BUILDING A BETTER VA: ASSESSING ONGOING MAJOR CONSTRUCTION MANAGEMENT PROBLEMS WITHIN THE DEPARTMENT

HEARING

BEFORE THE

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

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

WEDNESDAY, JANUARY 21, 2015

Serial No. 114–01

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.fdsys.gov

U.S. GOVERNMENT PUBLISHING OFFICE

97–992 WASHINGTON : 2016

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON VETERANS' AFFAIRS

JEFF MILLER, Florida, *Chairman*

DOUG LAMBORN, Colorado
GUS M. BILIRAKIS, Florida, *Vice-Chairman*
DAVID P. ROE, Tennessee
DAN BENISHEK, Michigan
TIM HUELSKAMP, Kansas
MIKE COFFMAN, Colorado
BRAD R. WENSTRUP, Ohio
JACKIE WALORSKI, Indiana
RALPH ABRAHAM, Louisiana
LEE ZELDIN, New York
RYAN COSTELLO, Pennsylvania
AMATA COLEMAN RADEWAGEN, American Samoa
MIKE BOST, Illinois

CORRINE BROWN, Florida *Ranking Minority Member*
MARK TAKANO, California
JULIA BROWNLEY, California
DINA TITUS, Nevada
RAUL RUIZ, California
ANN M. KUSTER, New Hampshire
BETO O'ROURKE, Texas
KATHELEEN RICE, New York
TIMOTHY J. WALZ, Minnesota
JERRY MCNERNEY, California

JON TOWERS, *Staff Director*
DON PHILLIPS, *Democratic Staff Director*

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Veterans' Affairs are also published in electronic form. The printed hearing record remains the official version. Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

Wednesday, January 21, 2015

	Page
Building a Better VA: Assessing Ongoing Major Construction Management Problems Within the Department	1

OPENING STATEMENTS

Jeff Miller, Chairman	1
Prepared Statement	48
Corrine Brown, Ranking Member	2
Prepared Statement	48

WITNESSES

Hon. Sloan D. Gibson, Deputy Secretary, U.S. Department of Veterans Affairs	3
Prepared Statement	49
Accompanied by:	
Mr. Dennis Milsten, Associate Executive Director, Office of Programs and Plans, Office of Construction and Facilities Management, U.S. Department of Veterans Affairs	
Mr. Lloyd C. Caldwell, P.E., Director of Military Programs, U.S. Army Corps of Engineers	6
Prepared Statement	52
Mr. David Wise	33
Prepared Statement	60
Mr. Roscoe Butler, Deputy Director for Healthcare, Veterans Affairs and Rehabilitation Division, The American Legion	35
Prepared Statement	75
Mr. Ray Kelley, Director, National Legislative Service, Veterans of Foreign Wars	36
Prepared Statement	79

FOR THE RECORD

Michael Gelber, Deputy Commissioner, U.S. General Services Administration	81
Mr. Sam Carter, Carter Concrete Structures	85

BUILDING A BETTER VA: ASSESSING ONGOING MAJOR CONSTRUCTION MANAGEMENT PROBLEMS WITHIN THE DEPARTMENT

Wednesday, January 21, 2015

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

The committee met, pursuant to notice, at 10:42 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [chairman of the committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Benishek, Huelskamp, Coffman, Wenstrup, Walorski, Abraham, Zeldin, Costello, Radewagen, Bost, Brown, Takano, Brownley, Titus, Ruiz, McLane Kuster, and O'Rourke.

OPENING STATEMENT OF CHAIRMAN JEFF MILLER

The CHAIRMAN. Ladies and gentlemen, the hearing will come to order.

I would like to welcome everybody to today's hearing entitled Building a Better VA: Assessing Ongoing Major Construction Management Problems Within the Department.

The purpose of this hearing is to address continued problems occurring in VA's persistent construction delays and cost overruns involving its construction of the replacement Aurora, Colorado VA Medical Center.

VA has been found by the Civilian Board of Contract Appeals to have breached its contract with its prime contractor on this project and the facility could eventually cost over a billion dollars to complete.

This committee has held numerous hearings in the last few years involving VA's inadequate management of its construction projects, each of those hearings being based on considerable evidence.

Quote, "We have come to a point in VA's major construction program where the administrative structure is an obstacle that is not effective supporting the mission. As a result, our veterans are the ones who are left without services and our taxpayers are the ones who are left holding the check or writing a new one," end quote.

Members, this was part of an opening statement that I made March 27th of 2012 at a hearing on VA major construction, but it seems that nothing has changed nearly three years later. Despite warnings and corrective suggestions being presented from inside and outside of the department, very little has changed.

Based on the lengthy committee investigations that gave rise to these hearings, the committee asked the GAO to audit VA major construction projects. Their report issued in April of 2013 found that on average, the hospital construction projects reviewed were about three years late and $360 million over budget.

Every time we have asked VA about those results, it has argued that it is not delayed or over budget based on its own accounting.

Further, when we held a hearing on the Aurora VAMC construction project in April of 2014, the tenor of VA responses was that it was the contractor's fault that the project was not completed and that it was still operating within its budget.

I have a feeling that the VA will not be able to cling to those illusions any longer because December 9th of 2014, the CBCA found that the VA materially breached its contract with its prime contractor on the Aurora construction project, Kiewit-Turner.

It found that VA did not provide a design that could be built within the stated budget and it was also the VA's fault to the point that CBCA said KT would be well within its rights to simply walk off the job. And that is exactly what was done.

Now VA is left scrambling to make KT whole enough to get back to work. VA may even have to come back to Congress to ask for perhaps 500 million or more dollars to fix the problems that the committee has brought to light year after year only to be ignored by the VA.

I visited the Aurora construction site on Monday with Congressman Coffman and Congressman Lamborn to see again in person what is taking so long and why this project has been a veritable money pit for the last several years.

Once completed, this facility will be well equipped to provide the best possible care available which is exactly what the veterans served by every VA facility deserve. It is long past time for these projects marred by bureaucratic ineptitude to be complete.

And I look forward to hearing from the VA and other witnesses here today on how we can correct the abysmal state that VA's major construction program has been in for years.

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

With that, I yield to the ranking member, Ms. Brown, for any opening statement she may have.

OPENING STATEMENT OF CORRINE BROWN, RANKING MEMBER

Ms. BROWN. Thank you, Mr. Chairman.

And I would like my complete statement to be entered into the record.

Ms. BROWN. As I said from the beginning, I am very excited about being the ranking member on this committee. And having been on this committee for over almost 23 years, I realize that for 20 years the VA has not built any VA facilities.

The VA has lost a lot of the expertise that has been there in the past. I think the role of this committee is to find out how we are going to move forward in making sure that the VA is able to provide the facilities that we need. Many of the facilities we are dis-

cussing Las Vegas, Orlando, Denver, New Orleans, were authorized years plus years ago.

These facilities have had major problems. There's enough fault and blame to be shared between the VA and the contractors. It is not just one issue it's a multiplicity of issues.

I look forward to hearing what VA and others have to say about how we should move forward.

I am going to yield back my time.

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

The CHAIRMAN. Thank you very much, Ms. Brown.

Members, I would ask that you waive your opening statements. They will be entered into the record as custom in our committee. Without objection, so ordered.

Our first panel today, we are going to hear from the Honorable Sloan Gibson, Deputy Secretary for the Department of Veterans Affairs. He is accompanied by Mr. Dennis Milsten, Associate Executive Director of the Office for Programs and Plans within VA's Office of Construction and Facilities Management. And we are also going to hear from Mr. Lloyd Caldwell, Director of Military Programs for the Army Corps of Engineers.

Your complete written statements will be made a part of the record. And I want to say for the record thank you for meeting with me on Monday in Aurora. It is good to see you again.

And, Deputy Secretary Gibson, you are recognized for your opening statement for five minutes.

STATEMENTS OF SLOAN D. GIBSON, DEPUTY SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY DENNIS MILSTEN, ASSOCIATE EXECUTIVE DIRECTOR, OFFICE OF PROGRAMS AND PLANS, OFFICE OF CONSTRUCTION AND FACILITIES MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS;

STATEMENT OF SLOAN D. GIBSON

Mr. GIBSON. Thank you, Mr. Chairman.

Chairman Miller, Ranking Member Brown, distinguished Members of the committee, thank you for this opportunity to update the committee on construction of the Denver VA Medical Center in Aurora and the actions that we are taking in light of the situation.

Let me introduce Dennis Milsten to the committee. Dennis is Director of VA's Construction and Facilities Management, Office of Operations.

In the wake of the board's decision on Denver, I asked Dennis to serve as senior leader on that project. He brings over three decades of construction experience in both the public sector and private sector including 19 years with the Corps of Engineers on projects like the Pentagon renovation.

Chairman Miller, Representative Coffman, and Representative Lamborn, thank all three of you for joining us at the site. Thanks for taking the time to be there. I don't think anything can take the place of actually being on the ground and seeing the facility and gaining an appreciation for the scale and for you can imagine what that facility will be like for veterans once it is completed.

I want to acknowledge some important partners. We have a long history of collaboration with the Corps of Engineers and we are grateful for their advice and support role in the interim agreement with Kiewit-Turner. And we are pleased that they are going to serve as our agent to manage this project to completion.

Yesterday I met again with leaders of Kiewit-Turner. KT is justifiably proud of the work they have done in Denver and they are looking forward to see the medical center complete and serving Colorado's veterans.

And we appreciate the good work of the Government Accountability Office including their recommendations in 2013 that we have integrated into our current construction practices.

We will continue to collaborate with these and other partners as well as this committee as we move forward.

To be clear, the situation in Denver is unacceptable and I apologize for that. It is not acceptable to veterans. It is not acceptable to taxpayers. It is certainly not acceptable to Secretary McDonald or me.

Veterans and taxpayers are right to expect more and they deserve much better from their VA. We have two priorities in Denver, complete the facility without further delay and deliver under the circumstances the best value that we can for taxpayers.

I understand that everyone is anxious to know what it will cost to complete the project. Right now we don't know. The Corps doesn't know and Kiewit-Turner doesn't know. That will be determined over the course of the next several months and we will work closely with Congress to develop the best options for funding completion.

Most immediately to settle claims and continue operations under the interim agreement, we are going to request reprogramming on some selected projects taking care to minimize the impact on other projects while we are working to get Denver back on track.

I think it is a very fair question to ask what went wrong in Denver. And I think as we explore the history of the project, it will be clear that there were many things. Among them, we did not have in place the benefit of a 35 percent design before we requested funding. We did not have in place a clear, structured, effective process to manage change. We didn't benefit from rigorous constructability reviews. And perhaps most fundamentally, our choice, timing, and management of the integrated design and contract vehicle resulted in a design that was never reconciled with the firm target price in the construction contract.

While we work to complete the project without further delay and deliver the best value we can, we have an obligation to ensure that this never happens again. That means learning all we can from past mistakes and putting in place corrective actions to improve future performance.

Veterans and taxpayers also expect that a thorough review be completed and those responsible be held accountable. There are several steps we are taking with these objectives in mind.

We have asked the Corps to complete a detailed review of the Denver project, to review VA's other largest projects, and in general to review the department's management of major projects.

I have directed that an administrative investigation board be convened to examine all aspects of the Denver project to determine the facts that led to the current situation and gather evidence of any mismanagement that contributed to this unacceptable outcome.

And effective immediately, the department's Construction and Facilities Management organization will report to me through the VA's Office of Management.

Stepping back for a moment from this immediate situation, I recall that in the months prior to my confirmation, I spent a lot of time reviewing hearing testimony, media clips, and IG and GAO reports. Coming in from the private sector, I had serious doubts about VA's construction management capability.

But what I found when I got to VA were many important changes already implemented. In some instances, changes that would improve projects that were already underway, but in every instance that would improve newly started projects.

For example, we were already committed to designs that emphasized functionality and good value. We were already requiring a 35 percent design before publishing costs and schedule information and requesting funding.

We were already using private construction management firms for constructability reviews at each major design phase. We were already using project management plans to improve communication among all participants. We were already integrating medical equipment planners into construction project teams.

We had already put in place thorough risk management practices to mitigate challenges. We had already set up project review boards modeled on the Corps of Engineers' district office design. And we had already added key talent from the outside of the department to strengthen training and require project management certification for our project leaders.

That does not excuse our failure to have these measures in place years ago, but it does mean that as they are relevant to particular phases of projects and construction, these and other measures are being applied now to our 53 ongoing major projects.

Notwithstanding all these changes already in place, I am confident that our current construction management practices can be further improved. My commitment is that we will learn all we can from the mistakes in Denver as revealed by the Corps' examination and our internal review. And we will implement changes with two fundamental criteria in mind, doing the right thing for veterans and getting the best value for taxpayers.

Finally, I don't want to lose sight of the fact that while we resolve the situation in Denver, the employees of the VA Eastern Colorado Healthcare System have continued to provide quality care to our veterans nonstop regardless of any issues with the construction of the new medical center.

Thank you for the opportunity to testify and we look forward to answering your questions.

[THE PREPARED STATEMENT OF SLOAN D. GIBSON APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Mr. Gibson.

Mr. Caldwell, thank you for being here. Again, thank you for meeting with us on Monday. You are recognized for five minutes.

STATEMENT OF LLOYD C. CALDWELL

Mr. CALDWELL. Thank you, Mr. Chairman.

Mr. Chairman and distinguished Members of the committee, I am pleased to be with you today representing the U.S. Army Corps of Engineers and Lieutenant General Thomas Bostick, the Chief of Engineers.

I provide leadership for execution of the Corps' engineering and construction programs worldwide to include our support to other agencies.

The U.S. Army Corps of Engineers is one of the Department of Defense construction agents who execute infrastructure projects for the Department of Defense. Interagency collaboration is an important element of the Corps' work as a part of our service to the Nation.

My testimony will address the Corps' assistance to the Department of Veterans Affairs', project acquisition process and our experience in medical facility construction.

The Corps has an established relationship with the VA from the national headquarters levels to our regional offices working with the 21 Veterans Integrated Service Network offices as well as with the National Cemetery Administration.

We have supported a broad range of construction and maintenance projects totaling almost $1.6 billion with the VA since 2007. Authority for the Corps' work with the Veterans Administration is based on the Economy Act which provides both parties with sufficient authorities to work collaboratively on VA projects.

In December of 2014, the VA requested our assistance to complete the Aurora, Colorado replacement VA medical center project and we have agreed to do so. We are assessing the requirements of the project and are developing a new interagency agreement that would transition construction agent authority and responsibility for this project to the Corps of Engineers.

We are also advising the VA on the management of their interim construction contract with the contractor, Kiewit-Turner, to allow continued progress on the project.

The Corps has developed processes and capabilities for design and construction which have been refined over the many years. Our project management process brings together teams of diverse professionals that are necessary for the project life cycle to deliver a successful project and that includes our construction, our acquisition, our design professionals as well as project management professionals. These teams work collaboratively to account for project delivery, methods, scope, schedule, and cost.

The Aurora project is unique in that we are entering the project at an advanced stage of the work, but with an assessment by our experts and with collaboration with the VA, we are confident that we can bring the project to successful completion.

Budget and schedule risk is inherent in executing any construction projects and medical facilities are among the most complex facilities that we construct and deliver. They require exacting technical design and construction standards which must be carefully

managed and are subject to changing requirements due to evolving medical technology even during construction.

To ensure the standards and criteria of the defense health system within which we most often operate, we have established a medical center of expertise which applies a full range of specialized knowledge to address demanding healthcare facility requirements. They help to integrate the clinician and other medical staff requirements to architectural and engineering standards.

The Corps has a long history of executing some of the Nation's most challenging construction programs. In the past 13 years, the Corps has physically completed 2,499 military construction projects to include for other agencies with a combined program amount of $52 billion.

The Corps has delivered or is in the process of designing and constructing a full range of medical facilities for the Department of Defense to include hospitals valued near a billion dollars that are capable of delivering world-class medical services for the members of our Armed Forces and their families.

Our relationship with VA is strong and we look forward to working with the VA as construction agent to complete the Aurora hospital project and, in doing so, to serve the Nation's veterans.

Thank you, Mr. Chairman, for inviting the Corps to testify to address its assistance to the Department of Veterans Affairs. I welcome your questions.

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

The CHAIRMAN. Thank you very much, Mr. Caldwell. We appreciate you being here to testify and also accept questions from Members of the full committee.

At this point, I want to yield my time for questions to the gentleman that represents the facility that we are here to talk about today, the subcommittee chair for Oversight and Investigations, Mr. Coffman.

Mr. Coffman, you are recognized.

Mr. COFFMAN. Thank you, Mr. Chairman.

Mr. Milsten, in its February 2014 fact sheet, VA had the total completion of the Aurora facility at 42 percent. On Monday, Deputy Secretary Gibson confirmed that the total completion of the project is now 50 percent. KT, however, maintains that the project is only 40 percent complete.

Either way, how has this project only progressed at best by eight percent in nearly a year?

Mr. MILSTEN. One of the things that goes into this process of determining percentage is we were basing our percentages of completion on an artificial budget and so we have lost some perspective on what the actual construction completion date is or percentages.

We have had some discussions that it is somewhere between 50 and 40. My experience from looking at this, we have the steel completed. We have the precast completed. We have roofs on facilities. We have curtain walls going up. We are about 50 percent complete with this construction.

Mr. COFFMAN. Deputy Secretary Gibson, VA is convening an administrative investigation board to investigate the Aurora project because VA central office officials have no idea what happened,

again despite years of warnings from inside and outside the department.

Who at VA's central office was tasked with providing oversight for the Aurora construction project?

Mr. GIBSON. I think you would look to the chain of command within Construction and Facilities Management which would include Stella Fiotes who is a relatively more recent addition to VA. It would include Glen Haggstrom. It would include the former deputy secretary and the secretary.

Mr. COFFMAN. Who is in charge of overseeing Glen Haggstrom?

Mr. GIBSON. The person in that position reports to the deputy secretary.

Mr. COFFMAN. Okay. So that would be your——

Mr. GIBSON. That would be me now, yes.

Mr. COFFMAN [continuing]. Position? Okay. And also, Deputy Secretary Gibson, why was the department's standard operating procedure opposed to involving the Army Corps for so long in Aurora despite repeated warnings of VA mismanagement?

Mr. GIBSON. Having not been a part of that discussion process over the years, I don't know that I have a good answer for you.

I think as I looked at the situation following the board's decision, it was very clear to me with the priorities to complete the project without further delay and with the best value for taxpayers that engaging the Corps was the right course of action on this project.

Mr. COFFMAN. Okay. Mr. Milsten, what is the estimated total cost of the Aurora project and what is now the estimated date for completion?

Mr. MILSTEN. First of all, the estimated date of completion, we are looking for a date in 2017 based on where we are today. And as far as the cost to complete, that is something that the Corps of Engineers is going through to determine what the cost to complete this project is.

As Deputy Secretary Gibson said, we will spend the next couple of months trying to figure that out because between the contractor, us, and the Corps of Engineers, we don't have that number today.

Mr. COFFMAN. Okay. And I think, Secretary Gibson, I think in our discussions on Monday, I think you discussed when the project may run out of money. And I think it kind of sort of corresponds in with the interim agreement.

Do you think with your programming capabilities, you think about June, sometime in June if there is not some type of supplemental appropriation by Congress that work could stop again on this project?

Mr. GIBSON. The idea here is for us to be able to go through some steps. We funded the interim contract. We are actually doing some internal reprogramming with the notice of Congress of some small additional amount. We will need to come to Congress for approval to reprogram some more substantial amount to carry us on the interim contract all the way through until June.

Our hope is and our expectation is we sync this up with the Corps of Engineers is that we are going to be able to provide the funding. The expectation is we will provide the funding to bridge the period from where we are right now until when the Corps is able to negotiate a contract to complete the project.

Mr. COFFMAN. My final question. Mr. Caldwell, as bad as the cost overruns are right now—we are hundreds of millions of dollars over budget. We are years behind schedule.

But if, in fact, this project were moth-balled, if, in fact, Congress didn't appropriate more money and the construction stopped in June and the whole project was demobilized, moth-balled, wouldn't that really greatly aggravate the cost when the project would be restarted?

Mr. CALDWELL. Yes, sir. In fact, it would cause a worse situation because you can't— to begin with, you have to take certain actions to close up a project, so you are using funds that otherwise would be used for construction to ensure that you are not creating a different hazard for the public and so forth and that the facility that is constructed doesn't degrade. So there are some caretaker requirements associated with that and then to restart it, it would be an additional cost as well.

Mr. COFFMAN. Okay. Mr. Chairman, I yield back.

The CHAIRMAN. Before I yield to Ms. Brown, Deputy Secretary, in your reprogramming, do you anticipate the dollars that you reprogram to exceed the cap of 800 or 880 with your ability to go above that?

Mr. GIBSON. I do expect that would be the case and we would need help and support from this committee and from Congress to raise that cap.

The CHAIRMAN. Yeah. The cap will have to be raised.

Mr. GIBSON. Yes, sir.

The CHAIRMAN. I mean, we cannot go around it. It is a firm——

Mr. GIBSON. Right.

The CHAIRMAN [continuing]. Firm cap. So at what point do you think you will know what number that will be, I mean, because surely it will be before June? Are you going to try and do it all at one time and just have one——

Mr. GIBSON. No. We will need that support prior to June. Congressman Coffman and I have been having a series of conversations about that. We think raising the cap to $1.1 billion from the current $800 million would be able to carry us during that interim period of time.

The CHAIRMAN. Okay. Thank you.

Ms. Brown.

Ms. BROWN. Thank you, Mr. Chairman.

I would have loved to have joined you in Denver, however, it was Martin Luther King's birthday and I had other commitments in my district. Hopefully I'll be able to join the delegation in the future.

Mr. GIBSON. We would love to host you out there.

Ms. BROWN. Thank you.

The VA facilities are having problems in Denver, Orlando and New Orleans.

This Committee has authorized, and Congress has appropriated, billion of dollars for VA construction programs over the past decade. The question we must asks ourselves is are we getting what we paid for, and has access improved for our veterans.

We must ask ourselves what must be done to make the VA construction program function as we intend it to. What must we do to make sure that the facilities we are building today do not come in

over budget and late. If we do not do this we run the risk of building facilities that may already be obsolete when the doors are open and are merely expensive memorials and little else.

For nearly two decades the VA was out of the major facility business. By not building any major medical centers in the 20 years preceding authorization of the Las Vegas, Orlando, Denver and New Orleans Medical Centers, has the VA lost the ability to manage a construction portfolio?

And I am going to say that I think a lot of the expertise, 20 years not building a facility is part of the problem.

Please give us not just an update on these projects, but tell us what we as Congress need to do to help you move forward.

The Army Corp of Engineers do great work with the ports. VA did great work with Katrina.

Mr. GIBSON. Yes, ma'am. First of all, as it relates to Orlando, the current schedule would call for construction to be complete the end of February.

Ms. BROWN. Then we do the punch?

Mr. GIBSON. We are working through the punch list. As you know, some portions of the facility have already been turned over. In fact, we are already seeing patients.

The progress really accelerated in Orlando as we got different leadership teams, both parties on the ground, and a series of meetings that I held directly with Brassfield & Gorrie over the previous seven or eight months. And I think we have moved that very expeditiously and Brassfield & Gorrie has performed really very well on that project.

I would say more broadly, and Congressman Coffman and I have had conversations about the expanded role for the Corps, Turning everything over to the Corps would be a very big decision and it would be a decision that we would want to make on a very well-informed basis.

I think some of the work that the Corps is doing for us right now to review Denver and other major construction activity will inform that process.

As I mentioned in my opening remarks, what we are after is quite simply doing the right thing for veterans and being a good steward of taxpayer dollars. And those are really the only two parameters.

If a more expansive role for the Corps is the best route to get there, then we are all for it. And, frankly, I would be surprised if we don't find ourselves working more closely with the Corps in the future.

Ms. BROWN. Right. Like the Jacksonville, I think it is very important to have the physicians and others in the planning stages. As you design more facilities to build, its important to have employees (i.e. doctors) inputs.

Mr. GIBSON. I think one of the lessons learned is the need to impose more discipline throughout the entire process. That includes a very rigorous requirements definition period and then the requirements get locked down. That also includes more robust communication with various stakeholders including Members of Congress.

I think what we have done habitually is conducted a fair amount of this behind the curtain. Sometimes because we are engaged in procurement sensitive activity, sort of been the excuse, we have got to find ways to work around that so that we are able to engage with various stakeholders on these projects on the front end and we have got good consensus and awareness. And where there is not a hundred percent agreement, which there oftentimes may not be, at least there is an awareness in place of where we are going and why we are going there.

Ms. BROWN. Give us the status of the Denver project now? Is it moving forward and how much additional funds will you need for this facility?

Mr. GIBSON. The construction is back underway at Denver. Kiewit-Turner is ramping up the number of trade on the site literally every single day. We expect to be up to about a thousand on the site by, I believe they told us by the end of March, if I am not mistaken, which is close to where they were prior to the shutdown.

We are operating under the interim contract. We will need some additional funds through a reprogramming action to extend that period of time and then bridge us to the period of when the Corps is able to negotiate a contract to complete.

Ms. BROWN. Just one quick question for Mr. Caldwell. The Army Corps' involvement in this project, and you mentioned that you all have been involved in building many hospitals all over the world and, of course, I am aware of that, how is the partnership working?

Mr. CALDWELL. The reports I have received have been very positive. We have sent a team of about 17 people to the project beginning in January. We actually had a couple of people there in mid December. And we have had a couple of our senior executives attend meetings there.

And all reports that I am receiving from them have been very positive that the Veterans Administration team that is on site has been very open and cooperative. And so we believe it will be a collaborative relationship as we go forward.

Ms. BROWN. Thank you.

I yield back the balance of my time.

The CHAIRMAN. Thank you very much, Ms. Brown.

Mr. Lamborn, you were also in the meeting on Monday. You are recognized for five minutes.

Mr. LAMBORN. Thank you. And thank you, Mr. Chair, for being there coming from Florida.

And I want to first of all recognize Representative Coffman and his foresight and leadership. When he was first saying the Army Corps of Engineers need to be brought in, a lot of people didn't believe him. And, yet, here they are now literally sitting at the table. So I appreciate that.

Secretary Gibson, we are all very concerned about the cost overruns and the time delays with the Denver hospital.

Can you reassure veterans in Colorado that the time delays will not prevent veterans from receiving the healthcare that they need in the meantime?

Mr. GIBSON. As I mentioned during my opening remarks, the Eastern Colorado VA Healthcare System continues to provide great care to veterans. You know, most recent number, probably the

month of December, November, December, 64,000 outpatient appointments completed during that month, 92 percent of those appointments completed within 30 days of when the veteran wanted to be seen.

Still not good enough, but it tells me that there is an awful lot of great care being delivered there. We are also ramping up both choice and also referrals to care in the community under VA's traditional non-VA care. So we are committed to delivering to veterans right now and for the interim period of time the best possible care.

Mr. LAMBORN. Okay. Thank you.

And for either one of you, and we have touched briefly on this, but when specifically will we know the final and best estimate of the cost overrun so we on this committee can begin the difficult work of identifying funds needs to bring the hospital to completion?

Mr. GIBSON. I will try to answer that and then defer to the two experts here.

The process that we are going to have to go through here, and this was a topic of robust discussion just yesterday with the senior leaders at KT, in a contract negotiation, typically price is the last thing that falls out of the process. And so we are applying a lot of pressure to our teams together collaboratively to provide as much information as early as we possibly can.

But I think the general time frame, some clarity, several months from now is going to be about the earliest I think we can hope to have a good idea.

Mr. LAMBORN. Okay. Several months from now.

Mr. GIBSON. Yes.

Mr. LAMBORN. And that is as specific as we can be right now?

Mr. GIBSON. That is as specific as I would want to be, yes, sir.

Mr. LAMBORN. Okay. And I know you don't want to get ahead where wrong figures are thrown out there creating false expectations.

Mr. GIBSON. You know, I think one of the biggest problems we ran into in this project is we tried to push to a firm target price before we had everything locked down. We rushed to get there. We were anxious. We were impatient. I think a lot of that probably had to do with the fact that it had taken forever to get to that point anyway and so everybody wanted to get on with it. And I think that is why we find ourselves sitting here today.

Mr. LAMBORN. Okay.

Mr. GIBSON. I want to do this right.

Mr. LAMBORN. Exactly. And I understand that. I mean, we are eager to move forward, but we want to do it right.

Mr. GIBSON. Yes, sir.

Mr. LAMBORN. And lastly, for either one of you, has the VA considered developing a standard hospital design template in light of all the current major construction overruns that could be used throughout the country with only minor local modifications which would, I believe, potentially save tens of millions of dollars on each project?

Mr. MILSTEN. Sir, I am happy to say that we have begun that program. We looked at our clinics, our leased clinics. We have developed some standards to go forward. One of the things that each

one of our medical centers has is a unique program of services that they provide to the veterans.

So what we are looking to do is develop templates that we can then say if we have got a 1A hospital with ten operating rooms is the workload, this is the configuration or template that we would use. And then by adjusting the adjacencies, looking at the physical constraints of the site, we can then build the building blocks that cut down on the design effort, cut down on the customization, if you will, and develop that better value for the taxpayers.

And this is experience that we have learned from the Army Corps of Engineers. They have done it with barracks, dining halls. They are doing it with some of their facilities. We work hand in hand with them on our space and equipment planning programs so that when we program out a hospital, we are using the same kind of background information that they use also.

So this is something we are also looking at our other partners within the federal space and within the other medical communities to make sure we get hospital templates that can be delivered, that we can cut down the design effort because one of the things that cuts down on the change orders on the back end is something that is important drivers, speed to delivery.

If I can cut down the distance between when a project gets visualized and doctors come up with their requirements and delivery of it, we cut down on the amount of change and turmoil that goes on in a project.

Mr. LAMBORN. Okay. Thank you for being here today. Thank you for being in Denver on Monday.

The CHAIRMAN. Mr. Takano, you are recognized.

Mr. TAKANO. Thank you, Mr. Chairman.

Mr. Gibson, I understand that the VA is reprogramming funds to the short-term contract with KT until a long-term contract can be completed.

Can you tell me where the funds are coming from that are being reprogrammed?

Mr. GIBSON. We have not identified the projects yet. The analysis that we are going through is we are trying to identify projects where we can reprogram funds with the least possible adverse impact on that project from a time table standpoint. And the intention certainly is going to be that we replenish those reprogrammed funds as quickly as we possibly can.

Mr. TAKANO. Okay. On January 19th, the Veterans Administration announced it was convening an administrative investigation board.

Can you please walk this committee through the time line and what you will accomplish by convening this board, the steps that are going to be taken, and who will preside over this board and who will serve on the board and any other details that you can tell us?

Mr. GIBSON. Sure. I will tell you what I can. An administrative investigative board is a formal investigative process that we use inside the department to investigate and gather evidence to support any misconduct, any wrongdoing, any management negligence, or the like.

It is a fairly routine measure, routine mechanism that is applied at various levels across the department. This would be one that would be—it is being established at my direction. And Office of Accountability Review is working to constitute that AIB, typically formed of three. In this case, it will be three senior executives.

Part of our challenge here on this particular AIB is having people with the right expertise. And so we are working, I suspect over the next several weeks, to identify individuals likely from outside the department, from other federal departments who will come and serve on this AIB because they bring that particular expertise with them.

The investigative process will last, you know, my guess is in this particular case many weeks if not several months at least as they work through to gather evidence. These projects have been in various degrees, various stages for a decade.

I think the challenge will be to focus on specific episodes and the history of these projects, do a much deeper dive exploring exactly what happened, who the involved parties were, what their responsibilities were, and was there any negligence or any mismanagement that happened and where that happened to gather the evidence that then becomes the basis for an administrative action.

Mr. TAKANO. Mr. Caldwell, you are with the Corps of Engineers, correct?

Mr. CALDWELL. Yes, sir, that is correct.

Mr. TAKANO. Can you tell me, you know, what is it going to cost the VA for the transfer authority to the Army Corps?

Mr. CALDWELL. Sir, as we determine what the scope of the effort is, part of that will be to determine what our cost is to execute that scope. For our initial work now that we are doing, the VA has provided funds to us just based on an estimate of the number of people and the amount of time that they will be working to scope out the requirements.

Typically, on large projects of this nature, if we were starting at the beginning, we would program an amount of about 5.6 percent for our cost to administer the contract and perform the requirements. And then there is additional funds for design. So something in that order of magnitude would be likely, although it could be greater in this case because the nature of what we are dealing with here is greater.

So the manner in which that operates is that we will assess what the requirements are. We will assess the level of effort. We will develop a budget and provide that budget to the Veterans Administration. And then our objective is to operate within that budget once the two parties have agreed to it.

Mr. TAKANO. As of now, you are still trying to assess those costs and——

Mr. CALDWELL. Yes, sir. At this point in time, we have got a bit of distance to go to have assessed what the entire scope of requirements are for this project.

Mr. TAKANO. Thank you, Mr. Chairman. My time is up.

The CHAIRMAN. Thank you very much.

Mr. Milsten, after the CBCA found that the VA, quote, "does not have sufficient funds to pay for construction of the entire project as currently designed and has no plans to ask for money," end

quote, so the question is, why were there no plans after GAO alerted the VA to significant cost overruns and delays in April of 2013 and this committee has held three hearings highlighting the same thing going back to March 2012, May of 2013, and April of 2014?

Mr. MILSTEN. I don't have a good answer for why we didn't come back and ask for funds other than the fact that our project teams out there on site felt that the hospital could, in fact, be built within the budget. They were relying on the advice of many people within the department to continue pushing this project forward.

The CHAIRMAN. On the 22nd of December, our staffs had conversations regarding the way ahead or the next steps at Aurora. Your staff at that time, according to my staff, promised to provide the committee with a risk assessment complete with cost estimates by the end of the following business day.

As you know, we don't have that. And from the testimony at the table today, it doesn't appear we are getting it any time soon.

Why would somebody promise that without the capability of delivering?

Mr. GIBSON. If I could address that, the response, Mr. Chairman, I think Mr. Milsten misspoke that day. It was just a bit out over the end of his skis. As we have looked at that request, and I think you are aware that we offered to make that document available in camera late last week to members of the staff or Members of the committee.

As we have discussed with the Corps and as we discussed a little bit on Monday, being able to keep close hold information that could potentially influence the ultimate negotiation of a contract is something that we need to be very cautious about. And there is information in the risk assessment that could compromise those conversations.

The CHAIRMAN. Again, as we have discussed in the past, and I have great understanding of not wanting to compromise any of the negotiations, but Congress has total oversight. And if we were at the beginning of the project, that might be one thing, but we are in the middle of something now. And it is not like the committee would intend to make anything public, you know, and you have opened the central office much more than it had in the past. And we appreciate that.

And, you know, I understand what getting out over your skis means even though I come from the great State of Florida. Ours is on the water.

Mr. GIBSON. You can do that on the water too.

The CHAIRMAN. Yeah. I tell you it hurts when you get out over your skis.

So, Mr. Gibson, talk a little bit about accountability within the agency because we are not talking about one project. We are talking about a number of projects and we are not talking about a small amount of money. We are talking about tens if not hundreds of millions of dollars in cost overruns.

The veterans are most important and to get the projects completed, we understand that. But, you know, there was complete inept abilities at a number of levels. And I don't think you necessarily need to name names here, but help assure this committee

that something is going to be done from within that would prevent this from ever occurring again.

Mr. GIBSON. Yeah. I think, first of all, you know that I haven't exactly been bashful about enforcing accountability where we had evidence to support that. Clearly veterans and taxpayers and Members of Congress, our elected representatives expect us to conduct a thorough review and where folks have not done their jobs that we hold them accountable.

And my commitment is that we will do that. That is why we asked the Corps to undertake an objective, and Joe Calcara, who you met on the project, is leading that effort for the Corps. And in my conversations with him, I made it very clear what I want is on-the-ground truth. Call it like you see it. I don't want you to pull any punches. I want to understand what went wrong here. We need to understand that.

And the same guidance will go to the members of the AIB once that investigative board is formed to ensure that we understand exactly who is accountable, at what point, for what decisions and what activities throughout the life of this project.

Ms. Brown Mr. Chairman——

The CHAIRMAN. Yes.

Ms. BROWN [continuing]. Before we move on, may I have just 30 seconds?

The CHAIRMAN. Certainly.

Ms. BROWN. I was at that particular meeting where we had a lengthy discussion and I felt that the person was, I don't want to say being threatened, but was pushed to the point that he said things that perhaps I didn't think it was appropriate because a legal lawsuit was also going on.

And I think maybe we should hear from counsel, our counsel as to our questioning when there is an active lawsuit against the VA, so it is against us. And I think we need to consider that when we are asking questions of the panel or the committee.

The CHAIRMAN. I certainly understand that, but remember that the VA is part of the administration and so the lawsuit is against the administration, not against the Congress. And we cannot abdicate our responsibility to provide oversight.

And I know that you and I will work together and we have assured the agency and the central office that we want to be a partner as we try to resolve that. We wouldn't want to do anything that would imperil any legal action that may be taken, but your comments are taken for the record and well deserved.

Ms. BROWN. Thank you.

I agree. As the army motto, one team, one fight, we are all in this together. And it is all taxpayers' dollars and we got to make sure that we protect them.

So I yield back the balance of my time.

The CHAIRMAN. Okay. Thank you very much.

And I have got some other questions, but I know there are other Members that want to talk. And even though Ms. Brown just took two minutes of my time, I would now yield to Ms. Brownley for five minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman.

And I wanted to just follow-up on the chairman's questioning around accountability too. And do you have any sort of time line? I think if evidence proves that steps need to be taken to hold people accountable within the VA going through this process, do you have a time line that you can share with us?

Mr. GIBSON. The honest and direct answer is no. And the reason has to do with the uniqueness of this particular investigation and the complexity of the issues.

I think our success is going to depend on our ability to focus, as I mentioned earlier, on particular episodes. And if we do that, I would expect that an investigation could be completed within probably several months' time, but it is not something—this is sworn testimony and a formal and elaborate process because, again, if we are going to take administrative action, the evidence that we collect has to withstand scrutiny on appeal.

Ms. BROWNLEY. So we can expect in a couple of months' time give or take a little bit that we would have a time line at that particular point?

Mr. GIBSON. I would be delighted to keep the Members updated on the progress of the AIB as I am aware of it.

Ms. BROWNLEY. Thank you very much.

My veterans in Ventura County in California are extremely, extremely excited about the prospects of an upcoming plan to build a new community clinic in our county really truly to fulfill really the long-awaited unmet needs for our veterans like dialysis treatment, expanded physical therapy, mental health, primary care services, and so on.

And so, you know, when I hear and understand these cost overruns and delays, it makes me very concerned about future projects. And so if you could just speak to what you are doing, you know, within the VA to ensure that these kinds of cost overruns and long delays aren't going to repeat itself again.

I know construction projects are tough and nothing can be perfect, but I want to have some sense of a feeling of security that these kinds of things aren't going to happen, we're going to repeat the same mistakes.

Mr. MILSTEN. Yes, ma'am. Some of the things that we are undertaking as we go forward is developing a 35 percent plan before we come forward for funding which then makes sure that the funding that we ask for is based on a sound set of requirements.

This is a similar process that the Corps uses in the MILCON process so that it again eliminates some of that back and forth on what the requirements are.

We have instituted a requirements management, change management process that says at the completion of 35 percent, the project is examined for how does it go against what the department approved as part of its strategic plan.

That again is looked at about the 65 percent to make sure that the project didn't grow without clear, concise reasons for the growth and that those changes were approved both in budget and in program or square footage and meet the strategic needs of the department.

That project is then again reviewed against the base requirement at the completion of the design before we move into construction.

In addition to that, we have instituted a program of contracting with the construction managers out there in the industry to come in and perform a rigorous constructability review. Again, this is something similar to what the Corps does with their constructability, bid ability reviews that they go through to make sure that the requirement can be built. And this begins to eliminate some of those change orders that come and delays that come downstream.

So those are some very important pieces that we put in place. In addition to that, we have adopted a project review board process similar to the Corps that has my boss looking at the projects on a periodic basis as they begin to see indicators come up that say their risks are getting a little high or their costs are getting close to the programmed amounts so that we have the ability as a department to intervene and get things back on track before they go totally off the rails and we have no option.

So those are some of the big things that we have put in place to make sure that we have control on our projects going forward.

Ms. BROWNLEY. And this is all modeled after the Army Corps and their military construction?

Mr. MILSTEN. Yes, it is. And that is because we have recently acquired a whole bunch of people with Corps of Engineers' experience and we are looking to put those sorts of controls that a significant number of them are familiar with and have demonstrated some success.

Ms. BROWNLEY. Thank you.

I yield back.

The CHAIRMAN. Dr. Roe.

Mr. ROE. Thank you all for being here and also thank you for taking on this very difficult project.

And not to be too flippant or not to be—I am sort of going back 40 years. This is a FUBAR on steroids if I have ever heard one or seen one. And I look at this and I have been involved in building a medical center, an office building, another hospital and an office building, another community hospital LEED certified, and a $20 million office building that my practice is currently in. All projects came in under budget and on time.

And I found this the most astonish—I feel like I am in the twilight zone when I listen to this. And if you are in private business, and, Mr. Secretary, you understanding this extremely well——

Mr. GIBSON. I do.

Mr. ROE [continuing]. Your lenders won't lend you any more money.

Mr. GIBSON. That is right.

Dr. ROE. You go out. A project like this would have been shut down and moth-balled years ago because it is so outrageous. And what I have heard is—I want to ask just a few questions and I want to make a statement.

After listening to this and listening to Ms. Brown for the last several years here, I am not sure the VA ought to ever build a hospital. I mean, this is not rocket science. There are 5,700 hospitals in the United States operating right now. And this one just can't ever seem to get to the finish line. It is amazing to me how badly this has been done.

And what I heard also today is there is no time line for accountability. Maybe sometime this year. And we still don't have any idea how much it is going to cost.

When this hospital first was bid out, what was the number that was put out there? So when the bid was made, we were supposed to build this hospital for, how much was that?

Mr. MILSTEN. The initial contract with the builder was for a firm target price of 604 and a ceiling of 610.

Dr. ROE. Okay. So you had a $600 million hospital?

Mr. MILSTEN. Yes.

Mr. ROE. So what I just heard a minute ago, and I heard the secretary say that the next number we are going to hear is $1.1 billion, and that is not the end of it. And just for the English translation for poor country people like me, reprogramming means you are going to take money from one project and move it over to another project, but you still need the money in the first project to move the money from.

Am I right about that?

Mr. GIBSON. That is correct.

Dr. ROE. So it is not less money. We are still going to—and I think we ought to be honest about that, we are at $1.1 billion.

Mr. GIBSON. And that includes——

Dr. ROE. And we don't know what the next number is going to be. Am I right?

Mr. GIBSON. That is absolutely right. The $1.1 billion includes not only the $600 million from construction. It includes the land acquisition. It includes the architects and engineers. It includes the construction management and other incidental costs associated with managing the project. So there are other elements to the $1.1 billion.

Mr. ROE. Look, I have been practicing medicine for over 40 years and, yes, technology is going to change. The hospital I started practicing, a new hospital 35 years ago looks very different today. You are going to make modifications to it.

But building an operating room is building an operating room. And if you are building one for cardiac surgery, we know what that looks like by the thousands in this country. And I for the life of me cannot understand how you could miss a number by a hundred percent.

And the other thing Ms. Brownley brought up was to date—and this project started when? When did somebody go with a shovel and everybody standing out there gets their picture?

Mr. GIBSON. There was actually dirt moving in 2010.

Dr. ROE. 2010, so five years ago. And the original completion date was when?

Mr. MILSTEN. Three years after that.

Dr. ROE. So 2013.

Mr. GIBSON. 2014.

Dr. ROE. And now we are looking at 2017 maybe. And so I certainly can understand the frustration of the veterans who would be in this, I think, a phenomenal facility if it ever gets built.

But do you think that the VA ought to build another hospital after this and after Orlando and we have got, I guess, Louisville coming up, isn't that right, it is going to be built, or should we just

give that to a company that builds hospitals and tell them what you want? Let them go build it and get a competent contractor and a competent architect and go build it.

Mr. GIBSON. I think the answer to that question——

Dr. ROE. It is embarrassing for me to go back and face my taxpayers at home and the veterans at home when they keep saying, Doc, when is this building going to be done. And we keep saying, and she has been saying this now for years, so maybe we should go another route.

Mr. GIBSON. It is embarrassing to me, too, sir.

Dr. ROE. I am not blaming you, Mr. Secretary. You weren't there at the original—you haven't been on the team very long, but I am just asking a rhetorical question.

Should the VA build another facility?

Mr. GIBSON. I think it is a fair question.

Dr. ROE. Let the private sector build it.

Mr. GIBSON. I think it is a fair question. And I think as we look at the Corps' assessment that we have asked them to do on this and other major projects that are under construction or have recently been completed, I think they come back and they look at what went wrong and they look at our structure and our processes.

And with that as part of the information, we make an informed decision about, okay, how do we do this part of your business in the future. And it may well be that the best outcome, the best outcome for veterans and for taxpayers is that we turn to the Corps and we say, Corps, we want you to build our hospitals from now on. That may be the decision. And if it is, so be it. That is all I am after. I want the best decision based on those two parameters.

Dr. ROE. Well, I don't see how it could have been done much worse.

Mr. GIBSON. No. On this one, I don't either. You know, I think frankly, and I alluded to it earlier, that the crux of the issue here happened as we were trying to push to get to a firm target price. And we were doing that without having design completed.

And what we did is we set up an inherent conflict and then we obligated ourselves to deliver a design that could be built for $604 million when the design was still moving and we never reconciled those two. We never forced the issue. And so you are right. It is a mess and it is what you referred to as FUBAR.

Dr. ROE. Thank you for taking this on.

I yield back.

The CHAIRMAN. I am not going to say anything.

Ms. Titus, you are recognized.

Ms. TITUS. Thank you, Mr. Chairman.

I am glad to learn what FUBAR means. I didn't know that.

The CHAIRMAN. Well, ma'am, I didn't say—I didn't say that now.

Ms. TITUS. Well, you know I represent Las Vegas, Mr. Chairman, and I have appreciated working with you and I thank you for being here. It is very important that we talk about this issue, not just because of the problems that exist now, but we have invested a lot in future expansion and more facilities; we want to be sure that they work right.

The hospital in Las Vegas had a lot of problems. You are aware of that. It was too small by the time it got built. They had to build

a new emergency room. They built it and opened it in pieces, so that is confusing to the veteran of what services are actually available.

You have given me some information in the past and you probably don't have this right in front of you, but I would ask that the VA give me some kind of hard facts about when it is going to be opened and what the timeline is for all of the facilities and all of that associated with the hospital, if I could get that from you in the future?

Mr. MILSTEN. Yes, ma'am. Of course.

Ms. TITUS. Thank you.

Now, one other thing is it seems to me that we need to take one step back. You have talked about all of the improvements in terms of more oversight for the contractors for the bids and how you are going to be doing the construction, but I think part of the problem is the metrics leading up to the decision of what to build and what to put in a facility. It is one of those "build it and they will come."

And Las Vegas, it was anticipated that once you had a hospital, the number of veterans served would increase by two percent; in Las Vegas, it increased by 19 percent. We are going to have more veterans who need these facilities. There are going to be different kinds of veterans with more serious problems, more women veterans. So can you tell me about what you all are doing about the metrics, in advance of deciding what you need and what to build?

Mr. MILSTEN. One of the other pieces that we have instituted in the department is a return to, if you will, market-area master planning. So we take an area—in this case, we are working with a VISN—and we look at all of the needs within the VISN. The Department sends down a set of gaps that they have identified that need to be closed by the VISN and then a rigorous process is undertaken. It takes about a year and a half to go through this where we look at both capital and noncapital solutions to close these gaps, and then we put the facility master plan together that then informs the SCIP process, the strategic capital plan going forward so that we have a true look at where we are going; that we have a Departmental control on the facilities that fill into a marketplace; that we have a better-defined requirement which cuts down on changes later on, cuts down on that flux and it will get our facilities built in the right fashion; and then after the project is built, we have gone back to instituting a—or we have instituted a post-occupancy evaluation that comes back in and says, okay, here was a set of gaps or requirements that the project was set to meet; did we, in fact, meet them? And if we didn't, then we still have something to accomplish and we also develop a lesson learned that says the way to close this gap may not be that particular path, so that we don't repeat the same mistakes over and over again.

Mr. GIBSON. And, Dennis, if I understand correctly, we use a ten-year planning horizon so that we are not looking out, you know, with year or two years; that we are looking much farther down the road forecasting changes in veteran population and unique patient growth.

Ms. TITUS. Well, I would just encourage you to work closely with local forecasters, economic and demographic forecasters, when it is

at the university think tanks so you can anticipate growth. That seems to be a factor that hasn't been a——

Mr. MILSTEN. One of the things we are doing is we are bringing in planning consultants that have that kind of expertise and have the ability to reach into the marketplace. We are not depending on our own in-house ability to forecast; we are looking at how we bring consultants in that have that experience, the same experience that supports the private sector, informing them on their healthcare-building decisions would be then helping us to help forecast our needs.

Ms. TITUS. Okay. That is good. I am glad to hear that.

And I would just, again, say please keep in mind women veterans. The secretary has assured me of that. The chairman has promised to hold a hearing on the needs of women veterans, and also keep that in mind, and I will look forward to getting the information about the Las Vegas hospital.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Dr. Benishek, you are recognized.

Dr. BENISHEK. Thank you, Mr. Chairman.

Mr. Gibson, Dr. Roe really said a lot of the things that I wanted to say, and to me, I am frankly shocked and I completely agree with Dr. Roe in that I don't see why I would ever want to trust the VA to build another thing ever. I mean the answers that you have given here, the reasons why this has all happened sounds to me like you have never built a hospital before.

We should have had the plans in before we did the bidding, oh, yeah. I mean the answers don't make any sense to me. My question, from what Dr. Roe has said, has anyone been disciplined during this whole process?

Mr. GIBSON. There have been, in Denver, for example, the project executive and the contracting officer were removed from those particular positions. But I would tell you the more comprehensive look at what happened in Denver will be taken by the AIB and——

Dr. BENISHEK. Frankly, one of your earlier answers sort of shocked me too: We are looking for evidence of mismanagement. Well, the fact that there is a cost overrun of a half a billion dollars is kind of a priori evidence that there has been mismanagement. And the answer that you are going to look for mismanagement is sort of a wash with me.

Mr. GIBSON. The issue is being able to document the individual accountability with evidence because what will happen is if we take an action and we don't document it with demonstrating that that particular individual was accountable for that particular issue and have the evidence to support that, our decisions are just going to get overturned. So we have to go through this process to gather that evidence.

Dr. BENISHEK. It just seems very difficult to me, Mr. Gibson.

Mr. GIBSON. It does to me, too.

Dr. BENISHEK. My opinion coming in on this committee, we shouldn't allow the VA to ever do any construction project again; they should just be bid out to the private sector and let the Army Corps of Engineers—because if you are telling me that you can't even discipline the people that cost a half-a-billion-dollar-cost over-

run because you don't have the right tools or your management plan or your union plan doesn't allow it to happen, there is a real problem here and the American taxpayers are paying for it and our veterans are paying for it with the lack of their care, and, you know, I just don't get it.

Let me ask you another question here. Now, do you know what the average cost per square foot of this hospital is going to end up being?

Mr. GIBSON. We won't know the answer to that question until we know the estimated cost to complete.

Dr. BENISHEK. All right. How much money have you spent already on the project?

Mr. GIBSON. Roughly, $800 million has been obligated.

Dr. BENISHEK. So that is the money that you have spent already?

Mr. GIBSON. The majority of that is spent, not quite all, but all of it has been obligated.

Dr. BENISHEK. So that is more than the original—$200,000 more than the original bid price of the project?

Mr. GIBSON. Well, as I mentioned earlier, there is—was a construction contract of about $600 million that didn't include architect engineer fees, construction management fees, the acquisition of the land, the site preparation, and other costs that are associated with building a project of this complexity and size.

Dr. BENISHEK. So those costs weren't taken into the account of the original price of the project?

Mr. GIBSON. They were taken into account.

Dr. BENISHEK. So what was the original price of the project supposed to be?

Mr. GIBSON. The original appropriated amount was somewhere just south of $800 million.

Dr. BENISHEK. So we spent all the money that we originally thought we were going to spend, but we only got a project that is half done?

Mr. GIBSON. That is correct.

Dr. BENISHEK. All right.

I don't have any more questions. I will yield back the remainder of my time. Thank you.

The CHAIRMAN. Ms. Kuster, you are recognized.

Ms. KUSTER. Thank you, Mr. Chair.

And just for the record, I share our colleague's frustrations and it is clear that all of you do, as well.

I want to learn from this in terms of going forward, and there was a comment in our brief about the model of hub-and-spoke medical services in the VA, and I am just wondering, given everything we have heard today and we have known for a few years now about the cost overruns, the complexity, I think I noted your comment about cutting speed to delivery, it seems exponential. The longer the delay, the more change orders, the more change in the scope, and I think certainly my colleague, Ms. Titus talking about let's try to be more focused on projecting what the needs are.

But given all of that, I am just wondering, is there any thought going on now at the VA—and this is for Mr. Gibson—about whether this hub-and-spoke model is the best model. Should we be trying to create these megacenters, medical centers, and in particular, in

light of the major reform that this congress passed and the president signed back in July about the concept of sending our veterans for private pay? In many parts of the country we have outstanding tertiary healthcare facilities that are complex and expensive to duplicate within the VA system. So I will just leave it for your comment.

Mr. GIBSON. I think, first, it is important to note that what came first were the hubs, and what you have seen happen at VA has happened across all of medicine in the United States over the last several decades, is a movement toward a primarily ambulatory care or an outpatient-care model. That is where the vast majority of your care is delivered. And so what we have done over the last 20 years is create these outpatient clinics, much more convenient, much more readily accessible, to provide a large portion of the healthcare services that our veterans require.

Ms. KUSTER. And presumably, less costly to build?

Mr. GIBSON. Yes, they are.

Ms. KUSTER. Okay.

Mr. GIBSON. In fact, principally, we have used a lease structure in order to be able to pursue that dramatic expansion. But there are still requirements, care requirements for veterans that will need hospitalization. So, as is the case in this particular instance, it is an instance of replacing an old and outdated facility.

Now, the question you raise is part of a much longer and philosophical kind of question about the role for non-VA care, the requirements to maintain continuity of care, and the recognition that the typical VA healthcare patient is older, sicker, and poorer than the average population. So there is a sense here of not, you know, do we just dump those veterans onto the public healthcare market and let them fend for themselves in terms of achieving the best healthcare outcomes or do we look to build an integrated system which would include medical facilities or hospitals as part of that system, but recognizing that some healthcare can and should be provided in the community.

Ms. KUSTER. And I appreciate that, the reality test, because I think that is a part of it. In terms of congress, our oversight is about the care for the veterans——

Mr. GIBSON. Yes.

Ms. KUSTER [continuing]. And the precious tax dollars and where we find that balance. But I think for the American people and for the Members of Congress, we need to address this issue that veterans are coming back with much more complex medical conditions. Veterans are aging, and as you say, due to the challenges they have, they have less resources on their own to seek their own care.

Mr. GIBSON. Right.

Ms. KUSTER. I appreciate what you are doing. I am taking up the mantle of being the ranking minority in the oversight committee and intend to work very closely with my colleagues on both sides of the aisle to help maintain the balance or hopefully restore the balance of providing the care in a timely way.

Mr. GIBSON. Thank you for your continued support and service, ma'am.

Ms. KUSTER. Thank you.

The CHAIRMAN. Thank you, Ms. Kuster.

Now, to a new member of our committee from New York: Mr. Zeldin, you are now recognized.

Mr. ZELDIN. Thank you, Chairman Miller.

And I appreciate your recognizing that I am a new member because I am going to ask a new question. In one of Mr. Coffman's questions, with regards to going from a 42 percent estimate, going up 8 percent over the course of the year, Mr. Milsten, you referred to a term called an artificial budget. Can you tell me what an artificial budget is?

Mr. MILSTEN. When the court decision came down and they said that we had failed to deliver a design that could be built for the contract amount of 604, we had been measuring progress against 604 and we were measuring it as a term of art where we use work in place. So what we paid for was then evaluated against what the total contract was. Well, the reality—what the court—what the civilian board told us is that the number was completely wrong, and so that is the artificial piece that we were measuring against.

So when we were—I mean there were fact sheets that showed that I think we were as high as 62 percent at one time out there, but that was against that 604 number for what we had put in place. And when the court board came down and said that number doesn't hold any water, that is the artificial piece that I was talking about.

Mr. ZELDIN. I also understand from the questioning that you need an authorization by June, but that it is going to be at least several months before we know how much money you would need. I am just trying to understand, are we going—would we find out how much money you would need before you are actually getting the money?

Mr. GIBSON. There is two steps in here. The first thing that is required will be—or requested, will be an increase in the authorization in order to allow us to continue to operate during this interim period of time. For reasons that were explained earlier, you know, the best course of action we believe is that we keep construction underway at this project, rather than shuttering, mothballing and demobilizing activity on the project. So we will need an increase in the ceiling prior to June, probably within the next 60 days or so in order to support a higher level of spending during this interim period, then there would have to be another one for the full construction cost.

Mr. ZELDIN. Right now, the contractor working at the site, what budget is the contractor operating off of? What are their numbers?

Mr. GIBSON. When we put the interim contract in place, what we did was we funded it with $70 million; $50 million to cover month-to-month new work that is being undertaken, based upon a detailed schedule that is being developed between Kiewit Turner and VA that focuses work on critical path items, plus there is about $20 million available for settlement of subcontractor disputes. And so we are going to be allocating another $31 million into the contract and we have some amount of money left that was unobligated under the contract that we will also use to settle subcontractor disputes.

Mr. ZELDIN. The $50 to $70 million numbers, is that between now and June? Is that per month?

Mr. GIBSON. That will likely—what we did in the interim contract is we put those amounts in place for a 90-day period of time. So whatever we run out of first, time or money, that ends that contract. Both parties reserve the right to extend it and our expectation is to extend it because we don't believe the Corps will be in a position to enter into a contract to complete the project until probably June.

Mr. ZELDIN. Mr. Takano was asking you about the investigation. Is it possible that people who are responsible for negligence are still working on this project?

Mr. GIBSON. I think it is unlikely. As I mentioned, we have changed the reporting relationship for construction facilities management, so that removes one particular senior executive. I mentioned earlier that we had also changed out the project executive and the contracting officer. I would tell you the project executive that we have on the scene now, and have had since April, is a star, a young fella named Kevin, Kevin Lindsay that came to us from Corps of Engineers.

Mr. ZELDIN. Mr. Caldwell, real quick question: Has the Army Corps ever build a hospital before?

Mr. CALDWELL. Yes, we have.

Within the last, let's say since 2007, about 12 either have been completed or are under construction.

Mr. ZELDIN. Okay. Great.

So this is very informative for me. Chairman Miller, you know, I have heard this new term of artificial budgeting. Ms. Brownley was asking for a timeline of when she is going to get the timeline.

Asking for funding without knowing what the cost is—that came from the State Legislature in New York—with $200,000, our county, which has the second-highest vets population of any county in the country, highest in the state, with $200,000, we created a program for PTSD. Hundreds of veterans—and we are saving lives with $200,000.

And the concern is when you are $500 million over budget, you are taking money away from other programs that can save lives and give care to our veterans who need it and deserve it. I actually think the whole thing is pretty outrageous and I am very grateful that Chairman Miller is having this hearing and Mr. Coffman is advocating so hard to keep us informed.

The CHAIRMAN. Thank you, Mr. Zeldin. Welcome to Congress.

(Laughter)

The Chairman. Mr. O'Rourke.

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

Since we last met, there was a strategic shooting at the El Paso VA.

The Court: You can stop the clock on this. Don't need to clock him on this.

Go ahead.

Mr. O'ROURKE. And I just wanted to take a moment, and I know that I speak for you and for the Committee in extending our condolences to the family of Dr. Fjordbak, who, following 9/11, left a lucrative practice is, moved to El Paso to work at the VA and help

treat our veterans who were returning from Afghanistan and Iraq, including veterans who had served in previous wars. And from everything we know about him, exemplified the kind of service and commitment to excellence that we wasn't to see more of in the VA.

And I want to thank the secretary for the leadership at the El Paso VA, your Interim Director Pete Dancy is doing a remarkable job. And as tragic as this shooting, this murder was, I note that the El Paso VA is going to come back better and stronger than ever. And I'd also like to conclude this part of my time by thanking all of the employees, many of whom are veterans, the frontline staff, the doctors, the providers, the mental health experts, the volunteers who do a remarkable job in El Paso day in and day out under some very trying circumstances, especially following the shooting on January 6th.

And I commit to you, Mr. Secretary, that we will do everything that we can to support that staff, be there for them, and make them stronger than ever going forward.

Mr. GIBSON. Thank you. Your support means the world to me and I know, to them.

Mr. O'ROURKE. Mr. Chairman, I would like to continue by developing on the theme that we are looking at in terms of the VA's opportunities and competence when it comes to building major medical facilities and providing world-class care and outcomes for our veterans in a timely fashion. Again, despite what I think are the best efforts of a truly remarkable team at the El Paso VA, due to a number of factors from staffing to resources to leadership, in some cases, we have not been able to deliver on that for the veterans.

What I hear day in and day out from the veterans that I represent and serve is that when they can get in, they are treated like royalty and very infrequently have any complaints at all. The struggle, of course, has been getting into the VA in the first place or having an appointment that is not cancelled or not having your records dropped or erased or feeling like you have been forgotten. One of the other factors that makes it difficult to deliver world-class care in El Paso and to better serve our veterans is the age and the state of the facility that we are in today. And you were kind enough, Mr. Secretary, to visit El Paso in July of last year, and after a tour of the facility, you confirmed that conclusion that we have reached, now for a very long time in El Paso, that the facility we have is inadequate, insufficient and unacceptable and we can and must do better for our veterans and for those who serve them out of that facility.

Further complicating things in El Paso is William Beaumont Army Medical Center is building a new $1.1 billion facility nine miles away from its currently co-located position with the VA health clinic. We have, what I would say is an opportunity, right now to decide what we can do to improve the kind of facility, the delivery of care, and the access to that care in El Paso. There are a number of partners there who want to work with you and want to work with us, including Texas Tech, which has the Paul L. Foster School of Medicine, the first four-year medical school built anywhere along the U.S./Mexico border. We have University Medical Center. We have Tenet and HCA Hospitals. We have a community,

though, one of poorest from income and property values, is one of the richest in service, that is willing to get behind this and make it a success.

I want to follow-upon your commitment to take El Paso from one of the worst performing to one of the best, and I want to help answer Dr. Roe's question, and a question that you agreed was a valid one, which is, should the VA be in the business of building these facilities? We certainly don't expect $1.1 billion to be spent in El Paso, Texas—we would gladly take it, we are not expecting it. What we will offer is that through these partnerships, through the commitment and funding from the local community, we can make a deal for the VA that would prevent you from building a brand new facility or a hospital that I think there are some serious questions about the competency of the VA to do just that, and instead, perhaps, test or prove a different model in the delivery of healthcare. It would solve, I think, a lot of problems for VA nationally, while meeting the expectations that we should have in El Paso of having world-class care for each and every veteran.

Now, we received a memo that was written by VHA Under Secretary Clancy August 18th of last year that said within 60 days, they would have a game plan for such a facility. I probably don't have to tell you that today, at least in our office, we do not have a copy of any such plan. And despite, I think, our polite but insistent demand that we see one and be a partner in that, we have yet to see anything.

You, current Secretary Bob McDonald, who also visited El Paso recently, we want to thank him for that—that was following the shooting—have both express to do me your commitment, but I need to see some follow-through. I need to be part of that process that you admitted often happens behind closed doors and doesn't involve members of congress. I want to be your partner in this; I don't want to be your adversary. But after two years and documented failings, including by VHA and the OIG, we absolutely need something better and we need to be part of it. So what I am asking you today is from all the lessons that we have learned from Aurora, from Florida, from other facilities, and from the opportunity that we have in El Paso, will you commit to working with us? Will you dedicate someone, even on a part-time basis, to working with this community to develop that plan? We will be your partner in implementing it.

Mr. GIBSON. Yes, we will.

I think one of the things both Bob and I have emphasized at our months at the department is the need to build on the strategic partnerships that we have out in our communities, and I think that El Paso is a great example of that. As you and I discussed a couple of months back, we really don't have a way forward there, and we are not positioned for success in El Paso today and we need to get ourselves positioned for success. And I think the circumstances on the ground you just outlined very ably, could create an ideal opportunity for us to leverage on those local partnerships and do the right thing for veterans and be good stewards of taxpayer dollars.

Mr. O'ROURKE. Thank you, Mr. Secretary.

And I will conclude by saying that we will follow-up this week to share what we have assembled and to gain from you what you have——

Mr. GIBSON. Thank you.

Mr. O'ROURKE [continuing]. And then from there, I think we need to move very quickly to implement something.

Mr. GIBSON. I understand.

Mr. O'ROURKE. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Costello, another new member who asked to be on this committee from the great state of Pennsylvania, you are recognized.

Mr. COSTELLO. Thank you, Mr. Chairman.

In applying my experience as a real estate lawyer who has been involved in acquisition and land-use approval and development and construction matters, but not focusing on what happened pre-bid award to KT, I want to share a couple of observations with you. In looking through the materials, I am just going to cite right from them.

First, the CBCA finding that VA delayed progress of construction by delaying the processing of design changes and change orders: Quoting, Much of the blame for the situation must be ascribed to the VA by failing to control the joint venture design team, delaying approval of the design, presenting KT with a design which was allegedly complete, but required an enormous number of modifications, failing to process change orders for approximately one year.

And then you look at Mr. Chang's emails, one in particular—two in particular, stand out: A June 13th, 2013, email where he says we hired a senior resident engineer who has never done anything that we have been doing in CFM, but he won't take advice from those who came from the VA system. The budget schedule and scope are not in control. I have no clue when this project is going to be finished and how much it is going to cost when this project is done.

That was in June of 2013. It concerns me from a construction-management perspective—again, leaving aside the design aspects that went into the actual bid, to which the contractor was awarded—it concerns me from a construction-management perspective that the moment that someone within the VA organization would send an email like that or feel that way, that it wouldn't simply freeze at that point and say, This problem is too big for us; we need to go somewhere else and get subject-matter expertise. Because when you are designing—when you are managing a construction project and you are bringing into the fold, construction-management firms or a construction manager, you are not hiring them for a project that 95 percent of which is going to go right. There is also going to be modifications or change orders along the way. You are hiring that construction-management firm or individual for when things are going to go really, really bad so that it doesn't become worse.

And when you go back, I think it is a year earlier in an email, Mr. Chang indicates, All I can say—this is a year prior to the email that I just cited to—all I can say is the storm is coming. How we got into this mess, it is simple: Scope, schedule, and budget were

not managed; no leadership; no knowledge and experience in this business; not following handbook; no skill and organization.

That points to, I think, a much more fundamental dynamic here, which is that subject-matter expertise on very sophisticated construction projects like this do not reside in the VA and so moving forward, similar to what Congressman Roe said and other Members here, I just question whether, as part of a general budget, you should be—we should be looking to fill subject-matter expertise of that sophistication when it is really better outsourced. And so I would like you to share your comments moving forward on the types of questions you are going to be asking yourself and what you are going to be presenting to the Chairman and this Committee on whether maybe you just don't want to be in the business of building hospitals, maybe that is something better outsourced, so that, frankly—again, looking at what the CBCA's findings were, a lot of the additional—at least some of the additional cost is actually a function of not merely mismanagement, but not managing it. It is not just the design, it is the management or lack of management here that has caused further delays and caused further expense and I think that is the real troubling—that is a deeply troubling aspect of the overall problem.

Mr. GIBSON. I am sure that you understand, based on your experience, that using a construction—a contract vehicle such as IDC or construction management at risk, in order for that to work effectively, you have to have very strong project leadership on the job, and frankly, we didn't have it. And those emails and the things that you just read make it very clear that we did not have it.

I would love for you to have the opportunity to come visit this facility today and sit down and spend time with the project engineer, project executive on this particular facility, and surmise from your own objective observations whether or not that is the kind of person we want leading complex projects, whether we do our own hospitals in the future or not—I have already put that on the table—and I said perfectly willing for us to look at that. All I am after is what is best for veterans and what is the right thing for taxpayers, and if that means turning over major hospital construction to the Corps of Engineers, I think that is fine. But that is a big decision, let's make it an informed decision.

Mr. COSTELLO. And my only follow-up to that would simply be, within a project this big you are talking about a team of highly skilled professionals——

Mr. GIBSON. Yes.

Mr. COSTELLO [continuing]. All of whom not only make—hold the project accountable, but hold one another accountable.

Mr. GIBSON. Yes.

Mr. COSTELLO. And the other underlying concern here is that there was not, I feel, at least from what I have seen, a lot of accountability within that team.

Mr. GIBSON. There was not.

Mr. COSTELLO. And that led to even more of a runaway expense and I think that is really a testament to what happens when we try to have—and this isn't a criticism directed at you, but a more broader point—that is what happens when we have bureaucracy trying to do too many things rather than what they are specifically

designed to do, and what you are specifically designed to do is not build hospitals. Thank you.

The CHAIRMAN. Thank you very much.

Ms. Radewagen, who is another new member who asked to be on this—who comes from the furthest location from any committee member, the American Samoa.

Ms. RADEWAGEN. Thank you, Mr. Chairman.

It is an honor and privilege for me to be a member of this committee. As you know, each May is Asian-Pacific American Heritage Month and National Military Appreciation Month. And over the years, I have traveled around to many bases to celebrate with the military and I discovered that American Samoa's vets, like other vets, they tend to settle near the base they were last stationed at because their families have settled in and their children are in school.

We have three major exports, canned tuna, NFL football players, and soldiers, military personnel. Veterans make up 10 percent of the territory's population, so access to veterans' healthcare is deeply important and I look forward to working with this committee.

My question, Secretary Gibson, is: How long will it take to get a new long-term contract with KT? Can you please explain the process that will be taken to get to that point?

Mr. GIBSON. Do you want me to answer that one, Lloyd? I'd be glad to.

Mr. CALDWELL. Yes, sir. Go ahead.

Mr. GIBSON. Let me take a shot at it and I will let Lloyd chime in here.

The Corps has an assessment team on the ground in and out at Denver right now; they are experts from all over the country. These are chiefs of sections, not deputies; it is a very expert team. They are going through their assessment. They are developing right now an acquisition plan, and they will go through that process and have that acquisition plan presented and, you know, everyone would hope approved during the month of February.

And then between the month of February—and their target time period is June—during that period of time, they would go through the careful, close work with KT, supported by VA, to determine the schedule; to determine the scope of work to ensure that the design has been completely locked down, and ultimately to determine the cost to complete and settle on a contract vehicle to enter into with, whether that is KT or whether that is another party, that would be determined as part of the acquisition strategy. So that is the general time frame.

Ms. RADEWAGEN. Thank you.

And lastly, Mr. Milsten, if you plan to move money from other major construction projects that Congress has appropriated money to build, what is stopping those projects from being mired down by the same cost overruns and delays that current VA major construction projects are facing?

Mr. MILSTEN. One of the things that we are looking at as we go forward with this reprogramming effort is to find those projects that taking some of the money off them will not or will have minimal impact on their ability to go forward. We continue to press for the speed to delivery to get these facilities done, and as part of any

effort, we want to work with the Committee and with Congress to replenish those funds that we reprogram off so that those projects can keep on-track to provide those services to veterans.

Mr. GIBSON. I would also point out the number of improvements that have been implemented over the last couple of years that are being applied currently, as well as the lessons that we will learn from the Corps' review of Denver, as well as other major construction projects, to ensure that we are using the very best practices possible in all of our projects.

Ms. RADEWAGEN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Ms. Radewagen.

And before we go to the second panel, Ms. Brown, do you have some comments?

Ms. BROWN. Yes, sir. Thank you, a couple of things.

Mr. Secretary, the Committee is asking me exactly when do we expect the Orlando hospital to be complete because they want invitations to come down——

(Laughter)

Ms. BROWN [continuing]. And former Members want invitations to come.

Mr. GIBSON. Yes, ma'am.

Ms. BROWN. So, we all want to participate.

Mr. GIBSON. We will plan a major celebration for the ribbon cutting in Orlando.

Ms. BROWN. Yes.

Mr. GIBSON. I know construction is scheduled to be complete at the end of February, but there is an activation period that will follow that where we are moving equipment in and all that sort of thing. We will be sure to get dates to the Committee ahead of time.

Ms. BROWN. We will ask the Committee Members to formally come down for a site visit when we open.

I do think that we need to separate building a hospital from building a clinic. I don't think that we have had the same problems with the clinics as we have had with the hospitals. Can you clear that up for me?

I haven't had any problems with my clinic in my district.

Mr. GIBSON. Yeah. I think there have been challenges with clinics, as well as hospitals. The nature of those challenges have, in most instances, been somewhat different. I would say where they are similar has to do with the early stages of developing and defining requirements and then locking down those requirements so that we are able to move expeditiously through the process.

Ms. BROWN. And at issue that maybe the Committee needs to deal with. We had a project in Miami that was two smaller projects and once we put them together, it became a larger, you know, one big project that you all need to come back for us, and maybe we need to develop some kind of authority so that you can move forward, because that held up that project. So we need to work together in areas that we can to make sure that we can expedite the process.

Mr. GIBSON. Yes, ma'am. We would appreciate that opportunity. Thank you.

Ms. BROWN. And so with that—and there are many other things. Someone said something about mismanagement and I want to say

that part of the problem—let's say in Orlando, part of it was we changed the sites. And in this Denver hospital, it was going to be a joint-use hospital and it became a single-use facility, so all of those things got to be considered as we discuss and decide how we are going to move forward, and you can't just say it is one item; it is a multiplicity of reasons why projects get delayed, and we need to do our part to make sure that doesn't happen also.

And so with that, Mr. Chairman, I am very excited about working with you to move the VA forward.

The CHAIRMAN. Thank you very much, Ms. Brown. We are all looking forward to working collaboratively with the VA. I would say that the one incident in Miami where there were two projects, actually, that was something that this Committee uncovered. That was a large project that was purposely split into two so that they could proceed forward, and that is why we had the problem that we did, and, you know, nobody wants to delay anything, but we certainly want to make sure that everybody follows the rules.

But with that, thank you, Mr. Gibson, for being here.

Mr. Milsten and Mr. Caldwell, thank you so much, and you are now excused.

Mr. GIBSON. Thank you, Mr. Chairman.

Thank you, Members.

The CHAIRMAN. We are going to go ahead and move forward with our second panel. We are going to hear from Mr. David Wise, director of physical infrastructure issues at the Government Accountability Office; Mr. Roscoe Butler, no stranger to this committee, the deputy director for healthcare for the American Legion's Veterans Affairs and Rehabilitation Division; and also Mr. Ray Kelley, also no stranger to this committee, director of the national legislative service for the Veterans of Foreign Wars.

As, per the custom, your statements will be entered into the hearing record.

And Mr. Wise, now that you have made it to your seat, we are going to let you go first. We will recognize you, sir, for five minutes.

STATEMENT OF DAVID WISE

Mr. WISE. Yes,

Chairman Miller, Ranking Member Brown, and Members of the Committee, I am pleased to be here today to discuss information from our April 2013 report regarding the construction of new major VA medical facilities. Our report examined the Agency's actions to address cost increases and schedule delays for VA projects in Denver, New Orleans, Las Vegas, and Orlando. At the time of our review, VA had 15 major medical facility projects underway at a cost of more than $12 billion, including new construction and renovation of existing medical facilities.

For those four projects we originally found that cost overruns range from 59 percent to 144 percent. Delays ranged from 14 to 74 months; however, costs and delays have since increased with cost overruns now ranging from 66 percent to 144 percent and delays ranging from 14 to 86 months with the potential for further increases.

My statement today discusses three key issues related to the VA medical facility construction program. One, the extent of and rea-

sons for cost overruns and schedule delays for the four new medical facility projects we reviewed; two, actions VA has taken to improve its construction management practices; and three, VA's response to our 2013 recommendations to improve the management of costs, schedule, and scope of these construction projects.

When comparing construction project data updates provided by VA for this testimony, with the cost and schedule estimates first submitted to Congress, we found the cost increases range from 66 to 144 percent representing a total cost increase of over $1.5 billion and an average increase of approximately $376 million per project. Since our 2013 report, some of the projects have experienced further cost increases and delays. For example, VA's reported delays for the four major projects now range from 14 to 86 months with an average delay of 43 months per project.

Of those projects, Denver had the highest cost increase and the longest estimated years to complete. Estimated costs increased from $328 million in June, 2004, to $800 million, as of November, 2012. VA moved the estimated completion date from February, 2014, to May, 2015; however, these estimates may further increase and VA has been unable to provide total estimated costs and schedule data for the Denver project at this time.

At each of the four projects, different factors contributed to cost increases and schedule delays as follows: Changing healthcare needs of the local veteran population expanded the scope at the Las Vegas project; decisions to change plans from a shared university-VA medical center to a standalone VA medical center affected plans in Denver and New Orleans; changes to the site location by VA delayed efforts in Orlando; unanticipated issues, especially environmental, in Las Vegas, New Orleans, and Denver, also led to delays. Some of these factors resulted in expensive, cumbersome and lengthy change orders.

Since 2012, VA has taken some steps to improve its construction management process including creating a construction view council to oversee VA's development and execution of its real property program. The council is intended as a single point of oversight and program accountability. Establishing a new project delivery method, known as integrated design and construction, which engages the construction contractor early in the design process to streamline construction and reduce the need for change orders. VA used this procedure in Denver—in the Denver project, but too late to fully benefit from it.

In our 2013 report we made three recommendations to address systemic issues that contributed to overall schedule delays and cost increases, including developing guidance on the use of medical equipment planners, as part of the design and planning process; sharing information on the roles and responsibilities of VA construction project management staff; and streamlining the change order process. VA agreed with our recommendations and has taken action to implement them. While we have closed out the recommendations, the impact of these actions may take time to show improvement, especially for ongoing construction projects, depending on several issues including the relationship between VA and its contractors.

Chairman Miller, Ranking Member Brown, and Members of the Committee, this concludes my formal statement, and I would be pleased to answer any questions you may have at this time.

[THE PREPARED STATEMENT OF DAVID WISE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Mr. Wise.

Mr. Butler, you are recognized.

STATEMENT OF ROSCOE BUTLER

Mr. BUTLER. Thank you.

Due to poor planning and budget execution with VA construction management, a project that could have come in under $600 million has spiralled into a billion-dollar debacle that has tarnished the good faith of the veterans of Colorado, the hundreds of workers who labored to build that hospital, and honestly, the good faith of veterans across the country. The veterans of America are crying out, Enough is enough and demand better results.

Good morning, Chairman Miller, Ranking Member Brown, and Members of the Committee. On behalf of our National Commander Mike Helm and the 2.4 million members of The American Legion, I want to say thank you for the scrutiny that you are applying to sorting out the unfortunate and unnecessary chaos with VA's construction projects. The veterans of Colorado have waited for a replacement hospital since the late 1990s. Three VA secretaries made promises, but failed to deliver. Now, VA's construction problems have spiralled into epic proportions, especially the Colorado replacement facility.

The American Legion's deputy director for healthcare, I have been an active participant in our organization's System Worth Saving Task Force. Last year, as you know, the chairman of our VA&R commission testified on behalf of The American Legion at a field hearing in Denver which critically—where, when critical errors were taking place.

There appears to be systemic problems with how VA manages their large construction projects. Let's examine the big four projects. In Colorado, they broke ground in 2009 and the replacement facility is still incomplete and is hundreds of millions of dollars in overruns. In Orlando, they broke ground on August 22nd, 2008, and they are hundreds of millions of dollars over budget and have missed deadlines after deadliness. In Las Vegas they broke ground in 2007 and after numerous delays the hospital was opened, but unfortunately needed millions of dollars in expansion because they couldn't even meet basic needs like a proper ramp for EMS to drop off patients at their emergency room. In New Orleans, they broke ground on October 24th, 2008, and six years later, veterans are still waiting for their replacement facility to open.

GAO said the average time overdue on these four projects is 35 months and this is just an average. The average cost overruns are $366 million, again, this is just an average. Frankly, this is unacceptable. Other agencies and private sector organizations continue to build major projects across the nation, yet VA replacement on the Fitzsimons campus continues to be delayed while the costs continues to skyrocket.

VA needs to complete their outstanding projects so veterans will no longer be required to use inadequate and outdated facilities. The American people want a first-rate healthcare system for veterans. You look at the internal planning process through the Strategic Capital Investment Planning Process and you will see that VA is trying to meet the needs of an expanding veterans population, but mistakes and mismanagement are crippling these projects and nobody seems to be held accountable.

VA also needs to take a look, a long hard look, as how they are managing their construction projects because their results across the board are unacceptable. All options must be put on the table to ensure that no stone is unturned. Steps need to be taken to assure that future VA hospitals are planned, designed, and built within a transparent, accountable system that puts veterans first. You have projects in four states and who knows how many more are needed as VA expands to meet the needs of our 21st Century veterans.

Falling behind schedule might be standard practice at VA, but you have to take—think about what that means. Behind schedule means veterans of Colorado, Florida and Louisiana are still asking, When is the waiting game going to end? The American Legion thanks the Committee for their close attention to the problems that veterans face accessing healthcare. The American Legion is working diligently and tirelessly to keep the focus on the VA hospital in Aurora, as well as other VA construction projects.

After a decade of broken promises, American veterans, those who gave 100 percent of the defense of our nation are tired of promises and simply ask VA to build them a 21st Century world-class VA medical hospital and to get the job done now. After all, American veterans deserve better.

[THE PREPARED STATEMENT OF ROSCOE BUTLER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Butler.

Mr. Kelly, you are recognized for five minutes.

STATEMENT OF RAY KELLEY

Mr. KELLEY. Mr. Chairman, thank you for inviting the Veterans of Foreign Wars. I am representing the men and women of the Veterans of Foreign Wars and our auxiliary at this hearing today.

Over the past few years, it has been very apparent that VA's ability to control costs and deliver major construction projects on time is and should be viewed as a great concern. Veterans are not being served when construction projects take months and years longer than expected to complete and the price tags inflate as time drags on.

Last year, the House passed legislation that would improve VA's major medical facility construction process. These improvements include using medical equipment planners, developing and using a project management plan, peer-reviewing all projects, creating and changing—creating a change order metric, and using a design-build process when possible. VA claims they have started using medical equipment planners. This practice will assist in reducing scheduling delays and cost overruns. To ensure VA's construction process

can be as efficient as possible, it is important that the other provisions are enacted.

VA's lack of standardized project management protocol has led to poor communication within VA and between VA and general contractors, which has led to delays and cost overruns. There have been cases where separate VA officials have provided contradictory orders to the general contractor. By developing and using a project management plan, all parties, at the onset of the project will have a clear understanding of the roles and authorities of each member of that project team.

Construction peer excellence review is an important aspect of maintaining a high level of construction quality and efficiency. When used, these review teams are made up of experts in construction management who travel to project sites and evaluate the performance of the project team. While meetings provide an important feedback, a separate set of eyes on the project management plan to ensure the plan is in place to make the project come in on time and on budget.

VA has historically relied on a design-bid-build project delivery system which, when entering into contracts to build major medical facility projects. With this model, an architect is selected to design a facility. The design documents are used to secure a bid, and then the successful contractor bid-holder builds the facility. Design-bid-build projects often encounter disputes between the customer, in this case, VA, and the construction contractor.

Because these contracts are generally firm, fixed price, based on a complete design, the construction contractor is usually responsible for cost overruns unless a change order is issued. This process can be 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.

A design-build project places the architectural engineering company and the construction contractor under one contract. Placing the architect as the lead from start to finish and having the prime contractor work side by side with the architect allows the architect to be an advocate to VA. Also, the architect and the prime contractor can work together early in the design phase to reduce the number of design errors. It also allows them to identify and modify the building plans throughout the project. While these initiatives work for improving future projects, the VFW believes a look back at all currently funded projects should take place to see what steps are needed to finish the nearly 50 partially funded, but not complete, major VHA construction projects.

VA's fiscal year 2015 budget submission showed that there was more than $6 billion available for 49 VHA projects through the end of fiscal year 2013. What the submission does not show is why some projects were initially funded years ago, but little to no progress has been made to complete them. Many of these projects have safety implications and provide specific services for spinal cord injuries and need to be set on course that will bring these projects to completion.

VA's Strategic Capital Plan, or SCIP, has been a great tool in identifying gaps and access utilization and safety, but if a clear

plan is not in place to close these gaps, delays in care, safety risks and, an increased cost to close these gaps will continue.

Mr. Chairman, this concludes my testimony. I will be happy to answer any questions the Committee has.

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

The CHAIRMAN. Thank you very much, Ray. Mr. Coffman, you are recognized.

Mr. COFFMAN. Thank you, Mr. Chairman. Mr. Wise, what are some of the key differences between how VA manages major medical facility construction projects compared to federal and private sector stakeholders responsible for similar projects? What are the likely effects of these differences?

Mr. WISE. Well Mr. Coffman, two things stood out to us when we did the work for the April, 2013 report. One was, and I think has been discussed in panel one, the entry of medical equipment planners at the early part of the planning process. Both the Naval Facilities Engineering Command and the Army Corps of Engineers official said this is very important to them. These units work hand in glove in order to make sure that you have a parallel and symbiotic relationship between the people who are building the facility as well as those who are bringing in the equipment that the facility needs to house. Obviously those things need to be completely compatible, otherwise you have some disconnects if not the inevitable result is change orders, which add time and cost to the project.

That brings me to my second point. Other with whom we spoke the change orders, also in both the public and private sector were, rather surprised at the amount of time that it took the VA to administer change orders. This was also discussed fairly thoroughly in the first panel. We saw VA change orders, that had taken up to a year to implement. This caused problems for the contractor because then he is waiting for payment while the process of winds its way through the Veterans Administration's approval process.

They have done a couple of things I think that may help in that process. They have raised the threshold a bit, up to $250,000 in some cases. They hired some additional attorneys who deal with the change order process. How this will work going forward we will see. But those are two things that really stood out when we did the research and the work in order to produce that report.

Mr. COFFMAN. Okay. I think in your report you also reference that the Army Corps of Engineers has built similar projects for the Department of Defense on schedule and within budget. Am I correct in that?

Mr. WISE. They have a track record of building a lot of medical facilities, that is true.

Mr. COFFMAN. But on schedule and within budget?

Mr. WISE. It was not in our scope to analyze USACE and NAVFAC projects regarding this timelines and adherence to budgets.

Mr. COFFMAN. Okay. Mr. Kelley, in your testimony you rightly acknowledge that many of VA's major construction projects were funded years ago but that very little progress has been made, giving rise to safety implications. What would you recommend VA do

in the future to expedite its processes in order to avoid these same mistakes?

Mr. KELLEY. There needs to be a prioritization of these. And the SCIP process does that. But then on the implementation side there seems to be a failing on that prioritization. So we have got nine of 12 seismic correction facilities that are partially funded at some phase. Some of them have been funded since 2010 and no money has been spent on them. And we need to understand why that money has been allocated and no progress has been made. And should we have entered into that contract to begin with if we were not ready to start the project as soon as the contract was completed? What missing link is causing that wait? And what, is that money having to be repurposed to another program and now we are waiting for money to be repurposed so we can start it? There are a lot of questions on the timing of funding and where that funding is sitting.

Mr. COFFMAN. Okay. Mr. Wise, the GAO report states that the problems experienced at the audited construction projects were representative of systemic problems throughout the VA. Could you elaborate on how these problems extend beyond just the facilities you assessed?

Mr. WISE. Well if you look back at the three recommendations that we made they point, to systemic issues that have a broader impact. For example, one recommendation dealt with the lack of communication and the inability to pinpoint exactly who at the VA is responsible for what. We also recommended that VA implement steps to streamline the change order process. We saw that these are the kinds of issues that have broad implications in terms of being able to administer what are very complex and very expensive projects.

Mr. COFFMAN. Very well. And so I think in your report you said that each of the hospitals under construction at that time, and I think there were four, I think over several hundred million dollars each, on average, over budget, and about three years behind schedule on average. Is that correct? And then would the Aurora situation be the worst one out of the four?

Mr. WISE. Aurora had the most egregious overruns, both in terms of cost and delay.

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

The CHAIRMAN. Thank you very much. Ms. Brown. Mr. Takano.

Mr. TAKANO. Yes, Mr. Wise, you know before I came to Congress I served on a humble community college district board, and I was elected, and we had bonding authority that allowed 55 percent of the local voters to approve capital construction bonds. And, you know, suddenly my district was dealing with upwards of a $1 billion program after we leveraged the local, the money. It seemed to me that cost overruns, the change orders, would frequently come before my committee. My one, I am wondering where was Congress' role in oversight? Is that any part of your recommendations as part of your GAO report? That somehow the oversight function of Congress, the subcommittee of this committee, should have been regularly informed about where things were with design, the design relationship with the contractor? I mean, how did this get out

from, well you were saying that the DoD has a better track record within its own bureaucracy of managing the building of hospitals?

Mr. WISE. Well—sorry, go ahead.

Mr. TAKANO. How was it that, what, how could the accountability be tightened up here?

Mr. WISE. Yes, it is, the relationship between the committee or the subcommittee and the Veterans Administration is not something I am privy to. But what I can say is that when we looked at the kind of activities going on in the Veterans Administration we saw that there were certainly a number of issues to do with the cost overruns and the delays that were extensive. And so it is fair to assume that in some kind of normal reporting process that this is something of interest to congress,. We make our recommendations obviously to the administration, to the federal agencies because we work for Congress. We are doing the work on behalf of the committee. So hopefully the work we do makes the committee more aware of the key issues enabling it to take positive action and work with the Veterans Administration to try to improve these projects and hopefully provide better services, more timely services, and cost effective services to the veteran community.

Mr. TAKANO. I am just referencing my experience as a local public official managing taxpayer dollars, capital construction dollars, and the frequency with which we would have to get progress reports from the staff as the elected officials. I am just wondering how effective it is for an administration, a department like the VA, to be able to provide that sort of accountability. I am just wondering if we have staffed up our Oversight Subcommittee enough, given it enough resources, so that it is able to inject itself on a regular basis to manage these hundreds of millions of dollars.

I am just astounded. I am trying to find enough money to fund graduate medical education. People do not know that we fund nearly 100 percent of the medical residencies in this country. And we are facing a shortage of doctors, both in the public sector and within the VA. And I am thinking about the hundreds of millions of dollars that we could have saved on these cost overruns to fund the education of these doctors.

Mr. Chairman, I would ask whether or not we are funding our oversight function enough on this committee to be able to oversee what goes on in that department. I do not see how else we are going to be able to hold the department accountable without enough of our Oversight Committee being able to be able to review these projects and to make sure that the project management is adequate.

The CHAIRMAN. Will the gentleman yield?

Mr. TAKANO. I know you have a background in this area as well.

The CHAIRMAN. If the gentleman will yield, yes. And we have asked for additional dollars. Last year we were given additional dollars by the Speaker. We have asked for additional budget. Ms. Brown and I have talked together, as has our staff, to hire additional forensic investigators in regards to computers and budgetary issues as it relates to these construction issues. So most definitely, our oversight role has been beefed up quite a bit since we took over this particular committee.

Ms. BROWN. Just 30 seconds?

Mr. TAKANO. I will yield.

Ms. BROWN. Thank you. However, I do not think that we want to get into cost overruns. I have, in the Orlando situation, spent three hours with VA, but I also spent three hours with the contractor. So it is not just one party that is at fault. Did you do the research on the, Orlando facility and why it took so long to move forward?

Mr. WISE. Well, madam I do recall in your statement you alluded to one of the major reasons that had resulted in the problems with Orlando i.e. several changes in the site location changed.

Ms. BROWN. Whoever was in charge.

Mr. WISE. I am sorry?

Ms. BROWN. If the Democrats were in charge, it would move to one city.

Mr. WISE. Right.

Ms. BROWN. If the Republicans were in charge, it moved to another. So I mean, we need to take the politics out of building hospitals. In the end the Secretary should have the authority to decide what is in the best interests of the VA. I was able to pull all of the players together and we were able to move forward. You cannot just say that it is one thing that has caused these problems. It is the multiplicity. We have been part of the problem. For over 25 years we were talking about a hospital in Orlando. It is ludicrous. We have the growth in Central Florida. We need that hospital up and operational and it will be, I hope, in my lifetime to be open in the next couple of months.

I yield back. But the point I am making is that we can do our oversight, and we can do other investigations. But we do not need to get into the business of change orders. I mean, if so we need to, go to the administration. We have oversight to make sure they are doing what they are supposed to do. I yield back.

Mr. TAKANO. Mr. Chairman, I——

The CHAIRMAN. The gentleman's time has expired.

Mr. TAKANO. Thank you.

Ms. BROWN. I took his time. I am sorry.

The CHAIRMAN. Again, you take mine, you take his. But, you know, I do not believe anybody on this committee can say that we have politicized anything within our purview. And I would say that this decision to put the facility where it is now was done under a different administration. And had it been a Republican administration at this point we would be going after them just like we are today. It is for the veterans of this country, not for a political reason. I need to go ahead and go on to——

Mr. TAKANO. Sir, if I could follow-up with you after the committee——

The CHAIRMAN. Yes, sir.

Mr. TAKANO. Yes.

The CHAIRMAN. Ms. Radewagen, do you have any questions that you would like to ask? Okay, thank you very much. Ms. Kuster.

Ms. KUSTER. Thank you, Mr. Chair. I wanted to ask Mr. Wise about your examination and this comparison of the, particularly the Army Corps and their oversight of the DoD facilities, and whether, what recommendations you would have going forward for the VA? Or do you have an opinion as to whether or not we should,

Congress should consider the Army Corps, because of their expertise, because of all their experience, supervising construction of large medical facilities at the VA going forward?

Mr. WISE. That is a good question and an interesting question. It sounded like from what I heard on the first panel today that this is something that is on the table. So it certainly seems worthy of consideration. It is not something we have examined in any detail. But it appears that VA certainly is looking to the Army Corps for some of its expertise in helping it to resurrect the situation in Aurora and get it moving again. And perhaps that could be a model. It is something that the Deputy Secretary is certainly open to based on his testimony. I presume he will be consulting with the committee and others to make that determination. It does sound like they have gotten a number of Army Corps people working in the construction area in the OACL in the VA. So perhaps VA is beginning to adopt some of those methods that have been used by the Army Corps.

Ms. KUSTER. That did sound encouraging, the hiring of people with this kind of expertise and this methodology of oversight for projects this size. And I am just wondering for our friends in the VSO community, Mr. Kelly and Mr. Butler, do you have an opinion, or does your organization have an opinion, about this notion of looking into the future now, particularly with, in relation to the reforms that had been passed, as to whether the VA should be creating such large hub facilities at such an expense? I am picking up on my colleague Mr. Takano's testimony. We can all think of lots of great uses for these billions of dollars to provide healthcare across this great country. Do you have an opinion about this? About the focus on these large tertiary facilities?

Mr. KELLEY. Yes, ma'am. I don't think you can wholesale say that large facilities should go by the wayside, or that we should only use large facilities. You have to look case by case. Large metropolitan areas are going to have to have large hospitals that are veteran centric. But as you look around the country there are services that are underutilized within VA and we are building a facility and underutilizing a service just because we need to have that service. We need to start looking at public-private partnerships to fill those holes. The hub and spoke method that you were talking about, having a central area and then having areas outside of that are more convenient.—Working with partner hospitals that can provide a service that is just underutilized but needed in the community. There is no need to have on staff a cardiology staff if they are doing one or two heart surgeries a day, when across the street they are doing 20 or 30 and they have got the staff and the expertise to do that. Why are we spending resources on that when it could be put somewhere else for need within that facility? So VFW is open to looking at those public-private partnerships, developing new ways to do that. But I cannot say never build a large hospital again.

Ms. KUSTER. Sure, yes. And I agree, we have a wonderful, at the White River Junction, Vermont, although right on the border so we consider it our facility in New Hampshire as well, they have a great relationship with Dartmouth Medical School. And that is what I am trying to, you know, not only is it expensive, the exam-

ple you gave about the cardiac surgery, it is not even safe in some circumstances if they are not doing the volume. So I, my time is up, but Mr. Butler, if you have anything to add? And I am not suggesting, by the way, that we do not build any more of these. But I just, more focus on getting the resources where they are needed. And I come from a rural district, it is not an urban center.

Mr. BUTLER. I would say, agree that you have to look at it on a case by case basis. But the challenge for the VA is the average age of a VA medical center. You know, a lot of the facilities have outlived their life cycle. And so VA needs to invest and reinvest in their medical facilities, whether it is building a hub and spoke facility or expanding upon its other additional resources. The one thing that the American Legion does not support is that we do not support voucher out care. We do not support shutting down the VA system and turning the VA system into a voucher system. We support that the VA system is for American veterans and the VA should maintain its system of healthcare for our American veterans and continue to build upon what it already has.

Ms. KUSTER. Absolutely. Thank you so much. I appreciate your service. Thank you. Mr. Chair, I yield back.

The CHAIRMAN. Thank you. Mr. O'Rourke.

Mr. O'ROURKE. Thank you, Mr. Chairman. To Mr. Wise, when we recently got a report back from the Office of the Inspector General on performance issues at the El Paso VA and we got it last month, we asked, our follow-up question to Dr. Day was what is the, of the 128 parts of the system, which is the best performer? And his response was I cannot single out one, but those medical facilities that are affiliated with an academic institution perform far better than the average VA medical facility. So my question to you is why was the decision made to separate Denver from a medical school, and how did that contribute to some of the problems that you have uncovered in your report?

Mr. WISE. To the first part of your question, I am not exactly sure why although I believe there were some issues about governance that the university and the VA were unable to resolve about how it would be run. The second part was about the contribution to the delay and overrun, right?

Mr. O'ROURKE. Right.

Mr. WISE. Yes, that was definitely a factor. Because once the original idea, of a shared facility, was off the table then you got into a situation where you needed to go back in to do redesign and then VA became responsible for a lot more costs than it had expected to share at the time. VA was absorbing a lot of standalone costs that were at that point rather unexpected. So all this resulted in numerous change orders, resulting in additional loss and delays.

Mr. O'ROURKE. And that also happened in New Orleans, did you say? Or did someone mention——

Mr. WISE. Yes, there was also a situation in New Orleans——

Mr. O'ROURKE. Where it was affiliated and then the affiliation was separated?

Mr. WISE [continuing]. Louisiana State University, LSU.

Mr. O'ROURKE. Okay.

Mr. WISE. It was a similar situation and partnership that was originally intended with an academic institution, also did not go

forward. And that also contributed to some of the delays and overruns in New Orleans.

Mr. O'ROURKE. I will follow-up with the VA. I would be really interested in understanding why they made that decision to separate if in fact VA medical facilities affiliated with academic institutions outperform the average. Did the GAO, did you look at accountability for the mistakes made related to these facilities?

Mr. WISE. Our parameters in this engagement were really to look at what happened and to try to identify the systemic issues that were behind it that caused it to happen, and try to identify some recommendations that would hopefully help mitigate it happening going forward.

Mr. O'ROURKE. And I will say that I understand the scope of your study. But one of the systemic problems that we have is a culture that has not historically valued accountability. I am not speaking about current leadership. I fully believe that Secretary Gibson and Secretary McDonald and their team fully understand this and are trying to change the culture. But I would say that that has contributed to problems. And one of my follow-up questions to the VA, perhaps I will submit it for the record, is Secretary Gibson said those responsible for some of these mistakes were removed from their positions. And I do not know if that is a term of art, meaning that they were fired, or that they were transitioned into some other position within the VA. In other words, was there personal accountability for very grievous mistakes, where you are taking resources in a zero sum system away from potentially facilities in El Paso to pay for facilities in Aurora, Colorado, and you have veterans in El Paso who are not getting the service they need. That is the urgency behind the question.

And I realize I only have a minute left. And so to follow-upon Ms. Kuster's question for Mr. Butler and Mr. Kelly, taking out the extremes which is, you know, continuing with the status quo, or as you said, Mr. Butler, privatizing, voucherizing VA medical care, let us just assume we are not going to do either of those. After mistakes of this proportion, what would your membership be open to in terms of a different system? In terms of having for example what I call the Summers model, core competencies delivered at a world class level, very accessible out of the VA, and then perhaps non-core competencies, diabetes, getting your teeth fixed, having something not related to your service, is not performed at the VA but somehow managed out of there. I do not know if you, Mr. Butler or Mr. Kelley, could quickly comment on that?

Mr. BUTLER. Well I think for the American Legion our resolution supports the VA remaining intact as a system of healthcare for American veterans. We support that VA can refer patients out. We supported the VACA with the provision that a sunset provision be added into the VACA. We, support veterans when they need to go outside the VA system to obtain their care, then we surely understand that need and that requirement. But our position is that the VA system is a VA system for American veterans and that system should be maintained.

Mr. O'ROURKE. Mr. Chair, could I have 20 seconds for Mr. Kelley.

The CHAIRMAN. You may.

Mr. O'ROURKE. Thank you.

Mr. KELLEY. I think the goal is to provide care for veterans that is conducive for them individually. We have found under VACA, under the Choice Act, that we have done a survey of our membership and pretty close to 60 percent of them, even when they had a choice, stayed with VA. They wanted to wait a little longer because that is where their continuum of care was. So we need to look at all these factors when we start making decisions. Yes, there are areas where veterans are, that they are not being served properly by VA. And opening up other opportunities outside of VA, whether it is short term or long term, need to be looked at. Specialty services that, you said diabetes care, may be an area where it is more suitable for that to be contracted out in certain areas. But we cannot, again, have one solution to be the fix. We need to look at every opportunity to improve the delivery of care for veterans.

Mr. O'ROURKE. Thank you. Thank you, Mr. Chair.

The CHAIRMAN. All right, everybody. Look outside, it is snowing. Heavily. Even for a Coloradan. Ms. Brown.

Ms. BROWN. Thank you. I guess I am stuck here so I can just go ahead and ask my questions now. Mr. Butler, I have a question for you. I think my position is closer to yours. But we do know that there are some financial restraints that we have. I guess my question is in some areas, rural areas, not addressing healthcare but cemetery. In some areas, I do not know whether it makes sense to build a full-fledged cemetery. Maybe we could do something, partner with the local community to expand it existing cemeteries. And maybe in some rural areas addressing healthcare we could, do some partnerships in order to provide, a wing in a hospital for veterans. I mean, there is no one answer. What would you all be open to?

Mr. BUTLER. Well I think your, under your existing authorities they allow for a lot of those opportunities, what you just mentioned. So under the current authority for healthcare you have your fee basis authority, you have the new legislation that was introduced through VACA, you have also PC3. The American Legion supports all of those options. So I would agree that it is not one option, that fixes everything. You have to look at all of the available opportunities and determine what is best for American veterans. And that is the key. What is best for American veterans, and to ensure that their needs are being taken care of and in a system that is designed for veterans. And if VA refers those veterans outside because they don't have the resources or service to provide that care then that is fine as long as VA has the appropriate funding to meet the needs of veterans.

Ms. BROWN. And Mr. Kelley.

Mr. KELLEY. I am with Mr. Butler on this in that there is no cookie cutter solution. Veterans in rural Montana need to be thought of differently than in downtown Chicago. And those veterans' expectations of delivery of care are different as well. So we need to take that into account. I think there is an understanding if you live in a rural remote area that life is a little tougher, and it is going to be a little tougher for you to get that care and there is some acceptance of that. But we need to look at ways to prevent

in the middle of a snowstorm allowing people, or insisting on people, driving several hundred miles for just follow-up care who could be seen in a community when, and as Mr. Butler said, those authorities are there. We need to exercise them. We need to, we need to not make that the exception in some cases and make it the rule until we have suitable solutions in place.

Ms. BROWN. Well you know, it was amazing because I am pretty old school that a lot of the veterans like the telemedicine, wherein they can do a lot from home and then if they need to come, they come in. What is your opinion of telemedicine?

Mr. KELLEY. Absolutely. We have veterans who swear by it, just as you said. And even within a community outpatient clinic, I will use myself as an example. I went in for my annual physical. My primary care saw a mole on my back that she didn't like. She said, do you have a few minutes? Let's have somebody take a picture of it, we'll send it up to Baltimore. They will look at it and if you need to be seen, you will be seen. I did not have to go to Baltimore for a second appointment. That was sent up there. Within a few days they came back and said, no, it's okay. So it saved me a trip. It saved VA resources. And quality healthcare was served. So we need to look at all avenues again.

Ms. BROWN. Mr. Butler.

Mr. BUTLER. I would agree. I was at a VA hospital in Georgia where they had a virtual lab, wherein veterans were being treated in their OR and—or, yes, not OR, but in their ICU. And the doctor was somewhere else at another place monitoring the veterans. So there are many advances in modern medicine that we need to bring all together to ensure that all of the advanced technologies out there that are made available are being used to treat our American veterans.

Ms. BROWN. And Mr. Wise, in closing thank you for your testimony. As I said, it is many issues. For example, I know a lot more about the New Orleans situation then I do Denver. I have been there several times. I was very instrumental in making sure that that particular New Orleans project moved forward because the hospital there was wiped out completely by Katrina.

Mr. WISE. Right.

Ms. BROWN. And so, you know, in visiting the area I knew it was not any other facilities nowhere near for the veterans to have the services that they needed. So it was going to be a joint between them and the universities. Part of the problem was the Governor, the Mayor, I mean, it was a mess. So I am happy that it is close to ending, coming to be open. And maybe we can find exactly when it is going to be open. Not you, I know. But the Secretary.

Mr. WISE. Okay.

Ms. BROWN. Yes. Thank you, though.

The CHAIRMAN. Thank you very much, Ms. Brown. I appreciate the good work and the comments. I have one follow-up question. Mr. Wise, I think in your written testimony you stated, actually it was your updated report of 2015, you reached out to VA and asked them for an estimated cost, final cost for the Orlando project and you were not given that cost estimate. At least, that is what I have been——

Mr. WISE. I think that was for the Denver project, that reference, no? I believe?

The CHAIRMAN. It is the Denver project?

Mr. WISE. That is the one we could not get final, well the same as what Mr. Gibson said this morning——

The CHAIRMAN. Yes, I just was asking for Ms. Brown's hospital. I was under the impression that it was the Orlando project, but I apologize. And with that, the one thing I think we can all agree, the way healthcare is delivered today is much different than it was delivered years ago. The idea of building massive hospitals at over $1 billion apiece is not a sustainable model. We have to look at other ways and options. Nobody on this committee is talking about dismantling the VA when we talk about providing choice to people on their healthcare. And I believe that we all want to work together to make sure that the veterans get the healthcare that they have earned, when they need it, where they need it, and that what they get is quality healthcare. So with that, we will adjourn.

[Whereupon, at 1:15 p.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF JEFF MILLER, CHAIRMAN

Good Morning. This hearing will come to order.

I would like to welcome everyone to today's hearing titled, "Building a Better VA: Assessing Ongoing Major Construction Management Problems Within the Department."

The purpose of this hearing is to address continued problems occurring in VA's persistent construction delays and cost overruns involving its construction of the Replacement Aurora, Colorado VA Medical Center. The VA has been found by the Civilian Board of Contract Appeals (CBCA) to have breached its contract with its prime contractor on this project and the facility could eventually cost as much as $1.4 billion to complete.

This Committee has held numerous hearings in the last few years involving VA's inadequate management of its construction projects, each of those hearings being based on considerable evidence. "We have come to a point in VA's major construction program where the administrative structure is an obstacle that is not effectively supporting the mission. As a result, our veterans are the ones who are left without services and our taxpayers are the ones who are left holding the check or writing a new one." That was part of my opening statement during our March 27, 2012, hearing on VA major construction, but it seems nothing has changed nearly three years later, despite warnings and corrective suggestions being presented from inside and outside the Department.

Based on the lengthy Committee investigations that gave rise to these hearings, the Committee asked the GAO to audit VA major construction projects. Their report, issued in April 2013, found that on average, the hospital construction projects reviewed were about three years late and $366 million over budget. Every time we have asked VA about those results, it has argued that it is not delayed or over budget based on its own accounting.

Further, when we held a hearing on the Aurora VAMC construction project in April 2014, the tenor of VA responses was that it was the contractor's fault that the project was not completed and that the project was still operating within its budget. I have a feeling that the VA will not be able to cling to those illusions any longer.

On December 9, 2014, the CBCA found that the VA materially breached its contract with its prime contractor on the Aurora VAMC construction project, Kiewit [Kee-Wit]-Turner (K–T). It found that VA did not provide a design that could be built within its stated budget, and it was also the VA's fault to the point that the CBCA said K–T would be well within its rights to simply walk off the job. And that is exactly what it did.

Now, VA is left scrambling to make K–T whole enough to get back to work. VA may even have to come back to Congress to ask for perhaps up to 600 million more taxpayer dollars to fix problems the Committee has brought to light year after year only to be ignored by the VA.

I visited the Aurora construction site Monday with Congressman Coffman to see again in-person what is taking so long and why this project has been a veritable money pit for the last several years. Once completed, this facility will be well-equipped to provide the best possible healthcare available, which is exactly what the veterans served by every VA facility deserve. It is long past time for these projects, marred by bureaucratic ineptitude, to be complete. I look forward to hearing from the VA, and the other witnesses here today, on how we can correct the abysmal state VA's major construction program has been in for years.

With that, I now yield to Ranking Member Brown for any opening remarks she may have.

PREPARED STATEMENT OF CORRINE BROWN, RANKING MEMBER

Thank you, Mr. Chairman, for holding this hearing today. From day one, I have been a member of this Committee, and I am pleased, after 22 years, to be the Ranking Democrat. I look forward to working with you and all the other members to help our nation's veterans.

We all agree that providing veterans timely, quality healthcare in a safe environment is a focus of this Committee. The VA provides the best care and treatment for veterans in the world and we need to make sure that continues.

One critical element of this focus is the manner in which VA provides veterans access to healthcare.

For many years, VA has structured itself around a "hub-and-spoke" system where clinics and other smaller facilities feed into large medical centers.

One of the discussions this Committee must begin to have is whether this structure is the best structure for VA healthcare looking into the future and again, looking down the road, what steps do we begin to take to ensure that veterans have reasonable access to the healthcare they need.

This Committee has authorized, and Congress has appropriated, billions of dollars for VA construction programs over the past decade. The question we must ask ourselves is are we getting what we paid for, and has access improved for our veterans.

We must ask ourselves what must be done to make the VA construction program function as we intend it to. What must we do to make sure that the facilities we are building today do not come in over budget and late. If we do not do this we run the risk of building facilities that may already be obsolete when the doors are open and are merely expensive memorials and little else.

For nearly two decades the VA was out of the major facility business. By not building any major medical centers in the 20 years preceding authorization of the Las Vegas, Orlando, Denver and New Orleans Medical Centers, has the VA lost the ability to manage a construction portfolio? Do we need to expect better management and more effective processes? What are the barriers currently in place that make it difficult for VA to come in on time and within budget? Should we look outside the VA for expertise?

From my personal experience with the years of delay in Orlando, and the issues in Denver, it seems the VA continues to struggle with construction planning and execution. What we need is to work together with the stakeholders to come up with a viable solution.

One possible solution is for the VA to work closer with the private sector and establish relationships with hospitals. One idea might be that VA use a ward in an existing hospital, bring it up to VA standards and then have a presence in that community. Facilities, resources and personnel could be shared, which would reduce costs for everyone involved and improve access.

Mr. Chairman, I am looking forward to hearing from the VA not only what they are going to do to address past problems and delays in the construction process, but other ideas on how they can ensure these problems actually get fixed and are not repeated in the future.

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

PREPARED STATEMENT OF MR. SLOAN D. GIBSON

Good morning, Mr. Chairman and Members of the Committee. I am here this morning to update the Committee on the status of the construction of the replacement medical center in Denver. Joining me today is Mr. Dennis Milsten, Director for the VA Construction and Facilities Management Office of Operations.

The Department's main priority regarding the Denver project is to complete this facility without further delay, and to do that while delivering the best possible value to taxpayers given the difficult circumstances that have occurred. Our commitment to completing this project intended to serve 390,000+ Colorado Veterans and their families has never wavered, and current VA medical facilities and programs continue to ensure that no Veteran or their families goes unserved.

We are working aggressively to rebuild trust, improve service delivery, and pursue longer-term excellence and reform. This includes initiatives like My VA, which involves building a world-class, customer-focused, Veteran-centered organization, and strengthening the efficiency and effectiveness of our array of support services.

Completion of the Denver replacement medical facility is important to improving access to care and services, and I again apologize for the delays that have occurred. Let me review where we are on this project.

The Department was notified on December 9, 2014, of the decision by the Civilian Board of Contract Appeals in favor of the construction contractor, Kiewit-Turner, thus allowing it the option to stop work. VA immediately contacted the contractor to determine a course of action to continue construction to complete the facility. I personally met with Kiewit-Turner leadership to forge a way ahead that would avoid the delay and disproportionate costs of stopping and re-starting construction activity immediately ahead of the holiday season.

VA reached an interim agreement on December 17, 2014, that was subsequently signed on December 22, 2014. As part of the interim contract, the U.S. Army Corps

of Engineers (USACE) is on site to provide technical and management advice. This will also allow USACE the time to review the specifics of the project and formulate the final plans to negotiate and administer a long-term agreement for construction completion.

We have undertaken a comprehensive review of VA's major construction program and have taken numerous actions to strengthen and improve execution of our on-going major construction projects. With the acceptance and closure of the April 13, 2013, Government Accountability Office report recommendations and the implementation of the Construction Review Council recommendations, VA has significantly changed the way it conducts business, but more work remains to be done.

To help ensure that previous challenges are not repeated and to lead improvements in the management and execution of our capital asset program as we move forward, we will continue to focus on these lessons learned:

- Integrated master planning to ensure that the planned acquisition closes the identified gaps in service and corrects facility deficiencies.
- Requiring major medical construction projects to achieve at least 35 percent design prior to cost and schedule information being published and construction funds requested.
- Implementing a deliberate requirements control process, where major acquisition milestones have been identified to review scope and cost changes based on the approved budget and scope.
- Institutionalizing a Project Review Board (PRB)—VA's Office of Acquisition, Logistics, and Construction worked with USACE to establish a PRB for VA that is similar to the structure at the USACE District Offices. The PRB regularly provides management with metrics and insight to indicate if/when the project requires executive input or guidance.
- Using a Project Management Plan—outlines for accomplishing the acquisition from planning to activation to ensure clear communication throughout the project.
- Establishment of VA Activation Office Ensures the integration of the facility activation into the construction process for timely facility openings.
- Conducting pre-construction reviews—Major construction projects must undergo a "constructability" review by a private construction management firm to review design and engineering factors that facilitate ease of construction and ensure project value.
- Integrating Medical Equipment Planners into the construction project teams—Each major construction project will employ medical equipment planners on the project team from concept design through activation.

These improvements are being applied to the 53 on-going major construction projects and our other major medical center construction projects, including the Orlando replacement facility, where construction is scheduled to be completed at the end of February, and our New Orleans replacement facility, which is currently on schedule, and is anticipated to be completed in the fall of 2016.

In the past five years, VA has delivered 75 major construction projects valued at over $3 billion that include the new medical center complex in Las Vegas; cemeteries; polytrauma rehabilitation centers; spinal cord injury centers; a blind rehabilitation center; and community living centers. This is not to diminish our concerns over the mistakes that led to the current situation on the Denver project, but only to remind that we have successfully managed numerous projects through our major construction program. VA takes full responsibility for the situation in Denver and we will continue to review our major construction program and the details of this project to improve our performance. In addition, as identified in section 201 of the Veterans' Access, Choice, and Accountability Act of 2014, VA's capital management program will undergo an independent assessment, which will be provided to you within 60 days of its conclusion.

In closing, each day, VA is moving toward its goal of improving and streamlining our processes to increase access to our Veterans and their families. I am personally committed to completing the Denver project without further delay and to do that while delivering the best possible value to taxpayers given the difficult circumstances that have occurred. Bottom line: We want to do what is right for Colorado Veterans and to get the Denver medical facility back on track in the most effective and cost efficient way.

This committee has been a strong and supportive advocate for Veterans' healthcare, and VA will continue its efforts to be transparent about the construction of the Denver replacement facility.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to testify before the Committee today. My colleague and I would be pleased to respond to questions from you and Members of the Committee.

U.S. ARMY CORPS OF ENGINEERS

DEPARTMENT OF THE ARMY

TESTIMONY OF

LLOYD C. CALDWELL, P.E.
U.S. ARMY CORPS OF ENGINEERS
BEFORE THE

COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

ON

BUILDING A BETTER VA: ASSESSING ONGOING MAJOR CONSTRUCTION MANAGEMENT PROBLEMS WITHIN THE DEPARTMENT

January 21, 2015

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

DOD's construction program utilizes designated Construction Agents, of which the Corps is one; who procure and execute design and construction of projects to deliver the Department's infrastructure requirements authorized by law. The Corps is also known for the Civil Works mission it provides for the Nation, and the Corps' capabilities are perhaps uniquely developed to fulfill both military and civil engineering responsibilities. Interagency collaboration is an important element of the Corps' work, and the Corps provides interagency support as a part of its service to the nation. The Economy Act (31 USC 1535 (b)) provides all necessary authorities for the Corps to assist the Department of Veterans Affairs (VA) with any construction requirements, from minor to major construction, to include completion of the Aurora, Colorado Replacement VA Medical Center (Aurora Hospital).

The Corps fully recognizes the importance of the service of members of the armed forces, the support of their families, and the service of our veterans, in sustaining the strength of our nation. We understand the vital link between the goals of their service and missions and the technical capabilities we provide, from consultation to delivery of infrastructure. As I testified on November 20, 2013, the Corps has significant construction management capabilities and experience delivering medical facilities for our service members and veterans. Today, we have been asked by the Committee to testify on the subject of construction delays and cost overruns involving the VA's major medical projects with a specific focus on the Aurora Hospital.

My testimony will specifically address what actions we are taking in partnership with VA to complete construction of the Aurora Hospital. I will also address the Corps interagency relationships, how our approach to constructing medical facilities can assist

VA and our veterans in delivering major medical construction projects, the Corps' project acquisition process, and our experience with medical facility construction

THE CORPS' RELATIONSHIP WITH THE DEPARTMENT OF VETERANS AFFAIRS

The Corps has an established relationship with the VA, providing support for a broad range of facility construction and maintenance requirements. Authority for the Corps' work with VA is based on the Economy Act, which provides both parties with sufficient authorities to work collaboratively on VA funded projects. During 2007, the Corps of Engineers and the VA formalized its relationship through a Memorandum of Agreement (MOA) for the Corps to provide the VA a broad range of engineering and construction services. In 2011, we signed a new agreement focused on supporting the Veterans Integrated Service Network (VISN) offices with execution of their minor construction and non-recurring maintenance needs, and in 2014, we signed an agreement to support the National Cemetery Administration (NCA) for its minor construction requirements.

Prior to fiscal year 2007, Corps execution support to VA was at or below $2 million. This workload has grown substantially in subsequent years as follows:

Fiscal Year	Execution Amount ($ millions)
2007	7
2008	14
2009	108
2010	348
2011	377
2012	340
2013	239
2014	156

As execution funds have increased over the years, so has the collaborative relationship between the Corps and VA. Corps Headquarters has an established relationship with the VA's Office of Construction and Facilities Management. Our regional and local

offices have also developed relationships with each of the 21 VISN offices around the country. In recent years, the Corps has managed work at 74 different VA facilities nationwide. Whether and how a VISN incorporates the Corps services into its projects is at the discretion of each VISN.

As a result of our relationship the Corps has executed projects and assistance for the VA valued at $1.59 billion since 2007. We have also initiated $49 million in new projects in support of the VA's NCA requirements. The Corps has not executed any of VA's major construction projects since 1956 when we supported the VA's post-World War II hospital construction program.

One successful example of our efforts in supporting VA with their minor construction program is the Post Traumatic Stress Disorder (PTSD)/Mental Health Research Addition at the Charleston, South Carolina VA Medical Center completed in 2014. The project provided a one story, 16,000 square foot building at a cost of $8.2 million.

VA WORKING WITH THE CORPS TO COMPLETE CONSTRUCTION OF THE AURORA HOSPITAL

In December 2014, the VA requested our assistance to complete the Aurora Hospital project. The Corps is working with VA to develop a new interagency agreement that would transition the project to the Corps. We are in the process of assessing the requirements of this project and working with VA to finalize the agreement. We must determine the amount of work that has been completed and develop a scope of work and cost estimate for the remaining construction activities. We have visited the site and have formed a team of technical experts that will be reviewing the completed work and contract documents. While these actions are occurring, we are also advising the VA in the management of their interim construction contract with the contractor, Kiewit-Turner. This approach will continue progress on the project while we prepare to assume project responsibilities. The existing authorities under the Economy Act are adequate for the Corps to reach an interagency agreement with VA and take over the role of Construction Agent of the Aurora Hospital. While the Corps will assume a major role in the construction execution for Aurora Hospital, the VA, as the project's proponent, is still responsible for project requirements, resourcing and facility transition to full operations.

By using our project delivery process, we are confident that the Corps, acting as Construction Agent, can complete construction of the Aurora Hospital for VA and meet the needs of our veterans and their families.

FACILITIES DEVELOPMENT PROCESS

Regardless of the nature of the facility, the Corps has developed and implemented processes and capabilities for design and construction, which have been refined over many years. Our project management business process brings together the range of diverse professionals and activities required of a successful project, which includes our design, construction, acquisition, and project management professionals. Success across the normal project life cycle depends upon early involvement of all team members to understand the overall project objectives and to plan the approach to execute the project from design through construction. The following are the four major phases of the facilities development process:

1. Planning and Programming;
2. Project Development and Design;
3. Construction; and
4. Operation and Maintenance.

Each of these elements represents unique skills, involving multi-disciplined teams who account for project scope, delivery schedule, and ultimate cost as team members work collaboratively with one another. These basics must be managed concurrently, in a continuous cycle that occurs throughout the life of a project.

The responsibility for Planning and Programming for construction projects rests with the service or agency requiring the facility. In the case of VA medical facilities, it is VA's responsibility to determine programming requirements and prepare budget requests to meet the medical needs of our veterans and their families. This role will remain with VA when the Corps acts in the role of Construction Agent. The ultimate success of a project depends upon early development of the scope and acquisition plans of action, including validation of the scope and cost estimates. The Corps in this phase is in an

assistance role; the proponent agency retains responsibility for the master plan and pre-design capital planning work.

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

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

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

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

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

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

The Corps has a long history of executing some of the nation's most challenging construction projects and programs, whether through our Military Missions or Civil Works responsibilities. The past 13 years have been especially demanding as we have simultaneously provided support to operations in Iraq, Afghanistan and to DOD as it transforms and realigns. During this period, the Corps physically completed 2,499 military construction projects with a combined programmed amount of $52 billion. The Corps has delivered, or is in the process of designing and constructing, a full range of medical facilities for DOD, to include very large hospitals valued near a billion dollars that are capable of delivering world-class medical services for the members of our

Armed Forces and their families. A summary of some of the recently completed and ongoing Corps work of significant medical facilities follows.

Location	Description	Delivery	Authorization
Fort Belvoir, VA	New Hospital completed	2011	$1.03 billion
Fort Sam Houston, TX	Hospital Addition completed	2011	$802 million
Fort Benning, GA	New Hospital completed	2014	$475 million
Fort Riley, KS	New Hospital under construction	2015	$404 million
Fort Bliss, TX	New Hospital under construction	2016	$966 million
Rhine Ordnance Barracks, Germany	New Hospital under construction	2022	$990 million

Our relationship with VA is strong and is growing. We look forward to working with VA as Construction Agent to complete the Aurora Hospital project and to continue our partnership and collaboration on future major medical construction projects. We also acknowledge the solemn duty to care for our veterans and will continue to support those efforts with our most capable teams as we continue to develop our support and assistance relationships with the VA.

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

United States Government Accountability Office

Testimony Before the Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 10:30 a.m. ET
Wednesday, January 21, 2015

VA CONSTRUCTION

VA's Actions to Address Cost Increases and Schedule Delays at Major Medical-Facility Projects

Statement of David Wise, Director
Physical Infrastructure Team

GAO-15-332T

GAO Highlights

Highlights of GAO-15-332T, a testimony before the Committee on Veteran's Affairs, House of Representatives

January 2015

VA CONSTRUCTION

VA Actions to Address Cost Increases and Schedule Delays at Major Medical-Facility Projects

Why GAO Did This Study

The VA operates one of the nation's largest health care delivery systems. In April 2013, GAO reported that VA was managing the construction of 50 major medical-facility projects at a cost of more than $12 billion. This statement discusses VA construction management issues, specifically, (1) the extent to which the cost, schedule, and scope for four selected major medical-facility projects has changed and the reasons for these changes, (2) actions GAO reported that VA had taken since 2012 to improve its construction management practices, and (3) VA's response to GAO's recommendations for further improvements in its management of these construction projects.

This statement is based on GAO's April 2013 report (GAO-13-302) and May 2013 (GAO-13-556T) and April 2014 (GAO-14-548T) testimonies. GAO included selected updates on VA projects—located in Denver, Colorado; Las Vegas, Nevada; New Orleans, Louisiana; and Orlando, Florida—and documentation obtained from VA in April 2014 and January 2015.

What GAO Recommends

In its April 2013 report, GAO recommended that VA (1) develop and implement agency guidance for assignment of medical equipment planners; (2) develop and disseminate procedures for communicating to contractors clearly defined roles and responsibilities of VA officials; (3) issue and take steps to implement guidance on streamlining the change-order process. VA implemented GAO's recommendations.

View GAO-15-332T. For more information, contact David Wise at (202) 512-2834 or WiseD@gao.gov.

What GAO Found

In April 2013, GAO found that costs substantially increased and schedules were delayed for Department of Veterans Affairs' (VA) largest medical-facility construction projects, located in Denver, Colorado; Las Vegas, Nevada; New Orleans, Louisiana; and Orlando, Florida. As of January 2015, in comparison with initial estimates, the cost increases for these projects ranged from 66 percent to 144 percent and delays ranged from 14 to 86 months. Since the 2013 report, some of the projects have experienced further cost increases and delays. For example, the cost for the New Orleans project increased by nearly $40 million, and delays at the Orlando project has extended from 39 months to 57 months. Several factors, including changes to veterans' health care needs, site-acquisition issues, and a decision in Denver to change plans from a medical center shared with a local medical university to a stand-alone VA medical center, contributed to increased costs and schedule delays.

In its April 2013 report, GAO found that VA had taken some actions since 2012 to address problems managing major construction projects. Specifically, VA established a Construction Review Council in April 2012 to oversee the department's development and execution of its real property programs. VA also took steps to implement a new project delivery method, called Integrated Design and Construction, which involves the construction contractor early in the design process to identify any potential problems early and speed the construction process. However, in Denver, VA did not implement this method early enough to garner the full benefits of having a contractor early in the design phase.

VA stated it has taken actions to implement the recommendations in GAO's April 2013 report. In that report, GAO identified systemic reasons that contributed to overall schedule delays and cost increases at one or more of four reviewed projects and recommended ways VA could improve its management of the construction of major medical facilities. In response, VA has

- issued guidance on assigning medical equipment planners to major medical facility projects who will be responsible for matching the equipment needed for the facility in order to avoid late design changes leading to cost increases and delays;
- developed and disseminated procedures for communicating to contractors clearly defined roles and responsibilities of the VA officials who manage major medical-facility projects to avoid confusion that can affect the relationship between VA and the contractor; and
- issued a handbook for construction contract modification (change-order) processing which includes milestones for completing processing of modifications based on their dollar value and took other actions to streamline the change order process to avoid project delays.

VA has implemented GAO's recommendations; however, the impact of these actions may take time to show improvements, especially for ongoing construction projects, depending on several issues, including the relationship between VA and the contractor.

Chairman Miller, Ranking Member Brown, and Members of the Committee:

I am pleased to be here today to discuss information from our April 2013 report regarding the construction of new major Department of Veterans Affairs' (VA) medical facilities. That report examined VA's actions to address cost increases and schedule delays at four of its largest and most expensive major medical-facility construction projects—located in Denver, Colorado; Orlando, Florida; New Orleans, Louisiana; and Las Vegas, Nevada.[1] At the time of our review, VA had 50 major medical-facility projects[2] under way, including new construction and renovation of existing medical facilities, at a cost of more than $12 billion.

My statement today discusses VA construction management issues, specifically (1) the extent to which the cost, schedule, and scope for the four selected medical-facility projects changed since this information was first submitted to VA's authorizing committees[3] and the reasons for these changes, (2) actions VA has taken to improve its construction management practices, and (3) VA's response to recommendations we made in our report for it to further improve its management of the costs, schedule, and scope of these construction projects. This testimony is based on our April 2013 report and May 2013, and April 2014 testimonies on this topic,[4] as well as selected updates. These selected updates

[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]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. §§ 8101, 8104. While these projects cost at least $10 million, some cost 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.

[3]No funds may be used for any major medical facility construction project over $10 million unless funds have been specifically authorized by law, and VA is required to submit a prospectus to the House and Senate Committees on Veterans' Affairs that contains information about each planned medical facility project. See 38 U.S.C. §§ 8101, 8104.

[4]GAO-13-302; GAO, *VA Construction: Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects*, GAO-13-556T (Washington, D.C.: May 7, 2013); and GAO, *VA Construction: VA's Actions to Address Cost Increases and Schedule Delays at Denver and Other Major Medical-Facility Projects*, GAO-14-548T (Washington, D.C.: April 22, 2014).

include information on the status of VA's major medical center projects in Las Vegas, Orlando, New Orleans and Denver.

To conduct these updates, we obtained documentation and other information from VA officials on the current status of its major medical-facility projects and actions it took to address our recommendations in April 2014 and again in January 2015. Detailed information on the scope and methodology used for our April 2013 report and April 2013 and May 2014 testimonies can be found in those products. We conducted the work for this statement in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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

Cost Increases and Schedule Delays

In our April 2013 report, we found that costs increased and schedules were delayed for all four of VA's largest medical-facility construction projects, when comparing November 2012 construction project data with the cost and schedule estimates first submitted to Congress. Since our 2013 report, these projects have experienced further increases and delays. When we compared the most recent construction project data,[5] as of December 2014, with the cost and schedule estimates first submitted

[5]VA provided an update in January 2015 for the total estimated cost and estimated completion date for some of its projects. The data was as of December 2014.

to Congress, cost increases ranged from 66 percent to 144 percent,[6] representing a total cost increase of over $1.5 billion and an average increase of approximately $376 million per project. For example, the cost for the New Orleans project increased by nearly $40 million. Schedule delays have also increased since our April 2013 report. Specifically, in April 2013 we reported that the schedule delays ranged from 14 to 74 months with an average delay of 35 months per project. The delays now range from 14 to 86 months. For instance, the delays in Orlando have extended from 39 months to 57 months. Table 1 presents updated information on cost increases and schedule delays for these four projects compared with original estimates.

Table 1: Veterans Affairs Major Medical-Facility Projects Cost Increases and Schedule Delays, as of December 2014

Project location	Initial total estimated costs	Total estimated costs	Percent increase	Initial estimated completion date	Estimated completion date	Number of months extended	Total estimated years to complete[a]
Las Vegas	$325 million	**$585 million**	80	April 2009	Summer 2015[b]	86	**11.25**
Orlando	$254 million	**$616 million[c]**	143	April 2010	January 2015	57	**10**
Denver	$328 million	**$800 million[d]**	144	February 2014	April 2015[d]	14	**10.5[d]**
New Orleans	$625 million	**$1.035 billion**	66	December 2014	February 2016	14	**8.5**

Source: GAO Analysis of VA data. | GAO-15 332T

[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, 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]The main medical center was completed in April 2012 and patients began utilizing the facility in August of 2012. However, in an update provided by VA in January 2015, the final phase of the Las Vegas project to expand the emergency department is projected to be completed in the summer of 2015. For the purpose of our analysis above, we calculated the number of months extended and the

[6]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. OMB Circular No. A–11, Appendix 8 (2012). 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.

total years to complete using the date of June 2015. However, schedule delays would increase if the project was completed later in the summer of 2015.

[5]In the January 2015 update, VA did not provide the total estimated cost for the Orlando project.

[6]In the update, VA stated that the final project cost and schedule will be determined pursuant to execution of interim cost plus fixed fee contract with VA and issuance of a long term contract by U.S. Army Corps of Engineers (USACE). As such, VA was unable to provide total cost and schedule information for the Denver project.

We found in April 2013 that of the four largest medical-facility construction projects VA had underway, Denver had the highest cost increase. We reported that the estimated cost increased from $328 million in June 2004 to $800 million, as of November 2012. Further, VA's initial estimated completion date was February 2014; subsequently VA estimated the project would be completed in May 2015. However, in April 2014, VA's primary contractor on the project had expressed concerns that the project would ultimately cost more to complete. In a January 2015 update, VA stated that the final project cost and schedule will be determined pursuant to execution of interim cost plus fixed fee contract and issuance of a long term contract by the U.S. Army Corps of Engineers.

In commenting on a draft of our April 2013 report, VA stated 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 before it awarded 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.[7] 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. 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. In our April 2013 report, we made recommendations to VA,

[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).

discussed later in this statement, to help address these cost and schedule delays.

Reasons for Cost Increases and Schedule Delays and Related Scope Changes

In our April 2013 report, we found that different factors contributed to cost increases and schedule delays at each of the four locations we reviewed:

- 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. For example, in Denver, plans went through numerous changes after the prospectus was first submitted to Congress in 2004. In 1999, VA officials and the University of Colorado Hospital began discussing the possibility of a shared facility on the former Fitzsimons Army base in Aurora, Colorado.[8] Negotiations continued until late 2004, at which time VA decided against a shared facility with the University of Colorado Hospital because of concerns over the governance of a shared facility. In 2005, VA selected an architectural and engineering firm for a stand-alone project, but VA officials told us that the firm's efforts were suspended in 2006 until VA acquired another site at the former Army base adjacent to the new university medical center. Design restarted in 2007 before suspending again in January 2009, when VA reduced the project's scope because of lack of funding. By this time, the project's costs had increased by approximately $470 million, and the project's completion was delayed by 14 months. The cost increases and delays occurred because the costs to construct operating rooms and other

[8]Fitzsimons Army base was closed in 1999 as part of the Department of Defense's base realignment and closure process.

specialized sections of the facility were now borne solely by VA, and the change to a stand-alone facility also required extensive redesign.

- 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, which impacted plans to build an underground parking structure.

VA Took Steps to Improve Its Construction Management Practices, But Did Not Implement Changes Early Enough to Impact Denver Project

In our April 2013 report, we found that VA had taken steps to improve 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.[9] 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.[10] The report stated that the challenges identified on a project-by-project basis were not isolated incidents but were indicative of systemic problems facing VA.

In our 2013 report we also found that VA had taken steps to implement a new project delivery method—called the Integrated Design and Construction (IDC) method.[11] In response to the construction industry's concerns that VA and other federal agencies did not involve the construction contractor early in the design process, VA and the Army Corps of Engineers began working to establish a project delivery model that would allow for earlier contractor involvement in a construction project, as is often done in the private sector.

We found in 2013 that VA did not implement IDC early enough in Denver to garner the full benefits. VA officials explained that Denver was initiated as a design-bid-build project and later switched to IDC after the project had already begun. According to VA officials, the IDC method was very popular with industry, and VA wanted to see if this approach would effectively deliver a timely medical facility project. Thus, while the intent of the IDC method is to involve both the project contractor and architectural and engineering firm early in the process to ensure a well coordinated

[9]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.

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

[11]The IDC method allows the construction contractor to be involved in the project from design to completion. VA believes this can help identify any potential issues early and speed the construction process. IDC is similar to a private sector approach called Construction Management At-Risk.

effort in designing and planning a project, VA did not hire the contractor for Denver until after the initial designs were completed. According to VA, because the contractor was not involved in the design of the projects and formulated its bids based on a design which had not been finalized, these projects required changes that increased costs and led to schedule delays. VA staff responsible for managing the project said it would have been better to maintain the design-bid-build model throughout the entire process rather than changing mid-project because VA did not receive the value of having contractor input at the design phase, as the IDC method is supposed to provide. For example, according to Denver VA officials, the architectural design called for curved walls rather than less expensive straight walls along the hospital's main corridor. The officials said that had the contractor been involved in the design process, the contractor could have helped VA weigh the aesthetic advantages of curved walls against the lower cost of straight walls.

VA Reports Taking Actions to Implement GAO Recommendations

In our April 2013 report we identified systemic reasons that contributed to overall schedule delays and cost increases, and recommended that VA take actions to improve its construction management of major medical facilities: including (1) developing guidance on the use of medical equipment planners;[12] (2) sharing information on the roles and responsibilities of VA construction project management staff; and (3) streamlining the change order process.[13] Our recommendations were aimed at addressing issues we identified at one or more of the four sites we visited during our review. VA has implemented our recommendations; however, the impact of these actions may take time to show improvements, especially for ongoing construction projects, depending on several issues, including the relationship between VA and the contractor. Since completing our April 2013 report, we have not reviewed the extent to which these actions have affected the four projects, or the extent to

[12]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.

[13]Most construction projects require some degree of change to the facility design as the project progresses, and typically, organizations have a process to initiate and implement these changes through change orders. VA requires multiple levels of review for many of VA's change orders, which can be another factor that can increase the time it takes to finalize them. According to VA, these reviews are necessary to ensure that VA is in accordance with its regulations and reduce the risk that changes will result in unwarranted costs to the government.

which these actions may have helped to avoid the cost overruns and delays that occurred on that specific project.

Using Medical Equipment Planners

On August 30, 2013, VA issued a policy memorandum providing guidance on the assignment of medical equipment planners to major medical construction projects. The memorandum states that all VA major construction projects involving the procurement of medical equipment to be installed in the construction will retain the services of a Medical Equipment Specialist to be procured through the project's architectural engineering firm.

Prior to issuance of this memorandum, VA officials had emphasized that they needed the flexibility to change their heath care processes in response to new technologies, equipment, and advances in medicine.[14] 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 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, in our April 2013 report we found that for costly and complex facilities, VA did not have guidance for how to involve medical equipment planners during each construction stage of a major hospital and has sometimes relied on local Veterans Health Administration (VHA) staff with limited experience in procuring medical equipment to make medical equipment planning decisions. Thus, we recommended that the Secretary of VA develop and implement agency guidance to assign medical equipment planners to major medical construction projects. As mentioned earlier, in August 2013, VA issued such guidance.

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

In September 2013, in response to our recommendation, VA put procedures in place to communicate to contractors the roles and responsibilities of VA officials that manage major medical facility construction projects, including the change order process. Among these procedures is a Project Management Plan that requires the creation of a

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

communications plan and matrix to assure clear and consistent communications with all parties.

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.[15] However, in our April 2013 report, we found that the roles and responsibilities of CFM and VHA staff were not always well communicated and that it was 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. 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. Therefore, in our 2013 report, we recommended that 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. As discussed earlier in this statement, VA disseminated such procedures in September 2013.

Streamlining the Change-Order Process

On August 29, 2013, VA issued a handbook for construction contract modification (change-order) processing which includes milestones for completing processing of modifications based on their dollar value. In addition, as of September 2013, VA had also hired four additional attorneys and assigned on-site contracting officers to the New Orleans, Denver, Orlando, Manhattan and Palo Alto major construction projects to expedite the processing and review of construction contract modifications. By taking steps to streamline the change order process, VA can better ensure that change orders are approved in a prompt manner to avoid project delays.

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

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

orders. Federal regulations[16] and agency guidance[17] state that change orders must be made promptly, and agency guidance states in addition 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 as part of our April 2013 review, including Denver, 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.[18] Processing delays may be caused by the difficulty involved in VA and contractors' coming to agreement on the costs of changes and the multiple levels of review required for many of VA's change orders. As discussed earlier, VA has taken steps to streamline the change order process to ensure that change orders are approved in a prompt manner to avoid project delays.

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

Contacts and Acknowledgements

If you have any questions about this testimony, please contact David Wise at (202) 512-2834 or WiseD@gao.gov. Other key contributors to this testimony include are Ed Laughlin (Assistant Director), Nelsie Alcoser, George Depaoli, Raymond Griffith, Hannah Laufe, Amy Rosewarne, Nancy Santucci, and Crystal Wesco.

[16]48 C.F.R. § 43.201

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

[18]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.

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.

GAO's Mission	The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.
Obtaining Copies of GAO Reports and Testimony	The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (http://www.gao.gov). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to http://www.gao.gov and select "E-mail Updates."
Order by Phone	The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, http://www.gao.gov/ordering.htm. Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537. Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.
Connect with GAO	Connect with GAO on Facebook, Flickr, Twitter, and YouTube. Subscribe to our RSS Feeds or E-mail Updates. Listen to our Podcasts. Visit GAO on the web at www.gao.gov.
To Report Fraud, Waste, and Abuse in Federal Programs	Contact: Website: http://www.gao.gov/fraudnet/fraudnet.htm E-mail: fraudnet@gao.gov Automated answering system: (800) 424-5454 or (202) 512-7470
Congressional Relations	Katherine Siggerud, Managing Director, siggerudk@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548
Public Affairs	Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800 U.S. Government Accountability Office, 441 G Street NW, Room 7149 Washington, DC 20548

Please Print on Recycled Paper.

STATEMENT
OF
ROSCOE BUTLER
DEPUTY DIRECTOR FOR HEALTH CARE
VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

ON

"BUILDING A BETTER VA: ASSESSING ONGOING MAJOR CONSTRUCTION MANAGEMENT PROBLEMS WITHIN THE DEPARTMENT"

JANUARY 21, 2015

For well over a decade, the veterans of Colorado have been promised a new, full service, state of the art Department of Veterans Affairs (VA) Medical Center. No less than three previous VA secretaries -- Anthony Principi, James Nicholson, and James Peak – have all failed to deliver. Secretary Shinseki approved the current site on Fitzsimmons campus in 2009 and as Congress appropriated funding, VA broke ground in August of that year – half a decade ago.

Six hundred million dollars later, Colorado veterans are still waiting.

Chairman Miller, Ranking Member Brown and distinguished Members of the committee, on behalf of National Commander Mike Helm and the 2.4 million members of The American Legion, I thank you and your colleagues for turning your attention to the problems inherent in the VA construction process. Not only are the failures of VA construction hurting the veterans of Colorado, systemic VA problems with communication, transparency and accountability threatens VA operations nationwide. The veterans of America deserve better.

This is not just a Coloradan veterans' problem – this is an American veterans' problem. Last fall Chairman Jeff Miller of the House Committee on Veterans' Affairs called for the Government Accountability Office (GAO) to determine why the "Big Four" VA construction projects were all delayed.[1] All four of these projects: Orlando, New Orleans, Las Vegas, and Colorado are delayed beyond their initial time and cost estimates. The previous year, GAO found the average delay on these four medical projects was 35 months and the lowest cost overruns were still 59 percent over initial estimates, while the highest cost overruns were a full 144 percent over estimate.[2] The *average* cost overrun was a staggering $366 million.[3]

---

[1] American Legion Magazine, OCT 2013
[2] GAO Report 13-302 "Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects" April 4, 2013
[3] Ibid

Even when VA displays that they can complete a construction project, as they were finally able to do in Nevada in August of 2012, the projects can hardly be considered flawless success stories. Despite an over $600 million budget on the Las Vegas VA Medical Center (VAMC) the project immediately drew fire for an emergency room that required a $16 million expansion because it was too small and lacked a drop off ramp for ambulances.[4] Just to be clear, the VA spent over $600 million building a major hospital without a drop off ramp for ambulances at the emergency room.

Throughout all of the "Big Four" construction projects VA has displayed questionable competency at best, but at least gross mismanagement. In October 2013, the Department of Veterans Affairs own Office of the Inspector General (VAOIG) admonished VA for lack of guidance, inaccurate milestones, lack of documentation and lack of central tracking.[5] Before VA managed to finish the Las Vegas project, they had not completed a major hospital construction project since 1995.

After meeting with VA construction officials, The American Legion believes VA needs to seriously examine how VA manages major construction projects, and that reform is needed in this process.

Recent events in Colorado further demonstrate the point. On December 9, 2014, Kiewit-Turner, the Colorado project's prime contractor, ceased work on the new VA hospital in Aurora after the Civilian Board of Contract Appeals (CBCA), a federal appeals board, afforded Kiewit-Turner the relief it was seeking and ruled that the VA breached its contract by failing to deliver a facility design that could be built for the approved budget of $582,840,000.

In the ruling, CBCA found that the "behavior of the VA has not comported with standards of good faith and fair dealing required by law. The agency failed to provide a design that could be constructed within the [estimated construction cost at award]..."[6]

CBCA also found that VA delayed progress of construction by delaying the processing of design changes and change orders. "Much of the blame for this situation must be ascribed to the VA; by failing to control the [joint venture design team], delaying approval of the design, presenting Kiewit-Turner with a design which was allegedly complete but required an enormous number of modifications, failing to process change orders for approximately one year, failing to process joint supplemental instructions in a timely fashion, and failing to make timely payment to Kiewit-Turner, the VA drove up the costs of construction."[7]

Finally, the CBCA also ruled that, "VA disregarded cost estimates by Kiewit-Turner and Jacobs, even to the point of rejecting a Jacobs' estimate because it was developed under restrictions

[4] http://www.reviewjournal.com/news/reid-heller-say-growing-pains-root-new-va-hospital-s-problems
[5] Testimony of Linda Halliday, Assistant Inspector General for Audits and Evaluations, Office of the Inspector General – HVAC "Building VA' s Future: Confronting Persistent Challenges in VA Major Construction and Lease Programs" November 20, 2013
[6] United States Civilian Board of Contract Appeals CBCA 3450 Kiewit-Turner, A Joint Venture v. Department of Veterans Affairs
[7] Ibid.

which the agency itself had imposed."[8] The VA ultimately directed Kiewit-Turner to continue its construction work for their agreed firm target price, even though VA had not been paying Kiewit-Turner properly.

After a two-week work stoppage, workers returned to the jobsite after VA and Kiewit-Turner came to an interim agreement. To assist with management of the project, VA called on the U.S. Army Corps of Engineers for assistance in Aurora, an action that falls in line with a resolution passed by the Legion last May, calling on Congress and VA to consider "all available options" (including the Corps of Engineers) "to ensure major construction programs are completed on time and within budget."[9]

The healthcare system operated by the Veterans Health Administration (VHA) is an area of special focus for The American Legion. The American Legion's *System Worth Saving Task Force* has been conducting nationwide visits to monitor the state of affairs in VA medical centers (VAMCs) since 2003. Through these visits, The American Legion has found that when veterans can access these healthcare facilities, they receive an excellent level of care and in many cases superior to what they could receive outside the VHA system. But veterans can't access that care if VA can't get the facilities built.

The American Legion supports VA's Strategic Capitol Investment Program (SCIP), which determines the system needs and provides long range planning to determine what facilities are needed to serve veterans. The American Legion strongly supports ensuring that budget appropriations match the deficiencies identified by SCIP, and that VA's construction budgeting not fall behind the levels needed to maintain this schedule of construction.[10]

However, it is vitally important that VA maintain transparency about the process involved in SCIP, and urges VA to continue publically posting all information about SCIP projects and costs.[11] When VA fails to be transparent, everyone loses. As in all processes within VA, whether they relate to construction, health safety, or the claims process, VA must improve their transparency with the veterans' community.

The American Legion calls on VA to critically evaluate how it conducts the management of construction projects, and recognize that the current state of affairs cannot be allowed to continue. With budgets drawn so tight in Washington, hundreds of millions of dollars of cost overruns on hospital projects hurt all veterans. Every dollar wasted in cost overruns on current projects is a dollar that can't be spent on future needs elsewhere.

The American Legion is deeply involved in tracking these projects because we are committed to ensuring that our nation's veterans continue to have access to the best possible care anywhere. We cannot continue to allow these projects to disappear into the maze of a faceless bureaucracy that allows spiraling cost overruns and fails to punish the responsible parties. The American

[8] Ibid.
[9] Resolution: Department of Veterans Affairs Construction Programs, 2014 Spring National Executive Committee meetings
[10] Resolution No. 150: "Strategic Capital Investment Planning (SCIP) Program" August 2014
[11] Ibid

Legion strongly urges VA to provide meaningful communication and transparency with the veterans' community, to provide visible accountability for failures, and to provide a clear roadmap to how the situation will improve.

Questions concerning this testimony can be directed to The American Legion Legislative Division (202) 861-2700, or lprovost@legion.org

PREPARED STATEMENT OF RAYMOND C. KELLEY

Mr. Chairman, Ranking Member and Members of the Committee:

On behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, I would like to thank you for the opportunity to testify today regarding the Department of Veterans Affairs' (VA) management of major construction projects.

Over the past few years it has become very apparent that VA's ability to control costs and deliver major construction projects on time is and should be viewed as a great concern. Veterans are not being served when construction projects take months or years longer than expected to complete and the price tags inflate as time drags on.

Last year, the House passed legislation that would improve VA's major medical facility construction process. These improvements include: using medical equipment planners, developing and using a project management plan, peer reviewing all projects, creating a change-order metric, and using a design-build process when possible.

VA claims they have started using medical equipment planners. This practice will assist in reducing scheduling delays and cost overruns. To ensure VA's construction process can be as efficient as possible, it is important the other provisions are enacted.

VA's lack of standardized project management protocol has led to poor communication within VA and between VA and the general contractor has also led to delays and cost over-runs. There have been cases identified where separate VA officials have provided contradictory orders to the general contractor, where one VA employee authorized the continuation or start of a new phase of building, while another VA employee gave the order not to continue or start a particular phase. This lack of VA project management coordination led to a portion of the Orlando, Florida facility to be built then removed.

By developing and using a project management plan, all parities at the onset of the project will have a clear understanding of the roles and authorities of each member of the project team. Included in the plan will be clear guidance on communication, staffing, cost and budget, as well as change-order management.

Construction peer excellence reviews are an important aspect of maintaining a high level of construction quality and efficiency. When used, these review teams are made up of experts in construction management who travel to project sites to evaluate the performance of the project team. These meetings provide important feedback—a separate set of eyes—on the project management plan to ensure a plan is in place to make the project come in on time and on budget.

VA has historically relied on the design-bid-build project delivery system when entering into contracts to build major medical facility projects. Sixty percent of current VA major medical facility projects use 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.

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 prime contractor work side-by-side with the architect, allows the architect to be an advocate for VA. Also, the architect and the prime 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.

While these initiatives will work to improve future projects, the VFW believes a look back at all currently funded major construction projects should take place to see what steps may be needed to finish the nearly 50 partially funded but not completed major Veterans Health Administration (VHA) construction projects.

VA's FY 2015 Budget Submission shows there was more than $6 billion available for 49 VHA projects through the end of FY 2013. What the submission does not show is why some projects were initially funded years ago, but little to no progress

has been made to complete them. Many of these projects have safety implications or provide specific services for spinal cord injuries and need to be set on a course that will bring these projects to completion.

VA's Strategic Capital Investment Plan (SCIP) has been a great tool in identifying gaps access, utilization and safety, but if a clear plan is not in place to close these gaps, delays in care, safety risks and the increased cost to close these gaps will continue.

Mr. Chairman, this concludes my testimony. I will be happy to answer any questions you or the Committee members 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 2014, nor has it received any federal grants in the two previous Fiscal Years.

The VFW has not received payments or contracts from any foreign governments in the current year or preceding two calendar years.

U.S. General Services Administration

Michael Gelber
Deputy Commissioner
Public Buildings Service

"Building a Better VA: Assessing Ongoing Major Construction Management Problems within the Department

Committee on the Veterans' Affairs
Subcommittee on Oversight and Investigations
January 21, 2015

Introduction

I would like to thank Chairman Miller and Ranking Member Brown for the opportunity to provide a statement on behalf of the U.S. General Services Administration (GSA) for this hearing before the House Committee on Veterans' Affairs on construction management practices at the Department of Veterans Affairs (VA).

GSA's mission is to deliver the best value in real estate, acquisition, and technology services to government and the American people. To meet this mission, GSA is working with agencies to reduce their space requirements, effectively managing GSA's real property inventory, while pursuing innovative real property proposals that will increase space utilization, reduce costs, and deliver better space to federal agencies.

GSA's Public Buildings Service (PBS) provides effective, mobile, sustainable workplace solutions for federal agencies at the best value for the American people. PBS is one of the largest and most diversified public real estate organizations in the world. GSA's inventory consists of more than 8,700 assets with more than 376 million rentable square feet of space. GSA's portfolio of public buildings consists primarily of office buildings, courthouses and land ports of entry. Five entities – the Departments of Homeland Security, Justice and Treasury, Social Security Administration, and Judiciary occupy more than 53 percent of that space.

For its part the VA has independent land-holding authorities, and manages a significant portion of its own real property inventory. It occupies approximately 7.8 million square feet of GSA-managed space, which amounts to about 2 percent of GSA's total inventory. While GSA has helped deliver VA building projects in the past, GSA does not have a role in VA's current construction program. However, GSA is working with VA to delegate GSA's leasing authority, under Title 40 of the U.S. Code, on a project-by-project basis to VA.

Investment in GSA's nationwide real property inventory

GSA's construction program delivers critical investments for the country and federal agencies. GSA prioritizes new construction and major repair projects by identifying imperative requirements such as mission-critical border and homeland security projects, projects that alleviate life and safety issues, and those that improve the condition of government-owned assets to provide long-term returns to the taxpayer.

When one of GSA's partner agencies has an emergent, long-term requirement for office space, GSA first seeks to meet the need by fully utilizing federally owned space. Under this Administration's direction to federal agencies to freeze the federal real estate footprint, GSA's first priority is maximizing the utilization of existing assets. When a space solution does not exist in the federal real estate portfolio, GSA will meet agency space needs by constructing or leasing new space. GSA constructs new facilities that have a special purpose that are not readily available in the real estate market, such as courthouses and land ports of entry.

Over the past several years, GSA prioritized significant homeland security investments for new construction projects. For example, GSA is working on the consolidation of the Department of Homeland Security (DHS) at St. Elizabeths in Washington D.C., where GSA is helping DHS consolidate from more than 50 locations across the National Capital Region into one central location. GSA has also requested more than $1 billion over the past five years for essential investments at land ports of entry (LPOEs). While most of this funding was not provided, GSA is working on LPOE projects that were funded in both Fiscal Year 2014 and 2015. GSA works closely with DHS-Customs & Border Protection to identify the most urgent investment needs along the border.

Similarly, GSA works closely with the Judiciary to prioritize the construction of new Federal courthouses. The Judiciary developed long-range facilities planning practices to identify its most pressing space and security needs. When Congress appropriates money for these projects, GSA pursues design solutions that maximize the positive civic impact of budgeted resources. In FY 2014, GSA began construction of a new federal courthouse in Mobile, Alabama, addressing the Judiciary's number one construction priority.

Additionally, GSA makes significant repairs and alterations to existing federal buildings through its annual capital investment program. These projects range from fire and life safety system replacements to security upgrades and renovation projects that consolidate offices out of expensive leases and into federally owned facilities, allowing our partner federal agencies to save taxpayer money by assigning more people to less space.

In a constrained fiscal environment, GSA must be a responsible steward of taxpayer dollars by carefully weighing investment needs across a large federal real estate inventory. To identify the highest priorities, GSA assesses agency requirements and building infrastructure needs based on the following criteria:

- Mission urgency;
- Physical condition of the asset;
- Improving asset utilization and making better use of existing inventory;
- Project timing and execution;
- Return on investment;
- Avoidance of lease costs;
- Benefits of installing high-performance features, concentrating on energy conservation and renewable energy generation; and
- Historic significance.

GSA's process for delivering construction projects

GSA's construction approach is focused on delivering major federal construction projects on time and on budget. GSA delivers its capital program through 11 regional offices, which manage construction and major repair projects across the country. These offices manage all design, construction and build out for GSA projects, and procure architect-engineer design and construction management services. By focusing project management at the local level, GSA achieves faster decision making and effective leadership from its project teams.

GSA's project management role begins with defining agency space requirements, and ends only after the facility is open to serve the public. GSA engages with leaders from the private sector architecture, engineering construction, and facility operations industries to implement innovative approaches to project management and execution. As GSA finalizes the design and prepares construction documents, the project team performs value engineering and verifies that the project is within budget. GSA works to monitor and control costs throughout the entire project.

Funding uncertainty remains a significant challenge for GSA. The Government Accountability Office noted that uncertainty in appropriations and limited access to the Federal Buildings Fund (GSA's source for capital expenditures) creates a serious challenge for the management of real property.[1] From Fiscal Year 2011 to 2013, GSA's new construction requests were cut by nearly 90 percent. These restraints stretch out construction schedules and result in increased project delivery costs. In Fiscal Years 2014 and 2015, Congress granted GSA access to a larger portion of the receipts in the Federal Buildings Fund, allowing the agency to begin addressing a significant backlog of repairs and new construction requirements. The Federal Buildings Fund is a quasi-revolving fund and was designed to allow GSA to spend at or above the anticipated level of collections. Failure to appropriate at the level of anticipated collections does not provide agencies with the space and services for which they pay a commercial equivalent rent.

Conclusion

Thank you again for the opportunity to provide this testimony on GSA's construction and capital planning processes. GSA looks forward to working with you throughout the 114th Congress to improve federal construction management, deliver better real estate solutions and provide the best value for the American taxpayer.

[1] *See* "Capital Financing: Alternative Approaches to Budgeting for Federal Real Property (GAO-14-239) and "Federal Buildings Fund: Improved Transparency and Long-Term Plan Needed to Clarify Capital Funding Priorities" (GAO-12-646).

House Veterans' Affairs Committee Hearing:
"Building a Better VA: Assessing Ongoing Major Construction Management Problems within the Department."

Sam Carter
President, Carter Concrete Structures
Statement for the Record
January 21, 2015

Carter Concrete Structures (CCS) is a construction contracting firm based in Stone Mountain, GA. CCS is also a Service Disabled Veteran Owned Small Business (SDVOSB) and has a strong record of service to public and private clients. It is important to note that CCS self-performs the majority of the work outlined in each contract with the federal government and does not simply act as a small business stand-in for a larger entity. In this statement I will outline CCS's ongoing issues and concerns with CCS's current contract work for the U.S. Department of Veterans Affairs (VA).

When the Atlanta construction market began slipping in 2007, CCS determined that it would seek federal contracting opportunities. Our first federal contract was as Design-Build Prime Contractor for a parking deck for the VA Medical Center in Nashville, TN. Although a technical challenge, this $8 million project proved to be a very successful venture and the VA Resident Engineer recommended us for future assignments with the VA. Aware of the federal government's ongoing efforts to stimulate the economy through small business participation, we enrolled in the VA Small Business Program, competed for and won two additional VA projects, and are now a $38 million small business stakeholder in two VA projects.

Our first project, administered locally by the Nashville VA Medical Center, proved to be straightforward and everyone was well satisfied. However, our second two projects have been poorly managed and have proven to be financially detrimental to CCS. The two projects in question are located at VAMC in Bay Pines, FL and VAMC in San Juan, PR. On the first, CCS subcontracted in 2011 to perform the concrete work for general contractor, Archer Western/Demaria JV II. Our role as concrete foundation and frame subcontractor is worth $11.4 million of the $92 million addition to the VA Bay Pines Florida Mental Health facility. On the second, CCS contracted as the Design-Build Prime Contractor with the VA to build a parking deck at the VA Medical Center in San Juan, PR, a contract totaling of $26.8 million.

Both projects are being managed by the VA at the national level, and both have suffered from significant delays, suspensions of work, change orders, and untimely responses from the VA. These issues have caused severe financial strains for CCS to bear. The Bay Pines contract has been delayed for a total of 605 days. The San Juan contract has been delayed 404 days. Not a single day of these delays is attributable to CCS. Between the two contracts, over $38 million of CCS's construction volume has been delayed over 38 months. Additionally, over $1,500,000 in scope changes are in play between both projects. We have reached out to the VA on countless occasions and have received inadequate and conflicting responses with nowhere near the urgency

1960 Parker Court • Suite C • Stone Mountain, GA 30087 • T. 770.978.1212 F. 770.978.1267

that we applied in the execution of our contracts.

Due directly to the VA delays and lack of responsiveness mentioned above, CCS has had to resort to borrowing, something which this small business has not had to do previously. CCS's resources have been exhausted financing the VA's delays. We are, effectively, banking the VA delays, and being overburdened in the process. It is important to note that VA delays disrupt operations and create losses. However, this is but the first harm. Resolution and eventual settlement take months and years, compounding the damage. Our claims for compensation have been a long time in the making, in some cases over thirty months.

In addition to costs of delay, the VA has not settled changes timely, another source of financial strain. Some of these changes go back over two years. The disruption to CCS's business is not restricted to financial strain. We are losing talented supervisors and craftsmen, losing our surety bonding credit, and losing our reputation for paying our suppliers timely. Most importantly, our plans to build our way out of the construction recession with the VA are denying this firm an opportunity to participate in the improving economy as we are dragging the VA through these projects. The value of CCS, a SDVOSB, has been catastrophically degraded by participation in VA projects.

For the Bay Pines project CCS is dependent on Archer Western/Demaria JV II to resolve claims with the VA. As such, it is difficult for CCS to provide you any specific details on the status of those claims. However, from conversations with Archer Western/Demaria JV II and CCS's limited contact with the Bay Pines VA Contracting Officer, we have been informed that five separate delay claims for this project have been submitted and are currently pending. What I can tell you is that CCS performed its subcontract as planned when finally released to work and topped out the structure in September 2014. With our work completed, the VA has an obligation to timely pay the full value of that work, including additional costs attributable to VA caused changes and delay. At this time, it appears that the five delay claims will go to court in October 2015, fully 13 months after our work was completed, so we are financing the delay as well as the drawn out aftermath.

At this point we are still awaiting a written response from the VA regarding both of CCS's claims, which for the Bay Pines project was submitted over a year ago and for the San Juan project were submitted over six months ago. We have requested mediation. In November 2014 we requested a meeting with VA Undersecretary Gibson to discuss our ongoing issues with these two projects and to develop a solution. We have yet to be granted such a meeting with him or any member of his staff. Meanwhile, CCS continues to accommodate the VA's schedule delays at our expense.

As a veteran myself I was proud to contract with the VA and contribute construction improvements to facilities that my fellow veterans would utilize. CCS has always been proud of our record of service to our public and private clients. At first our work with the VA was a project we could be equally proud of, now we are confronted with delays and a financial burden that is no fault of ours. When we have requested updates or answers to remedy the situation we have been given incomplete and contradictory responses.

1960 Parker Court • Suite C • Stone Mountain, GA 30087 • T. 770.978.1212 F. 770.978.1267

At this point CCS recommends that the House Veteran's Affairs Committee request that the VA improve its overall management of construction projects from award to completion. The VA should be strongly encouraged to avoid introducing changes that burden and delay all contractors, but especially the small business contractor. Changes and delays destroy well formulated schedules. Coupled with poor response, changes are destructive, financially unfair, and unsustainable. CCS also recommends that the Committee advise the VA to improve its responsiveness to small businesses who are directly involved in VA construction projects. Small businesses are inherently nimble and responsive, and therefore uniquely suited to construction projects. CCS has provided superior values to the VA, an efficiency the VA should be encouraged to utilize. However, the VA must reciprocate to sustain the increased economy that small businesses provide. That is not happening in our case.

An increased focus on communications with small businesses should include efforts by the VA Office of Small Business to engage directly with small business owners to resolve contract and payment issues in a timely manner.

My immediate and primary concern is the future of my firm, which provides employment to 228 employees. CCS does not seek special privilege, despite the fact that our VA contracts have enfeebled a previously healthy contractor. We merely insist upon reciprocity and want our claims settled, equitably, and immediately. The VA and Small Businesses should be a productive match. Small Businesses should not be crippled by working with the VA.

If you or your staff have any questions or require additional information please feel free to contact me directly.

Sincerely,

Sam Carter

President

Carter Concrete Structures

1960 Parker Court • Suite C • Stone Mountain, GA 30087 • T. 770.978.1212 F. 770.978.1267

○