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VA REAL PROPERTY

VA Should Better Justify Its Need to Lease Major Medical Facilities

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Physical Infrastructure Issues

GAO-16-884T

Chairman Barletta, Ranking Member Carson, and Members of the Subcommittee:

I am pleased to be here today to discuss our report on the Department of Veterans Affairs' (VA) leasing practices. VA operates the largest health care network in the United States through the Veterans Health Administration, with over 2,700 health care sites, including hospitals and outpatient facilities. However, many facilities are outdated and VA estimates it will need $63 billion over the next 10 years to address its capital needs. In recent years, VA has increasingly leased space for its medical facilities, including major medical facilities.[1] From 2005 to 2015, the number of VA's leased medical facilities grew by 80 percent to 1,246 facilities and included leases for 57 major medical facilities. VA's major medical facilities provide numerous services such as mental health and other clinical care, are generally built by developers to meet VA and federal-design requirements, can exceed 200,000 square feet, and have an average annual rent in excess of $1 million. Before it can execute leases for certain facilities, a prospectus must be submitted to Congress for authorization.

My statement today summarizes the findings from our June 2016 report, which examined the factors that account for VA's decisions to lease major medical facilities and the extent to which VA's cost-estimating process for leasing these facilities reflects best practices.[2] To conduct that work, we reviewed documentation on VA's Strategic Capital Investment Planning process, GAO and Office of Management and Budget (OMB) guidance on capital planning, and GAO guidance on cost-estimating, and reviewed prospectuses for the 51 major medical facilities submitted to Congress for fiscal years 2015 through 2017. We also analyzed data and other documentation on VA's 23 major medical facility leases authorized and completed between fiscal year 2006 and fiscal year 2015, and interviewed VA officials. More detailed information on our scope and

[1]VA considers major medical facility leases as those with annual unserviced rent costs of more than $1 million. Unserviced rent includes base or shell rent, real estate taxes and insurance, and excludes all operating expenses and utilities. VA submits its prospectuses for major medical facility leases, which provide the agency's justification for each proposed project, as part of its annual budget submission.

[2]GAO, *VA Real Property: Leasing Can Provide Flexibility to Meet Needs, but VA Should Demonstrate the Benefits*, GAO-16-619 (Washington, D.C.: June 28, 2016).

methodology can be found in the issued report. Our work was performed in accordance with generally accepted government auditing standards.

Our review resulted in the following findings. First, VA leases major medical facilities to benefit from shorter timeframes to open a facility and to attain flexibility to relocate, but VA has not assessed and provided information to decision-makers on how it has benefited from the flexibility to relocate. Second, VA's cost-estimating procedures for major medical facility leases generally align with our 12 cost-estimating best practice steps and recent changes in VA's approach may improve the quality of VA's estimates.

VA Justifies Leasing to Open Facilities More Quickly and to Obtain Flexibility to Relocate but Does Not Provide Information to Decision Makers Demonstrating the Benefits of This Flexibility

VA prioritizes all proposed capital projects using six major-decision criteria (see table 1), which focus on addressing needs that (1) can demand quick solutions, such as the need to replace an expiring lease that cannot be renewed, and (2) often change, such as demands for veterans' access to care options.[3] As such, according to VA officials, leasing is often VA's preferred alternative for major medical facilities because project implementation times are often shorter than the time for constructing a federally-owned facility and leasing can provide flexibility to relocate in the future to meet changes in VA's needs.

[3]According to VA officials, the weightings of these decision criteria are subject to change based on annual evaluations of department-wide priorities. Each criterion also includes several sub-criteria.

Table 1: VA's Criteria for Evaluating and Prioritizing Capital Projects for Fiscal Year 2016, in Order of Priority Weight from Most to Least Weight

Decision criterion	Priority weight	Description
Improve safety, security, and compliance	.324	Improving compliance with safety (e.g., seismic) and security laws, building codes, and regulations (including patient privacy standards).
Fixing what we have	.216	Managing buildings to minimize the extent to which deficiencies in infrastructure, such as information technology, impact the delivery of benefits and services to veterans.
Increasing access	.206	Increasing access for veterans by reducing the time and distance a veteran must travel to receive the best quality services and benefits and providing adequate patron support structures at VA facilities, such as parking facilities.
Rightsizing inventory	.097	Managing space inventory by removing excess space, building new and renovating existing space in order to provide the highest quality services to veterans at the right time and in the right place.
Ensure value of investment	.088	Choosing the best value solution to meeting gaps in care and services.
Departmental initiatives	.069	Aligning projects with department goals, such as reducing energy usage, and VA's strategic plan.

Source: GAO analysis of VA planning documentation. | GAO-16-884T

VA cited a shorter project time frame and flexibility to relocate in all 51 of its prospectuses for major medical facilities' leases submitted to Congress since fiscal year 2015. For example, in the fiscal year 2015 submission, VA cited a shorter implementation time frame and flexibility to relocate as justifications for a new lease in Johnson County, Kansas, to address growing demand and overcrowding at the Kansas City Veterans Medical Center and to reduce the drive time for a high concentration of veterans in the area to within VA's 30-minute drive-time target.

VA also generally identified leasing as the lowest cost alternative in its prospectuses, but in some cases preferred leasing for the two previously cited reasons when other options may have been less costly. For example, in fiscal year 2015, VA proposed a new lease in Lafayette, Louisiana, to replace a facility that the VA determined was too small and estimated leased space would have a total life-cycle cost of approximately $259 million, compared to $201 million for construction of a new federally-owned facility.[4] According to VA, an owned facility would

[4]VA estimated total life-cycle costs in discounted dollars.

require a longer time frame to open than a leased facility and limit VA's flexibility to adapt to potential changes in the veterans population, demand for services, new technologies, or health care delivery.

Leasing may offer VA greater efficiencies and flexibilities when major medical-facility projects are compared to construction. Specifically, VA's use of GSA delegated leasing authority to execute its major medical facility leases requires that VA's lease terms not exceed 20 years.[5] This period provides some of the flexibility that VA values in terms of relocating to facilities that align with VA's changing needs. Construction of federally-owned facilities may not offer this flexibility given the challenges that we have previously identified with renovating and disposing of some federal properties, including VA's, due to issues such as competing stakeholder interests that can make renovating or closing facilities difficult.[6] Further, construction of a federally-owned facility requires a full upfront funding commitment that can be difficult to secure in the current budgetary environment. VA officials added that although VA's major medical facility lease projects also generally require a lessor to construct a new facility to VA's specifications, leasing tends to have a shorter project timeframe because it does not require VA to acquire the land on which the facility will be constructed, which can require additional time and resources.

Although VA has justified leasing its major medical facilities to its department leadership and congressional decision makers based on the flexibility that leasing offers compared to other alternatives, VA has not provided these stakeholders with information on the extent to which it has benefited from that flexibility, nor does VA regularly assess information that would help it do so. In particular, while VA regularly cited future "flexibility," such as ability to move when needs change, as a justification for the leases included in its annual capital plans, the benefits that VA has experienced from this flexibility with major medical facility leases are not presented to VA stakeholders responsible for selecting projects to present

[5]According to VA officials, VA currently applies to GSA for delegations of leasing authority to execute all of its leases. GSA may execute leases for terms of up to 20 years. 40 U.S.C. § 585(a)(2).

[6]See GAO, *Federal Real Property: The Government Faces Challenges to Disposing of Unneeded Buildings,* GAO-11-370T (Washington, D.C.: Feb. 10, 2011) and GAO, *Federal Real Property: Progress Made in Reducing Unneeded Property, but VA Needs Better Information to Make Further Reductions,* GAO-08-939 (Washington, D.C.; Sept. 10, 2008).

to Congress or to congressional decision makers. VA officials told us that VA's data systems do not provide VA staff responsible for planning new leases with information on the use of flexibilities with existing major medical facilities' leases, such as how far VA has moved from a previously occupied medical facility and why it has moved to new leased locations. We and OMB have previously identified the importance of assessing the results of capital decisions and incorporating lessons learned from those assessments into capital decisions.[7] Without transparency on the actual benefits VA has experienced from leasing its major medical facilities, VA and congressional decision-makers may lack information to make informed decisions about the need for VA's major medical facility leases. Further, greater transparency could help decision-makers and taxpayers understand the value of leasing in cases in which VA proposes leasing major medical facilities when other alternatives, such as construction of a federally-owned facility, may have a lower cost.

In our issued report, we recommended that the Secretary of Veterans Affairs annually assess how VA has benefited from flexibilities afforded by leasing its major medical facilities and use information from these assessments in its annual capital plans in order to enhance transparency and allow for more informed decision making related to VA's major medical facility leases. VA agreed with our recommendation, noting that assessing and explaining the benefits and flexibilities of leasing major medical facilities could improve transparency. VA agreed to add this information to future annual budget submissions.

[7]GAO, *Executive Guide: Leading Practices in Capital Decision-Making*, GAO/AIMD-99-32 (Washington, D.C.: Dec. 1, 1998) and Office of Management and Budget, Supplement to Circular No. A-11: *Capital Programming Guide* (Washington, D.C.: June 2015).

VA's Cost Estimating Process for Major Medical Facility Leases Aligns with Most of Our Best Practice Steps and Recent Changes May Improve VA's Estimates for These Leases

VA's cost-estimating procedures for major medical facilities' leases generally align with 9 of the 12 best practice steps for cost-estimating that we have previously identified,[8] and recent changes may improve the quality of VA's cost-estimating process for these leases. (See fig. 1.) For a cost-estimating process to support the creation of reliable cost estimates, it should substantially or fully meet each of the four characteristics in GAO's Cost Guide—comprehensive, well-documented, accurate, and credible—based on the extent to which the procedures incorporate the underlying best practice steps for each characteristic. We found that VA's cost-estimating procedures for major medical leases fully met the comprehensive characteristic, substantially met the well-documented characteristic, and partially met the accurate and credible characteristics.

Figure 1: Cost-Estimating Best Practice Steps Aligned with Characteristics of High-Quality Estimates

Characteristic	Best practices	Assessment	
Comprehensive	Develop estimating plan	Fully met	Fully met
	Determine estimating structure	Fully met	
Well-documented	Define estimate's purpose	Fully met	Substantially met
	Define program characteristics	Fully met	
	Identify ground rules and assumptions	Substantially met	
	Obtain data	Substantially met	
	Document the estimate	Fully met	
	Present estimate to management for approval	Fully met	
Accurate	Develop point estimate and compare to an independent cost estimate	Substantially met	Partially met
	Update estimate to reflect actual costs and changes	Partially met	
Credible	Develop point estimate and compare to an independent cost estimate	Substantially met	Partially met
	Conduct sensitivity analysis	Partially met	
	Conduct risk and uncertainty analysis	Minimally met	

Fully met: Completely satisfied the best practice
Substantially met: Satisfied a large portion of the best practice with only minor issues
Partially met: Satisfied about half of the best practice
Minimally met: Satisfied a small portion of the best practice

Source: GAO analysis of U.S. Department of Veterans Affairs data. | GAO-16-884T

[8]GAO, *GAO Cost Estimating and Assessment Guide: Best Practices for Developing and Managing Capital Program Costs*, GAO-09-3SP (Washington, D.C.: March 2, 2009).

Our finding that VA's cost-estimating process partially met the characteristics for producing reliable cost estimates is based on the following:

- **Comprehensive:** VA's cost-estimating process fully met the comprehensive characteristic because its procedures include both the best practice steps of developing an estimating plan and determining the estimating structure.
- **Well-documented:** VA's process substantially met the well-documented characteristic because its procedures incorporate a large number of related best-practice steps, such as defining the estimate's purpose and presenting the estimate for approval.
- **Accurate:** VA's process partially met the accurate characteristic because the procedures incorporate some elements of the two associated best practice steps. Specifically, VA's process includes the best practice step of developing a point estimate and comparing it to an independent estimate, which is based on the market rental rate determined by a market survey that VA conducts and the cost of specific improvements required for VA's intended medical purposes. VA applies several standard and variable adjustments to the market rental rate to determine the rental portion of the estimated first-year lease cost to include in the VA's prospectuses to Congress. (See Table 2.)

Table 2: VA's Adjustments to Market Rental Rates to Estimate Lease Costs

Adjustment	Description
Delineated market	A variable adjustment to account for the difference between the age, condition, and location of the properties identified by a market assessment within a delineated area and what VA plans to lease. For example, an otherwise comparable property may be older, or in a more or less desirable location. This adjustment takes these differences into account.
Insurance and taxes	A variable adjustment to account for estimated insurance and property taxes VA would pay for a lease. These amounts vary by location.
Conversion of space to VA medical use	A standard 35-percent adjustment to account for the conversion of shell space to VA-specific medical use.

Adjustment	Description
Physical security and sustainability	A standard $3 per net usable square foot adjustment to account for federally-mandated and VA-required standards for security and sustainability features. The percentage of the square-foot cost that this standard adjustment represents can vary greatly. For example, if the prospectus usable square foot rental rate is $15, the $3 charge would represent 20 percent of it, whereas if that rent rate were $100, it would represent just 3 percent of it.
Conversion of market rates	A standard 15-percent adjustment to convert rentable square foot rates to usable square foot rates—the latter of which being the standard used by VA.
Escalation rate	A variable adjustment, applied after the above adjustments, to account for inflation and market fluctuation between the time of the proposal and estimated year of facility acceptance.

Source: GAO analysis of VA and GSA documentation. | GAO-16-884T

This best practice step normally includes comparing the estimate to an independent cost estimate, which VA does not obtain. Because of the standardized nature of the adjustments to the rent rate and pricing for improvements for major-medical facilities' lease cost estimates,[9] obtaining an independent cost estimate for these inputs would likely yield little new information; accordingly, we consider the rating for this best practice step to be substantially met. The procedures also include updating the estimate, another best practice step supporting this characteristic, but VA does not update it with actual costs as the best practice step requires. Estimates are updated during the development process to calculate whether actual costs are likely to rise more than 10 percent above the prospectus-estimated cost.[10] For leases executed under GSA authority, the estimated maximum cost provided in a prospectus may be increased for construction or alterations but may not exceed 10 percent.[11] After leases are executed VA does not update the estimate with actual costs. Updating the estimate with actual costs is a best practice step because it

[9]We did not review the suitability of the standard and variable adjustments VA applies.

[10]To calculate whether actual costs may rise more than 10 percent above the prospectus-estimated cost, the prospectus estimate is first multiplied by a standard rate, called an escalation factor, for each year between prospectus authorization and VA's likely acceptance of the facility from the developer at completion. This adjusted rate is compared to the awarded lease rate to determine if congressional approval is necessary.

[11]40 U.S.C. § 3307.

enables a “lessons learned” analysis, which can strengthen estimates going forward.

- **Credible:** VA’s process partially met the credible characteristic because VA’s procedures incorporate some elements of the three associated best practice steps. For example, the best practice step of conducting a sensitivity analysis on the lease’s cost estimate is not directly included in VA’s procedures, but some procedures do address uncertainty and risk. A sensitivity analysis reveals how to assess the potential variability in the estimate by calculating how the estimate is affected by a change in any single underlying assumption. These calculations identify the cost elements that represent the most risk to an estimate. Instead, VA officials said that VA applies an annual escalation rate[12] to adjust for increases in market rental rate and inflationary increases in the cost for tenant improvements over time,[13] two key assumptions supporting the estimate that could cause actual first-year lease costs to fluctuate from the prospectus estimated costs. We found that VA’s use of an escalation rate often did not fully account for variation in lease costs. Specifically, our review of cost data provided by VA for 18 of the 23[14] most recently completed major medical-facility leases activated by the end of fiscal year 2015 shows that actual costs for 15 of the 18 leases varied substantially from adjusted prospectus costs, including 7 leases that were more than 15 percent above VA’s adjusted estimates and 8 that were more than 15 percent below the VA’s adjusted estimates.[15] For example, actual first-year lease costs increased about 26 percent over the adjusted estimate for VA’s San Francisco, California, medical facility’s lease

[12]Through fiscal year 2015 the escalation rate was 4 percent, but VA adjusted this amount to about 2 percent for fiscal year 2016 to align with GSA’s escalation factor.

[13]The escalation rate is applied to estimate costs every fiscal year from prospectus authorization through facility acceptance.

[14]Five leases in our population accounted for their lump sum payments at facility acceptance differently than the other 18, so these leases were excluded from our calculations.

[15]“Adjusted prospectus costs” include the 4 percent escalation rate applied to rent (and not to tenant improvement costs) for each fiscal year between prospectus approval and facility acceptance. “Actual costs” include first-year shell rent and lump sum payments for tenant improvements to bring the facility up to par with standards for VA medical space that are listed in the supplemental lease agreement signed when VA accepts the facility from the developer.

and decreased about 44 percent for the VA's Montgomery, Alabama, facility.

VA recently issued a new standard design guide to increase the reliability of its prospectus estimates for major medical facilities and plans to conduct a "lessons learned" study that could further improve how VA estimates its costs. The standard design guide, issued in January 2016, covers the different types of outpatient clinic facilities and provides guidance on VA activities, such as site selection, and delineates minimum federal-facility requirements for security, sustainability, and seismic standards. VA officials told us that the new guide was developed to reduce the risk of facility changes and consequent cost changes for lease projects, and that moving forward all authorized major medical facility leases would use this guide. Reducing the potential for design changes—which we have previously found to be a main driver of increases in facility costs[16]—after a prospectus is submitted may enable VA to better estimate facility costs. Second, VA officials told us that the department is planning a "lessons-learned" review that would involve updating data used for planning major medical facilities' leases with actual cost data after the facility is accepted. This type of review can improve cost-estimating processes over time by exposing the precise reasons why actual costs differed from the estimate, such as faulty project ground rules and assumptions, and previously unrecognized risks. The new design guide and the lessons-learned study are in the early stages, and their success will depend on how quickly and successfully VA implements them.

In conclusion, the recent changes in VA's leasing program show promise for improving cost estimates for VA's major medical facility leases. In particular, VA's new guidance could introduce more discipline into the process and VA's "lessons learned" study could identify factors that lead to cost variance from what is proposed to Congress. Further, VA's commitment to assess and provide information to Congress on the benefits and flexibilities of leasing major medical facilities could provide much needed transparency to VA's decisions to pursue leasing versus other alternatives. We will continue to monitor how VA proceeds with these changes.

[16]GAO, *VA Real Property: Action Needed to Improve the Leasing of Outpatient Clinics*, GAO-14-300 (Washington, D.C.: April 30, 2014).

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

GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact Rebecca Shea, (202) 512-2834; shear@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions include Heather MacLeod, Assistant Director; Jennifer Echard, Delwen Jones, James Leonard, and Crystal Wesco.

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