STATEMENT OF
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DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON
"BUILDING VA'S FUTURE – CONFRONTING PERSISTENT CHALLENGES IN VA'S MAJOR CONSTRUCTION AND LEASE PROGRAMS"
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Mr. Chairman and Members of the Committee, thank you for the opportunity to testify on the results of the Office of Inspector General's (OIG) work related to the Department of Veterans Affairs (VA) construction and lease programs. Our focus will be on a recently released OIG report on health care centers, including issues related to a health care center in Butler, Pennsylvania, and a facility in Cleveland, Ohio, as well as OIG reports over the past 2 years related to the Veterans Health Administration's (VHA) management of its Minor Construction Program, VA's execution and utilization of capital assets in Marion County, Florida, and information regarding the new VA medical centers (VAMCs) under construction in New Orleans, Louisiana, and Orlando, Florida. I am accompanied today by Ms. Maureen Regan, Counselor to the Inspector General.

BACKGROUND

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

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

HEALTH CARE CENTER LEASE MANAGEMENT

In October 2013, we reported that VA's management of timeliness and costs in the Health Care Center (HCC) lease procurement process was ineffective.[1] As of August

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

2013, only four of seven leases had been awarded and no HCCs had been built, despite VA's target completion date of June 2012. Congress authorized approximately $150 million for the HCC facility activations.

We found the following deficiencies:

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

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

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

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

Butler, Pennsylvania Health Care Center Lease

In response to an anonymous complaint received in late March 2013, the OIG's Office of Contract Review conducted a review of the proposal submitted by Westar

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

Development Company, LLC, for the contract of the lease to develop an HCC in Butler, Pennsylvania. The complainant alleged that Westar was actually conducting business for entities created and controlled by Mr. Michael Forlani who was suspended from doing business with VA in December 2011. In 2012, he pled guilty to bribery and racketeering charges, and on April 1, 2013, was sentenced to 97 months in Federal prison.

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

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

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

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

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

Brecksville, Ohio, Enhanced Use Lease

In December 2011, the OIG's Office of Contract Review initiated a review of the Enhanced Use Lease (EUL) between VA's Office of Asset Management and Veterans Development, LLC (VetDev). The EUL was entered into as part of VA's consolidation of the Cleveland, Ohio, campuses located in Brecksville and the Wade Park area of Cleveland, Ohio. VA's EUL authority allows VA to lease underutilized property to

private developers. Under the EUL with VetDev, VA leased the Brecksville campus to VetDev for a one-time cash payment of $2 million and in-kind consideration of not less than $4 million. The "in-kind" consideration was space provided at no cost to VA in an administrative building and a parking garage that VetDev constructed adjacent to the Wade Park campus and leased back to VA. The package also included payment to VetDev for care provided to veterans in a domiciliary that VetDev built adjacent to the Wade Park campus. Payments for the space and domiciliary care are paid under service agreements entered into as part of the EUL.

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

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

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

As previously noted, the criminal charges against Mr. Forlani included bribes made to obtain an interest in the property adjacent to the Wade Park campus on which the two buildings and garage were constructed as well as preferential tax breaks. In addition, interactions between Mr. Forlani and the Director of the Cleveland Health Care System at the time, Mr. William Montague, resulted in criminal charges filed against Mr. Montague in June of this year.

VHA'S MINOR CONSTRUCTION PROGRAM

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

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

Proper Use of Minor Construction Funding

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

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

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

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

Medical Facility Funding and Minor Construction Projects

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

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

expanded NRM to include projects that renovated and modernized existing facility square footage between $500,000 and $10 million.

Monitoring of Minor Construction Projects

OCAMS and VISN officials did not routinely monitor minor construction project schedules and financial performance. Rather, OCAMS assigned responsibility to VA medical facility project engineers to monitor the projects and notify OCAMS if significant changes occurred or additional project funding was required. The draft minor construction program Handbook required OCAMS to create Minor Program Review Teams to perform quarterly reviews of project schedules and financial performance at selected sites. However, we found no evidence that the Minor Program Review Teams were formed and instead that internal program reviews were performed. As a result, VHA lacked the ability to effectively identify projects with cost overruns, significant schedule slippages, or significant construction scope changes in a timely manner and take corrective actions when necessary.

Recommendations

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

The Villages Outpatient Clinic, Marion County, Florida

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

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

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

primary care, 34 percent of mental health care, and 24 percent of specialty care visits planned for FY 2012.

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

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

We recommended that the VA Sunshine Healthcare Network Director conduct a thorough utilization review of The Villages Outpatient Clinic to ensure facility resources efficiently target the medical needs of the most underserved veterans. Further, the Network Director should determine whether to relocate the unused nuclear medicine machine to another VA medical facility. The VA Sunshine Healthcare Network Director agreed with our finding and recommendations. The Villages OPC began phasing in use of the operating room suite in June 2012. In addition, the North Florida/South Georgia Veterans Health System has finalized plans to move the Single Photon Emission Computed Tomography machine to Gainesville, Florida, to improve utilization. We closed the recommendations in our report in August 2013.

CONSTRUCTION OF THE NEW ORLEANS VA MEDICAL CENTER

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

Our review of VA's expenditures did not identify substantive issues with VA's stewardship of the project. At the time of our review (February 2012), VA had obligated $359 million (36 percent) and expended $105 million (11 percent) of the $995 million appropriated for the New Orleans VAMC. This was due to delays in the City of New Orleans delivering the site to VA and a need for additional VA remediation of hazardous

substances that was identified after site transfer in April 2011.[5] VA has preliminary plans to mitigate delays by adjusting construction activities and if necessary compensating contractors negatively impacted by delays outside of their control in the construction phase of the project.

CONSTRUCTION OF THE ORLANDO VA MEDICAL CENTER

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

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

CONCLUSION

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

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

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