA asked GAO to consider and include a clarifying/amplifying footnote to the Initial 'Estimated Completion Date' column of Tables 3 and 5, as follows, "The dates represented here are from the initial budget prospectus, which assumed receipt of full construction funding within one to two years after budget submission. In some cases, construction funding was phased over several years, and the final funding was received several years later."

A more accurate depiction of the project cost and construction schedule would be to make a comparison between the total appropriations received and the current total estimated cost. For schedule issues, a more accurate comparison would be the initial completion date established at the award of construction contract and the actual or estimated construction contract completion date.

Therefore, VA recommended adding the table below to supplement Table 3:

Location/ Description	Last FY that Construction Appropriations were Received	Total Appropriations Received ($M)	Current Total Estimated Costs ($M)	Difference between Total Appropriations Received & Current Total Estimated Costs (%)	Initial Contract Completion Date at Award	Actual/ Estimated Construction Contract Completion Date	Months Extended	Actual/ Estimated Years to Complete Construction
Las Vegas	2008	$600	$585	-2.6%	8/2011	4/2012	8	5.5
Orlando	2008	$665	$616	-7.4%	10/2012	8/2013	10	4.0
Denver	2012	$800	$800	0.0%	4/2015	4/2015	0	5.7
New Orleans	2012	$995	$995	0.0%	2/2016	2/2016	0	4.7

a. Considering that VA's estimates are provided to Congress to authorize and appropriate funds to projects, please discuss the validity of these initial estimates?

VA Response: The initial project construction cost estimates are valid, based on the situation at the time of submission; however, as noted above, the time of these initial estimates may precede actual appropriation by several years, during which significant changes in requirements (i.e., Veterans' needs, material and labor costs, and market pricing) may necessitate adjustments to cost and schedule.

b.What steps has VA taken to develop accurate cost estimates?

VA Response: As noted in the November 2012 Construction Review Council report, VA began requiring that major construction projects reach 35 percent design completion prior to budget submission. The 35 percent design threshold will establish a true baseline cost estimate, reflective of all requirements, with the benefit of engineering studies. Furthermore, the 35 percent design threshold incorporates user group input, thus ensuring a coordinated facility approach.

c.Would VA's recommended methodology account for any delays experienced prior to awarding the construction contract?

VA Response: To reiterate, VA did not recommend an alternative methodology; VA requested the inclusion of additional relevant cost and estimate data. VA believes that providing the above table based on final appropriations, along with Tables 3 and 5 of the report, based on initial budget estimates provides specific context and helps account for delays experienced prior to award of construction project contracts.

4. In response to GAO's recommendation to develop and disseminate procedures for communicating to contractor's clearly defined roles and responsibilities of VA officials responsible for managing major medical-facility projects, VA states that it will develop procedures to ensure distribution to all stakeholders. Please explain what these procedures might include to ensure all stakeholders are made aware of these roles and responsibilities.

VA Response: Please refer to response to Question 1, Recommendation 2.

5. Where are the contracting officers located?

VA Response: Contracting Officers (CO) in support of OALC's major construction program are currently located at four regional offices (National Region, Washington, DC; Eastern Region, Silver Spring, Maryland; Central Region, North Chicago, Illinois; Western Region, Mare Island, California), and at the project sites in Denver, Coloardo; New Orleans, Los Angeles; Orlando, Florida; and Palo Alto, California. OALC has Administrative Contracting Officers (ACO) who are Senior Resident Engineers (SRE) on every construction site. The ACOs/SREs hold Level I contracting warrants and have the authority to issue contract changes up to $100K each.

a. If long distance, how well does the long-distance management model work when the Contracting Officer has the ultimate responsibility to ensure this gets done on time and within budget for the job site?

VA Response: The acquisition team is comprised of a Project Manager (PM), CO and ACO. PMs hold a Federal Acquisition Certification for Program and Project Managers (FAC–P/PM) and ACOs hold a Federal Acquisition Certification for Contracting (FAC–C). The COs maintain close communications with on-site ACOs, PMs and SREs. The COs visit the project site as needed; have regularly-scheduled meetings with the contractors both in person and using available technology, and; hold conferences, review progress status reports, and participate in weekly progress meetings.

b. How many projects are the Contracting Officers responsible for?

VA Response: The number of COs varies from site to site, depending on the demands of the project. The average workload is four to six projects per CO.

6. Has the VA developed specific guidance on implementing the recommendations of the Construction Management Review Council?

VA Response: Yes, VA has developed specific guidance on implementing the recommendations of the Construction Review Council (CRC).

a. Please provide this committee with a copy of that implementation plan.

VA Response: VA has a draft Capital Programs Improvement Plan (CPIP) which details VA's plan of action to implement the CRC report requirements. This plan has been drafted in coordination with the appropriate internal stakeholders and with the oversight of the former Deputy Secretary of VA. The draft CPIP is currently going through formal internal VA review and approval and VA will provide a copy upon completion. In the interim, progress continues to be made to close the CRC recommendations.

b. Please provide a copy of the Construction Management Review Council's report from November 2012.

VA Response: A copy of the Construction Review Council report was provided to Congressional committees, including HVAC, on January 23, 2013. See Attachment A.

7. What obstacles prevent VA from completing major medical-facility projects on time and within cost?

VA has outlined its cost and schedule challenges in completing major medical facilities in the CRC Report. VA is working to eliminate these challenges and improve its delivery of major medical facility projects, on time and within budget.

8. Can you describe in greater detail the problems you found with the way change orders are processed? When does VA plan on completing the development and implementation of new guidance concerning change orders?

VA Response: VA's change order process involves several levels of internal and external review to ensure due diligence is taken. VA's review of the process found several opportunities for improvement in the following areas:

1. Construction change orders require analysis against the contractor's Critical Path Method (CPM) project schedule. VA in-house expertise was over-extended, and this contributed to delays in analyzing time extension requests. VA is in the process of hiring CPM scheduler consultants for on-site support starting on the large projects. VA also has plans to maximize use of existing Indefinite Delivery/Indefinite Quantity contracts for additional support.

2. VA has taken several steps to address any delays attributed to Office of General Counsel reviews. OALC's Senior Procurement Executive granted individual deviations from VA Acquisition Regulation (VAAR) 801.602–83 (concerning the documents submitted for legal or technical review on contract modifications) for the Denver, New Orleans, and Orlando projects. The VAAR requires legal review of all unilateral contract modifications when one or more of the following conditions are met:

- The total modification value is $100,000 or more.
- The modification is for a time extension of sixty (60) days or more.
- The contractor takes exception to VA's accord and satisfaction language.

The individual deviations granted exemption from legal review modifications with a value of $250,000 or less, and with time extensions of no more than sixty (60) days. The deviations for these projects provided an opportunity to expedite contract modifications under $250,000. In addition, VA has made additional positions available within the Office of General Counsel (OGC) to allow additional staffing to assist in processing reviews. This has increased the ability of COs, ACOs and SREs to process change orders.

3. VA encountered Defense Contract Audit Agency (DCAA) audit delays on contractor's proposals. OALC received a VAAR deviation for a third-party audit through the General Services Administration to mitigate dependence on DCAA. VA also engaged in a service agreement with VA Office of the Inspector General to assist OALC with the audit demands.

4. In order to meet project demands due to the hiring problems, VA has temporarily assigned COs and ACOs/SREs with warrant authority to support the Denver project and complete the review of contracting modifications. There are contract specialists and one additional CO supporting the New Orleans project on-site. At the Orlando project, in addition to the onsite ACOs/SREs and a contract specialist, the CO travels to the site every other week.

5. VA is in the process of developing internal project control measures to monitor progress and expedite the change order process.

9. What actions can VA take if a prime contractor is not paying a subcontractor on time or at all for work that is completed?

VA Response: VA requires all prime contractors provide a payment bond as required by the Miller Act (40 U.S.C. §§ 3131–3134). The performance bond guarantees the United States that the construction work will be performed to completion. The payment bond assures payment to subcontractors and suppliers supplying labor and materials in the course of performance of the contract. Any subcontractor or supplier who has so furnished labor or material under a contractual relationship with the contractor and who has not been paid in full within ninety (90) days after the last labor was performed or material supplied, may bring suit on the payment bond for the unpaid balance. Subcontractors and suppliers to second or lower-tiered subcontractors are not protected by the Miller Act. VA routinely provides the bond information to subcontractors that allege non-payment. VA also engages the prime contractor on all non-payment issues brought forward by subcontractors and reminds the prime contractor of its responsibility to pay subcontractors in a timely manner from the money VA provides for progress payments. Continued non-payment will impact the prime's final performance evaluation.

10. VA states that it is currently evaluating criteria for assigning medical equipment planners to major construction projects and will later develop and implement appropriate guidance for VA. What criteria are being weighed and when does VA expect to make a final decision on the matter?

VA Response: VA has directed that all major medical projects employ a medical planner. The medical planner will be provided by the designer and continue with the project through construction.

VA's goal is timely procurement of medical equipment. VA sent the following guidance to all project managers on May 15, 2013:

> "Effective immediately, all medical projects that involve the medical center procuring medical equipment to be installed during the construction will retain the services of a Medical Equipment Planner. The Medical Equipment Planner services shall begin during design and continue through construction. The Medical Equipment Planner will work with the medical center Activation Team and provide reports to the Project Manager through the Design Manager and Senior Resident Engineer."

The Medical Equipment Planner is to provide the Project Manager with the information to update the Integrated Master Schedule and will provide advance notice of delays so the Project Manager has the opportunity to implement mitigation measures.

Projects under construction and over 40 percent complete are considered far enough along that they do not need to hire Medical Equipment Planner services. Medical Equipment Planners are not required for parking structures, central energy plants, or other projects that do not include medical equipment. The Medical Equipment Planner role is being incorporated into the Project Management Plan.

VA Central Office will issue a formal set of instructions by end of July 2013.

11. How does the VA deal with the volatility of the construction market as experienced in Las Vegas?

a. In its assessment of the Las Vegas medical-facility project, GAO notes that, "As construction of the medical facility progressed, the economic recession that began in 2008 drove construction costs lower than what was estimated. As a result, VA was able to add features back into the project that had been eliminated and still stay on budget." What happens when the construction market picks back up and costs once again increase?

VA Response: VA includes an allowance for cost escalation in every project estimate. OALC performs local market surveys for each major project area to keep abreast of factors that may affect construction costs and contractor bids. OALC also requires the design and Architect-Engineering firm to submit a local market survey with each design submission. Escalation factors are based upon these surveys and Office of Management and Budget (OMB) guidance. VA also structures Requests for Proposals to include deductive alternate bids that may be exercised in the event that bids exceed available funds.

The years just prior to 2008 were a period of high cost escalation. Escalation rates far exceeded OMB projections and escalation allowances used by Federal agencies across the board. In order to mitigate market escalation, value engineering was conducted to reduce the cost of the Las Vegas VA Medical Center (VAMC) and all other projects under design during that period. In 2008 the construction market abruptly changed from one of hyper-escalation and little competition to one of hyper-competition and plummeting costs. This amplified the cost savings of value engineering measures that had been taken and resulted in project bids far below budget.

Currently there are no indications that escalation will return to the double-digit rates experienced in the years immediately preceding the recession. All market surveys and industry analyst projections indicate escalation will be below five percent annually for the next three to five years. Projects in development include appropriate allowances for escalation based on their projected schedules. Costs may exceed current budget estimates should projects be delayed beyond the projected schedules. Value engineering measures would be taken and project scopes may need to be reduced.

Question 12: In the recent GAO report, it was noted how additional phases of the Las Vegas medical center project – specifically the upgrade to the women's clinic – have pushed the completion date back to June 2014. As female Veterans account for approximately 10 percent of the overall Veteran population, can you explain why the decision was made mid-construction to upgrade the women's clinic?

VA Response: VA completed the construction documents used to award the construction contract for the new medical center on May 22, 2008. The standards used in the design of the Women's Clinic were from VHA Handbook 1330.1, dated July 16, 2004. VA updated this VHA handbook on May 21, 2010, to incorporate new standards for the delivery of health care to Women Veterans. Since the new medical

center tower is still under construction, the Las Vegas VAMC decided to pursue upgrading the Women's Clinic prior to the opening. On July 21, 2011, the Las Vegas VAMC requested approval from VA's Capital Asset Board to upgrade to the Women's Clinic to meet the new standards. The request was approved. VA has proceeded with the design and construction.

Additionally, construction of four large Primary Care Clinics (PCC) was underway. Timing of construction at these PCCs allowed for modifications to meet these increased privacy standards. Change orders were issued to the three contractors adding the individual restrooms to four exam rooms at each PCC with minimal cost and no delay in schedule. The PCCs currently provide care to female Veterans until the new medical center can be completed. This has led to a good response from female Veterans enrolled in the program with improved convenience and access. The remodel of the Women's Health Center at the medical center has not delayed or interfered with the activation of the rest of the facility.

Question 12a: Did the VA utilize the women stakeholders in designing the clinic?

VA Response: Yes. Throughout the design, women stakeholders participated in all user group meetings and VA solicited, reviewed, and incorporated comments/suggestions in the design.

13. Please provide a status update on the Orlando, New Orleans, and Denver projects? When do you anticipate these projects will be completed? What major obstacles still remain for each project, if any?

VA Response: Attached are the April 2013 fact sheets for the Denver (Attachment B), Orlando (Attachment C), and New Orleans (Attachment D) major construction projects, which include current project status and any major obstacles. VA is finalizing internal review of the May 2013 fact sheets, and will provide immediately after internal clearance. VA will continue to provide this information monthly.

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