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Report to Congressional Requesters

April 2014

VA REAL PROPERTY

Action Needed to Improve the Leasing of Outpatient Clinics

GAO-14-300

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GAO Highlights

Highlights of GAO-14-300, a report to congressional requesters

Why GAO Did This Study

VA operates one of the nation's largest health-care delivery systems. To help meet the changing medical needs of the veteran population, VA has increasingly leased medical facilities to provide health care to veterans. As of November 2013, VHA's leasing program has long-term costs of $5.5 billion and growing. Given previous problems that GAO has identified with VA's hospital construction program, GAO was asked to review VA's leasing program.

This report examined (1) the extent to which schedule and costs changed for selected VA outpatient clinics' leased projects since they were first submitted to Congress and factors contributing to the changes and (2) actions, if any, VA has taken to improve its leasing practices for outpatient clinics and any opportunities for VA to improve its project management. GAO analyzed agency documents as well as VA data for 41 ongoing major outpatient-clinic lease projects, for which a prospectus was submitted to Congress with an average annual rent of more than $1 million as of January 2014. We also interviewed VA officials and representatives from private companies, involved in VA leasing projects.

What GAO Recommends

GAO recommends that VA update VHA's guidance for the leasing of outpatient clinics. VA concurred with GAO's recommendation and discussed actions under way to implement the recommendation. VA also provided technical comments, which GAO incorporated as appropriate.

View GAO-14-300. For more information, contact Lorelei St. James, at (202) 512-2834 or stjamesl@gao.gov

What GAO Found

Schedules were delayed and costs increased for the majority of the Department of Veterans Affairs' (VA) leased outpatient projects reviewed. As of January 2014, GAO found that 39 of the 41 projects reviewed—with a contract value of about $2.5 billion—experienced schedule delays, ranging from 6 months to 13.3 years, with an average delay of 3.3 years. The large majority of delays occurred prior to entering into a lease agreement, in part due to VA's Veterans Health Administration (VHA): 1) providing project requirements late or changing them or 2) using outdated guidance. Costs also increased for all 31 lease projects for which VA had complete cost data, primarily due to delays and changes to the scope of a project. First-year rents increased a total of $34.5 million—an annual cost which will extend for 20 years (the life of these leases).

VA has begun taking some actions to address problems managing clinic-leased projects. First, it established the Construction Review Council in April 2012 to oversee the department's real property programs, including the leasing program. Second, consistent with the council's findings and previous GAO work (December 2009, January 2011, and April 2013), VA is planning the following improvements:

- *Requiring detailed design requirements earlier in the facility-leasing process*. VA issued a guidance memorandum in January 2014 directing that beginning with fiscal year 2016, VA should develop detailed space and design requirements before submitting the prospectus to Congress.
- *Developing a process for handling scope changes.* In August 2013, VA approved a new concept to better address scope changes to both major construction and congressionally authorized lease projects. According to VA officials, among other improvements, this process ensures a systematic review of the impact of any ad-hoc changes to projects in scope, schedule, and cost.
- *Plans to provide Congress with more complete information on costs of proposed projects.* VA's 2014 budget submission did not clarify that its estimates for future lease projects included only one year's rent, which does not reflect the total costs over the life of the leases, costs that VA states cannot be accurately determined in early estimates. VA officials clarified this estimate beginning with VA's 2015 budget submission.

However, these improvements are in the early stages, and their success will depend on how quickly and effectively VA implements them.

- Finally, VA is also taking steps to refine and update guidance on some aspects of the leasing process, for example the VA's design guides, but VHA has not updated the overall guidance for clinic leasing (used by staff involved with projects) since 2004. Specifically, VHA's *Handbook on Planning and Activating Community Based Outpatient Clinics*, which established planning criteria and standardized expectations for outpatient clinics, was based on past planning methodologies that no longer exist. *Standards for Internal Control in the Federal Government* calls for federal agencies to develop and maintain internal control activities, which include policies and procedures, to enforce management's directives and help ensure that actions are taken to address risks.

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Abbreviations

CFM	Office of Construction and Facilities Management
CRC	Construction Review Council
OIG	Office of Inspector General
OMB	Office of Management and Budget
RPS	Real Property Service
SCIP	Strategic Capital Investment Planning
VA	Department of Veterans Affairs
VHA	Veterans Health Administration

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April 30, 2014

The Honorable Jeff Miller
Chairman
Committee on Veterans Affairs
House of Representatives

The Honorable John Mica
Chairman
Subcommittee on Government Operations
Committee on Oversight and Government Reform
House of Representatives

The Department of Veterans Affairs (VA) operates one of the largest integrated health care networks in the United States through the Veterans Health Administration (VHA), serving more than 8-million enrolled veterans each year at over 1,600 health care sites, including hospitals and outpatient clinics. To help meet the changing medical needs of the veteran population, including a greater need for outpatient services, VA has increasingly leased the facilities from which it provides its health care services. According to VA, leasing medical facilities rather than owning them allows VA to provide more veterans with accessible health-care services and gives VA the flexibility to respond to changing service demands, demographic shifts, and improvements in medical technology.[1] Depending on the facility's size and scope of services, VA outpatient clinics can provide primary care; dental care; pharmacy, laboratory, and radiology services; nutritional medicine; women's health care; mental health and suicide prevention services; and other types of specialty care.

[1]The purpose of this report is not to determine whether it is more appropriate for VA to lease versus own. Instead, the report identifies changes to schedule and costs of major VA leasing projects, actions VA has taken to improve its management of these projects, and further opportunities for improving management of the VA leasing program. Although not addressed in this report, GAO has previously reported on some federal agencies overreliance on costly leasing, which is one reason that federal real property has remained on GAO's high-risk list. See GAO, *Greater Transparency and Strategic Focus Needed for High-Value GSA Leases,* GAO-13-744 (Washington, D.C.: Sept. 19, 2013).

VA is required to submit a prospectus to Congress for all major medical-facility leases and construction projects.[2] A major medical-facility lease project is one with average annual rent of more than $1 million.[3] VA may contract for space either by leasing space in an existing building or the construction of new facilities that VA then leases back from the developer.[4]

In April 2013, we found that costs substantially increased and schedules were delayed for VA's largest medical-center construction projects.[5] To address the factors contributing to this situation and help VA better manage its construction projects, we recommended that VA (1) develop and implement agency guidance for assigning medical equipment planners to major medical-construction projects; (2) develop and disseminate procedures for communicating to contractors clearly defined roles and responsibilities of VA officials who manage major medical-facility projects, particularly the change-order process; and (3) issue and take steps to implement guidance on streamlining the change-order process. VA has implemented each of the recommendations by taking such actions as (1) issuing a memorandum for each major medical facilities construction project involving the procurement of medical equipment to be installed during construction ensure that the architectural-engineering firm retain the services of a medical equipment planner and (2) requiring for each major medical facilities construction project a VA Contracting Officer appointment letter to the contractor that

[2]38 U.S.C. § 8104(b). A prospectus is a statement required to justify a proposed project when its cost exceeds a legislatively established threshold. A prospectus includes information on the project's size, cost, location, and other features and is submitted to the appropriate House and Senate authorizing committees. VA. *Directive 7815: Acquisition of Real Property by Lease and by Assignment from General Services Administration* (Washington, D.C.: January 2012). Generally, VA submits its prospectuses as part of its annual budget submission.

[3]38 U.S.C. § 8104(a)(3). VA considers major medical facility leases as those with 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 currently has 97 major medical leases; however an additional 32 active major medical leases are currently being procured or built.

[4]The use of a landlord or developer to construct a building according to VA's requirements is known as a build-to-suit lease. A build-to-suit lease is one type of lease that VA uses for its outpatient clinics and other facilities, in addition to procuring leases in existing space.

[5] GAO, *VA Construction: Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects*, GAO-13-302 (Washington, D.C.: Apr. 14, 2013).

clearly delineates the responsibilities and limits of authority to execute project changes; and (3) issuing a handbook for construction change-order processing that includes milestones for completing processing of change orders based on their dollar value.

Because of the cost increases and schedule delays for VA's major construction projects, you asked us to review how VA manages its major leasing projects. This report examines (1) the extent to which schedule and costs changed for selected VA leased outpatient clinic projects and the factors that have contributed to any changes, and (2) actions, if any, VA has taken to improve its leasing practices for outpatient clinics, and any opportunities that may exist for VA to improve its management of project schedules and costs.

To address these objectives, we selected 41 current major medical leases that are outpatient clinic projects for which a prospectus has been submitted to Congress, as required by law.[6] The total contract value of these 41 projects is $2.5 billion.[7] These projects were authorized by Congress from 1997 to 2011. We reviewed VA data as of January 2014 on each of these projects. We reviewed and analyzed original cost estimates and completion dates from when a project's prospectus was

[6]38 U.S.C. § 8104. VA provided data for its 82 major lease facility projects; however, for the purpose of this report, we reviewed VA's outpatient clinics since these facilities are leased by VA. In total, 69 of the 82 leasing projects VA provided data for were outpatient clinics; however, 24 of these outpatient clinics were submitted in VA's fiscal year 2014 budget request and have yet to be authorized by Congress. Furthermore, 4 additional outpatient clinic projects were eliminated from our review for the following reasons: (1) Peoria, IL and Columbus, GA – these facilities were added to VA's budget request as "extra" projects and were not included in VA's official budget submission. As such, a prospectus was never submitted for these projects; (2) Boston, MA – The procurement for this project was canceled due to lack of competition and has not yet been restarted; and (3) Norfolk, VA – This project was not procured. As such, the scope of our review focuses on the 41 ongoing outpatient clinic lease projects already authorized by Congress. The following non-outpatient clinic leases were also excluded from our review: (1) VA's 7 larger health care centers which were recently reviewed as part of a VA Office of Inspector General audit; (2) VA's 5 new leased research center projects; and (3) one community care center project.

[7]Total contract value includes annual rent for the duration of the contract (in some cases, 20 years) and build-out costs, which are paid to the developer by VA as a one-time lump sum payment once a project is completed.

first submitted to Congress[8] and the projects' current status. We assessed the reliability of VA's leasing data through interviews with knowledgeable VA officials and a review for completeness and any unexpected values. We determined that the VA's leasing data were sufficiently reliable for the purposes of this report. We reviewed VA's leasing guidance and directives, VA's *Strategic Plan Fiscal Year 2011 to 2015*, and other relevant documents. In addition, we reviewed prior GAO reports, Office of Management and Budget guidance on leasing practices, and relevant legislation pertaining to VA's leasing authority and amounts appropriated for these projects. We interviewed VA officials from the Office of Construction and Facilities Management (CFM), CFM's Real Property Service (RPS) division, and VHA. We also interviewed representatives from private companies, involved in VA leasing projects, including a general contractor construction firm, and development leasing firm. Our findings from these select sites should not be used to make generalizations about VA sites agency-wide.

To examine specific outpatient projects in greater detail, we selected 11 clinic projects in 8 locations: (1) Jacksonville, Florida; (2) Baltimore, Maryland; (3) Las Vegas, Nevada (four facilities);[9] (4) Austin, Texas; (5) McAllen, Texas; (6) Corpus Christi, Texas; (7) Parma, Ohio; and (8) Ft. Wayne, Indiana. We selected these projects and locations based on the following criteria: (1) projects status; (2) project costs; (3) scope and cost changes; and (4) schedule delays.[10] For these projects, we interviewed officials either on site or by phone discussing the reasons for changes in costs and schedules and possible improvements for VA's leasing program. Our findings from our site visits are illustrative and provide examples of the issues faced by specific projects; our findings should not be used to make generalizations about VA sites agency-wide. See appendix I for more information about our scope and methodology.

[8]38 U.S.C. § 8104. For the purposes of this report, when we refer to submitting a prospectus to Congress, we mean submitting the prospectus to relevant congressional committees.

[9]In Las Vegas, Nevada, we visited four clinics that were accepted by VA from between September 2011 to January 2012 and interviewed officials from each site.

[10]We selected projects that were far enough along in the leasing process to have actual or projected scope, cost, and schedule data, which allowed us to identify projects that experienced changes in scope, cost, and schedule.

We conducted this performance audit from May 2013 to April 2014 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.

Background

VA generally provides inpatient care at large VA medical facilities that are owned by the federal government and provides outpatient care at leased facilities.[11] As of fiscal year 2013, VA had 1,889 leases, of which 1,192 were medical outpatient clinics and other medical facilities, varying in size and cost.[12] Leased medical space generally consists of outpatient clinics, mental health clinics, readjustment-counseling centers, research, and other types of clinical leases. Non-medical space generally consists of administrative, warehouse, data center, parking, and regional office leases. According to VA, much of the non-medical space is integral to providing medical services in other locations. See table 1 for the numbers of VA leased properties from fiscal years 2004 through 2013.

Table 1: VA Leased Facilities Used for Medical and Non-Medical Functions, Fiscal Years 2004 to 2013

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Medical space	665	689	721	770	829	931	1,030	1,107	1,193	1,192
Non-medical space	332	355	365	395	458	525	588	633	688	697
Total	**997**	**1,044**	**1,086**	**1,165**	**1,287**	**1,456**	**1,618**	**1,740**	**1,881**	**1,889**

Source: VA data.

VA has recognized the need to modernize its facilities and realign its real property portfolio to provide accessible, high-quality, and cost-effective

[11]VA owned 1,344 medical space facilities and 4,668 non-medical space facilities, as of November 2013.

[12]As of November 2013, the leasing liability of these 1,889 leased facilities was $5.5 billion. According to VA, lease term liability includes long-term VA direct leases and leases that are administered through the General Services Administration. The liability is calculated as the base term, i.e., the number of years for the term of the lease, times the annual rent; however, this calculation does not include past payments. VA has leased 848 of 1,393 total outpatient clinics.

services. However, much of VHA's infrastructure was designed and built decades ago when there was a greater focus on hospital-centered, inpatient care.[13] VA officials recognize that VHA's infrastructure does not fully align with the health care needs of the current veteran population[14] and that VHA faces challenges in updating its infrastructure, such as:

- providing medical services for returning veterans from Afghanistan and Iraq, who increasingly require specialized care for injuries such as the treatment of spinal cord and traumatic brain injuries;
- keeping pace with advancements in health care services and technologies that often dramatically change the physical infrastructure requirements of hospitals and clinics; and
- addressing changes in veteran demographics, including the differing treatments and care required for veterans of different generations and the shifts in veteran populations among different areas of the country that place continued demands on the capital-asset portfolio.

To plan for future infrastructure needs, VA established its Strategic Capital Investment Planning (SCIP) process for its fiscal year 2012 budget submission to Congress.[15] As part of this planning effort, VA annually reviews its real property priorities and conducts a gap analysis to identify its need for medical facilities. The SCIP process includes major construction projects and leasing projects. Local plans are centrally validated, evaluated, and consolidated into a prioritized national project list. VA also uses this planning process to develop a 10-year long-range plan, which prioritizes a list of projects targeted to reduce service gaps.

VA is authorized to lease property for use as a medical facility.[16] VHA is responsible for developing the requirements for build-to-suit and remodeled lease facilities. CFM's Office of Real Property Service (RPS) is responsible for acquiring land and leasing space for the construction of medical and medically-related facilities for VA, and provides guidance to regional and local VA offices regarding real property. VA is required to

[13]VA, *Fiscal Year 2014 Budget Request. Summary Volume I* (Washington, D.C.: 2014).

[14]VA, *Fiscal Year 2013 Budget Request, Construction IV* (Washington, D.C.: 2012).

[15]VA, *Fiscal Year 2013 Budget Request, Construction IV* (Washington, D.C.: 2012).

[16]38 U.S.C. §§ 8103, 8104

submit a prospectus to Congress for all major medical facility leases.[17] VA submits a prospectus for new projects (property that it has never before leased) as well as succeeding or follow-up leases that have expired or will soon expire. VA's annual budget submissions provide Congress with the prospectuses for all proposed new major-medical lease projects for which VA is seeking authorization for the next fiscal year, including life-cycle costs.[18] In addition, VA provides estimates for future leasing needs. However, according to VA officials, VA does not submit a prospectus when exercising pre-negotiated options to extend the lease within the stipulated maximum lease term.

VA's process for procuring major leases is two-part: (1) CFM and VHA plan and prepare for a leasing project prior to entering into a lease agreement, and (2) CFM oversees the build out of the leasing project, not the administration of the lease. CFM has the overall responsibility for managing VA's nationwide leasing program, including negotiating and executing development of the lease project. After completion of the facility, VHA activates it to provide medical care. See table 2 for information on VA's two-part leasing process.

[17]A major medical facility lease project is a lease for space for use as a new medical facility at an average annual rental of more than $1 million. 38 U.S.C. § 8104(a)(3)(B).

[18]Life-cycle cost is the total cost of a capital asset in addition to the construction costs, including all direct and indirect costs for planning, procurement, operations and maintenance, and disposal.

Table 2: VA's Two-Part Leasing Process, 2013

Planning and preparing	VA first identifies the need for a major lease facility. The Secretary must then approve the project and a prospectus is developed, which is subsequently included in VA's budget submission. When a project is authorized by Congress, VA then begins developing an acquisition plan and market analysis and determines the best procurement methodology for the lease.[a] Afterward, VA selects a lease site using established criteria that include a review of (1) the surrounding area, (2) accessibility issues, and (3) site characteristics.[b] VA uses the listed criteria to evaluate sites and either determine a preferred site or prequalify all sites that meet the minimum criteria, depending on the procurement methodology selected by the contracting officer. In some cases, VA can contract with an agent to identify parcels of land and an appraiser to assess the value. Once a site is selected, VA then develops the "schematic design"[c] using its design guides and solicitation offers to prospective developers of the facility.
	VA commonly enters into a 20-year lease agreement to occupy space. Once the agreement is completed, the developer contracts with a construction firm to build the outpatient clinic. Once offers have been submitted in response to VA's solicitation for sites, VA then conducts a multi-stage review of the proposals prior to selecting a developer. Finally, after VA has selected a developer and has cleared all needed reviews, it then enters into a lease agreement with the selected development firm.
Managing and overseeing	Once VA has entered into a lease agreement with the development firm, VA CFM officials then host a project kickoff meeting to introduce the lessor to the VHA officials responsible for providing medical services at the facility and establish roles and responsibilities for the project. The responsibility of the project then changes from VA's Central Office contracting officer and project manager to VA's on-site resident engineer, who ensures the facility is built to VHA specifications.[d]
	Prior to accepting a project, VA conducts a final inspection of the constructed facility. Once accepted, in some cases, VA pays the developer a one-time lump-sum payment for all tenant improvements, depending on the lease. First years' rent is not paid in lump sum, but rather it is paid in arrears on a monthly basis following commencement of the lease contract. VA does not make any payments to the developer until construction of the leased premises is completed and subsequently accepted by VA. VA then transfers responsibility for managing the leased space to the local contracting officer, a step that is followed by activation of the facility by VHA staff. CFM local officials are responsible for the day–to-day operations of maintaining the facilities thereafter.

Source: GAO Analysis of VA data.

[a]When procuring a lease, VA has three leasing options: leasing existing space; 1-step build-to-suit leases; and 2- step build-to-suit leases. The existing lease option requires VA to retrofit the incorporated space to all governmental physical-security and sustainability requirements. The 1-step leasing process involves procuring the site and developer in one procurement process. The 2-step leasing process includes separate procurements for the site and for the developer.

[b]In a 2-step lease, VA negotiates and enters into an Assignable Option to Purchase contract that allows VA to select a developer to buy the land, construct the clinic, and lease it back to VA for the duration of the lease. Notably, VA never takes title to the property.

[c]According to VA officials, a "schematic design" is a conceptual design that is approximately 35 percent complete.

[d]It should be noted that since the developer owns the property, the developer contracts with a construction firm and assumes the risk for the project. In some cases the developer or the construction firm can enter into a contract with the architectural and engineering firm for the design of the facility. However, CFM officials also work with the architectural and engineering firm to review design documents for the leased facility. Post-lease agreement design efforts then begin, followed by facility construction.

Project Delays and Cost Increases for Outpatient Leases Mostly Occurred Prior to Entering into the Lease Agreement

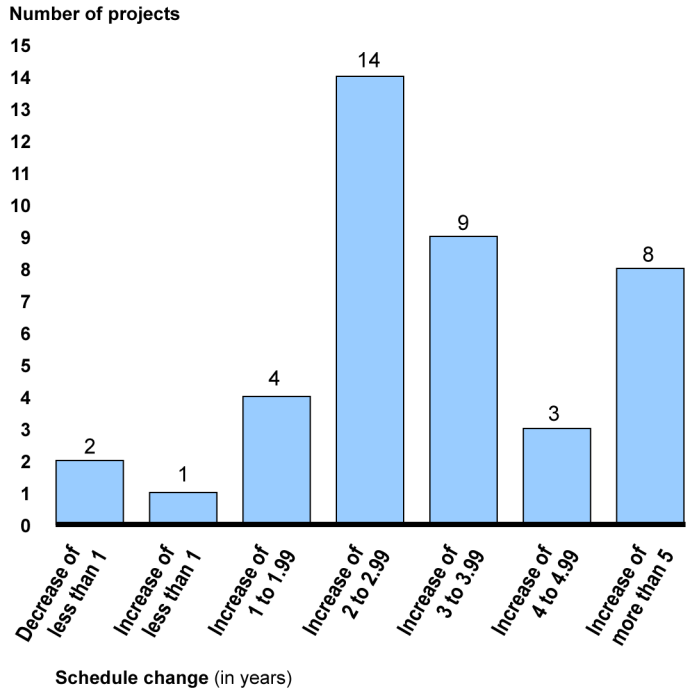
Project Delays

VA has experienced substantial delays in executing new outpatient clinic lease projects, nearly all of them occurred prior to entering into a lease agreement with the developer.[19] We found that 39 of the 41 congressionally authorized outpatient clinic projects we reviewed experienced schedule delays, ranging from 6 months to 13.3 years, with an average delay of 3.3 years, while 2 projects experienced schedule time decreases. Our data analysis showed that 94 percent of these delays occurred prior to entering into the lease agreement. For all but one of the projects that experienced a delay, the delay occurred during the pre-lease agreement stage. We also compared the length of delays that occurred during the pre-lease agreement stage to the length of delays that occurred once a lease agreement was entered into with the development firm. We found that the average delay during the pre-lease agreement stages for all 41 projects totaled nearly 3.1 years.[20] Conversely, the average project delay once a lease agreement was finalized totaled approximately 2.5 months, and 11 outpatient clinic projects actually experienced schedule decreases during this stage. VA officials at 6 of our 11 outpatient clinic projects selected for detailed review mentioned that the large majority of schedule delays occur during the period prior to entering into a lease agreement. See figure 1 for an overview of schedule changes experienced by the 41 outpatient clinic projects we reviewed during the pre-lease agreement stage. (See app. II for schedule information for individual clinic projects.)

[19]In this report, the term "delay" refers to an increase in the scheduled or actual acceptance date for a VA major outpatient clinic lease project when compared to the acceptance date identified in the prospectus first submitted to Congress.

[20]The average schedule delay was determined by calculating the average schedule change for all 41 projects including the 39 that experienced delays and the 2 that experienced schedule time decreases.

Figure 1: Range of Pre-Lease Schedule Changes in Years among VA's 41 Major Outpatient-Clinic Projects, January 2014



Source: GAO analysis of VA data.

For the 41 lease projects we reviewed, we found that several factors contributed to delays:

VHA's Late or Changing Requirements. According to data we analyzed and VA officials we interviewed, late or changing requirements were the most common reasons for delays. Requirements can pertain to facility size, types of treatment rooms, types of medical equipment, electrical voltage needs, and other details. We found that in many instances, CFM either did not receive VHA's requirements on time, or VHA changed its requirements during the solicitation of offers,[21] necessitating a re-design that affected the schedule. In evaluating VA data, we found that 23 of the

[21]As we describe in table two, once a site is selected, VA then develops the schematic design using its design guides and solicitation offers to prospective developers of the facility.

41 leasing projects (56 percent) experienced delays because VHA was late in submitting space requirements to CFM, or VHA changed space requirements and thus the scope of the project. For example, the size of the Jacksonville outpatient clinic had increased by 29 percent, and the Austin outpatient clinic site we visited had increased by 36 percent from the time the prospectuses for these projects were submitted to Congress. Furthermore, officials at the Austin outpatient clinic said delays or changes to VHA's requirements necessitated the project's re-design, which, in turn, caused a delay of 19 months. Specifically, the initial authorization request for the Austin project was for 85,000 square feet and 400 parking spaces. VHA revised the space plan to 135,322 square feet to accommodate projected increases in patient visits, and subsequently approved a second revised space plan of 185,822 square feet and 1,200 parking spaces. VA did notify Congress of its intent to increase the size of clinic by more than 10 percent. The completed solicitation for offers was not finalized until July 2009, though several amendments were issued in October 2009 due to revised specifications. Consequently, VA had to extend the due date for the offers to provide bids.

Site Selection Challenges. In analyzing VA data, we found that 20 of the 41 outpatient clinic projects we reviewed (49 percent) experienced delays due to difficulties in locating or securing a suitable site. For example, an increase in scope to the Jacksonville project resulted in a larger building design that then required more land. To accommodate these changes, the landowner worked to acquire additional properties around the already selected site. Although the developer was ultimately successful in obtaining additional land for the project, this process led to delays. According to VA officials, prior to entering into the lease agreement, there were delays associated with difficult negotiations with the developer. In addition, there were significant environmental clean-up requirements at the site, which needed to occur before construction began. The original site's location was obtained in December 2002, but the larger site was not obtained until December 2009, a delay of 7 years. VA officials said that without these negotiations, it is likely that the project would have been significantly more expensive. Site selection challenges were also noted by VA officials in Las Vegas. According to those officials, the site VA selected for a new outpatient clinic was located under the Nellis Air Force Base fly-over space, and VA discovered contamination issues on the property. These problems forced VA to alter the location of the outpatient clinic on the property, contributing to delays.

Outdated Guidance. We found that outdated policy and guidelines resulted in challenges for VA staff in completing leasing projects on time at the sites we reviewed. For example, officials from the four Las Vegas outpatient sites we visited stated that VA's policies for managing leases seem to change for each project, creating uncertainty regarding CFM job responsibilities. An official from the Ft. Wayne outpatient clinic also stated that VA's leasing process is confusing and seems to frequently change. A contracting official from one of the Las Vegas clinics said she had to call various VA headquarters officials while involved in the planning phase to obtain the latest management procedures, because some of VA's guidance had not been updated since 1998. VA is now drafting its leasing *Handbook Guidance 7815*, which VA officials said they plan to finalize by the end of fiscal year 2014. As we will discuss in more detail later in the report, this handbook covers the authorities, roles and responsibilities, policies, procedures, administration, and management of VA's real property leasing program.[22]

In commenting on our draft, VA noted that many lease delays resulted from external influences to VA's leasing process and out of VA's control. VA also noted that other factors could cause delays including site selection issues involving the National Environmental Policy Act requirements, stakeholder concerns, procurement and lessor issues, solicitation/award protects, and post-award contracting issues. Furthermore, these comments stated that some projects required updates to space requirements to accommodate improved delivery of care for veterans. VA noted that as delays to a lease occur, VHA re-evaluates and updates the design and space program to ensure the contemplated lease project will meet VA's latest requirements and optimally serve veterans.

Project Cost Increases

In addition to substantial delays, VA also experienced cost increases to its outpatient clinic projects when compared to the costs in the projects' prospectuses. VA provided cost data for its outpatient clinic lease projects in January 2014. Table 3 includes a description of the key cost data elements we reviewed.

[22]VA. *Handbook Guidance 7815 [Draft]*. (Washington, D.C.: July 2012.) VA expects to publish and finalize the draft handbook in fiscal year 2014.

Table 3: Description of Key VA Cost Data Elements

Data element	Description
Prospectus cost	This cost provided by VA in its annual budget submission represents the total amount estimated to be paid by VA in the first year of the lease (first year's rent and the lump sum payment for special-purpose, medically related improvements).
Prospectus first year rent	This cost provided by VA in its annual budget submission represents the total amount of rent estimated to be paid by VA in the first year of the lease.
Prospectus build-out cost	This cost provided by VA in its annual budget submission represents the estimated first year lump sum payment for special-purpose, medically related improvements the developer makes specifically for VA.
Awarded rent (first year)	The rent due to the lessor for the first year of the lease. The amount of rent due is determined by the competitive selection of the lessor and is the amount offered by the lessor as part of its proposal. This is memorialized in the lease when the lease contract is awarded.
Awarded build-out cost (lump-sum payment)	VA structures its leases so that the cost of the basic building is included in the rental rate, and special-purpose, medically-related special improvements (the items that make the space "clinical") are paid by VA as a lump sum upon acceptance.
Total first year cost	Total of awarded rent and awarded build-out cost, which yields the total amount due to the lessor in the first year of the lease.

Source: GAO analysis of VA data.

When compared to the prospectus costs for the 31 projects with complete cost data,[23] we found that total first-year costs increased from $153.4 million to $172.2 million, an increase of nearly $19 million (12 percent). For the 31 projects, the total prospectus' first year rent was estimated at $58.2 million, but the total awarded first-year rent for these projects equaled $92.7 million as of January 2014, an increase of $34.5 million (59 percent). Such increases in rent have long term implications for VA, because the Department must pay the higher rent over the lifetime of the lease agreement. For example, all 31 VA lease projects included in this cost analysis have lease terms of 20 years, and the increase in rent must be paid for the duration of the contract.

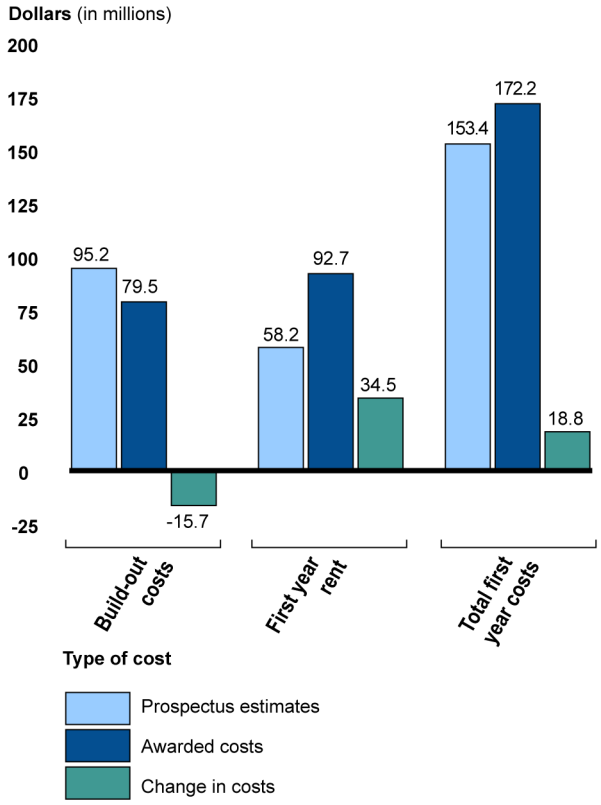
The causes of the total cost increase can be attributed primarily to increases in the projects' awarded first-year rent due to the schedule delays and changes to the design or scope of a project that we discussed previously. Schedule delays can increase costs because of changes in

[23]Of the 41 projects included in our review, 10 projects are not included in our cost analysis. Nine of these projects did not have reported first year rent and build-out costs because the projects have yet to be awarded to a developer. In addition, the Baltimore clinic project is not included in this analysis because its build-out costs were amortized across multiple years rather than included as a lump sum payment for the first year.

the local leasing market during the period of the delay. Therefore, when VA estimates costs as part of the prospectuses submitted to Congress in the annual budget request, an automatic annual escalation is applied to each project to account for rising costs and market forces that make construction and leased space more expensive over time. VA officials said the escalation ensures that the authorized cost of the project is in line with the realities of the real estate and construction markets. As discussed earlier, the average schedule delay for the 41 outpatient clinics we reviewed was approximately 3.3-years per project. Because VA annually adjusts a project's cost by an increase of 4 percent for each year the project is delayed, project delays directly result in cost increases. Additionally, we found that projects we reviewed increased in total size by 203,000 square feet. Changes in a project's size expand the scope of the project, requiring design changes, which can result in schedule delays, further adding to costs. More specifically, the VA outpatient clinic in Austin, Texas, discussed above, increased in size by 36 percent and first year rent and build-out costs increased from $6.2 million to $19.8 million, a total increase of $13.6 million, or 219 percent.

Although first year rents increased for the 31 projects—increasing overall total costs—VA's total build-out costs were lower than reported in the projects' prospectuses. As described in table 3, build-out costs are one-time, lump-sum payments VA makes to developers for special purpose, medically related improvements to buildings when VA accepts the projects as completed. For example, once a building is constructed to provide standard office space, changes to transform the building to a medical clinic, such as providing a nurses' station, would be considered a build-out cost. In the prospectuses, VA estimated that build-out costs for the 31 projects would total $95.2 million, but the total awarded build-out costs totaled $79.5 million as of January 2014, a decrease of $15.7 million (16.5 percent). VA officials said the decrease in build-out costs from those originally estimated in the prospectuses was due to the national downturn in the commercial real estate market starting in 2008. According to VA officials, this created more competition among developers and helped VA realize more competitive pricing on its medical build-out requirements than was anticipated in the prospectuses. Figure 2 provides an overview of first year rent and build-out costs for VA's 31 outpatient clinics with complete cost data. (See app. III for cost information for individual clinic projects.)

Figure 2: Build-Out Costs and First Year Rent and Total First Year Costs for 31 VA Lease Projects, January 2014



Source: GAO analysis of VA data.

Note: Of the 41 projects included in our review, 10 projects are not included in our cost analysis. Nine of the 10 projects did not have reported first year rent and build-out costs because the projects have yet to be awarded to a developer. In addition, the Baltimore clinic project is not included because its build-out costs were amortized across multiple years rather than as a lump sum payment for the first year.

VA Has Taken Some Actions to Improve Its Leasing-Management Practices for Outpatient Clinics; However, Its Guidance Could Be Improved

VA has made some progress in addressing issues with its major medical-facilities leasing program. In 2012, VA formed a high level council, the Construction Review Council, to oversee its capital asset program, including leasing. Based on the findings of the council and our work, VA is planning the following improvements to the major medical facilities leasing program:

- requiring detailed design requirements earlier in the design process to help avoid the delays, scope changes, and cost increases, and
- providing Congress with more complete information on the cost of proposed future lease projects.

However, we also found that while VA has updated and refined some guidance for specific aspects of lease projects—including design guidance for the construction of outpatient clinics—to better support VA's leasing staff and prevent project delays; it has not updated its overall guidance for staff involved in leasing projects.

Creating a Review Council

In April 2012, the Secretary of Veterans Affairs established a Construction Review Council (CRC) to serve as the single point of oversight and performance accountability for the planning, budgeting, execution, and delivery of the VA's real property capital-asset program, including the leasing program.[24] The council issued an internal report in November 2012 that contained findings and recommendations resulting from meetings it held from April 2012 to July 2012. The CRC also held a meeting specifically focused on VA's leasing program in June 2012.[25] The objectives for that meeting were to create an efficient and effective leasing process that would help make projects available to the veteran community more quickly and improve collaboration between leasing-program stakeholders (such as CFM and VHA officials and contractors), thus reducing the risk of projects' experiencing the previously described cost increases and delays. The CRC report, along with GAO's past work

[24]The Council comprised 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.

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

on VA leasing,[26] provided the impetus for many of the actions discussed below.

Requiring More Detailed Design Requirements Earlier in the Process

In part based on CRC findings, VA recognizes that firm design requirements need to be established earlier to help major lease projects avoid delays and cost increases. As part of the review of the leasing program, the CRC reviewed three leasing-project case studies where it found that VA was taking too long to initiate leasing projects after VA had submitted the required prospectus to Congress, and that VA's multiple changes to requirements before or during the acquisition and construction process contributed to delays. As noted earlier in the report, we also found that delays occurred prior to entering into a lease agreement, due in part to changing requirements. To limit the need for making changes to design requirements, VA is moving forward with plans to provide detailed requirements prior to submitting a prospectus to Congress for major construction and lease projects for congressional authorization. During our review in January 2014, VA issued a guidance memorandum directing that beginning with fiscal year 2016, VA would develop more detailed space requirements before a prospectus is submitted to Congress for major construction and major leased projects.[27] According to VA officials, the more detailed requirements should be prepared as part of a business case for each major construction and lease project during the SCIP planning process that occurs before a prospectus is prepared. The business case will be required to include a detailed Space and Equipment Planning System plan documenting space requirements to a more detailed level than previously required. Officials stated that this process should help ensure that the prospectus is supported by more detailed space planning and thus provides more accurate scope and cost information to Congress. We did not evaluate the effectiveness of this new process because it has not been fully implemented.

[26] 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. GAO: *VA Real Property: Realignment Progressing, but Greater Transparency about Future Priorities Is Needed* GAO-11-197, (Washington, D.C., Jan 31, 2011); and GAO, *VA Construction: Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects*, GAO-13-302 (Washington, D.C.: Apr. 4, 2013).

[27] VA, *Additional VHA Guidance to the FY2016 SCIP Call Memo*, (Washington D.C.: Jan. 2, 2014).

Developing a Process for Handling Scope Changes

VA has also taken steps to better manage scope changes to project leases. The CRC's review of the three leasing projects noted that certain changes in requirements, such as to facility size or layout, required additional approvals and notifications, which consequently delayed the signing of the lease. During our review, on August 30, 2013, the Secretary of Veterans Affairs approved a new concept—the Capital Program Requirements Management Process—to better address scope changes to both major-construction and "prospectus-level"[28] lease projects that have been approved through the SCIP process. According to VA officials, this process will help ensure review and approval of any proposed scope changes by the appropriate department officials and will require a systematic review of projects at pre-defined stage-gates, as well as reviews of the effects of any changes to scope, schedule, and cost. We did not evaluate the effectiveness of this new process because it has not been fully implemented.

Providing Congress with More Complete Information on Costs for Proposed Projects

VA provided incomplete information to Congress on the estimate of total costs for proposed future projects as a part of the SCIP Long Range Capital Plan program.[29] VA's 2014 budget submission includes an estimate of total costs for proposed future lease projects for the next 10 years; however, this estimate only provides the first year's annual rent and build-out costs, and not the complete lifecycle costs for these leases. Thus, in the budget submission, VA reported that future leasing costs for more than 221 leasing projects were $779 million[30]—less than the estimated total lifecycle cost of the Myrtle Beach outpatient clinic alone.[31]

[28]"Prospectus level" lease projects are VA-leased projects that require VA to submit a prospectus to Congress and are required to be authorized by Congress.

[29]These estimates are located in the 2014 VA budget submission, page 1-4 in Table 1-1: *VA Estimated Cost of Full SCIP Implementation by Investment Type, by Administration*.

[30]According to VA officials, of the $779 million, $588 million are for 221 new leases and $191 million are for an unspecified amount of future leases planned for the out years of the SCIP long range plan. This $191-million estimate is based on leases that are expiring or new leases needed for those out years to close SCIP gaps or maintain access and capacity to meet workload demand.

[31]In its budget prospectus, VA *does* provide total costs—the estimated annual costs, build-out costs, and lifecycle costs—for each individual leasing project it wants Congress to authorize for the fiscal year. For example, the fiscal year 2014 budget submission, VA reported that the Myrtle Beach, South Carolina, outpatient clinic has an annual rent cost of $3.4 million and build-out cost of $4.6 million, with a total lifecycle cost of $805 million.

Because many of VA's leases are 20 year leases, reporting only one year's rent underestimates the cost considerably. VA officials stated that the lifecycle costs cannot be accurately determined until the leases are closer to being entered into because of potential changes in market conditions and demographic demand that could affect terms of the lease. However, at the time of our review, it was not clear what was included and excluded from the estimate of total costs for proposed future lease projects presented to Congress. In January 2014, VA officials told us they plan to clarify information presented on these leases beginning in the fiscal year 2015 budget submission. VA's 2015 budget submission stated that estimated costs presented are first year annual rent and build-out costs, and do not include future annual rent payments.[32]

Refining and Updating Leasing Guidance

The CRC report recognized the need to improve the guidance for planning and implementing major construction projects. In addition, our past work has documented that insufficient guidance can cause confusion among VA officials and contractors.[33] VA decided to apply this lesson learned to its leasing program and is taking steps to update and refine some of its guidance.

- VA is updating its solicitation for offers, which describes the requirements for the leases.[34] The solicitation for offers is issued during the planning phase. According to CFM officials, these efforts are scheduled to conclude in 2014.
- CFM is updating its design guides, such as its design guide for lease-based outpatient clinics, which is intended to help speed the design process, control cost, and avoid errors and omissions. According to VA officials, design guides are in a continual process of refinement, and new design guides are always being developed.
- VA is implementing more stringent procedures for CFM to validate the representations made by developers as part of their proposals,

[32]VA, *Fiscal Year 2015 Budget Request. IV Construction, Long Range Capital Plan, and Appendix.* (Washington, D.C.: 2014); pp.1.4; 9.2-8, 9.2-9.

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

[34]Subsequently, VA reviews the offers, accepts an offer, and then enters into a lease agreement.

including providing leasing officials with new checklists, having VA officials provide peer reviews, and having leadership clear project documents before awarding leases.

- VA has created standardized project schedules to ensure uniformity in reporting, tracking, and managing projects, in an effort to provide realistic timelines across all leased facilities.

VHA efforts have primarily focused on updating guidance on specific aspects of the leasing process, such as design and offer solicitation, rather than the overall guidance that is used by all headquarters and field staff involved in leasing projects. Although VA has taken steps to improve guidance on specific aspects of the leasing program, it has not made changes to its handbook for planning outpatient clinics. We reviewed VHA's 2004 *Handbook on Planning and Activating Community Based Outpatient Clinics*, which is VHA's overall guidance for leasing outpatient clinics. The *Handbook* is intended to establish consistent planning criteria and standardized expectations.[35] The handbook is widely used by VA officials and provides important guidance, in particular, clarifying the differing responsibilities of officials and departments and the legal authorities of the leasing process. However, this guidance is so out of date that it no longer adequately reflects the roles and responsibilities of the various VA organizations involved in major medical facilities leasing projects.[36] According to VA officials, the close collaboration of these offices is necessary for a successful lease project. The lack of updated guidance can affect coordination among stakeholders, which could contribute to schedule delays and cost increases. Using outdated guidance can lead to miscommunications and errors in the planning and implementing of veterans' leased clinics. Furthermore, the policy, planning criteria, and business plan format were developed based on an old planning methodology[37] that VA no longer uses,[38] thus the guidance does not reflect VA's current process.

[35]VA. *VHA's Handbook 1006.1, Planning and Activating Community-Based Outpatient Clinics*. (Washington, D.C.: May 19, 2004).

[36]The guidance makes no specific reference to Office of Construction and Facilities Management or the Real Property Services, whose officials play an instrumental role in working with VHA to plan and execute the lease agreement.

[37]The Capital Asset Realignment for Enhanced Services' planning methodology.

[38]VA now uses SCIP for its infrastructure planning.

As of November 2013, VHA's leasing program has a long-term liability of $5.5 billion and growing, but its guidance on outpatient clinics is a decade old and no longer relevant. Standards for Internal Control in the Federal Government calls for federal agencies to develop and maintain internal control activities, which include policies and procedures, to enforce management's directives and help ensure that actions are taken to address risks.[39] Such activities are an integral part of an entity's planning, implementing, reviewing, and accountability for stewardship of government resources and achieving effective results.

Conclusions

Similar to VA's largest medical-center construction projects, we found that its major leasing projects have experienced substantial delays as well as cost increases. In looking closer at the leasing program, we found that VA is taking steps toward improving its management of the program; steps that may help address these issues. Most notably, VA's Construction Review Council should improve management of both the construction and leasing program. Furthermore, the improvements VA is planning based on the findings of the council and our work—1) requiring more detailed design requirements, 2) improving the process for handling scope changes, and 3) providing Congress with more complete information—represent a good start. However, these efforts are still in the early stages, and some were undertaken during the course of our review. Thus, the success of those efforts will depend on how quickly and effectively VA implements them. Furthermore, the guidance used by all staff involved in planning and implementing leasing projects is outdated and does not reflect recent organizational changes affecting the way leasing projects are managed. Without current guidance, stakeholders may have difficulty knowing with whom to coordinate, and projects could continue to experience delays and cost increases resulting from late-stage design changes.

Recommendation for Executive Action

To improve the management of VA's leased outpatient-clinic projects, we recommend that the Secretary of Veterans Affairs update VHA's guidance for leasing outpatient clinics to better reflect the roles and responsibilities of all VA staff involved in leasing projects.

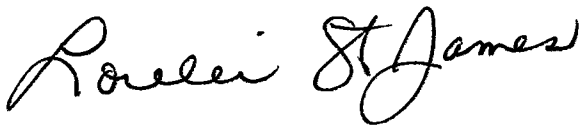
[39]GAO, *Standards for Internal Control in the Federal Government,* AIMD-00-21.3.1 (Washington, D.C.: Nov. 1, 1999).

Agency Comments and Our Evaluation

We provided a draft of this report to VA for review and comment. In its written comments, VA concurred with our recommendation and discussed actions under way to implement it. However, VA cited concerns that the report did not fully reflect the reasons for lease delays. VA noted that many lease delays resulted from influences external to VA's leasing process and out of VA's control. For example, other factors that could cause delays include site selection issues involving the National Environmental Policy Act's requirements, stakeholders' concerns, procurement and lessor issues, solicitation/award protects, and post-award contracting issues. Furthermore, these comments stated that some projects required updates to the space requirements to accommodate improved delivery of care for veterans. VA also noted that as delays to a lease occur, VHA re-evaluates and updates the design and space program to ensure the contemplated lease project will meet VA's latest requirements and optimally serve veterans. We added this information in the section of the report that discussed contributing factors to delays at VA projects. VA suggested a number of technical corrections, which we incorporated as appropriate. VA's letter is reprinted in appendix IV.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the appropriate congressional committees, the Secretary of Veterans Affairs, and other interested parties. In addition, the report will be available at no charge on GAO's website at http://www.gao.gov.

If you or your staff have any questions regarding this report, please contact me at (202) 512-2834 or stjamesl@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix V.



Lorelei St. James
Director
Physical Infrastructure Issues

Appendix I: Scope and Methodology

To determine the extent to which costs and schedules changed for selected Department of Veterans Affairs' (VA) outpatient clinic lease projects, we obtained and analyzed data that VA provided on VA's 41 authorized major outpatient-clinic projects as of January 2014.[1] The data included a short project description, project location, the original and current total estimated cost of the project, and the original and current completion date. We analyzed the current cost and completion dates to determine any increases in costs and the extent to which projects may have exceeded original schedules and summarized the results. We also collected VA information on reasons for cost increases and schedule changes to VA's outpatient-clinic leased projects. We assessed the reliability of the data through interviews with knowledgeable VA officials and a review for completeness and any unexpected values. We determined that the data were sufficiently reliable for the purpose of this report.

To identify factors contributing to cost and schedule changes in VA's leased outpatient-clinic projects, we interviewed VA's headquarters officials regarding the status of all major outpatient clinic lease projects and examined project documents and interviewed on-site managers and engineers. We selected eleven clinic projects in eight locations including (1) Jacksonville, Florida; (2) Baltimore, Maryland; (3) Las Vegas, Nevada (four facilities)[2]; (4) Austin, Texas; (5) McAllen, Texas; (6) Corpus Christi, Texas; (7) Parma, Ohio; and (8) Ft. Wayne, Indiana. We selected these projects and locations based on the following criteria: (1) projects status;

[1]VA provided data for its 82 major lease facility projects; however, for the purpose of this report, we reviewed VA's outpatient clinics since these facilities are leased by VA. In total, 69 of the 82 leasing projects VA provided data for were outpatient clinics; however, 24 of these outpatient clinics were submitted in VA's fiscal year 2014 budget request and have yet to be authorized by Congress. Furthermore, 4 additional outpatient clinic projects were eliminated from our review for the following reasons: (1) Peoria, IL, and Columbus, GA—these facilities were added to VA's budget request as "extra" projects and were not included in VA's official budget submission. As such, a prospectus was never submitted for these projects; (2) Boston, MA—the procurement for this project was canceled due to lack of competition and has not yet been restarted; and (3) Norfolk, VA—this project was not procured. As such, the scope of our review focuses on the 41 ongoing outpatient clinic lease projects already authorized by Congress. The following non-outpatient clinic leases were also excluded from our review: (1) VA's 7 larger health-care centers, which were recently reviewed as part of a VA Office of Inspector General audit; (2) VA's 5 newly leased research center projects; and (3) one community-care center project.

[2] In Las Vegas, Nevada, we visited four clinics that were accepted by VA between September 2011 and January 2012 and interviewed officials from each site.

(2) project costs; (3) scope and cost changes; and (4) schedule delays.[3] We conducted site visits to the projects in Las Vegas (four projects), Baltimore, and Austin based on the status, size, and costs for these projects. For these projects, we talked to officials either on site or by phone discussing the reasons for changes in costs and schedules and possible improvements for VA's leasing program. We obtained specific information for VA's ongoing major outpatient- clinic lease projects as of January 2014. The information from our site visits is illustrative of issues affecting particular sites and should not be used to make generalizations about VA sites agency-wide.

To identify any actions VA has taken to improve its leasing management, and any opportunities that exist for VA to further improve its management of leased projects, we reviewed VA's management practices of leased projects at the 11 locations we selected. We interviewed VA headquarters' officials from the Veterans Health Administration, Office of Construction and Facilities Management, Office of General Counsel, as well as contract specialists and senior resident engineers at the leased sites we visited. We reviewed and analyzed leasing documents, directives, agency policy and guidance, previous VA reports, and interviewed representatives from a project development firm and general contractor construction firm. We also reviewed the Office of Management and Budget's (OMB) *Capital Programming Guide, Supplement to Office of Management and Budget Circular A-11*, VA's *Strategic Plan*, VA Office of Inspector General (OIG), Congressional Budget Office, and GAO's past reports related to federal leasing issues.

We conducted this performance audit from May 2013 to April 2014 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.

[3]We selected projects that were far enough along in the leasing process to have actual or projected scope, cost, and schedule data, which allowed us to identify projects that experienced changes in scope, cost, and schedule.

Appendix II: Changes in Schedule for Department of Veterans Affairs' Major Medical Facility Leases

In January 2014, VA provided us with data for its 41[1] ongoing major outpatient-clinic lease projects.[2] We calculated the "total years changed" column by counting years from the prospectus acceptance date, which was the date first submitted to Congress, to the actual or anticipated acceptance date, as reported by VA. There are no reported data for VA outpatient clinic projects submitted as part of VA's fiscal year 2014 budget submission because these projects have yet to be authorized. Of the outpatient clinic projects reviewed, 39 of 41 (95 percent) experienced schedule delays. Table 4 provides a summary of schedule data for each of VA's 41 major medical facility lease projects.

Table 4: Schedule of VA's 41 Major Outpatient-Clinic Lease Projects as of January 2014

Location	Project description	Date authorized	Prospectus acceptance date	Actual or anticipated acceptance date as of January 2014	Total years changed
Projects experiencing schedule delays					
Jacksonville, FL	Satellite outpatient clinic	11/21/97	July 1999	November 2012	13.25
Greenville, NC	Outpatient clinic	11/30/04	June 2007	November 2013	6.5
Brandon, FL	Outpatient clinic	10/10/08	June 2011	December 2016	5.5

[1]VA provided data for its 82 major lease facility projects; however, for the purpose of this report, we reviewed VA's outpatient clinics since these facilities are leased by VA. In total, 69 of the 82 leasing projects VA provided data for were outpatient clinics; however, 24 of these outpatient clinics were submitted in VA's fiscal year 2014 budget request and have yet to be authorized by Congress. Furthermore, 4 additional outpatient clinic projects were eliminated from our review for the following reasons: (1) Peoria, IL and Columbus, GA – these facilities were added to VA's budget request as "extra" projects and were not included in VA's official budget submission. As such, a prospectus was never submitted for these projects; (2) Boston, MA – The procurement for this project was canceled due to lack of competition and has not yet been restarted; and (3) Norfolk, VA – This project was not procured. As such, the scope of our review focuses on the 41 ongoing outpatient clinic lease projects already authorized by Congress. The following non-outpatient clinic leases were also excluded from our review: (1) VA's 7 larger health care centers which were recently reviewed as part of a VA Office of Inspector General audit; (2) VA's 5 new leased research center projects; and (3) one community care center project.

[2]VA officials define a "major medical lease project" as a facility that meets the following three criteria: (1) lease for space for use as a new medical facility with an average annual rental that exceeds $1 million, (2) at least 75% of space is occupied by VHA staff, and (3) project is fully funded by VHA.

Location	Project description	Date authorized	Prospectus acceptance date	Actual or anticipated acceptance date as of January 2014	Total years changed
Grand Rapids, MI	Satellite outpatient clinic	12/22/06	May 2009	November 2014	5.5
Wilmington, NC	Outpatient clinic	11/30/04	July 2007	December 2012	5.5
Corpus Christi, TX	Outpatient clinic	11/30/04	June 2007	September 2012	5.25
Bakersfield, CA	Outpatient clinic	10/26/09	May 2012	June 2017	5
Toledo, OH	Outpatient clinic	11/30/04	June 2007	June 2012	5
Savannah, GA	Satellite outpatient clinic	10/10/08	June 2011	February 2016	4.75
Crown Point, IN	Outpatient clinic	11/30/04	June 2007	August 2011	4.25
Eugene, OR	Satellite outpatient clinic	10/10/08	June 2011	July 2015	4
Austin, TX	Satellite outpatient clinic	12/22/06	May 2009	February 2013	3.75
San Juan, PR	Mental health clinic	10/13/10	September 2013	June 2017	3.75
Tallahassee, FL	Outpatient clinic	10/26/09	May 2012	March 2016	3.75
Atlanta, GA	Specialty care clinic	10/26/09	May 2012	July 2015	3.25
Birmingham, AL	Annex clinic and parking garage	10/26/09	May 2012	September 2015	3.25
Colorado Springs, CO	Outpatient clinic	10/10/08	June 2011	August 2014	3.25
Huntsville, AL	Outpatient clinic	10/26/09	May 2012	September 2015	3.25
Anderson, SC	Outpatient clinic	10/26/09	May 2012	June 2015	3
Tampa, FL	Primary care annex	10/10/08	June 2011	May 2014	3
Las Vegas, NV Northeast	Satellite outpatient clinic	12/22/06	May 2009	January 2012	2.75
Mesa. AZ (Gilbert)	Satellite outpatient clinic	10/10/08	June 2011	April 2014	2.75
Parma, OH	Satellite outpatient clinic	12/22/06	May 2009	January 2012	2.75
Evansville, IN	Satellite outpatient clinic	12/22/06	May 2009	November 2011	2.5
Las Vegas, NV Northwest	Satellite outpatient clinic	12/22/06	May 2009	December 2011	2.5
Mansfield, OH	Satellite outpatient clinic	10/10/08	June 2011	January 2014	2.5
Rochester, NY	Outpatient clinic	10/5/11	January 2015	June 2017	2.5

Location	Project description	Date authorized	Prospectus acceptance date	Actual or anticipated acceptance date as of January 2014	Total years changed
Mayaguez, PR	Satellite outpatient clinic	10/10/08	June 2011	October 2013	2.25
Las Vegas, NV Southwest	Satellite outpatient clinic	12/22/06	May 2009	September 2011	2.25
Las Vegas, NV Southeast	Satellite outpatient clinic	12/22/06	May 2009	September 2011	2.25
Mobile, AL	Outpatient clinic	10/5/11	January 2015	March 2017	2.25
San Jose, CA	Outpatient clinic	10/5/11	January 2015	March 2017	2.25
Baltimore, MD	Satellite outpatient clinic	12/22/06	June 2009	June 2011	2
Springfield, MO	Community-based outpatient clinic	10/5/11	January 2015	February 2017	2
Green Bay, WI	Outpatient clinic	10/10/08	June 2011	March 2013	1.75
Greenville, SC	Outpatient clinic	10/10/08	June 2011	March 2013	1.75
McAllen, TX	Outpatient clinic	10/26/09	May 2012	August 2013	1.25
South Bend, IN	Outpatient clinic	10/5/11	January 2015	May 2016	1.25
Billings, MT	Satellite outpatient clinic	10/13/10	September 2013	February 2014	.5
Projects experiencing schedule decreases					
Ft. Wayne, IN	Outpatient clinic	10/5/11	January 2015	May 2014	.75
Salem, OR	Community-based outpatient clinic	10/5/11	June 2014	May 2014	0 (1 month)

Source: GAO analysis of VA data.

Appendix III: Changes in Cost for Department of Veterans Affairs' Major Medical Facility Leases

In January 2014, VA provided us with data for its 41[1] ongoing major outpatient-clinic lease projects.[2] Of these 41 projects, 31 projects contained complete cost data.[3] We compared the prospectus cost submitted to Congress for authorization to the total current estimated first year cost for the 31 projects with complete cost data. We found that the costs for these projects increased from $153.4 million to $172.2 million, an increase of nearly $19 million (12 percent). Table 5 provides a summary of cost data for the 31 projects.

Table 5: Cost of VA's 31 Major Outpatient-Clinic Lease Projects as of January 2014

Location	Prospectus rent (first year)	Prospectus build-out cost	Prospectus cost	Awarded rent (first year)	Awarded build-out cost	Total first year rent and build-out	Change in first year cost
Projects experiencing increases to total first year Costs							
Austin, TX	$2,337,500	$3,825,000	$6,162,500	$10,764,098	$9,036,141	$19,800,239	$13,637,739
Jacksonville FL	$1,009,519	$2,085,335	$3,094,854	$4,330,000	$4,690,000	$9,020,000	$5,925,146

[1]VA provided data for its 82 major lease facility projects; however, for the purpose of this report, we reviewed VA's outpatient clinics since these facilities are leased by VA. In total, 69 of the 82 leasing projects VA provided data for were outpatient clinics; however, 24 of these outpatient clinics were submitted in VA's fiscal year 2014 budget request and have yet to be authorized by Congress. Furthermore, 4 additional outpatient clinic projects were eliminated from our review for the following reasons: (1) Peoria, IL and Columbus, GA – these facilities were added to VA's budget request as "extra" projects and were not included in VA's official budget submission. As such, a prospectus was never submitted for these projects; (2) Boston, MA – The procurement for this project was canceled due to lack of competition and has not yet been restarted; and (3) Norfolk, VA – This project was not procured. As such, the scope of our review focuses on the 41 ongoing outpatient clinic lease projects already authorized by Congress. The following non-outpatient clinic leases were also excluded from our review: (1) VA's 7 larger health care centers which were recently reviewed as part of a VA Office of Inspector General audit; (2) VA's 5 new leased research center projects; and (3) one community care center project.

[2]VA officials define a "major medical lease project" as a facility that meets the following three criteria: (1) lease for space for use as a new medical facility with an average annual rental that exceeds $1 million; (2) at least 75% of space is occupied by VHA staff; and (3) project is fully funded by VHA.

[3]Of the 41 projects included in our review, 10 projects are not included in our cost analysis for the following reasons: (1) Nine projects do not have reported first year rent and build-out costs because the projects have yet to be awarded to a developer, and (2) the Baltimore clinic project is not included in this analysis because its build-out costs were amortized across multiple years, rather than including it as a lump sum payment for the first year.

Location	Prospectus rent (first year)	Prospectus build-out cost	Prospectus cost	Awarded rent (first year)	Awarded build-out cost	Total first year rent and build-out	Change in first year cost
Las Vegas, NV[a]	$3,604,000	$4,914,000	$8,518,000	$7,100,000	$4,377,101	$11,477,101	$2,959,101
Green Bay, WI	$2,008,000	$3,883,000	$5,891,000	$5,624,632	$3,050,671	$8,675,303	$2,784,303
Eugene, OR	$2,196,000	$3,630,000	$5,826,000	$4,029,577	$4,571,067	$8,600,644	$2,774,644
Mayaguez, PR	$2,421,000	$3,885,000	$6,306,000	$5,089,216	$3,648,036	$8,737,252	$2,431,252
Greenville, NC	$1,216,000	$2,880,000	$4,096,000	$3,843,391	$2,626,926	$6,470,317	$2,374,317
Grand Rapids, MI	$1,447,600	$2,961,000	$4,408,600	$3,323,035	$3,085,591	$6,408,626	$2,000,026
Greenville, SC	$1,206,000	$2,525,000	$3,731,000	$2,600,439	$3,081,780	$5,682,219	$1,951,219
Atlanta, GA	$2,207,500	$2,964,500	$5,172,000	$3,262,652	$3,348,437	$6,611,089	$1,439,089
Tallahassee, FL	$5,300,000	$7,865,000	$13,165,000	$5,888,423	$8,651,500	$14,539,923	$1,374,923
Toledo, OH	$1,440,000	$2,700,000	$4,140,000	$2,400,670	$3,085,518	$5,486,188	$1,346,188
Crown Point, IN	$800,000	$1,800,000	$2,600,000	$1,719,390	$2,155,500	$3,874,890	$1,274,890
McAllen, TX	$1,600,500	$2,843,500	$4,444,000	$1,983,199	$2,823,776	$4,806,975	$362,975
Parma, OH	$1,702,000	$3,330,000	$5,032,000	$1,954,541	$3,300,000	$5,254,541	$222,541
Projects experiencing decreases to total first year costs							
Wilmington, NC	$1,305,150	$2,796,750	$4,101,900	$3,164,216	$928,384	$4,092,600	-$9,300
Salem, OR	$1,119,320	$1,430,000	$2,549,320	$936,000	$1,430,000	$2,366,000	-$183,320
Mansfield, OH	$700,000	$1,512,000	$2,212,000	$959,894	$740,811	$1,700,705	-$511,295
Birmingham, AL	$3,501,500	$2,777,500	$6,279,000	$3,887,875	$1,357,724	$5,245,599	-$1,033,401
Anderson, SC	$1,622,500	$3,151,500	$4,774,000	$1,898,410	$1,697,608	$3,596,018	-$1,177,982
Corpus Christi, TX	$1,200,000	$2,700,000	$3,900,000	$1,525,504	$1,103,591	$2,629,095	-$1,270,905
Huntsville, AL	$1,745,000	$2,629,000	$4,374,000	$1,904,830	$1,102,325	$3,007,155	-$1,366,845
Mesa. AZ (Gilbert)	$1,806,000	$3,300,000	$5,106,000	$1,957,684	$1,141,383	$3,099,067	-$2,006,933
Evansville, IN	$3,291,600	$5,697,000	$8,988,600	$4,044,552	$2,827,493	$6,872,045	-$2,116,555
Ft. Wayne, IN	$1,359,720	$1,485,000	$2,844,720	$469,224	$239,000	$708,224	-$2,136,496
Tampa, FL	$3,152,000	$5,500,000	$8,652,000	$3,291,645	$1,892,969	$5,184,614	-$3,467,386
Billings, MT	$3,298,400	$3,850,000	$7,148,400	$1,801,356	$1,770,801	$3,572,157	-$3,576,243
Colorado Springs, CO	$3,600,000	$6,300,000	$9,900,000	$2,903,420	$1,780,982	$4,684,402	-$5,215,598
Project Totals	**$58,196,809**	**$95,220,085**	**$153,416,894**	**$92,657,873**	**$79,545,115**	**$172,202,988**	**$18,786,094**

Source: GAO analysis of VA data.

[a]Cost data for the four Las Vegas outpatient clinic projects have been combined in this table; however, these projects remain four separate projects in our review.

Appendix IV: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

April 16, 2014

Ms. Lorelei St. James
Director, Physical Infrastructure Issues
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. St. James:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***"VA REAL PROPERTY: Action Needed to Improve the Leasing of Outpatient Clinics"*** (GAO-14-300). VA concurs with GAO's recommendation to the Department.

VA, however, is concerned that the draft report does not accurately reflect the reasons for lease delays, but rather attributes 94 percent of delays to the planning stages prior to entering into a lease agreement.

Many lease delays resulted from influences external to VA's leasing process and out of VA's control. Such factors include site selection issues involving National Environmental Policy Act requirements, stakeholder concerns, procurement and lessor issues, solicitation/award protests, and post-award contracting issues.

Some projects required updates to the space program to accommodate improved delivery of care to our Veterans. As delays to a lease project occur, VA's Veterans Health Administration re-evaluates and updates the design and space program to ensure the contemplated lease project will meet VA's latest requirements and optimally serve Veterans.

The enclosure specifically addresses GAO's recommendation in the draft report and provides an action plan and technical comments to GAO's draft report. VA appreciates the opportunity to comment on your draft report.

Sincerely,

Jose D. Riojas
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
"VA REAL PROPERTY: Action Needed to Improve the Leasing of Outpatient Clinics"
(GAO-14-300)

GAO Recommendation: To improve the management of VA's leased outpatient clinic projects, we recommend that the Secretary of Veterans Affairs:

Recommendation 1: update VHA guidance for leasing outpatient clinics to better reflect the roles and responsibilities of all VA staff involved in leasing projects.

VA Comment: Concur. The Veterans Health Administration (VHA) updated the VHA Lease Guidebook in fiscal year 2013, and it was published on VHA's Center for Engineering and Occupational Safety and Health's (CEOSH) webpage. This was communicated to the field for coordination and general information. This guidebook addresses the roles and responsibilities of staff involved in leasing projects. Based on the Department of Veterans Affairs (VA) Directive 7815, *Acquisition of Real Property by Lease and by Assignment From GSA*, VHA has created a VHA Lease Handbook, which is in the concurrence process. This handbook also addresses the roles and responsibilities of staff involved in leasing projects. VHA's Office of Capital Asset Management, Engineering, and Support currently anticipate concurrence of this handbook by September 30, 2014.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Lorelei St. James, (202) 512-2834 or stjamesl@gao.gov.

Staff Acknowledgments

In addition to the contact named above, Ed Laughlin, Assistant Director; Nelsie Alcoser; George Depaoli; Raymond Griffith; Amy Rosewarne; and Crystal Wesco made key contributions to this report.