



June 2016

VA REAL PROPERTY

Leasing Can Provide Flexibility to Meet Needs, but VA Should Demonstrate the Benefits

Accessible Version

GAO Highlights

Highlights of [GAO-16-619](#), a report to congressional requesters

Why GAO Did This Study

VA operates the largest health care network in the United States, with over 2,700 health care sites, including hospitals and outpatient facilities. However, many facilities are outdated, and VA estimates that its capital needs will require up to \$63 billion over the next 10 years. In recent years, VA has increasingly leased its facilities, including major medical facilities. These facilities can exceed 200,000 square feet; provide services to veterans such as mental health and other clinical care; are generally built by private developers to meet VA and federal design requirements; and have average annual rent rates in excess of \$1 million. VA must submit proposals to Congress and receive authorizations for major medical facility leases.

GAO was asked to review VA's leasing program. This report examines: (1) the factors that account for VA's decisions to lease major medical facilities; (2) the extent to which VA's cost-estimating process for leasing these facilities reflects best practices; and (3) steps VA has taken to align its lease process to GSA requirements for delegated leasing authority. GAO analyzed agency documents, VA data on major medical facility leases and lease delegation requests to GSA, compared VA's cost-estimating procedures to best practices in GAO's *Cost Guide*, and interviewed VA and GSA officials.

What GAO Recommends

GAO recommends that VA assess the benefits of major medical facility leasing and use the information in VA's annual capital plans. VA concurred with GAO's recommendation, and GAO incorporated VA's technical comments as appropriate.

View [GAO-16-619](#). For more information, contact Rebecca Shea at (202) 512-2834 or shear@gao.gov.

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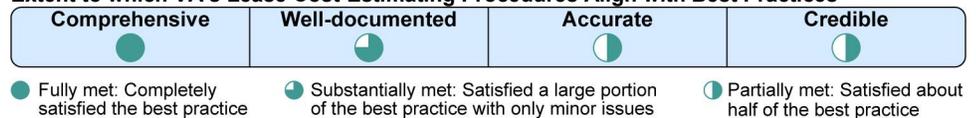
Leasing Can Provide Flexibility to Meet Needs, but VA Should Demonstrate the Benefits

What GAO Found

The Department of Veterans Affairs (VA) leases major medical facilities to benefit from shorter time frames to open a facility and to attain flexibility to relocate. These factors may help VA to meet its needs, such as improving facility compliance with standards and increasing veterans' access to care and services. Unlike owned facilities that can be difficult to dispose of, VA must vacate leased facilities at the end of the lease term, which can allow VA to relocate to space better aligned with its needs. Leases executed under a delegation of authority from the General Services Administration (GSA) can be obligated on an annual basis, whereas owned facilities require full upfront funding that can be difficult to obtain. VA cited flexibility to move as a justification in all 51 of its proposals for these leases since 2015. VA does not, however, assess and provide information to decision makers on how it has benefited from this flexibility. Without transparency on these benefits, VA and congressional decision makers may lack information to understand the need for these leases. GAO and the Office of Management and Budget have reported on the importance of assessing the results of capital decisions in making future decisions.

VA's cost-estimating procedures for major medical facility leases generally align with GAO's 12 cost-estimating best practice steps and recent changes in VA's approach may improve the quality of VA's estimates. GAO's review of cost data for these leases since 2006 found that actual costs often varied more than 15 percent above or below the estimates included in their proposals, often due to project design changes. In 2016, VA introduced a design guide for leased medical facilities that delineates VA and federal requirements, such as security and sustainability standards, that may reduce the risk of project, and thus cost, changes from those included in proposals. VA also initiated a lessons-learned effort to evaluate the factors that contribute to differences between actual lease costs and those included in proposals. The success of these steps will depend on how quickly and effectively VA implements them.

Extent to which VA's Lease Cost-Estimating Procedures Align with Best Practices



Source: GAO analysis of U.S. Department of Veterans Affairs data. | GAO-16-619

VA has made progress meeting GSA's requirements to obtain needed delegations of authority to pursue VA leases by expanding training, implementing a management review process, and working more closely with GSA. According to GSA, VA's requests for delegation of authority now regularly include required documentation, such as justifications for paying above market lease rates. As a result, VA has received delegations of authority in about 21 days, down from 58 days when VA first started to apply for delegations in July 2014. However, it is too early to assess the effectiveness of these steps with VA's prospectus-level leases, executed under GSA's delegated authority, that exceed \$2.85 million in average annual rent. These leases require authorization from GSA's authorizing committees and can be more difficult to align with GSA's requirements.

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CEA cost-effectiveness analysis

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G-REX	GSA Real Estate Exchange
GSA	General Services Administration
OMB	Office of Management and Budget
SAT	SCIP Automated Tool
SCIP	Strategic Capital Investment Planning
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



June 28, 2016

Congressional Requesters

The Department of Veterans Affairs (VA) operates the largest health care network in the United States through the Veterans Health Administration (VHA), with over 2,700 health care sites, including hospitals and outpatient facilities. However, much of VHA's infrastructure was designed and built decades ago under an older concept of health care delivery focused on hospital-centered, inpatient care, and VA has estimated that up to \$63 billion is needed over the next 10 years to address its capital needs. To help meet the changing needs of the veteran population, particularly greater demand for outpatient care, VA has increasingly leased space for its medical facilities. From 2005 to 2015, the number of VA's leased medical facilities grew by 80 percent to 1,246 facilities and included 57 major medical facility leases—i.e., a leased, new medical facility with an average annual rent in excess of \$1 million.¹ These facilities operate as large, outpatient facilities generally built by the lessor to VA's specifications. Congress passed the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act) that authorized 27 additional major medical facilities.² Since 2014, VA has pursued delegations of leasing authority on a lease-by-lease basis from the General Services Administration (GSA), which requires VA to complete additional steps to execute its leases.³

¹38 U.S.C. § 8104(a)(3)(B). VA considers major medical facility leases as those with unserviced rent costs of more than \$1 million. Unserved rent includes base or shell rent, real estate taxes and insurance, and excludes all operating expenses and utilities. VA must submit a prospectus to certain congressional committees for all major medical-facility leases. 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 submits its prospectuses as part of its annual budget submission.

²Pub. L. No. 113-146, § 601 (2014).

³40 U.S.C. § 121(d). According to VA officials, major medical facility leases must be authorized by VA's congressional oversight committees, then as part of a delegation, be approved by GSA's authorizing committees if the leases are over GSA's threshold for congressional approval (\$2.85 million).

We and others have raised concerns about VA's leasing and construction activities. In January 2011, we found that VA's capital-planning process lacked transparency about its long-term costs, and VA has implemented our recommendation to provide that information annually to Congress. In April 2013, we found that schedules were delayed and costs increased for several major VA construction projects, and VA implemented our recommendation to improve guidance related to its construction process. In March 2014, the VA's Office of Inspector General raised concerns about VA's decision to lease a major medical facility in Butler, Pennsylvania, rather than construct a federally-owned facility. In April 2014, we reported that schedules were delayed and that costs increased for the majority of VA's major medical facility lease projects that we reviewed. To address the factors contributing to this situation and help VA better manage its leasing projects, we recommended that VA update its leasing guidance.⁴ In 2015, management of federal real property remained on our high-risk list, in part due to concerns that some federal agencies rely on leasing when ownership may be more cost effective over the long term, due to various reasons such as lack of funding for ownership.⁵

Because of VA's increasing reliance on leasing to provide health care services, you asked us to review how VA plans its lease projects. This report examines: (1) the factors that account for VA's decisions to lease major medical facilities; (2) the extent to which VA's cost-estimating process for leasing these facilities reflects best practices; and (3) any steps VA has taken to align its leasing process to the conditions and requirements of GSA's delegated leasing authority.

To examine the factors that account for VA's decisions to lease major medical facilities, we reviewed VA guidance and other documentation on VA's Strategic Capital Investment Planning (SCIP) process, including descriptions of the process provided in budget submissions, as well as prospectuses for the 51 major medical facilities submitted to Congress since fiscal year 2015. In addition, we reviewed prior GAO reports, Office

⁴GAO, *VA Real Property: Action Needed to Improve the Leasing of Outpatient Clinics*, [GAO-14-300](#) (Washington, D.C.: April 30, 2014). This recommendation had not been implemented at the time of our review.

⁵GAO, *High-Risk Series: An Update*, [GAO-15-290](#) (Washington, D.C.: Feb. 11, 2015).

of Management and Budget guidance pertaining to capital planning, and relevant legislation pertaining to VA's leasing activities. We interviewed VA officials from VHA, the Office of Management, and the Office of Construction and Facilities Management.

To evaluate the extent to which VA's cost-estimating process for leasing these facilities reflects best practices, we analyzed documentation about the cost-estimating process, including the SCIP process and other tasks related to cost estimating as well as the internal tools used to facilitate the process, and interviewed VA officials about the process. We also analyzed data on VA's 23 major medical facility leases authorized from fiscal year 2006 through fiscal year 2015 and completed by the end of fiscal year 2015 to find the extent to which actual lease costs varied from estimated budget prospectus costs and why. We evaluated the reliability of these lease data by comparing them to source data included in lease contracts, budget prospectuses, and other documentation provided by VA that was related to these leases, and determined they were reliable for our purposes. In addition, we reviewed the extent to which market appraisals for these properties influenced lease rates by reviewing the market appraisals and interviewing VA officials on the processes for incorporating market surveys and appraisals into the lease cost-estimating and cost-determination processes.

To describe the steps VA has taken to align its leasing process to the conditions and requirements of GSA's delegated leasing authority, we reviewed GSA and VA documentation related to the lease delegation process, including GSA guidance for agencies seeking delegation of leasing authority and a March 2015 VA-GSA memorandum of understanding describing the roles and responsibilities of GSA and VA in the lease delegation process. Further, we reviewed summary data from GSA and VA showing the status of VA requests for delegations of authority since July 2014, when VA started seeking delegations of leasing authority from GSA on a lease-by-lease basis. We assessed VA documentation on how this data was gathered and interviewed VA officials about how the data was maintained, and concluded that the data were reliable for our purposes. We also interviewed GSA and VA officials about the challenges VA has experienced meeting GSA's conditions of delegated leasing authority and any steps VA has taken to address those challenges.

We conducted this performance audit from June 2015 to June 2016 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 owned by the federal government and outpatient care in both federally-owned and leased facilities.⁶ Outpatient facilities vary in size, from under 20,000 square feet to more than 200,000 square feet, and include minor leases that cost under \$1 million in annual rent and major leases that cost over \$1 million in annual rent. VA generally uses build-to-suit lease agreements for its major leases, whereby a developer constructs a facility to VA's design specifications and leases it to VA, generally for a 20-year term.⁷ VA's use of GSA's delegated leasing authority requires that VA's lease terms not exceed 20 years.⁸

In 2015, VA had 1,951 leases, of which 1,246 were leased medical space, including 57 major medical facilities. Leased medical space generally consists of outpatient facilities, but also includes mental health clinics, readjustment-counseling centers, research, and other types of clinical spaces. See table 1 for the numbers of VA's operational leased facilities, including major medical leases, by year from fiscal years 2005 through 2015.

⁶VA provided services at 1,459 federally-owned medical space facilities and 4,801 federally-owned non-medical facilities, as of March 2016. Non-medical space generally consists of administrative, warehouse, data center, parking, and regional office leases.

⁷According to VA, use of existing space for major medical facility leases typically involves substantial demolition or renovation to meet VA's requirements.

⁸GSA may execute leases for terms of up to 20 years. 40 U.S.C. § 585(a)(2).

Table 1: VA’s Operational Leased Medical Facilities, by Lease Type and Year, Fiscal Years 2005 through 2015

	2005	2006	2007	2008	2009 ^a	2010	2011	2012	2013	2014	2015
Medical Facilities (Minor Leases)	653	684	734	790	914	1,009	1,079	1,157	1,150	1,169	1,189
Medical Facilities (Major Leases)	36	37	36	39	17	21	28	36	42	55	57
Total	689	721	770	829	931	1,030	1,107	1,193	1,192	1,224	1,246

Source: VA data. | GAO-16-619

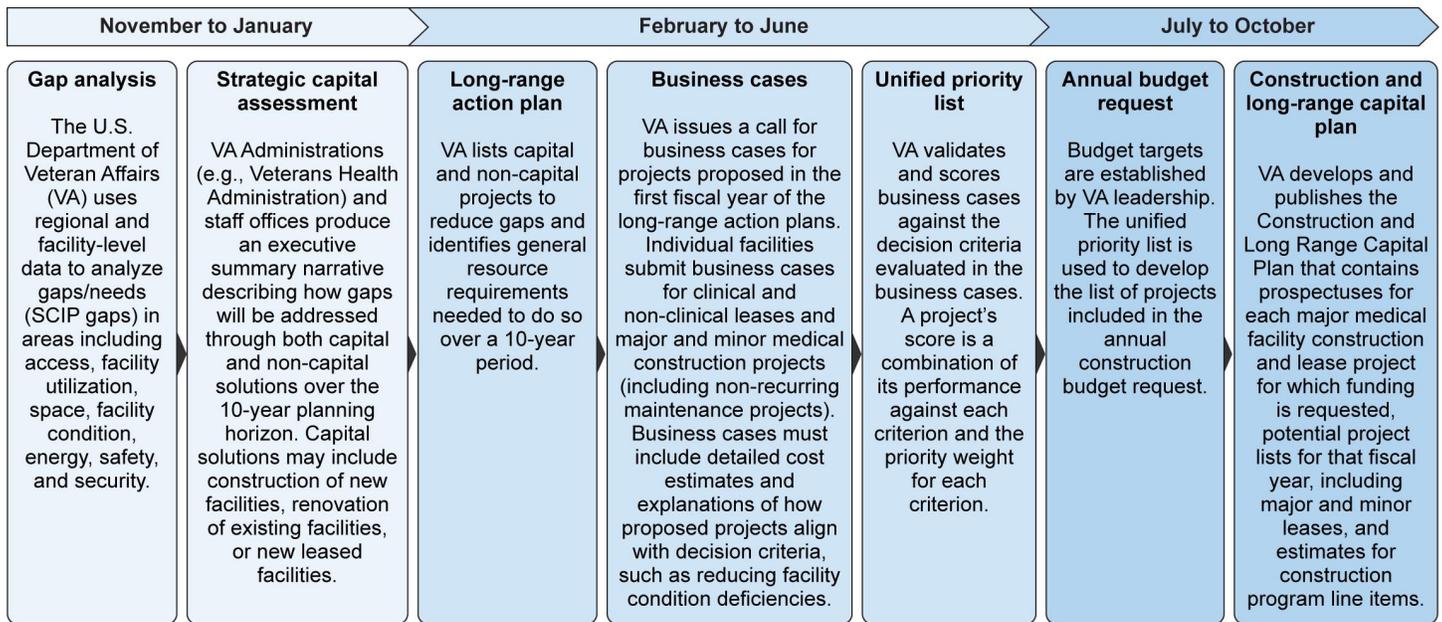
^aIn 2008, the average annual rent amount for major medical facility leases was increased from \$600,000 to \$1 million. Pub. L. No. 110-387, § 705 (2008). For leases subject to GSA’s lease requirements, the annual rent threshold, currently at \$2.85 million, may be adjusted annually. 40 U.S.C. § 3307.

VA established its Strategic Capital Investment Planning (SCIP) process for assessing and identifying capital needs, starting with those included in its fiscal year 2012 budget submission.⁹ Figure 1 describes the steps in this process, which starts each fiscal year with VA’s assessment of its needs, based on gaps in areas such as providing care to veteran populations and existing facility conditions, and concludes with the identification of capital projects to propose to Congress in VA’s annual budget submission and a long-range capital plan that identifies VA’s capital needs over a 10-year horizon. As of fiscal year 2017, VA estimated that \$52 billion to \$63 billion would be required over the next 10 years to close gaps identified in VA’s long-range capital plan.¹⁰

⁹In January 2011, we found that the SCIP process reflected several leading practices in capital planning. See, GAO, *VA Real Property: Realignment Progressing, but Greater Transparency about Future Priorities Is Needed*, [GAO-11-197](#) (Washington, D.C.: Jan. 31, 2011).

¹⁰This figure includes activation costs, which include furniture, equipment, training, and other expenditures required to open a facility for use.

Figure 1: Components of the Department of Veterans Affairs' (VA) Annual Strategic Capital Investment-Planning Process



Source: GAO analysis of VA information. | GAO-16-619

VA submits a proposal, known as a prospectus, to certain congressional committees for major medical facility leases. A prospectus should include information on a project's size and location, and a detailed estimate of the total costs of the medical facility to be leased.¹¹ Alternatively, as part of its leasing process, VA decides whether to obtain a delegation of authority from the General Services Administration (GSA) in order to award and execute certain leases. According to VA officials, VA does not have authority to enter into multi-year leases or to obligate funds on a year-to-year basis. Consequently, according to VA officials, currently VA applies to GSA for delegations of leasing authority to execute all its leases, which, if approved, enable VA to enter into leases consistent with GSA conditions and obligate funding on a year-to-year basis.¹² Leases executed under GSA's leasing authority that exceed the prospectus

¹¹38 U.S.C. § 8104(b).

¹²40 U.S.C. § 585(a)(2).

threshold of \$2.85 million require GSA to obtain approval from GSA's authorizing committees.¹³

Both GSA's lease delegation process and VA's use of it have changed in recent years. In September 2007, we found that GSA's lease delegation process lacked basic management controls, such as current written policies and procedures, and made recommendations to address these deficiencies that GSA concurred with.¹⁴ In November 2007, GSA issued new guidance to clarify the responsibilities of agencies seeking delegations of authority.¹⁵ In 2013, GSA started using a new system—the GSA Real Estate Exchange (G-REX) system—to review and process applications for delegations of leasing authority, and in 2014, VA started applying for delegation of leasing authority through this system on a lease-by-lease basis. GSA's review process includes oversight of agencies' compliance or adherence with conditions and requirements set forth in federal regulations or guidance, such as adherence to guidance from the Office of Management and Budget (OMB) on scoring of capital and operating leases.¹⁶ According to GSA officials, GSA has only granted delegations of leasing authority to VA for operating leases. In 2015, according to GSA, VA applied for 449 delegations of authority, second only to the U.S. Department of Agriculture.

In 2009, we issued the *GAO's Cost Estimating and Assessment Guide (Cost Guide)*,¹⁷ to assist federal agencies in developing reliable cost

¹³40 U.S.C. § 3307.

¹⁴GAO, *General Services Administration: Improvements Needed in Managing Delegated Authority of Real Property Activities*. [GAO-07-1000](#) (Washington, D.C.: Sept. 5, 2007).

¹⁵See FMR Bulletin C-2. In 2014, FMR Bulletin C-2 replaced FMR Bulletin B-1.

¹⁶Under the budget-scoring rules, to be considered an operating lease, all of the following criteria must be met: (1) ownership of the asset remains with the lessor during the term of the lease and is not transferred to the government at, or shortly after, the end of the lease period; (2) the lease does not contain a bargain-price purchase option; (3) the lease term does not exceed 75 percent of the estimated economic life of the asset; (4) the present value of the minimum lease payments over the life of the lease does not exceed 90 percent of the fair market value of the asset at the inception of the lease; (5) the asset is a general-purpose asset rather than being for a special purpose of the government and is not built to the unique specification of the government as lessee; and (6) there is a private-sector market for the asset. *OMB Circular A-11*.

¹⁷GAO, *GAO Cost Estimating and Assessment Guide: Best Practices for Developing and Managing Capital Program Costs*, [GAO-09-3SP](#) (Washington, D.C.: March 2, 2009).

estimates and also as a tool for evaluating existing cost-estimating procedures. To develop the *Cost Guide*, GAO cost experts assessed measures applied by cost-estimating organizations throughout the federal government and industry, and considered best practices for the development of reliable cost estimates. While the *Cost Guide* has a focus on developing cost estimates in the context of government acquisition programs, it outlines best practice steps that are generally applicable to cost estimation in a variety of circumstances. For example, an agency's cost-estimating procedures can be assessed to determine whether they are likely to produce reliable cost estimates. The *Cost Guide* identifies 12 best practice steps that, when performed correctly, should produce reliable cost estimates and can be used to determine whether an agency's procedures meet the four characteristics of a reliable cost estimate. (See appendix I for more information on the 12 cost-estimating best practice steps and how they support the four characteristics). According to the *Cost Guide*'s four characteristics, a reliable cost estimate is:

- comprehensive when it accounts for all possible costs associated with a project, is structured in sufficient detail to ensure that costs are neither omitted nor double-counted, and the estimating teams' composition is commensurate with the assignment;
- well-documented when supporting documentation is accompanied by a narrative explaining the process, sources, and methods used to create the estimate, and contains the underlying data used to develop the estimate;
- accurate when it is not overly conservative or too optimistic and is based on an assessment of the costs most likely to be incurred; and
- credible when it has been cross-checked with independent cost estimates, the level of confidence associated with the point estimate—the best guess at the cost estimate given the underlying data—has been identified, and a sensitivity analysis has been conducted—that is, the project has examined the effect of changing one assumption related to each project activity while holding all other variables constant in order to identify which variable most affects the cost estimate.

VA Justifies Leasing to Open Facilities More Quickly and to Obtain Flexibility to Relocate, but Does Not Demonstrate the Benefits of This Flexibility

For each new major project proposed to address SCIP gaps, VA requires an alternatives analysis for contracting out to non-VA providers, new lease, renovation, and new construction options, but VA's preferred option is often to lease new major medical facilities due to generally shorter project timeframes and flexibility to relocate.¹⁸ VA scores and prioritizes all proposed projects using six major-decision criteria (see table 2). These criteria focus on addressing needs that can demand quick solutions, such as the need to replace an expiring lease that cannot be renewed, and that often change, such as demands for veteran access to care options.¹⁹ As such, according to VA officials, leasing is often VA's preferred alternative for major medical facilities because it can have shorter project implementation times than if VA were to construct a government-owned facility and can provide flexibility to relocate in the future to meet changes in VA's needs.

Table 2: 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.

¹⁸VA officials told us that although contracting out services to non-VA providers is evaluated as an alternative to addressing SCIP gaps, it is often not considered a viable alternative to major medical facility leases. In particular, the officials noted that VA generally determines that non-VA providers would not be able to address the larger scope of SCIP gaps that VA is seeking to close with these major medical facility leases.

¹⁹According to VA officials, the weightings of the SCIP decision criteria are subject to change based on annual evaluations of department-wide priorities. Each criterion also includes several sub-criteria.

Decision Criterion	Priority Weight	Description
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-16-619

We found that VA cited a shorter project timeframe and flexibility to relocate in all 51 of its prospectuses for major medical facility leases submitted to Congress since fiscal year 2015, and that these leases may help address changing and near-term needs. For example, in its fiscal year 2014 submission, VA proposed a new lease to replace an expiring lease in Chattanooga, Tennessee, that would address gaps in federal seismic and accessibility standards, and provide additional space to address projected growth in veteran demand in the area. According to VA, new construction was not preferred because land acquisition would be required, which would extend the project's implementation timeframe and would not provide flexibility to move in the future should VA's needs change again. In the fiscal year 2015 submission, VA proposed a new lease in Johnson County, Kansas, to support its finding of growing demand and overcrowding at the Kansas City Veterans Medical Center, and reduce the drive time for a high concentration of veterans in the area to within VA's 30-minute drive time target.²⁰ For this proposed lease, VA similarly cited flexibility to relocate in the future and shorter implementation timeframes for preferring a lease to new construction.

We also found that VA generally identified leasing as the lowest-cost alternative, but in some cases preferred leasing when other options may have been less costly in order to attain flexibility to relocate in the future and benefit from potentially shorter project timeframes. While VA considers costs when deciding among alternatives, project cost has lower weight among VA's decision criteria than other criteria, such as increasing veteran access. For example, in fiscal year 2015, VA proposed a new lease in Lafayette, Louisiana, to replace a facility that it had determined was too small and estimated a leased space would have a total life-cycle cost of approximately \$259 million, compared to \$201 million for construction of a new government-owned facility.²¹ According to VA, a

²⁰According to VA officials, the department is currently reassessing its goals for veterans' driving time to VA healthcare facilities in response the Choice Act.

²¹VA estimated total lifecycle costs in discounted dollars.

federally-owned facility would require a longer timeframe 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 with major medical facility projects compared to construction. Specifically, as previously discussed, VA's use of GSA delegated leasing authority requires that VA's lease terms not exceed 20 years, and thus VA must vacate a space acquired with this authority at the end of a lease term. This can allow VA to relocate to facilities more aligned with changes in VA's 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, including VA, properties due to issues such as competing stakeholder interests.²² In December 2012, we reported that VA faced challenges renovating its aging properties due to structural limitations, such as floor-to-floor heights and column spacing.²³ Further, construction of a federally-owned facility requires a full upfront funding commitment that can be difficult to attain in the current budgetary environment. In March 2014, we reported federal agencies, including VA, experienced challenges receiving the full upfront project funding for federal real property projects.²⁴ 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. In April 2013, we also identified problems, including

²²GAO has previously identified challenges with disposal of federal property, including VA property. 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).

²³GAO, *Federal Real Property: Improved Data Needed to Strategically Manage Historic Buildings, Address Multiple Challenges*, [GAO-13-35](#) (Washington, D.C.: Dec. 11, 2012).

²⁴GAO, *Capital Financing: Alternative Approaches to Budgeting for Federal Real Property*, [GAO-14-239](#) (Washington, D.C.: March 12, 2014).

delays and cost overruns, in VA's construction of major medical facilities.²⁵

Although VA justifies 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 does not provide 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, we found that 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 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 facility leases, such as how far VA has moved and why it has moved to new leased locations. In September 2015, a private consulting firm also found that VA did not sufficiently track leases requiring renewal or replacement, potentially requiring costly lease extensions.²⁶ 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.²⁷ 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.

²⁵GAO, *VA Construction: Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects*. [GAO-13-302](#) (Washington, D.C.: April 4, 2013). GAO is currently conducting another review of VA's major medical facility construction efforts.

²⁶McKinsey & Company, Assessment K (Facilities), At the Request of: Veterans Access, Choice, and Accountability Act of 2014, Section 201: Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs. (Washington, D.C., September 1, 2015). In 2015 we also found that the cost of lease extensions was difficult to estimate but they may carry higher rental rates due to their shorter terms. See GAO, *Federal Real Property: Performance Goals and Targets Needed to Help Stem GSA's Reliance on Lease Extensions and Holdovers*, [GAO-15-741](#) (Washington, D.C., Sept. 30, 2015).

²⁷GAO, *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).

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 may have a lower cost. As of March 2016, according to VA, 24 major medical facility leases proposed since fiscal year 2015 were yet to be authorized.

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 facility leases generally align with 9 of our 12 cost-estimating best practice steps and recent changes may improve the quality of VA's cost-estimating process for these leases. 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. VA's overall process incorporates some best practice steps for each of the four characteristics. Specifically, we found that VA's major medical lease cost-estimating procedures fully met the comprehensive characteristic, substantially met the well-documented characteristic, and partially met the accurate and credible characteristics.²⁸ (See figure 2.) Because VA's cost-estimating procedures do not fully incorporate relevant best practices for developing comprehensive, well-documented, accurate, and credible estimates, the cost estimates it produces may be unreliable. Appendix I summarizes our detailed assessment of VA's procedures.

²⁸Our review found that some of these ratings were different for government construction projects, due to the different types of inputs required to estimate construction-project costs than to prepare the prospectus estimate for operating leases for facilities built by the private sector.

Figure 2: Cost-Estimating Best Practice Steps Aligned with Characteristics of High-Quality Estimates

Characteristic	Best practices	Assessment
Comprehensive	Develop estimating plan	Fully met
	Determine estimating structure	Fully met
Well-documented	Define estimate's purpose	Fully 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
	Update estimate to reflect actual costs and changes	Partially met
Credible	Develop point estimate and compare to an independent cost estimate	Substantially 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

Source: GAO analysis of U.S. Department of Veterans Affairs data. | GAO-16-619

Partially met: Satisfied about half of the best practice

Minimally met: Satisfied a small portion of the best practice

Our conclusion that VA's cost-estimating process partially met the characteristics for producing reliable cost estimates is based on the following observations from our analysis of VA documentation and interviews with VA officials:

- Comprehensive:** VA's cost-estimating process fully met the comprehensive characteristic because the procedures incorporate the elements of the two associated best practice steps. The procedures include the best practice step of developing an estimating plan. For example, VA's procedures outline the timeline for developing, submitting, and reviewing the estimate, as well as who has responsibility for the various aspects of estimate development. VA's procedures also include the best practice step of determining the estimating structure. For example, the estimate's inputs are clearly defined, and VA provides detailed guidance to staff on the steps required to estimate those inputs.
- Well-documented:** VA's cost-estimating process substantially met the well-documented characteristic because the procedures incorporate a large number of related best practice steps. Although VA's procedures fully include tasks related to the underlying best practice steps of defining the estimate's purpose, defining the program's characteristics, documenting the estimate, and presenting the estimate for approval, the procedures substantially met the tasks related to obtaining the data and identifying ground rules and assumptions. For example, the need to fill previously identified gaps in

service to veterans defines the purpose of an estimate. The program characteristics are defined during the development of an action plan to design a facility to address those identified needs. The organization-wide system used to develop business plans for major medical facility leases requires documentation of the sources for lease estimates. Last, the same system used to develop business plans for major medical facility leases is the system through which management accesses all the data on these potential leases for review. However, while staff obtain required data internally from VA and external trusted proprietary sources, the data are not uniformly normalized, which can lead to unintended errors in the estimate. For example, five leases' awarded data was recorded at the fully serviced instead of unserviced rent rates. This could lead to unintended errors in the estimate. In April 2014 we found that changes to the underlying design assumptions for major medical facility lease projects commonly cause variation in VA's actual first-year lease costs from estimated, prospectus first-year lease costs.²⁹ We have previously found that better development of assumptions and ground rules can improve cost-estimating procedures.

- **Accurate:** VA's cost-estimating process partially met the accurate characteristic because the procedures incorporate some elements of the two associated best practice steps. The procedures include the best practice step of developing the point estimate and comparing it to an independent estimate, which is based on the market rental rate determined by the market survey conducted during the SCIP process and the cost of specific improvements required for VA's intended medical purposes.³⁰ VA applies several standard and variable adjustments to the derived market rate to determine the rental portion of the estimated first-year lease cost to include in its prospectus to Congress. Table 3 below describes the adjustments that VA makes to the market rates it identifies. Although we did not assess these adjustments and how they compare to the private sector, a 2015 independent assessment of VA's capital planning process found that unique design requirements and limited locations for where VA wants

²⁹[GAO-14-300](#).

³⁰VA estimates its rent costs during the SCIP process by surveying market rates in a 5- to 10-mile radius of where it plans to lease a facility.

to lease a facility likely contribute to VA's lease rates exceeding those of private sector medical facilities.³¹

Table 3: VA Adjustments to Market 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.
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-16-619

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 facility lease cost estimates,³² obtaining an independent cost estimate for these inputs would likely yield little new information; the rating for this best practice step is 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

³¹McKinsey & Company, Inc., Assessment K (Facilities), September 1, 2015.

³²We did not review the suitability of the standard and variable adjustments VA applies.

more than 10 percent above the prospectus estimated cost.³³ If so, VA must notify certain congressional committees and provide an explanation for the increase in authorized costs.³⁴ Leases executed under a GSA delegation must follow certain requirements for GSA leases.

After leases are executed VA does not go back and update the estimate with actual costs. Updating the estimate with actual costs is an identified best practice step because it enables a “lessons learned” analysis, which can strengthen estimates going forward. According to VA officials, the agency plans to conduct a “lessons learned” study, as discussed later, to further understand how actual lease costs compare to estimated costs, which could improve the accuracy of its cost estimates.

- **Credible:** VA’s cost-estimating process partially met the credible characteristic because the procedures incorporate some elements of the three associated best practice steps. The best practice steps of conducting sensitivity and risk analyses on the estimate are not directly included in the 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 rate³⁵ to adjust for increases in market rental rate and inflationary increases in the cost for tenant improvements over time,³⁶ 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

³³To calculate whether actual costs may rise more than 10 percent above the prospectus estimated cost, a portion of 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 increased by 10 percent and compared to the awarded lease rate to determine if congressional approval is necessary.

³⁴38 U.S.C. § 8104(c).

³⁵Through 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.

³⁶The escalation rate is applied to estimate costs every fiscal year from prospectus authorization through facility acceptance.

account for variation in lease costs. Specifically, our review of cost data provided by VA for 18 of the 23³⁷ 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 its adjusted estimates.³⁸ For example, actual first-year lease costs increased about 26 percent over the adjusted estimate for VA's San Francisco, California, medical facility lease and decreased about 44 percent for its Montgomery, Alabama, facility. Regarding risk analysis, VA does not perform risk analysis on variables affecting the first-year lease cost estimate. The current cost-estimating process does, however, account for some previously determined risks during the action plan development phase. Conducting risk analyses is a best practice because it reveals the effects particular risks can have on the cost estimate.

VA recently made a change intended 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. First, VA issued a new standard design guide in January 2016 covering the different types of outpatient clinic facilities and providing 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 after prospectus submission may enable VA to better estimate facility costs because, again, we have found that facility design is a main driver of facility costs. VA officials said that annually VA staff update underlying

³⁷Five 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.

³⁸"Escalated 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.

assumptions in the various major medical facility project cost estimating tools and disseminate updates to field staff to use when developing action plans. This includes basic parameters for lease cost estimating, such as build-out cost per net usable square foot and annual lease rate. Second, VA plans to implement a change to its cost-estimating procedures to improve the process over time. In particular, VA officials told us that the department is planning a “lessons learned” review that would involve updating data used for planning major medical facility leases with actual cost data after the facility is accepted. The intention, the officials added, is to compare actual data with assumptions and estimates to improve the cost-estimation procedures over time. This type of review can improve the cost-estimating process 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. Both of these steps are in the early stages, and their success will depend on how quickly and successfully VA implements them.

VA Has Made Progress Meeting GSA’s Requirements for Delegated-Leasing Authority

In July 2014, VA started requesting delegations of leasing authority on a lease-by-lease basis from GSA to pursue its major medical facility and other leases, and initially experienced challenges meeting GSA’s conditions in order to receive these delegations of authority. VA has taken steps to address these challenges, including developing a management review process for all applications to GSA for delegations of leasing authority, but it is too early to assess the effectiveness of these steps in helping VA to pursue all types of major medical facility leases. In particular, GSA’s process for providing delegations of authority to VA requires that leases be planned according to OMB criteria in order to be considered “operating” leases, which, among other things, requires that the net present value of the proposed lease not exceed 90 percent of the fair market value of the planned facility.³⁹ This can be challenging with VA’s more costly major medical facility leases given that they must both meet VA’s needs and future needs of the lessor after VA’s lease term ends, as discussed later.

³⁹See OMB Circular A-11. To be considered an operating lease, the present value of the minimum lease payments over the life of the lease does not exceed 90 percent of the fair market value of the asset at the inception of the lease.

Although GSA's system for processing these applications, known as G-REX, does not maintain records of how many applications did not initially meet GSA's requirements or why, GSA and VA officials told us that prior to its current practices, VA's applications in G-REX frequently lacked required information, such as floodplain maps or a justification for why VA would be paying above market rates. Consequently, according to VA, these applications often required multiple corrections and took on average 58 days before GSA approved them and provided delegations of authority. VA officials told us that 58 days was too long and added unacceptable delays to their desired timetables for opening leased facilities. In response, VA took the following three main steps, partly in coordination with GSA, to better align its application process with GSA's requirements.⁴⁰

1. VA expanded training of its contracting officers to ensure that they were informed about GSA's requirements for completing requests for delegations of authority. As part of this effort, VA disseminated new guidance to its contracting officers for completing these requests and held training sessions, sometimes with GSA officials.
2. VA implemented an internal management review process, whereby VA officials would review draft applications for delegation of authority prior to submitting them to GSA. As part of this effort, VA developed a lease delegation tracking system for contracting officers to send lease delegation applications to VA management for review and to track the status of the applications once they have been submitted to GSA. According to VA officials, this tracking and reporting system assists in the management of the lease delegation process to ensure compliance to OMB, VA, and GSA requirements from planning through execution.
3. VA increased coordination with GSA, including a weekly GSA-VA meeting to discuss the status of, including any issues with, pending applications.

In addition to these steps, in March 2015, VA and GSA entered into a memorandum of understanding governing the request and approval of

⁴⁰Two of VA's 572 applications for delegation of leasing authority between July 2014 and January 2016 were denied. GSA and VA officials told us that these 2 applications were denied because GSA was able to identify existing GSA-held property for VA to use instead of leasing new non-federal space.

delegations of leasing authority to VA. As part of the memorandum, GSA agreed that if VA's applications met GSA requirements, GSA would aim to provide delegations of leasing authority to VA within 30 days for applications not requiring the signature of the GSA administrator (generally those below prospectus level) and within 45 days for those requiring administrator approval.⁴¹ According to VA officials, VA uses its lease delegation tracking system to help monitor progress toward achieving those 30-day and 45-day goals. According to VA's summary data on lease delegation status, the average processing time for VA's delegation requests fell from 58 days between July 2014 and February 2015 to 21 days between February 2015 and February 2016.⁴² According to GSA officials, VA's applications have not had any significant problems meeting GSA's submission requirements since VA implemented the steps above, and regularly include required documentation, such as justifications for paying above market lease rates. GSA officials noted that other agencies that apply for GSA delegated authority may have fewer challenges meeting GSA's requirements if they took similar steps as those taken by VA.

While VA has made progress meeting GSA's requirements to receive delegations of leasing authority, only 6 of VA's 572 applications for delegation of leasing authority between July 2014 and January 2016 were above GSA's current prospectus threshold of \$2.85 million in average annual rent. According to VA officials, GSA's prospectus-level projects can be more difficult to plan as operating leases given their cost and complexity. For example, a lessor has to be willing to lease the facility, often constructed to meet certain VA specifications, to VA for, at most, 90 percent of the fair market value of the facility. Further, while a facility must be configured to meet VA's needs during the lease term, it must also have a potential use for the lessor beyond VA's lease term. VA officials added that they had worked with OMB and GSA to develop a methodology for ensuring that these leases would meet those requirements. According to GSA, this new methodology includes a revision of VA's methods for calculating fair market value and scoring

⁴¹According to GSA officials, these time frames are standard time frames used by the agency for providing delegations of leasing authority.

⁴²We reviewed VA's system for tracking this data and found that it and the summary data we received from it were reliable for our purposes.

proposed leases to conform to GSA's methods for leases above GSA's prospectus level. In January 2016, VA also issued new guidance for leased medical facilities emphasizing that these facilities should only meet minimum VA and federal requirements given that the government cannot own the leased space at the end of the lease term.⁴³ GSA approved delegations of leasing authority for VA to pursue 5 of the 6 GSA-prospectus-level leases as operating leases.⁴⁴ GSA officials added that GSA was awaiting receipt of complete applications for up to 17 additional GSA-prospectus-level leases from VA. As more of these types of leases are reviewed by GSA and executed by VA, a better understanding of VA's progress meeting GSA's requirements for them will be possible.

Conclusion

VA has made changes to improve its leasing program, including issuing new guidance to introduce more discipline into its cost-estimating process for major medical facility leases and efforts to further understand the factors contributing to actual lease costs compared to those VA identified in its prospectuses. In particular, VA's new design guidance for major medical facility leases could mitigate design, and thus cost, changes from those included in proposals to Congress. Further, VA's decision to conduct a "lessons learned" study of actual lease costs compared to estimated costs shows promise for VA to understand the factors that impact cost variance from proposal estimates. Some of these efforts were implemented during our review, and a comprehensive evaluation is not yet possible. While we found that leasing can offer flexibility to address a variety of the department's and veterans' needs and help avoid potential challenges with owned properties such as difficulties disposing of them, VA does not assess information to demonstrate to stakeholders how it has benefited from this flexibility. Thus, VA and congressional decision makers may not fully understand the value of leasing these facilities, such as in cases when VA has recommended leasing even when it has determined that other alternatives may be less costly. Although there may

⁴³VA, *Lease Based Outpatient Clinic Design Guide* (Washington, D.C.: January 2016).

⁴⁴According to GSA, VA withdrew its application for delegation of leasing authority for one of the 6, so a delegation of authority was never provided. GSA officials added that VA would be required to submit final lease documentation and scoring before awarding its leases to ensure that the leases meet operating lease requirements.

be challenges to providing this information given the setup of VA's data systems, doing so would provide greater transparency to decision makers and taxpayers regarding the need and how best to pay for major medical facilities.

Recommendation for Executive Action

To enhance transparency and allow for more informed decision making related to VA's major medical facility leases, we recommend 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.

Agency Comments

We provided a draft of this report for review and comment to VA and GSA. VA concurred with our recommendation and provided technical clarifications, which we incorporated as appropriate. GSA provided no comments. VA's comments are reprinted in Appendix II.

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 the Department of Veterans Affairs, and the Administrator of the General Services Administration. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-2834 or shear@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 III.



Rebecca Shea
Director, Physical Infrastructure Issues

List of Requesters

The Honorable Bill Shuster
Chairman
The Honorable Peter A. DeFazio
Ranking Member
Committee on Transportation and Infrastructure
House of Representatives

The Honorable Jeff Miller
Chairman
The Honorable Corrine Brown
Ranking Member
Committee on Veterans Affairs
House of Representatives

The Honorable Lou Barletta
Chairman
The Honorable André Carson
Ranking Member
Subcommittee on Economic Development, Public Buildings,
and Emergency Management
Committee on Transportation and Infrastructure
House of Representatives

The Honorable Ralph Abraham
House of Representatives

The Honorable Daniel Benishek
House of Representatives

The Honorable Gus Bilirakis
House of Representatives

The Honorable Mike Coffman
House of Representatives

The Honorable Ryan Costello
House of Representatives

The Honorable Tim Huelskamp
House of Representatives

The Honorable Ann McLane Kuster
House of Representatives

The Honorable Doug Lamborn
House of Representatives

The Honorable Jerry McNerney
House of Representatives

The Honorable Beto O'Rourke
House of Representatives

The Honorable Amata Radewagen
House of Representatives

The Honorable Kathleen Rice
House of Representatives

The Honorable Jackie Walorski
House of Representatives

The Honorable Tim Walz
House of Representatives

The Honorable Brad Wenstrup
House of Representatives

Appendix I: Summary of GAO’s Assessment of VA’s Cost-Estimating Process for Major Medical Facility Leases

The *Cost Guide* can be used to assess cost-estimating procedures to determine whether they meet the four characteristics—comprehensive, well-documented, accurate, and credible—for being reliable. Table 1 presents our assessment of VA’s overall cost-estimating process against the four characteristics and related best practices.

Table 4: Summary of GAO’s Assessment of VA’s Cost-estimating Process for Major Medical Leases

Characteristic	Overall assessment	Related best practice steps for cost-estimating procedures	Detailed assessment by best practice step ^a
Comprehensive	Fully met	Develop estimating plan	<i>Fully met.</i> VA’s timeline for developing, submitting, and reviewing the estimate, and the data required to complete the submission, are clearly stated. Staff in field-office locations where service gaps to veterans have been identified have responsibility for developing action plans and business cases using the SCIP Automated Tool (SAT). A completed cost-effectiveness analysis is required to be uploaded into the SAT, and management with cost-estimating responsibilities review the business cases using the SAT. VA provides key guidance to field staff on how to develop and submit action plans and business cases.
		Determine estimating structure	<i>Fully met.</i> The inputs to VA’s major medical facility lease estimates are defined in GSA’s guidance for requesting delegations of leasing authority, and include first year lease payments. ^b First-year lease payments include estimated first-year rent payments plus the lump sum payment for medical and other related alterations that is typically paid at lease award and reconciled at construction completion. VA provides detailed guidance to field staff on the steps required to estimate both first-year rents by net usable square feet and lump sum payments for improvements, such as conducting a local market survey of comparable properties, and checking proprietary, subscription databases such as CoStar and LoopNet to determine a base rate for comparable rents in an area. VA staff also have access to specific cost schedules to account for federal requirements such as energy efficiency and security.
Well-documented	Substantially met	Define estimate’s purpose	<i>Fully met.</i> Within VA’s overall cost-estimating process, the SCIP process identifies the purpose of major medical facility lease projects to be filling gaps in service needs to veterans. For each potential project, VA staff provide the necessary level of detail to show how the project will fill the gap. Management review of the business case during the development of the estimate is defined in the SCIP process. Ultimately, all approved estimates are presented to Congress in budget prospectuses for review and authorization.

**Appendix I: Summary of GAO's Assessment of
VA's Cost-Estimating Process for Major
Medical Facility Leases**

Characteristic	Overall assessment	Related best practice steps for cost-estimating procedures	Detailed assessment by best practice step ^a
		Define program characteristics	<i>Fully met.</i> The SCIP business cases that VA staff develop articulate facility characteristics needed to address the identified gaps in service to veterans, such as general location, square footage, and required parking spaces. For example, for its proposed Fort Wayne, Indiana, facility VA field staff developed a business case in 2012 that identified a need to address gaps in providing mental health care and to alleviate excess demand at a nearby existing VA facility. To do so, VA proposed a 27,000 square-foot build-to-suit leased building with 216 parking spaces to provide care to approximately 48,000 enrolled veterans in gap areas such as substance abuse and post-traumatic stress disorder.
		Identify ground rules and assumptions	<i>Substantially met.</i> VA defines specific design assumptions about a project, such as the population size of veterans that will patronize a facility and the services they need; these determine the project characteristics, such as needed net usable square feet. Further, VA tracks the data behind those assumptions and can make adjustments in design characteristics while developing the SCIP business case if those assumptions change. However, we reported in April 2014 that changes to the underlying design assumptions for major medical facility lease projects are a common reason for variation in VA's actual first-year lease costs from estimated, prospectus first-year lease costs. We have previously found that better development of assumptions and ground rules can improve cost-estimating procedures.
		Obtain data	<i>Substantially met.</i> VA's cost-estimating process includes a data collection plan to collect relevant data from identified, trusted data sources, such as the proprietary subscription real estate databases CoStar™ and LoopNet, and its own internal data on veteran populations and needs. ^c However, the data are not normalized, which could lead to unintended errors in the estimate. For example, in the population of leases we reviewed, fully serviced lease rates, as opposed to unserviced lease rates, were mistakenly used to calculate first-year lease costs for five leases.
		Document the estimate	<i>Fully met.</i> For the first-year lease cost estimate, the market analysis performed and other factors included when determining the point estimate for rental rates as well as the costs for tenant-improvements buildout are documented.
		Present estimate to management for approval	<i>Fully met.</i> VA staff within each field office develop action plans and business cases using the SAT. ^d Management, both regional and in headquarters, use the SAT to review action plans and business cases, respectively. Further, VA officials reported that when a business case presented for management review is found to be incomplete or inconsistent, it is returned for correction or receives a higher level of scrutiny before continuing to move through the process if the reviewer deems it is warranted.

**Appendix I: Summary of GAO's Assessment of
VA's Cost-Estimating Process for Major
Medical Facility Leases**

Characteristic	Overall assessment	Related best practice steps for cost-estimating procedures	Detailed assessment by best practice step ^a
Accurate	Partially met	Develop point estimate and compare to independent cost estimate	<i>Substantially met.</i> During the action-plan phase, VA staff develop a point estimate which is based on the market rental rate determined by the market survey conducted during the SCIP process and the cost of specific improvements required for VA's intended medical purposes. ^e VA staff apply several standard and variable adjustments to the derived market rate to determine the rental portion of the estimated first-year lease cost to include in its prospectus to Congress. Estimates are refined as projects move from the action plan phase to the business case phase. In addition, for major medical lease and major construction projects selected for inclusion in the budget request, cost estimates are refined as prospectus documents are prepared.
		Update estimate to reflect actual costs and changes	<i>Partially met.</i> VA's cost-estimating process partially meets the best practice for updating estimates because VA officials are required by law to report whenever a major medical facility lease's first-year costs will exceed adjusted prospectus costs more than 10 percent. However, VA does not update estimates again with actual costs after it enters into a lease agreement and the facilities are ready for use by VA. Updating estimates with actual lease cost data and comparing that data to prospectus estimates as part of a "lessons learned" review helps agencies understand the specific factors influencing variation between actual costs and cost estimates. This would enable "what if" sensitivity analyses on those specific factors in place of VA's practice of applying a standard escalation factor to approximate potential but unknown factors. Sensitivity analyses enable risk analyses that help predict results when a confluence of factors occurs, as it does in real life. With this knowledge, agencies can improve their cost-estimating processes in the future. VA is planning a "lessons learned" effort that would support such activities.
Credible	Partially met	Develop point estimate and compare to independent cost estimate	<i>Substantially met.</i> See above.
		Conduct sensitivity analysis	<i>Partially met.</i> VA does not directly conduct a sensitivity analysis on the estimate, but the cost-estimating procedures do address this issue indirectly. Instead of conducting the analysis, VA applies an annual escalation rate ^f to adjust for increases in market rental rate and inflation, ^g two key factors that could cause actual first-year lease costs to fluctuate from the prospectus estimate. Although we reported in April 2014 that design changes are a common reason for variation in VA's actual first-year lease costs from estimated, prospectus first-year lease costs, performing a further analysis of factors affecting actual costs can help agencies create better estimates moving forward. VA is planning a "lessons learned" effort that would support such activities.

Appendix I: Summary of GAO's Assessment of VA's Cost-Estimating Process for Major Medical Facility Leases

Characteristic	Overall assessment	Related best practice steps for cost-estimating procedures	Detailed assessment by best practice step ^a
		Conduct risk analysis	<i>Minimally met.</i> VA does not directly conduct risk analyses on the estimate but does analyze some project risks during the action plan phase. In the past, design changes were found to be the most common risk factor in cost changes. Because of that, the SCIP process now requires more design certainty earlier in the process than previously required for VA project business cases.

Source: GAO analysis of VA documentation. | GAO-16-619

^aRatings information as previously defined in previous figure 2.

^bFMR Bulletin C-2 and GSA, Policy Clarification for Delegations of Lease Acquisition Authority (July 11, 2006).

^cAs of June 2016, GAO is currently reviewing VA's use of veteran data to align its facilities with veteran populations.

^dThis also applies to major and minor construction projects' business cases.

^eVA estimates its lease costs during the SCIP process by identifying the average market rate in a 5- to 10-mile radius of where it plans to lease a facility.

^fThrough fiscal year 2015 the escalation rate was 4 percent, but VA changed this to about 2 percent for fiscal year 2016 to align with GSA's escalation factor.

^gThe escalation rate is applied to estimate costs every fiscal year between prospectus authorization and facility acceptance.

Appendix II: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

June 14, 2016

Ms. Rebecca Shea
Director, Physical Infrastructure Issues
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Shea:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, "**VA REAL PROPERTY: Leasing Can Provide Flexibility to Meet Needs, but VA Should Demonstrate the Benefits**" (GAO-16-619). VA concurs with GAO's recommendation to the Department.

The Department is pleased that GAO recognizes the importance of medical leasing and that leasing offers VA the opportunity to align with changing health care needs. The report highlights improvements made to VA's lease delegation processes as a result of the implementation of a detailed, internal peer review process. The report also recognizes VA's documented process to estimate lease costs and explain those costs in order to comply with Office of Management and Budget and General Services Administration requirements.

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

Sincerely,

A handwritten signature in black ink that reads "Gina S. Farrissee".

Gina S. Farrissee
Deputy Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs Comments to
Government Accountability Office (GAO) Draft Report
***“VA REAL PROPERTY: Leasing Can Provide
Flexibility to Meet Needs, but VA Should Demonstrate the Benefits”***
(GAO-16-619)

GAO Recommendation: To enhance transparency and allow for more informed decision making related to VA’s major medical facility leases, we recommend that the Secretary of Veterans Affairs annually assess how VA has benefited from the flexibilities afforded by leasing its major medical facilities and use information from these assessments in its annual capital plans.

VA Comment: Concur. The Department of Veterans Affairs (VA) agrees that assessing and explaining the benefits and flexibilities provided by major medical facility leases can improve transparency. VA’s Office of Management will lead the effort to assess and document information on why major medical facility leases are chosen, including the benefits gained by VA and Veterans. This information will be used in future annual budget submissions as part of the published Strategic Capital Investment Planning process long-range plan.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Rebecca Shea, (202) 512-2834; shear@gao.gov

Staff Acknowledgments

In addition to the contact named above, Heather MacLeod, Assistant Director; Jennifer Echard; Elke Kolodinski; James Leonard; Josh Ormond; Sarah Sheehan; Delwen Jones; and Crystal Wesco made key contributions to this report.

Appendix IV: Accessible Data

Agency Comment Letter

Text of Appendix II:
Comments from the
Department of Veterans
Affairs

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DEPARTMENT OF VETERANS AFFAIRS

Washington DC 20420

June 14, 2016

Ms. Rebecca Shea

Director, Physical Infrastructure Issues

U.S. Government Accountability Office

441 G Street, NW

Washington, DC 20548

Dear Ms. Shea:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, "VA REAL PROPERTY: Leasing Can Provide Flexibility to Meet Needs, but VA Should Demonstrate the Benefits" (GAO-16-619). VA concurs with GAO's recommendation to the Department.

The Department is pleased that GAO recognizes the importance of medical leasing and that leasing offers VA the opportunity to align with changing health care needs. The report highlights improvements made to VA's lease delegation processes as a result of the implementation of a detailed, internal peer review process. The report also recognizes VA's documented process to estimate lease costs and explain those costs in

order to comply with Office of Management and Budget and General Services Administration requirements.

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

Sincerely,

Gina S. Farrissee

Deputy Chief of Staff

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Data
Tables/Accessible
Text

Data Table for Highlights Figure: Extent to which VA’s Lease Cost-Estimating Procedures Align with Best Practices

Comprehensive	Well-documented	Accurate	Credible
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	Partially met: Satisfied about half of the best practice

Source: GAO analysis of U.S. Department of Veterans Affairs data. | GAO-16-619

Accessible Text for Figure 1: Components of the Department of Veterans Affairs’ (VA) Annual Strategic Capital Investment-Planning Process

November to January

Gap analysis:

The U.S. Department of Veteran Affairs (VA) uses regional and facility-level data to analyze gaps/needs (SCIP gaps) in areas including access, facility utilization, space, facility condition, energy, safety, and security.

Strategic capital assessment:

VA Administrations (e.g., Veterans Health Administration) and staff offices produce an executive summary narrative describing how gaps will be addressed through both capital and non-capital solutions over the 10-year planning horizon. Capital solutions may include construction of new facilities, renovation of existing facilities, or new leased facilities

February to June

Long-range action plan:

VA lists capital and non-capital projects to reduce gaps and identifies general resource requirements needed to do so over a 10-year period.

Business cases:

VA issues a call for business cases for projects proposed in the first fiscal year of the long-range action plans. Individual facilities submit business cases for clinical and non-clinical leases and major and minor medical construction projects (including non-recurring maintenance projects). Business cases must include detailed cost estimates and explanations of how proposed projects align with decision criteria, such as reducing facility condition deficiencies.

Unified priority list:

VA validates and scores business cases against the decision criteria evaluated in the business cases. A project’s score is a combination of its

performance against each criterion and the priority weight for each criterion.

July to October

Annual budget request:

Budget targets are established by VA leadership. The unified priority list is used to develop the list of projects included in the annual construction budget request.

Construction and long-range capital plan:

VA develops and publishes the Construction and Long Range Capital Plan that contains prospectuses for each major medical facility construction and lease project for which funding is requested, potential project lists for that fiscal year, including major and minor leases, and estimates for construction program line items.

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