



Building VA's Future – Confronting Persistent Challenges in VA's Major Construction and Lease Programs

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STATEMENT OF

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FOR THE RECORD

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

Building VA's Future – Confronting Persistent Challenges in VA's Major Construction and Lease Programs

WASHINGTON, D.C.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

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

The vastness of VA's capital infrastructure is rarely fully visualized or understood. VA currently manages and maintains more than 5,600 buildings and almost 34,000 acres of land. Although VA has decreased the number of critical infrastructure gaps, there remain

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more than 3,900 gaps that will cost between \$54 and \$66 billion to close, including \$10 billion in activation costs.

Major Construction

Decades of underfunding has led to a major construction backlog that has reached between \$19 billion and \$ 23.3 billion. There are currently 21 Veterans Health Administration (VHA) major construction projects that have been partially funded dating back to 2007. In the Administration's budget request for FY 2014, VA requested funding for only one project. The total unobligated amount for all currently budgeted major construction projects exceeds \$2.9 billion. Yet, the total budget proposal for FY 2014 major construction accounts was less than \$342 million.

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

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

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

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

Design-bid-build is the most common method of project design and construction. In this method, an architect is engaged to design the project. At the end of the design phase, that

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

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

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

Use of contractor-led design-build has several inherent problems. A shortcut design process reduces the time available to provide a complete design. This provides those responsible for project oversight inadequate time to review completed plans and specifications. In addition, the construction documents often do not provide adequate scope for the project, leaving out important details regarding the workmanship and/or other desired attributes of the project. This makes it difficult to hold the builder accountable for the desired level of quality. As a result, a project is often designed as it is being built, compromising VA's design standards. Contractor-led design-build forces VA to rely on the contractor to properly design a facility that meets its needs. In the event that the finished project is not satisfactory, VA may have no means to insist on correction of work done improperly unless the contractor agrees with VA's assessment. This may force VA to go to some form of formal dispute resolution, such as litigation or arbitration.

An alternative method of design-build project delivery is architect-led design-build. This model places the architect as the project lead rather than the builder. This has many benefits to VA, such as ensuring the quality of the project, since the architect reports directly

to VA. A second benefit to VA is the ability to provide tight control over the project budget throughout all stages of the project by a single entity. As a result, the architect is able to access pricing options during the design process and develop the design accordingly.

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

Health Care Center Leasing

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

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

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

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

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

Committee may have.

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

Ibid. p. 8.2-12

Ibid. p. 2-49

Ibid. p. 1-4