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VA HEALTH CARE FACILITIES

Leveraging Partnerships to Address Capital Investment Needs

Statement of Catina Latham, Acting Director
Physical Infrastructure

GAO-22-106017

GAO Highlights

Highlights of GAO-22-106017, a testimony before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

May 12, 2022

VA HEALTH CARE FACILITIES

Leveraging Partnerships to Address Capital Investment Needs

Why GAO Did This Study

VA administers one of the largest health care systems in the nation. VA estimates that fulfilling all of its priority infrastructure projects would cost approximately $63-$76 billion as of fiscal year 2021. GAO has reported that VA has struggled with instances of cost overruns and time delays in constructing some facilities. VA has leveraged partnerships to address its capital needs, including a donation partnership with the private sector (known as CHIP-IN) and an integrated health care facility with DOD.

This statement discusses (1) VA's donation partnership pilot program, efficiencies identified, and considerations relevant to seeking additional donation partnerships, and (2) VA's and DOD's integration of their health care facilities in North Chicago, IL and the agencies' observations on the integration. This statement is based on GAO's prior work.

What GAO Recommends

GAO has made recommendations to VA regarding the use of leading practices for pilot programs (GAO-19-117) and a lessons-learned process for the donation partnership projects (GAO-21-133). VA concurred with and implemented these recommendations.

GAO also recommended that VA and DOD collaborate to update a cost-effectiveness analysis for the Lovell Center (GAO-17-197). VA and DOD concurred with and implemented this recommendation.

View GAO-22-106017. For more information, contact Catina Latham at 202-512-2834 or LathamC@gao.gov.

What GAO Found

The Department of Veterans Affairs (VA) offers health care services to about 9 million veterans at its 171 medical centers and more than 1,100 outpatient facilities. VA has long faced challenges addressing its pressing infrastructure demands. As part of a partnership pilot program, VA is authorized to accept up to five donations of real property—such as buildings, facility construction, or facility improvements—from non-federal entities before the end of 2026. It is also authorized to use certain appropriated funds to help the donating entity finance, design, or construct a facility in connection with its donation. Through this program, VA has received one real property donation—an ambulatory care center in Omaha, NE—and a second—an inpatient hospital in Tulsa, OK—is planned. The Omaha project has provided lessons learned regarding efficiencies of this approach—such as the use of an electronic design-review process—that could benefit future VA construction projects. We identified several considerations that are relevant in seeking additional donation partnerships, such as challenges related to restrictions on which projects are eligible and the sizeable donation required.

Completed Department of Veterans Affairs' (VA) Ambulatory Care Center in Omaha, NE, and Rendering of Planned Inpatient Facility in Tulsa, OK

Sources (left to right): VA; Veterans Hospital in Tulsa, LLC by GH2 Architects, LLC of Tulsa, Oklahoma. I GAO-22-106017

In 2010, VA and the Department of Defense (DOD) integrated two medical facilities in North Chicago, IL into the Captain James A. Lovell Federal Health Care Center as a 5-year demonstration project. The Lovell Center was intended to create a national model for the joint delivery of health care. It was also expected to inform decision makers about whether this model of care would be effective if replicated at other VA and DOD locations. However, the departments determined that evaluations of the Lovell Center integration did not find that sharing facilities provided benefits over a "joint venture" approach. In a joint venture, the departments share space but manage their operations separately. In part because of the challenges of converting the Lovell Center to a joint venture, in 2016 VA and DOD jointly recommended continuing the Lovell Center's operation as an integrated facility with periodic reviews and implementation of the recommended improvements.

Chairwoman Brownley, Ranking Member Bergman, and Members of the Subcommittee:

Thank you for the opportunity to testify today on partnerships for capital investments in VA health care facilities. The Department of Veterans Affairs (VA) administers one of the largest health care systems in the nation. VA offers health care services to about 9 million veterans at its 171 VA medical centers and more than 1,100 outpatient facilities as of September 2021. VA has pressing infrastructure demands and estimates that fulfilling all of its priority infrastructure projects would cost approximately $63-$76 billion as of fiscal year 2021. We have reported that VA has struggled with instances of cost overruns and time delays in constructing some facilities. VA has also struggled to lease health care facilities; no major leases have been authorized in nearly 5 years.

In recent years, VA has leveraged two partnership approaches to address its capital investment needs: (1) a donation partnership with non-federal entities (known as CHIP-IN) authorized by the Communities Helping Invest through Property and Improvements Needed for Veterans Act of 2016;[1] and (2) integration of a health care facility with the Department of Defense (DOD) in North Chicago, IL. VA may seek additional partnerships, which VA refers to as strategic collaborations, with other entities to help meet capacity in its medical centers and facilities.

My testimony today focuses on our prior work on these two partnership approaches. Specifically, my testimony discusses (1) VA's CHIP-IN pilot program, efficiencies identified, and considerations relevant to seeking additional donation partnerships, and (2) VA's and DOD's integration of their health care facilities in North Chicago, IL and the agencies' observations on the integration. For this statement, we primarily relied on four reports we issued from January 2017 to February 2022.[2] Information

[1]Pub. L. No. 114-294, 130 Stat. 1504 (2016).

[2]We also reviewed relevant statutes; information about the CHIP-IN project in Tulsa, OK; and updates to the cost-effectiveness metrics for the Captain James A. Lovell Federal Health Care Center.

on our objectives, scope, and methodology for that work can be found in each of the reports.[3]

We conducted the work on which this statement was based 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 the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Status of VA's CHIP-IN Pilot Program, Efficiencies Identified, and Considerations for Potential Future Donation Partnerships

VA's CHIP-IN Pilot Program Has Resulted in One Facility Donation and a Second is Planned

To date, VA has received one real property donation and is planning for a second through the CHIP-IN partnership pilot program. The CHIP-IN Act was enacted to pilot a new approach to help address VA's infrastructure needs—allowing donation partnerships with non-federal entities for construction projects. The Act authorizes VA to accept up to five donations of real property—such as buildings, facility construction, or facility improvements—from non-federal entities.[4] The CHIP-IN Act also authorizes VA to use certain appropriated funds to help a donating entity

[3]GAO, *VA Construction: VA Should Enhance the Lessons-Learned Process for Its Real-Property Donation Pilot Program,* GAO-21-133 (Washington, D.C.: Dec. 10, 2020); *VA Construction: Strengthened Pilot Design and a Dedicated Team Could Improve Real-Property Donation Pilot Program*, GAO-19-117 (Washington, D.C.: Dec. 13, 2018); *Federal Health Care Center: VA and DOD Need to Develop Better Information to Monitor Operations and Improve Efficiency,* GAO-17-197 (Washington, D.C.: Jan. 23, 2017); and *VA Health Care: Incomplete Information Hinders Usefulness of Market Assessments for VA Facility Realignment*, GAO-22-104604 (Washington, D.C.: Feb. 2, 2022).

[4]CHIP-IN Act § 2.

finance, design, or construct a facility in connection with real property and improvements donated under the pilot program.[5]

The pilot was originally authorized for 5 years, and in September 2021, it was extended for an additional 5 years, to conclude in December 2026.[6] VA also has a separate statutory authority[7] that allows VA to accept non-federal donations of facilities but does not authorize the use of certain appropriated funds to help the donating entity finance, design, or construct a facility in connection with the project.[8]

The first CHIP-IN project—an ambulatory care center in Omaha, NE—opened in August 2020. (See figure 1.) The ambulatory care center is a three-story, 157,000 square foot facility that is connected to the existing medical center. The new center includes three primary medical clinics, five new dedicated ambulatory-surgical suites, radiology facilities, and specialty clinics for dermatology, neurology, infectious disease, endocrinology, and allergy. The center also includes a dedicated clinic for women's health care with a separate entrance. The Omaha donor group completed construction of the Omaha ambulatory care center on time and within its estimated $86 million budget. VA contributed $56 million and the Omaha donor group contributed $30 million in private sector donations.[9]

[5]According to VA officials, the CHIP-IN Act streamlined the funding process for CHIP-IN pilot projects by eliminating VA's need to seek additional authorization to use funds previously appropriated for a major medical facility construction project where 1) the same facility is a CHIP-IN pilot project for which Congress has not previously provided authorization, and 2) where the completed medical facility is consistent with the purpose of the previous appropriation.

[6]Department of Veterans Affairs Expiring Authorities Act of 2021, Pub. L. No. 117-42, § 4, 135 Stat. 342.

[7]38 U.S.C. § 8103(a)(2).

[8]According to VA officials, along with this donation acceptance authority, VA can use the appropriations process to seek appropriated funds to make improvements to a donated facility.

[9]All monetary figures reported for the CHIP-IN projects are in nominal dollars.

Figure 1: Department of Veterans Affairs' (VA) Ambulatory Care Center in Omaha, NE—Exterior and Interior Views

Source: VA. I GAO-22-106017

The Omaha CHIP-IN project was executed in two main phases. The donor group told us that in the first phase, they managed the project's design and construction, including developing the cost estimate and hiring the architect, general contractor, and construction manager. A VA senior resident engineer and VA Construction and Facilities Management staff also supported the project, according to officials from VA and the donor group. In the second phase, VA managed the center's activation.[10]

VA and another donor group are planning for a second CHIP-IN project—the construction of an inpatient hospital in Tulsa, Oklahoma. The facility was proposed in December 2018 by a donor group led by representatives from a Tulsa foundation and the Oklahoma State University (OSU) Center for Health Services. The facility will be adjacent to the OSU medical center, a large teaching hospital, and a new state-operated psychiatric hospital. (See figure 2.) The project will renovate existing office buildings into a 260,000 gross square foot inpatient facility that includes 58 beds for medical/surgical care, intensive care, and medical rehabilitation as well as an emergency department, operating rooms, radiology, and ancillary and support services. According to the donor group, the facility is expected to open to patients in 2025.

[10]Activation refers to the process of bringing a constructed facility into full operation, such as purchasing and installing furniture and medical equipment and hiring staff.

Figure 2: Proposed Department of Veterans Affairs' (VA) Inpatient Facility in Tulsa, OK—Planned Site and Rendering of Completed Facility

Sources (left to right): Oklahoma Office of Management & Enterprise Services; Veterans Hospital in Tulsa, LLC by GH2 Architects, LLC of Tulsa, Oklahoma. I GAO-22-106017

VA is contributing $120 million to the Tulsa project and the Tulsa donor group is providing a $10 million community donation. The state of Oklahoma transferred land and existing office buildings for the project valued at $35 million.

To date, we have issued two reports on the CHIP-IN pilot program.[11] In the first report, we made three recommendations related to use of leading practices for pilot programs.[12] Specifically, we recommended that, in accordance with leading practices for pilot programs, VA (1) establish pilot program objectives, (2) develop an assessment methodology and an evaluation plan, and (3) document roles and responsibilities and identify available and needed staff resources. VA concurred with and has implemented these recommendations. In the second report, we made two recommendations related to use of a lessons-learned process for CHIP-IN projects.[13] Specifically, we recommended that VA (1) conduct a lessons-learned process for the Omaha project, and (2) implement a lessons-learned process for future CHIP-IN projects that aligns with lessons-learned key practices, including documentation and

[11]The CHIP-IN Act, as amended, includes a provision for us to report on the pilot's donation agreements on a biennial basis.

[12]GAO-19-117.

[13]GAO-21-133.

dissemination of lessons. VA concurred with and has implemented these recommendations.

Some Practices Used on CHIP-IN Projects Can Contribute to Construction Efficiencies, According to VA and Stakeholders

The CHIP-IN donation approach and use of private sector practices resulted in various efficiencies on the Omaha CHIP-IN project, including time and cost savings compared to a typical VA construction project, according to VA and the donor group. The donor group completed the facility in 26 months, according to donor group representatives, compared to the 36 months that they said VA estimated. In addition, VA estimated that building the facility as a CHIP-IN project achieved a potential $34 million cost savings, compared to VA's estimated cost for building the project outside of a donation partnership.[14]

Many of the efficiencies for the Omaha project occurred because of avoided costs and schedule delays. For example, we found that the Omaha project used private-sector construction standards in combination with VA construction standards that resulted in both cost and time savings.[15] Additionally, the Omaha donor group introduced VA to an electronic design-review process that was more efficient and allowed for shorter time frames for each round of review.

According to VA and the Omaha donor group, certain private sector practices, such as involving the general contractor during the design phase of the project, beginning construction soon after the completion of the project's design, and an overall emphasis from all parties on cost containment and schedule control throughout the project also contributed to the efficiencies realized on the project. According to VA officials, VA may be able to incorporate some, but not all, of the private sector

[14]GAO-19-117. VA estimated that the Omaha ambulatory care center would cost about $120 million for VA to build outside of a donation partnership. However, under the CHIP-IN pilot, the total estimated cost was $86 million. It is not possible to provide a firm estimate of the cost savings due to the use of CHIP-IN for the Omaha project because a variety of aspects of the project were modified since its original conception by VA. However, according to VA, the final cost of the project came in somewhat below the estimated $86 million. As such, it is likely that some proportion of the cost differential as well as the accelerated completion of the project was due to the CHIP-IN program process and inclusion of private-sector building methods with VA methods for this project.

[15]The CHIP-IN Act requires that a formal agreement provide that the donating entity shall use construction standards required of VA when designing, repairing, altering, or building the facility, except to the extent the Secretary determines otherwise as permitted by applicable law. Mutually agreed-upon standards were included in the Omaha project's donation agreement, which was approved by the VA Secretary.

practices that were leveraged in the Omaha project into typical VA-led construction projects.

Considerations Relevant to Seeking Additional Donation Partnerships

In our 2020 report,[16] we found several considerations that are relevant in seeking additional donation partnerships through a CHIP-IN program model.

- The number of communities and donor partners that could lead a CHIP-IN project may be limited, according to representatives from the Omaha and Tulsa donor groups. Specifically, the Omaha and Tulsa donor groups both have experience in managing large construction projects, the ability to raise substantial donations, and the support of philanthropic communities.
- VA may need to invest resources, including time and staff, to actively recruit donors, according to our previous review of the relevant literature and interviews with selected nonprofits. We previously found that VA generally does not possess marketing and philanthropic development experience, which VA officials said makes the inherent challenge of finding donors more difficult.
- Representatives we previously interviewed from veterans service organizations raised concerns about VA seeking donations if the CHIP-IN pilot was scaled up or continued over the longer term. Specifically, these representatives said that if VA greatly expanded its donor recruitment efforts and began seeking private donations for several more CHIP-IN projects, VA may find itself competing with veterans' service organizations and other charitable groups for the same donations. These representatives were also concerned with the optics of VA regularly seeking donations for projects that are typically taxpayer funded.

In addition, we reported in 2018 and 2020 that a main challenge to establishing CHIP-IN pilot partnerships was the considerable size of the donations required.[17] Specifically, under the CHIP-IN Act, VA may only contribute funding that has been "appropriated for the facility" as of the date of the formal agreement. VA officials interpret this phrasing to mean that VA may only provide funds to donating entities entering into agreements involving major construction (over $20 million) because only

[16]GAO-21-133.

[17]GAO-19-117 and GAO-21-133.

major projects are specifically identified by Congress in the appropriations process. However:

- Donating to projects of this size may be out of reach for many philanthropic organizations, according to VA officials.
- Smaller projects such as minor construction ($20 million and under) and nonrecurring maintenance can be accepted as CHIP-IN projects under certain circumstances, but under VA's interpretation of CHIP-IN Act language, the donor group would need to fund the entire project. Potential donors may prefer projects that have funding by both VA and the donor to demonstrate VA's vested interest in the project.
- VA cannot contribute funding before a CHIP-IN project receives appropriations[18]—meaning that a prospective donor must be willing and able to fund initial planning efforts if a project does not yet have appropriated funds. Both the Omaha and Tulsa donor groups told us that making this early investment carries a risk for the donor.

VA's assessments of its capacity for delivering health care in different geographic areas could help guide VA as it considers recruiting future CHIP-IN partners by allowing VA to compare those areas' service needs to locations of potential donations. In 2018, VA began to conduct assessments of the capacity within 96 geographic areas (markets) to deliver health care to veterans through available VA and non-VA health care resources.[19] We reported that as part of these market assessments, VA officials said that they planned to compile data on key projects for improving VA capacity and services at facilities run by other federal agencies, such as DOD.[20] Further, VA's recommendations from its

[18]With respect to funds VA may provide to help a donating entity finance, design, or construct a facility under the CHIP-IN Act, VA may not provide such funds "that are in addition to the funds appropriated for the facility as of the date on which the Secretary and the entity enter into a formal agreement…." CHIP-IN Act, § 2(e)(1)(A).

[19]The VA MISSION Act of 2018 required VA to follow specified procedures in conducting system-wide assessments to be used for making recommendations regarding modernizing or realigning the department's facilities. Pub. L. No. 115-182, tit. II, § 203, 132 Stat. 1393, 1446. In response to this and other requirements, in December 2018 VA began its Market Area Health System Optimization Assessments. For these assessments, markets are usually designated geographic areas made up of a set of contiguous counties that contain one or more VA medical centers and associated clinics.

[20]GAO-22-104604. We made recommendations related to improving the completeness of certain market assessment data and communicating information about data reliability and limitations. VA concurred with the recommendations, and identified steps it will take to implement them. We will continue to monitor these efforts.

market assessments discussed using a mix of alternatives such as public-private partnerships.[21]

VA and DOD Integration of Medical Facilities in North Chicago and the Agencies' Observations on the Integration

The integration of VA and DOD medical facilities in North Chicago, Illinois, begun in 2010, had not produced clear facilities benefits and had faced cost challenges at the time we reported on this project in 2017.[22] As authorized by the National Defense Authorization Act for Fiscal Year 2010 (NDAA 2010), VA and Navy facilities in North Chicago were integrated into a first-of-its-kind facility known as the Captain James A. Lovell Federal Health Care Center (Lovell Center). (See figure 3.) Although VA and DOD have shared resources at some level since the 1980s, the Lovell Center is the first integrated health care center with a unified governance structure, workforce, and budget.[23]

[21]VA established 10 system-wide principles for the market assessments. One of these principles was to optimize health care services for Veterans in each market using a mix of VA care first, supplemented by the Department of Defense, academic affiliates, Federally Qualified Health Centers, and community providers. According to VA, options should include consideration of innovative alternatives such as "Hospital within a Hospital" ventures and public-private partnerships. Another principle was to maximize productivity, strategically prioritize investments, and leverage virtual care modalities and partnerships rather than build facilities, when possible.

[22]GAO-17-197.

[23]The Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act was enacted in 1982. See 38 U.S.C. § 8111. The Department of Veterans Affairs was previously known as the Veterans Administration. The NDAA 2010 established the Joint DOD-VA Medical Facility Demonstration Fund (Joint Fund) as the funding mechanism for the Lovell Center, with VA and DOD both making transfers to the Joint Fund from their respective appropriations. As authorized in the NDAA 2010, the Executive Agreement requires a financial reconciliation process that permits VA and DOD to identify their contributions to the Joint Fund each year.

Figure 3: The Integrated Medical Facility in North Chicago, the Captain James A. Lovell Federal Health Care Center

Source: Captain James A. Lovell Federal Health Care Center Communications Department. | GAO-22-106017

The integration, which the NDAA 2010 set up as a 5-year demonstration project, was intended to create a national model for the joint delivery of health care that would be more accessible and less expensive than operating two federal medical centers serving VA and DOD beneficiaries in the same area.[24] It was also expected to inform decision makers about whether this model of care would be effective if replicated at other VA and DOD locations.

The Lovell Center was established on October 1, 2010 when the Secretaries of VA, DOD, and the Navy signed an Executive Agreement. The agreement defined the departments' roles in operating and overseeing the Lovell Center and outlined requirements in 12 specific

[24]VA beneficiaries include veterans of military service and certain dependents and survivors. DOD beneficiaries include active duty servicemembers (including Navy recruits) and their dependents, medically eligible National Guard and Reserve servicemembers and their dependents, and military retirees and their dependents and survivors. Active duty personnel also include Reserve members on active duty for at least 30 days. Military retirees are dually eligible for both VA and DOD benefits.

"integration areas," such as governance, workforce management, and facility operations, including information technology.[25] According to the agreement, the Lovell Center was intended to meet the health care missions of both departments—including DOD's operational readiness mission—by integrating services previously provided by the former North Chicago VA Medical Center and the Naval Health Clinic Great Lakes into a single facility.[26]

VA and DOD integrated the Lovell Center in order to improve services and reduce costs, but at the time of our reporting in 2017, the demonstration project had not produced clear benefits and had encountered cost challenges. VA and DOD each conducted separate assessments in 2015 of the areas of integration within the Lovell Center and then provided a joint recommendation. Evaluations that VA and DOD reviewed found that sharing facilities did not provide significant benefits over a "joint venture" approach in which the departments would continue sharing medical facility space but would manage their operations with separate governance structures, staff, and budgets. Also, a contractor analysis, using data from fiscal year 2014, showed that the integrated facility was not performing as well financially as the separate facilities had before integration. Both DOD and VA acknowledged that the costs associated with the demonstration project were "very high" and not in keeping with the initial goal of delivering more cost-effective health care. They further noted that the increased costs were due, in part, to the departments' inability to appropriately downsize staff, as well as efforts to integrate their separate information systems.

However, in July 2016 the VA and DOD jointly recommended continuing the Lovell Center as an integrated facility in part because of the complexities of separating the integrated facility. VA and DOD recommended periodic reviews and the implementation of 17 recommended improvements that had been identified by the subject matter teams.

[25]The NDAA 2010 authorized the Secretaries of VA and Defense to execute an Executive Agreement to combine medical facilities. Pub. L. No. 111-84, tit. XVII, § 1701(a), 123 Stat. 2190, 2567 (2009).

[26]DOD's operational readiness mission includes ensuring that Navy recruits are medically ready to accomplish military duties and deployments and ensuring that active duty providers develop and maintain clinical skills necessary to serve at military treatment facilities and in combat environments.

In our 2017 report, we recommended that VA and DOD collaborate to update the contractor's cost-effectiveness analysis of the Lovell Center.[27] VA and DOD concurred with and implemented our recommendation. In June 2018, VA and DOD completed their analysis on the cost-effectiveness of the Lovell Center, which covered fiscal years 2012 through 2017. At the time, VA and DOD officials said the analysis would serve as a baseline for VA and DOD to determine whether the Lovell Center is improving its cost-effectiveness over time. The departments have continued to update the cost-effectiveness metrics through fiscal year 2021, but it remains unclear the extent to which the Lovell Center has achieved the original goal of reducing costs.

In conclusion, VA may be able to further leverage partnerships to address its longstanding capital infrastructure needs but is likely to face challenges in doing so. Lessons learned from the CHIP-IN donation partnerships and the Lovell Center integration may provide insights as to whether these approaches can or should be scaled and their potential for benefitting taxpayers and veterans.

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

GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Catina Latham, Acting Director, Physical Infrastructure at (202) 512-2834 LathamC@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Bonnie Anderson and Keith Cunningham (Assistant Directors), Kate Perl (Analyst in Charge), Melissa Bodeau, and April Yeaney. In addition, Amy Abramowitz, Geoffrey Hamilton, Jacquelyn Hamilton, Terence Lam, Joshua Ormond, E. Jane Whipple, and Rebecca Rust Williamson provided key support. Other staff who made key contributions to the reports cited in the testimony are identified in the source products.

[27]GAO-17-197.

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