United States Government Accountability Office

Report to Congressional Requesters

January 2020

VA REAL PROPERTY

VHA Should Improve Activation Cost Estimates and Oversight

Accessible Version

GAO-20-169

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GAO Highlights

Highlights of GAO-20-169, a report to congressional requesters

Why GAO Did This Study

VHA operates one of the nation's largest health care systems with more than 1,200 sites across the country; however, many facilities were built decades ago and do not align with the agency's current emphasis on outpatient and specialized care. Additionally, new or expanded facilities are needed to accommodate veterans returning from recent conflicts. VHA is constructing and leasing new facilities to respond to these needs. GAO was asked to review VHA's efforts to activate new major medical facilities.

This report examines the extent to which VHA is able to compare the actual costs of activation against the estimated costs, among other objectives.

GAO analyzed VHA's documentation on estimating activation costs. GAO also interviewed officials and analyzed cost information reported by a non-generalizable selection of eight medical facilities. The facilities had more than $1 million in annual rent or $20 million in construction costs, reported finishing activation in fiscal years 2016 and 2017, and were located in various regions.

What GAO Recommends

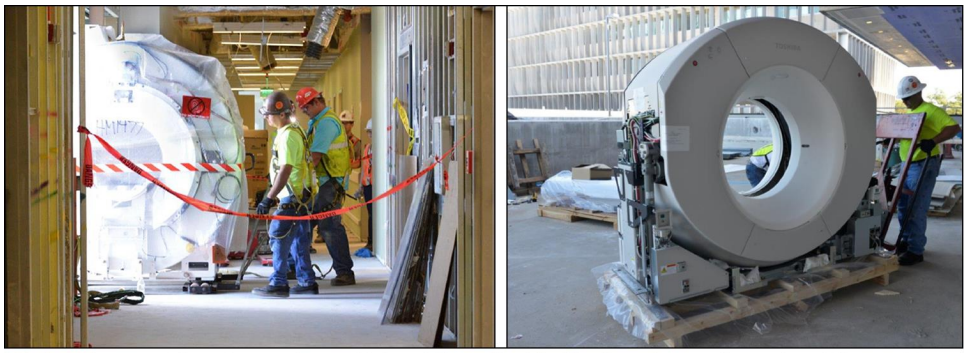
GAO recommends that VA (1) develop and document a process for estimating total activation costs, (2) develop and document a process for comparing actual activation costs to the estimates, (3) define allowable activation expenses, and (4) clarify when facilities should cease to classify expenses as activation-related. VA agreed with GAO's recommendations.

View GAO-20-169. For more information, contact Andrew Von Ah at (202) 512-2834 or vonaha@gao.gov.

What GAO Found

The Veterans Health Administration (VHA) under the Department of Veterans Affairs (VA) is constructing and leasing new medical facilities, such as outpatient clinics, to better serve and meet the changing needs of veterans. VHA equips and staffs these new facilities in a multi-year process called "activation." From fiscal year 2012 through 2018, VHA channeled more than $4 billion to major medical facilities undergoing activation, which these facilities could use toward furniture, equipment, and new staffing costs, among other start-up expenses.

Activation Costs Include Equipment Purchases and Installation, among Others



Workers transport imaging equipment into a VA medical facility. Imaging equipment and the cost to install it in a new facility are both activation costs.

Source: Veterans Affairs. | GAO-20-169

VHA lacks processes and clear definitions for estimating total activation costs and for comparing actual expenses against these estimates. Specifically,

- VHA's current cost estimation process does not cover the full duration of activation.
- Headquarters officials have never compared activation costs against estimated costs because until recently, officials said, VHA lacked the accounting mechanisms to facilitate such comparisons; however, while VHA now possesses these mechanisms, it has not documented the process for how the new information should be used.
- VHA documentation does not clearly define allowable activation expenses or the appropriate spending timeframes. Local and regional officials expressed confusion over what items could be purchased with activation funds. In addition, local officials held inconsistent beliefs regarding how long expenses could qualify as activation-related.

VHA management's priorities include data-driven decision-making. Further, the Office of Management and Budget's guidance states that agencies should compare actual project costs against planned expenses so managers can determine if cost goals are being met. Without processes and clear definitions associated with measuring activation costs, VHA does not have reasonable assurance that it will be able to effectively manage the resources associated with activation.

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Abbreviations

CBOC	community-based outpatient clinic
NAO	National Activations Office
OCAM	Office of Capital Asset Management
VA	Department of Veterans Affairs
VERA	Veterans Equitable Resource Allocation
VHA	Veterans Heath Administration
VISN	Veterans Integrated Service Network

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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January 2, 2020

The Honorable Jon Tester
Ranking Member
Committee on Veterans' Affairs
United States Senate

The Honorable David P. Roe
Ranking Member
Committee on Veterans' Affairs
House of Representatives

The Veterans Heath Administration (VHA) under the Department of Veterans Affairs (VA) operates one of the nation's largest health-care systems with more than 1,200 sites across the country. However, many facilities were built decades ago and were designed for an inpatient-driven health-care system. These facilities do not align with the agency's current wellness approach, which emphasizes outpatient and specialized care. Additionally, new or expanded facilities are needed to accommodate veterans returning from countries such as Iraq and Afghanistan, who need different types of services than veterans of earlier conflicts.[1] VHA is constructing and leasing new facilities to respond to these needs, and it equips and staffs them through a multi-year process called "activation."

Generally speaking, activation refers to the process of bringing a new facility into full operation, such as purchasing and installing furniture and medical equipment as well as hiring staff. From fiscal years 2012 through

[1] In June 2019, we reported that VA expects that veterans' health care needs and expectations will change due to changes in veteran demographics. For example, VA estimates that there will be an increase in the percentage of enrollees with severe service-connected disabilities in coming years, a rise that will increase the need for services like outpatient mental-health services, and prosthetics. See GAO, VA REAL PROPERTY, *Improvements in Facility Planning Needed to Ensure VA Meets Changes in Veterans Needs and Expectations*. GAO-19-440, (Washington, D.C.: June 13, 2019).

2018, VHA spent more than $4 billion on activation activities at 96 new major medical facilities.[2]

Previously, we have found that VHA struggled with certain aspects of activation, such as equipment purchases and cost estimation for the overall activation process. In 2013, for example, we reported that some medical equipment did not fit into previously constructed areas of the medical center in Orlando, Florida, and the building needed to be altered in order to accommodate the equipment.[3] In addition, in 2017, we found that VA had minimal supporting documentation for its $341 million estimate for the cost to activate the medical center in Denver, Colorado, and as a result we determined that the activation estimate was unreliable.[4]

You asked us to review VHA's efforts to activate new medical facilities. This report: (1) describes the tasks associated with activation, (2) determines the extent to which VHA activated selected new medical facilities within planned time frames, and (3) assesses the extent to which VHA is able to compare actual activation costs against the estimated total costs.

To describe what tasks are associated with activation, we reviewed relevant VHA documentation, such as VA's *Activation Process Guide*, VA's Strategic Plan for Fiscal Years 2018–2024, and VHA's training modules associated with activation processes. To examine specific

[2] In general, "major" medical facility projects are those projects for which the construction, alteration, or acquisition involve a total expenditure of more than $20 million, or a lease that exceeds $1 million in annual rent. See 38 U.S.C. § 8104. The activation spending from fiscal years 2012–2018 reflects the activation expenses reported by these 96 facilities, but this amount does not reflect the total cost of activation for those sites because some facilities may have incurred activation costs prior to 2012.

[3] Medical equipment planners can help coordinate with architectural and engineering firms to ensure that the project's design and construction will accommodate the necessary medical equipment. In April 2013, we found that VA did not have guidance that explained which projects require medical planners and at what stage they should be used. We recommended that VA develop and implement such guidance, which they did later that year. See GAO, *VA CONSTRUCTION: Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects.* GAO-13-302, (Washington, D.C.: Apr. 4, 2013).

[4] We recommended that VA develop a reliable activation estimate for the medical center in Denver; however, it opened the following year and did not complete this task. See GAO, *VA CONSTRUCTION: Improved Processes Needed to Monitor Contract Modifications, Develop Schedules, and Estimate Costs.* GAO-17-70, (Washington, D.C.: Mar. 7, 2017.)

activation efforts in greater detail, we obtained documentation and interviewed officials from 8 of the 13 major medical facilities that reported that they completed activation in fiscal years 2016 or 2017.[5] We selected one facility in each geographic region where major activations were completed during this time period.[6] In cases where a region contained more than one such facility, we selected facilities that, when considered with the other selected facilities, reflected a range of facility sizes and total reported activation costs. For a list of the eight selected facilities and their reported activation costs, please see appendix I. No medical centers (i.e., inpatient hospitals) completed activation in 2016 or 2017. Therefore, to provide context for that type of facility, we also interviewed officials from a medical center that opened in 2016 about their activation experiences.[7] The information from all of these facilities is illustrative and cannot be generalized to facilities agency-wide, but collectively, the experiences of these facilities provide insight into the tasks associated with activation. We also interviewed regional officials supporting the selected sites,[8] and VHA officials responsible for managing activation at the national level.

To determine the extent to which VHA activated selected facilities within planned time frames, we focused on the activation period leading up to the provision of medical services (i.e., when each service department, such as dentistry or physical therapy, first treated patients). For each of the eight selected facilities, we compared the month and year when the first patient received each service against the month and year officials at

[5] For the purposes of this report, we defined "completing activation" as the fiscal year when the facility ceased to spend activation funding.

[6] VA organizes its system of care into 18 regional networks called Veterans Integrated Service Networks (VISN). Each VISN is responsible for managing and overseeing VA medical facilities within a defined geographic area.

[7] Four VHA medical centers opened in recent years: Las Vegas, Nevada (2012); Orlando, Florida (2015); New Orleans, Louisiana (2016); and Denver, Colorado (2018). We interviewed officials from New Orleans because it did not share a VISN with any of the eight selected facilities.

[8] We spoke with the planning officials at VISN 6 (North Carolina and Virginia); VISN 7 (Alabama, Georgia, and South Carolina); VISN 8 (Florida, Puerto Rico, and the U.S. Virgin Islands); VISN 10 (Indiana, Ohio, and Michigan); VISN 17 (Texas); VISN 19 (Colorado, Montana, Oklahoma, Utah, and Wyoming); VISN 20 (Idaho, Oregon, and Washington); and VISN 22 (Arizona, New Mexico, and Southern California).

each facility planned to start providing that service. [9] In making these calculations, we used the planned dates that were in place at the time of building acceptance (i.e., the date on which staff gained access to a facility after construction finished).[10] To determine planned and actual dates, we asked officials from each of the eight facilities to complete a form with this information and to provide supporting documentation—such as plans, written communications, and service logs—when available. We also interviewed officials from each of the eight selected sites to determine reasons for any differences between the planned and actual dates of care for any of the services. To further assess the timeliness of activation activities, we determined the proportion of medical services at the selected sites that were provided within 6 months of opening day, as VA's *Activation Process Guide* states that patients can generally expect all services to be available within that time frame.

To assess the extent to which VHA is able to compare actual activation costs against estimated costs, we first evaluated VHA's process for developing activation cost estimates. To do so, we reviewed VHA's cost estimation tools to determine if they covered the full activation time frame, and assessed the process that VHA uses to develop cost estimates against the 12 steps in the GAO *Cost Estimating and Assessment Guide*.[11] The evaluation was performed by one analyst and the conclusions were reviewed and verified by another analyst. To determine the extent to which VHA compares actual costs against a baseline estimate, we reviewed cost documentation (including any estimates and actual costs) from each of the eight selected sites. We assessed the reliability of the cost data by comparing the data to the supporting documentary evidence that we received from VHA; interviewing knowledgeable VHA officials; and reviewing the data for completeness. In

[9] Given that documentation often expressed planned dates in general terms, such as "October 2015" or "late October 2015," we used month and year—instead of the difference between precise dates—to calculate time frames.

[10] Multiple VA officials told us that construction delays can significantly affect activation timelines. By measuring planned service dates as of building acceptance, we were able to identify delays that were more likely to be associated with activation activities than with construction.

[11] VHA does not have a specific policy or manual describing the cost estimation process for activation; therefore, we reviewed two estimation tools in conjunction with other VHA-supplied information, such as the *Activation Process Guide*, interviews, and documented answer sets from VHA officials. See GAO, *GAO Cost Estimating and Assessment Guide: Best Practices for Developing and Managing Capital Program Costs.* GAO-09-3SP, (Washington, D.C.: Mar. 2, 2009).

addition, we researched and reviewed relevant legislation pertaining to the amounts that were authorized for a selection of these projects. The data were sufficiently reliable for the purposes of this report. Lastly, we interviewed officials from the Activations Office, regional support staff, and finance officials at the selected sites regarding cost estimates and the extent to which actual costs are compared to those estimates.

We conducted this performance audit from September 2018 to January 2020 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's mission is to serve America's veterans and their families, and one of the ways it does so is by providing veterans with medical services. To help meet the health care needs of veterans, VHA is planning to complete approximately 70 new major medical projects between 2020 and 2024. Activation is one of the key steps that must occur before veterans can access care at these facilities.

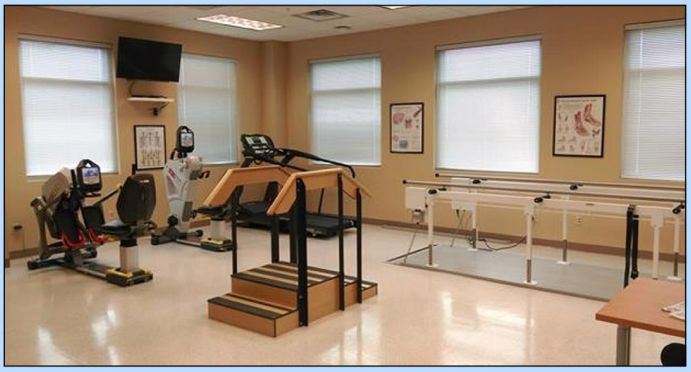
According to VA's *Activation Process Guide*, activation typically involves activities such as planning for, purchasing, and installing new furniture, fixtures, and equipment (FF&E), ordering supplies, and hiring staff. For new buildings, the Guide states that activation activities begin when the building is being designed, continue through construction, and end when the facility is fully operational.

The expenses associated with activation can reflect either one-time purchases or ongoing expenditures. One time purchases—called non-recurring activation expenses—involve the acquisition of assets such as furniture or equipment, or payment to a contractor for services such as equipment installation. Ongoing expenses, or expenses incurred more than once—called recurring activation expenses—are for staff salaries and consumable supplies, such as gowns and gloves. After a facility opens and begins serving patients, facilities are permitted to treat supplies and the salaries of new staff as activation costs until the site is serving enough patients to receive funding through one of VA's regular funding processes, known as the Veterans Equitable Resource Allocation

(VERA). Figure 1 provides examples of recurring and non-recurring activation expenses.

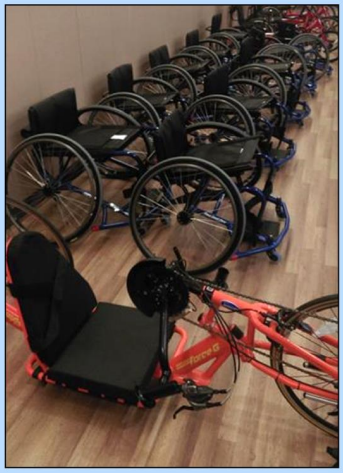
Figure 1: Examples of Activation Expenses for the Veterans Health Administration's (VHA) New Medical Facilities

A worker moves a large piece of imaging equipment into a new facility. Installing equipment is a **non-recurring** activation expense.



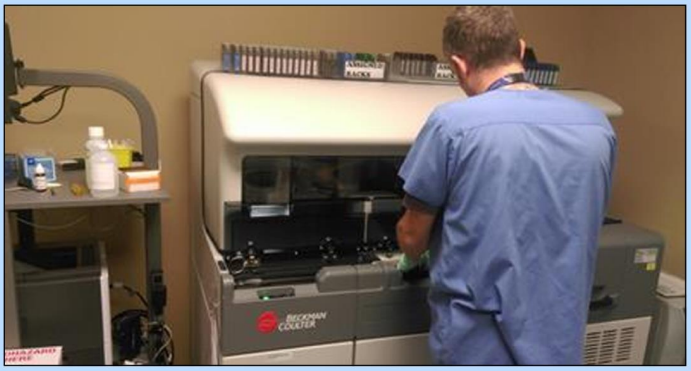
Physical therapy equipment is a **non-recurring** activation expense.

Furniture in waiting rooms, such as chairs, side tables, and bookshelves, is a **non-recurring** activation cost.



Bicycles adapted for disabled veterans (which allow them to participate in VA sports programs) are a **non-recurring** activation cost because they are only purchased once.

Supplies include gloves and gowns, among other items. Supplies are a **recurring** activation expense because they are purchased multiple times during activation.



A staff member processing blood. Staffing costs can be a **recurring** activation expense under certain circumstances.

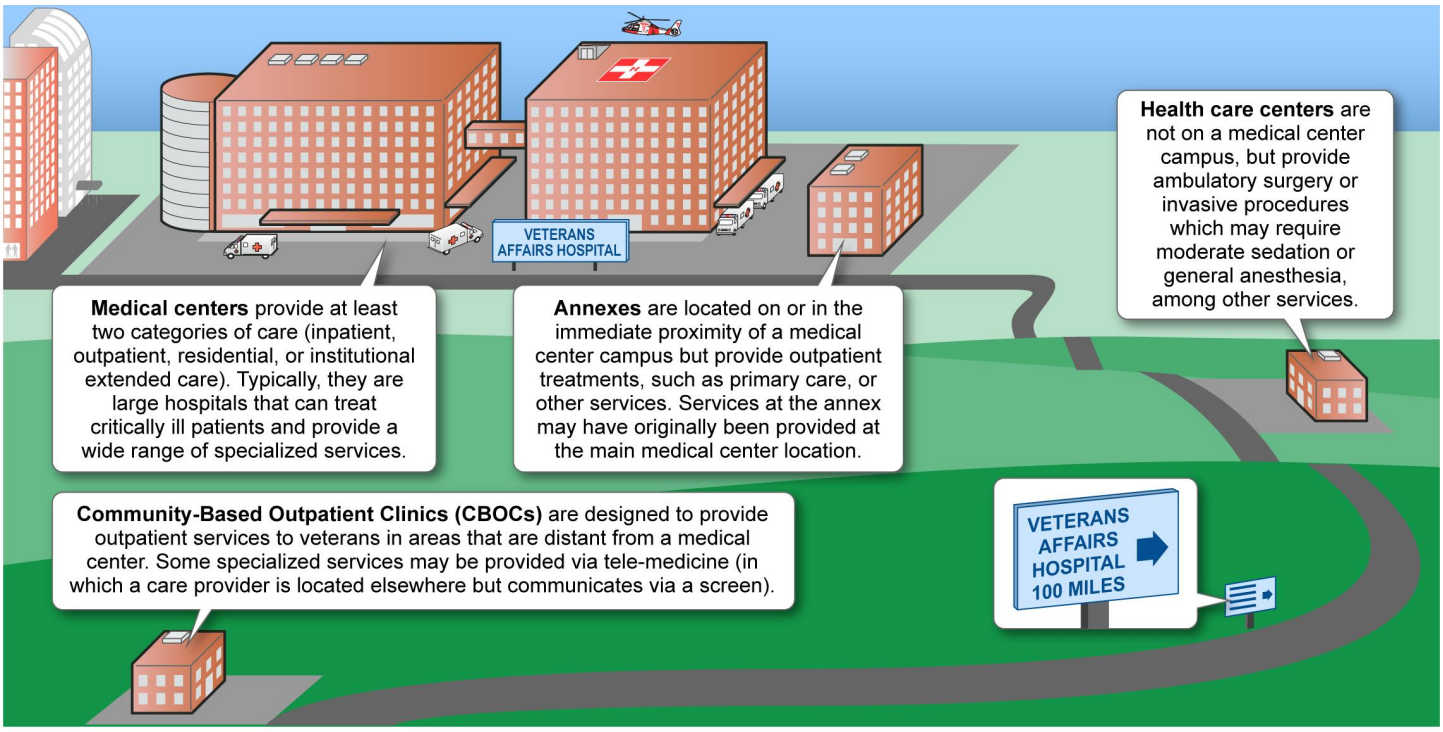
Sources: Veterans Affairs (photograph at top left) and GAO. | GAO 20-169

The total cost of activation for major lease and major construction projects can be substantial. The median activation funding that facilities reported spending on major activations from fiscal year 2012 through 2018 was approximately $16 million. The four newest hospitals (in Denver, Las Vegas, Orlando, and New Orleans) spent a cumulative total of more than $1.9 billion for activation during this time period.[12]

The types of facilities undergoing activation can vary in size, services provided, and overall purpose within the VHA healthcare system, as shown in figure 2. For example, a community-based outpatient clinic (CBOC) is typically much smaller than a medical center but can provide primary, specialty, subspecialty, mental health, or any combination of delivery services that can be appropriately provided in an outpatient setting. Large medical centers can provide outpatient services as well as a broad range of inpatient services, including emergency services, surgery, and acute psychiatric care. Smaller facilities may refer patients to medical centers for complex treatment.

[12] As discussed below, VHA's Activations Office determines the base amount of activation funding that a major project will receive. Projects can supplement their Activation Office funding from other sources within VA. In addition, funding for information technology purchases comes from VA's Office of Information and Technology.

Figure 2: Examples of Veterans Health Administration (VHA) Medical Facilities of Varying Size and Purpose



Source: GAO analysis of Veterans Health Administration (VHA) documentation. | GAO 20-169

National, regional, and local staffs play different roles in the activation process:

National: VHA's Activations Office—under the Office of Capital Asset Management (OCAM)—historically provided ad-hoc support to sites activating a major lease or construction project, such as providing on-site training related to the activation process and facilitating input from subject matter experts within VHA.[13] The office also determines the base amount of activation funding that sites receive. Officials overseeing the office stated that its role is being reassessed and that the type of support it provides for activations may change in light of an internal reorganization and consideration for VA's future growth plans.

[13] The Activations Office is referred to in various documents as the "National Activations Office (NAO)"; "OCAMES-Activation"; the "activations program"; and the "Activations Office". For the purposes of this report, we refer to it as the Activations Office.

Regional: VHA's18 regional networks, known as Veterans Integrated Service Networks (VISN), are responsible for the coordination and oversight of all administrative and clinical activities at health care facilities within their specified region. A VISN's role in activation varies depending on the expertise available at the facility level, but VISNs can help facilities arrange contracts for services (like laundry or hazardous waste removal); review a facility's budget submissions to VHA; and facilitate discussions with senior management or knowledge-sharing with other sites that have recently completed activation. The VISNs are also responsible for distributing activation funding from VHA.

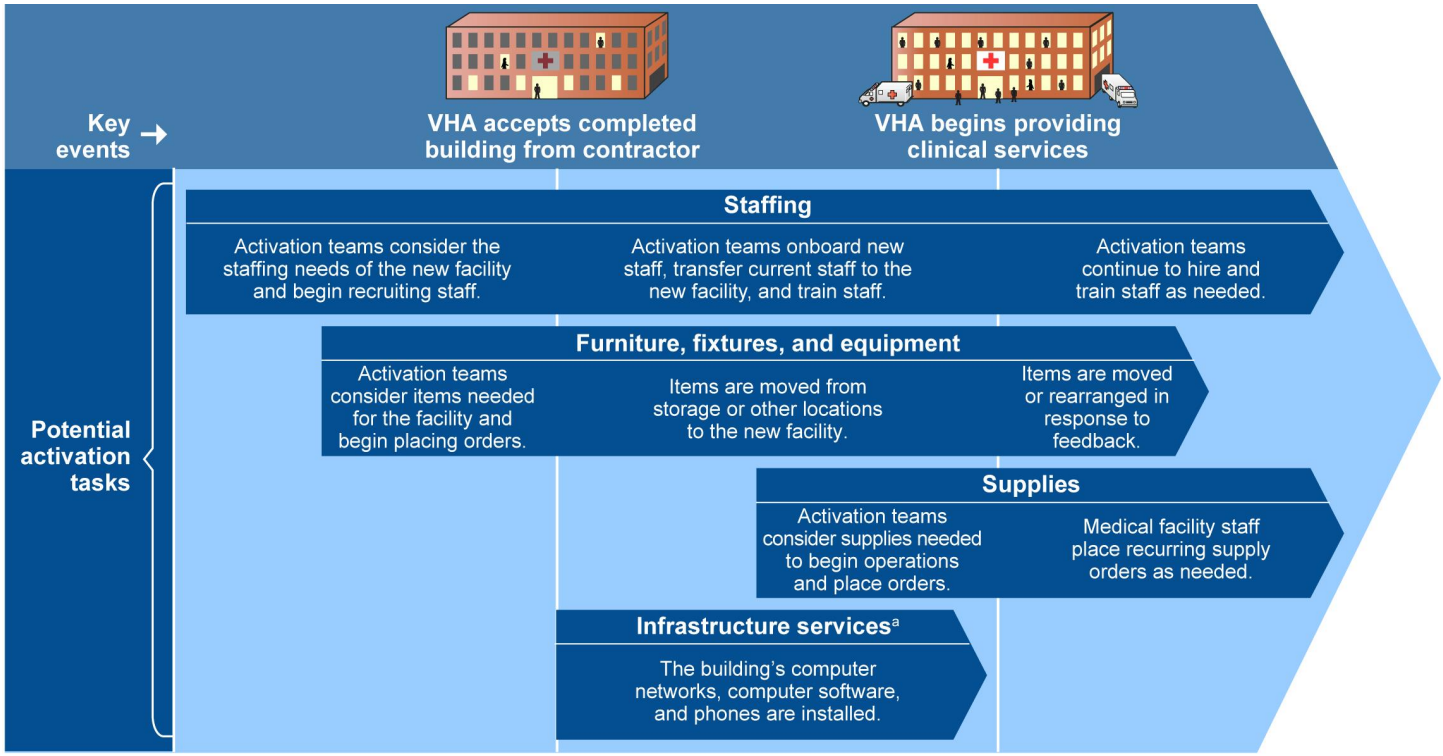
Local: In addition to providing medical services, medical centers function as administrative hubs for services in the area. As a result, the medical center director is ultimately responsible for activating facilities within the center's administrative boundary. The medical centers can appoint staff to manage the activities required for activation. These staff can include the activations project manager, financial officers, and subject matter experts like interior designers. As a team, the staff are responsible for developing technical requirements, creating risk mitigation strategies, and deciding key acquisition dates, among other tasks.

Activation Tasks Include Identifying and Fulfilling Staffing, Equipment, and Other Needs

Planning and Execution of Activation Tasks Align with Building Acceptance and the First Day of Clinical Services

While VHA has not identified standard milestones for activation, based upon our review of VHA documents and interviews with local and regional VHA officials, we found that two events are especially relevant to the planning and execution of activation activities: (1) building acceptance (when VHA formally takes possession of and occupies a building) and (2) providing medical services to the first patient. Figure 3 describes examples of activation activities in relation to these events, although the actual timing of tasks will vary depending on the needs of individual facilities.

Figure 3: Examples of Activation Activities for Veterans Health Administration (VHA) New Medical Facilities, in Relation to Key Events



Source: GAO analysis of Veterans Health Administration (VHA) documentation and interviews with VHA officials. | GAO 20-169

[a]Infrastructure Services are not supported by funding from the Activations Office. VA's Office of Information and Technology funds infrastructure expenses for facilities undergoing activation.

Activation Teams Begin Equipping and Staffing New Facilities Prior to Building Acceptance

Officials from selected facilities said that prior to building acceptance, their activation activities typically focus on determining furniture and equipment needs, placing orders, anticipating staffing needs, and hiring new staff.

Determining furniture and equipment needs is intertwined with the building design process, according to officials from three VHA facilities, because the design of the physical space can dictate what equipment is purchased. For example, a VHA official from one health-care center said that the activations team showed the medical care providers a mock-up of a treatment room and created cardboard models of furniture to help them

select items. The official told us that getting the medical care team's input early in the planning process can avoid the need to make costly changes in order to make the physical space fit the equipment or furniture requested by the medical care providers.

Conversely, the building may be designed to accommodate specific equipment. For example:

- Officials from one facility shared the specifications of the radiology equipment with the team designing the building in order to leave a proper amount of space for the equipment.
- Similarly, an annex's activation staff worked with the resident engineer to design an enclosed area separate from their main building for a mobile MRI machine. This design ensured a new MRI machine could be swapped out in the event of a breakdown without causing a disruption to the facility's operations.

Officials said that they also begin the purchasing process for equipment and furniture prior to building acceptance. VHA officials stated they work backwards from the construction endpoint to determine when to order items. VHA officials told us they need to place orders for certain items—such as high-tech equipment or made-to-order furniture—well in advance of the facility's opening because the items are known to have long delivery times. For example:

- Officials from one clinic reported they ordered their facility's imaging equipment 22 months before they needed it.[14]
- Similarly, an official from a different clinic said that furniture is often not manufactured until it is ordered, so it can take several months to arrive. In contrast, the official said items like a staff refrigerator could be picked up at a local store within days and do not require substantial advance planning.

Facilities also begin planning for their workforce needs prior to building acceptance. For example:

[14] Depending on the cost of the equipment, VHA officials might utilize different ordering procedures. VHA orders high-tech medical equipment in a consolidated order three times a year.

- An official from one clinic stated that facilities typically identify their staffing needs during this time period by position, title, and pay.
- Officials from an annex said that before their facility's construction groundbreaking, they discussed how many staff would move from the old facility to the new facility, and how many new staff they expected to hire.

After activation teams determine their staffing needs, facilities hire and begin training new staff. For example:

- An official from one clinic said that new staff needed to be trained prior to opening day, so it is not uncommon for staff to be hired and brought on-board before the facility begins providing clinical services.
- In the case of a very large facility, such as a medical center, hiring the required staff can require an extensive search that must commence before the building is finished. An official from a medical center said that a shortage of skilled medical workers required a nationwide search for suitable candidates.

New Facilities Prepare for Patient Care after Building Acceptance

Officials said that after a building is accepted as complete, activation typically focuses on tasks associated with moving into the space, such as equipment installation and training staff. For example:

- One clinic's project calendar showed in the weeks leading up to opening day that the activations staff planned to install office furniture such as desks and filing cabinets, as well as to perform checks on biomedical equipment to ensure proper functioning.
- Officials from another clinic coordinated equipment and furniture deliveries between the warehouse (where items were being stored) and the new facility.

The extent of staff training after building acceptance depends on the need to familiarize staff with the new facility, and the complexity of services offered. Activation staff might choose to have medical staff become familiar with the new facility by working at the facility prior to new operations. For example:

- One clinic's staff started working in the building before their first patient was seen in order to become familiar with the new space.
- An official from a medical center said that facility staff adjusted to operating newer infrastructure, such as learning to operate a modern computerized boiler system. That official also stated that the medical center might need to conduct extensive training exercises to simulate 24/7 inpatient care. In contrast, outpatient facilities that do not operate around the clock may not have these same training needs.

Activation Continues after Facilities Begin Providing Clinical Services

Once a facility begins providing medical care, officials said that activation tasks are typically related to facility operations. These tasks can include on-the-job training in the new space and making necessary adjustments to the facility to ensure it runs properly while concurrently serving new patients. For example:

- An official at one clinic said that beginning patient care with a decreased workload, known as a "soft opening," can help facilitate on-the-job training. The same official explained that this approach allows staff to become accustomed to their new facility's operations and address any issues that may emerge without the demands of operating at full capacity.
- VHA officials from a health care center said that space adjustments included repositioning exam beds and ordering ergonomic chairs.
- Officials at several sites stated that they used SharePoint, an internal communication tool, to keep track of needed adjustments.[15] This approach enables staff to monitor ongoing issues during the beginning of new operations, resolve unexpected problems, and track issues as they occur.

Several VHA officials also said that some activation tasks —such as hiring staff—may occur after a facility begins serving patients. If a facility plans on a phased opening, in which some services will not be available on the first day, processes that would typically be completed earlier may take place during this time frame instead. For example, a medical center

[15] SharePoint services include intranet portals, document and file management, and team collaboration tools.

in our review utilized a phased-opening approach, as it expanded its capabilities with new medical services after opening.

Selected Facilities Provided Most Clinical Services within Expected Time Frames, but Delays Occurred for a Variety of Reasons

The facilities included in our review provided most medical services within planned time frames;[16] however, nearly one-third of services were delayed for various reasons. Overall, 59 of the 87 services were offered within planned time frames (69 percent). Of the 28 services that were not provided on time, staffing, equipment size, "commissioning",[17] and procurement issues contributed to the delays, according to officials.

[16] Officials explained that they did not always have detailed clinical service delivery timelines early in the planning process; rather, service delivery goals are sometimes represented broadly (e.g., first quarter 2020) and then more specifically (e.g., late October 2020, or October 31, 2020) as construction advances. In some cases, the facility's management had not established a precise opening day at the time of building acceptance, and still referred to the goal by month and year. To address this issue, we calculated time frames using months instead of days or weeks. While we selected and reviewed eight facilities, one facility was unable to determine when it had planned to offer all 25 of its services. Officials explained that the documentation was incomplete and the staff associated with the activation process were no longer available. As a result, we excluded this facility's information from our analysis.

[17] "Commissioning" is a systematic approach to testing building systems, like heating and lighting. Commissioning also seeks to determine whether the installed building equipment (e.g. chillers, boilers, motors, airflow system) meets a facility's goals or needs to be adjusted to improve efficiency and overall performance, consistent with the original design intent. Commissioning is related to design and construction, not activation.

- **Staffing** issues delayed a total of 14 services in two of the seven facilities reviewed.[18] One facility had 13 services with delays that ranged from 4 to 6.5 months. Officials said the delays were due to difficulties recruiting the staff necessary for those services, which included various types of surgery, radiology, and mental health, among others. Similarly, difficulties recruiting a dentist at a second facility delayed dental service 4 months beyond the expected delivery time frame.
- **Equipment** at one facility did not fit into some of the rooms and the space needed to be altered in order to accommodate it.[19] Officials said that all 12 services were delayed by approximately 1 month so that the facility could open with all services available, though officials noted that the full extent to which the equipment issues contributed to these delays was unknown (i.e., there could have been other causes that they could not recall.)
- **Commissioning** issues delayed women's healthcare services at one annex by approximately 1 month. Officials said that the air circulation rate—which needed to be higher in rooms where certain procedures are performed—was inadequate. As a result, the air exchange had to be

[18] VA's workforce-related challenges are well-documented, and we have made numerous recommendations related to this issue. We and the VA Office of the Inspector General have issued reports that raise a variety of concerns about VHA's workforce planning and management. Specific concerns have included whether or not VHA has sufficient numbers of certain types of clinical employees; is using reliable data to measure workload and productivity; and has sufficient oversight of recruitment and retention incentives for nurses and performance pay for physicians. In 2017, we recommended that VA (1) establish a system-wide method to share information about physician trainees to help fill vacancies across facilities, and (2) conduct a comprehensive, system-wide evaluation of physician recruitment and retention strategies to determine their overall effectiveness, identify and implement improvements, ensure coordination across VHA offices, and establish an ongoing monitoring process, among other improvements. VA agreed with these two recommendations and is working to address the first recommendation and has implemented the second. See GAO, *Veterans Health Administration: Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies.* GAO-18-124, (Washington, D.C.: Oct. 19, 2017).

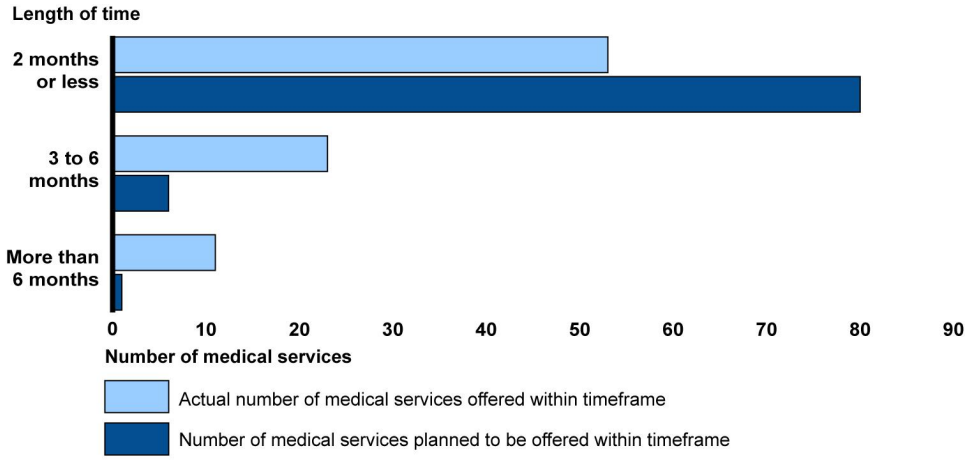
[19] Medical equipment planners can help coordinate with architectural and engineering firms to ensure that the project's design and construction accommodates the necessary medical equipment. In April 2013, we found that VA did not have guidance that explained which projects require medical planners and at what stage they should be used. We recommended that VA develop and implement such guidance. See GAO, *VA Construction: Additional Actions Necessary to Decrease Delays and Lower Costs of Major Medical-Facility Projects*. GAO-13-302 (Washington, D.C.: Apr. 4, 2013).On August 30, 2013, VA issued a policy memorandum that stated that all VA major construction projects would retain the services of a Medical Equipment Specialist to be procured through the project's architectural engineering firm. At the time this policy was issued, the selected facility had already been designed and was in the process of being built.

improved before the facility could begin performing the planned clinical procedures.

- **Procurement** issues led to delays in providing radiology services at one facility. Officials told us that x-ray services were delayed by 3 months because the equipment was ordered through the centralized purchasing process, which took longer than local officials had anticipated.

These delays primarily affected services that were originally planned to be offered within 2 months of building acceptance. While selected facilities planned to offer approximately 92 percent of services within 2 months of building acceptance, as shown in figure 4, 61 percent were actually offered within that time frame.

Figure 4: Planned and Actual Length of Time to Provide Medical Services after Building Acceptance at Seven Selected Veterans Health Administration (VHA) Facilities



Source: GAO analysis of information provided by seven selected VA medical facilities. | GAO 20-169

VHA does not provide a guideline for how much time facilities should need after building acceptance to provide clinical services. Officials explained that the appropriate amount of time will vary based upon the scope of the project, including factors such as the number and kinds of services offered and the level of effort associated with installing the equipment (e.g., a replacement hospital will require more effort than a small outpatient clinic). Thus, we did not determine if facilities were allotting appropriate amounts of time to complete activation activities and serve patients. However, VA's *Activation Process Guide* provides some information regarding when full services should be available. The *Guide*

states that clinical services can be added for up to 6 months after opening day (i.e., the first day that patients receive any services at the facility).[20] The *Guide* further states that facilities may expect to offer services gradually—versus all on opening day—when services are new to an area.

Of the 87 services offered by the facilities in our review, 86 were offered within 6 months of opening day. The remaining service—a clinic that provides colonoscopy and other related procedures at one facility—opened on schedule approximately 11 months after opening day. This facility was replacing another facility that had not previously offered this service. Officials explained that because the service was new, they needed more time to develop and equip the space as well as hire staff, so they planned on offering this service later than services that were being transferred from the previous facility.

VHA Lacks Processes and Clear Definitions to Estimate and Oversee Total Activation Costs

VHA lacks processes to develop total cost estimates for major activations. Without total cost estimates, VHA is unable to determine whether actual activation expenses are higher or lower than planned. Furthermore, VHA does not have documentation that defines allowable activation costs, including what facilities can purchase with activation funding and when facilities should cease spending activation funds. As a result, VHA officials lack critical information to support decision-making about resource allocation, and are not well positioned to effectively identify and investigate deviations from planned spending.

VHA Lacks Processes to Develop Total Activation Cost Estimates and Compare Them against Actual Costs

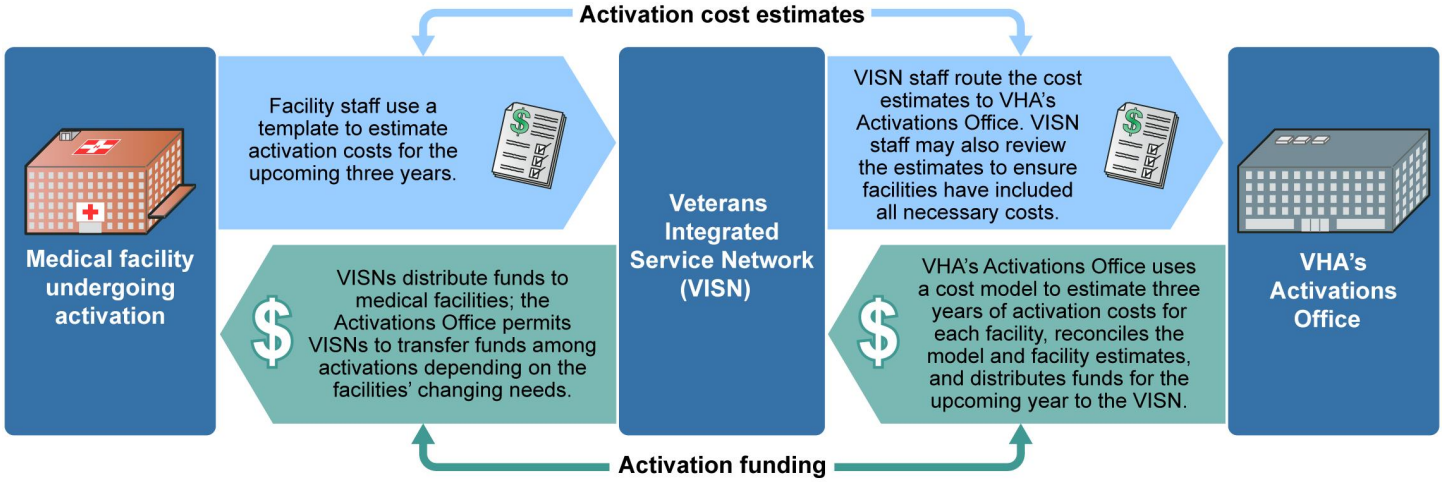
VHA lacks processes to develop reliable total activation cost estimates for major activation projects and to compare actual costs against these estimates. According to our assessment of information from VHA, the current cost estimation process does not cover the full duration of activation and does not reflect best practices for developing reliable cost

[20] The *Guide* also states that processes and approaches are expected to vary by facility. VA officials noted that all aspects of the *Guide*, including providing services within 6 months of opening day, are not requirements.

estimates. In addition, VHA officials said that until recently, the agency lacked the accounting mechanisms necessary to facilitate comparisons of a project's total activation costs against estimated costs; however, while VHA now possesses these mechanisms, it has not documented the process for how the new information should be used.

The Activations Office and facility activation staff annually develop cost estimates for the upcoming 3 fiscal years using (1) an activation cost model (the model) and (2) a cost template (the template). According to Activations Office officials, the model is managed by the Activations Office and uses inputs such as a facility's square footage and project schedule. Activations Office officials also said that the template is typically completed by facility activation staff and includes inputs such as planned clinical services as well as estimated staffing, equipment, and supply costs. While the cost estimate is driven primarily by the model, information in the template is also considered before annual activation funds are distributed, according to Activations Office officials. Figure 5 shows the steps for determining and distributing annual activation funds.

Figure 5: The Steps the Veterans Health Administration (VHA) Uses to Determine and Distribute Funds to Activate New Major Medical Facilities



Source: GAO analysis of interviews with Veterans Health Administration (VHA) officials and VHA documentation. | GAO 20-169

We determined that the model and template do not estimate costs for the entire duration of a facility's activation. According to our review of facilities' spending data, activation spending for a given facility can occur over more than 3 fiscal years. All eight of the facilities in our review, for example, spent activation funds over 4 or 5 fiscal years. Thus, the estimate the Activations Office would have developed at the beginning of

these projects would not have reflected total activation costs. Moreover, we did not see evidence that VHA medical facilities independently develop total activation cost estimates that are appropriate to compare against total actual costs. None of the eight selected facilities we reviewed could provide total activation cost estimates appropriate for this use, according to officials at each facility. Officials from five facilities stated that they had not developed such estimates, an official from one facility said that an estimate could not be located and probably had never been done, and officials from two facilities said that such documentation could not be located.

VHA officials said that the existing cost estimation tools reflected the budgeting process (i.e., the current fiscal year and two future years) and that they had not previously been required to develop a cost estimate for the entirety of activation. Officials noted that as the Activations Office's role shifts to include more oversight, it will be important for the Office to have total cost estimates for activation; however, as of September 2019, VHA did not have any specific plans for how to collect estimates for a project's entire activation cost.

We also found that VHA's current process for developing activation cost estimates does not fully align with best practices for developing cost estimates as established in the GAO Cost Guide (see table 1 below).[21] VHA's process minimally met 10 and did not meet 2 of the steps—each of which reflects multiple best practices—required to develop reliable cost estimates. A reliable cost estimate is critical to the success of any program, providing the basis for informed decision-making, realistic budget formulation and program resourcing, and accountability for results. VHA officials acknowledged that following these practices would be valuable for the activations process, and explained that the agency did not previously incorporate these practices because they had not assessed the strength of their activation cost estimation process in this manner.

[21] Because VHA does not have a specific policy or manual describing the cost estimation process for activation, we reviewed two estimation tools (i.e., the model and the template) in conjunction with other VHA-supplied information, such as the *Activation Process Guide*, interviews, and documented answer sets from VHA officials.

Table 1: Summary Assessment of Veterans Health Administration (VHA) Activation Cost Estimating Process Compared to Best Practices

Step	GAO's overall assessment[a]	GAO's detailed assessment of the extent to which VHA's process aligned with best practices[b]
1. Define estimate's purpose.	Minimally Met	The cost model and template refer to the estimate's purpose and high-level descriptions of the scope. However, VHA has no documentation requiring the cost estimate to have a clearly defined scope.
2. Develop the estimating plan.	Minimally Met	The cost model and template mention medical center staff, field personnel, the Activations Office, and other stakeholders as being involved with developing cost estimates. However, there is no documentation discussing who is responsible for developing the estimates or establishing adequate time to develop an estimate.
3. Define the program's characteristics.	Minimally Met	The cost model and template describe the attributes used (for example, project type, square footage, milestone dates, and staffing). However, there is no evidence that VHA's process addresses all technical aspects of activations, identifies who develops or approves the attributes, or specifies how often the attributes are updated.
4. Determine the estimating structure.	Minimally Met	The cost model and template break costs down into multiple categories; however, there is no evidence that VHA's process requires that all work be identified.
5. Identify ground rules and assumptions.	Minimally Met	The cost model and template identify some ground rules and assumptions—such as incorporating inflation—but there is no evidence that either requires the identification and documentation of these rules and assumptions for activation cost estimates. Furthermore, there is no documentation that identifies who should develop the ground rules and assumptions, whether management should approve these rules and assumptions, whether the rationale behind the assumptions and historical data back up any claims, and discussion of associated risks if an assumption changes.
6. Obtain the data.	Minimally Met	The cost model and template describe some programmatic and cost data at a high level. However, there is no evidence of criteria for collecting valid and useful historical data to develop a sound cost estimate.
7. Develop the estimate and compare to an independent cost estimate.	Minimally Met	VHA uses the cost model and template to develop activation cost estimates. However, there is no evidence of a policy regarding the development of a point estimate (i.e., a "best guess" at the cost estimate), comparing the point estimate to an independent cost estimate, validating the estimate by looking for errors, and performing cross-checks on cost drivers.
8. Conduct a sensitivity analysis.	Not Met	A sensitivity analysis examines the effect of changing ground rules and assumptions. VHA provided no documentation showing that a sensitivity analysis must be performed on activation cost estimates.
9. Conduct a risk analysis.	Not Met	A risk analysis identifies and examines factors that will affect the program's cost, schedule, or technical status, including political and organizational issues. VHA provided no documentation that a risk analysis must be performed on activation cost estimates.
10. Document the estimate.	Minimally Met	While the cost model and template lay out costs by year, VHA has no documentation providing for a narrative description or documentation of the basis of the estimate.

Step	GAO's overall assessment[a]	GAO's detailed assessment of the extent to which VHA's process aligned with best practices[b]
11. Present estimate to management.	Minimally Met	The cost model and template generally mention who reviews estimating results; however, VHA has no documentation of how estimates are approved, how the results are presented to management, who modifies the results, or how the results are to be validated.
12. Update the estimate.	Minimally Met	The cost model and template describe the Activations Office reviewing the estimate annually; however, there is no evidence of guidance that describes the frequency of updates, updating with actuals, and other associated best practices for updating an estimate.

Source: GAO comparison of the Activation Office's activation cost estimating process and GAO Cost Guide. GAO-09-3SP | GAO-20-169.

[a]Fully Meets: the Activations Office provided complete evidence that satisfies the elements of the best practice; Substantially Meets: the Activations Office provided evidence that satisfies a large portion of the elements of the best practice; Partially Meets: the Activations Office provided evidence that satisfies about half of the elements of the best practice; Minimally Meets: the Activations Office provided evidence that satisfies a small portion of the elements of the best practice and Not Met: the Activations Office provided no evidence that satisfies any of the elements of the best practice.

[b]The documentation on the activation cost estimating process consists of a cost model used by VHA's Activations Office and a template used by officials at activating facilities to estimate activation costs. However, neither document discusses cost estimating policy or best practices. Without a specific cost estimating policy or manual, we reviewed the model and template in conjunction with other VHA-supplied information.

Lastly, the Activations Office does not compare existing estimates and actual activation costs. While the Activations Office develops activation cost estimates for the upcoming 3 fiscal years and has some capabilities to track activation costs, to date it has not compared the planned costs to actual expenses. According to Activations Office officials, they have historically been unable to track how activation funding was spent at the facility level, which impeded such comparisons.[22] Starting in fiscal year 2020, officials from the Activations Office plan to use accounting codes associated with each activation project, which will allow them to track expenses at the facility level. An internal review conducted in mid-2019 by the department overseeing the Activations Office concluded that the agency needed to regularly assess the extent to which activations spent funds as planned. As of October 2019, however, officials said the office has not documented the process for how they will deploy their new accounting oversight capabilities, including which personnel would be responsible for conducting such comparisons, the frequency of

[22] VISNs have the authority to transfer activation funds from one facility to another depending on the facilities' needs (i.e., one facility was delayed due to construction issues while another was ahead of schedule). Officials said that the Activations Office was previously only able to track activation funding by the medical center that oversees the activating facility. They stated that if a medical center oversaw more than one activation, the Activations Office was previously unable to identify how much activation funding the individual facilities spent.

comparisons, and any follow-up steps that would be considered in the event of significant differences.

Without processes for estimating total costs and comparing them against actual expenses, the Activations Office is limited in its ability to improve resource planning, budgeting, and allocation—critical elements that support VA's stated management priority to enhance data-driven decision-making.[23] Further, guidance from the Office of Management and Budget states that agencies should obtain information on actual project costs and compare them against planned expenses so managers can have a clear understanding of how resources are being used and whether cost goals are being met.[24] Documented processes for cost estimation and comparison would be particularly important in the case of large medical centers, whose activation costs are in the hundreds of millions of dollars.

VHA's Activations Office Has Not Clearly Defined Allowable Activation Costs or Spending Time Frames

The Activations Office has not clearly defined what officials at local facilities can purchase with activation funding and how long activation funding should continue after opening day. Activations Office officials said that there is a general understanding that some expenses, such as medical equipment for new facilities or services, are activation expenses, and that the Activations Office intends to provide activation funding until the facility begins to receive VERA funding to cover operational expenses. However, there is no policy to inform facility activation staff of what they can purchase with activation funding and when funding will cease. In mid-2019, an internal review conducted by the department overseeing the Activations Office found that the lack of clarity regarding what could or could not be purchased should be remedied; however, as of September 2019, no specific plans have been established to define appropriate purchases.

[23]Department of Veterans Affairs, *FY 2018–2024 Strategic Plan* (Washington, D.C.: May 31 2019).

[24]Office of Management and Budget, *Circular No. A-11, Preparation, Submission, and Execution of the Budget* (Washington, D.C.: June 2019).

Officials we spoke with—both at the selected medical facilities and VISNs—expressed uncertainty about what expenses they could pay for using activation funding.

- Officials from two of eight facilities told us that there were times when they did not know if they should charge an expense to activation or another funding source, such as construction accounts.[25] For example, officials at one facility told us that they were unsure whether construction or activation funds would pay for the special window blinds needed for the intensive care units.
- Officials at four of the VISNs also said that when contacted by medical facility officials for guidance on allowable expenses, there were times when they did not know if facilities should charge an expense to activation or another funding code.

In addition, officials from the selected sites held differing views on how long they were eligible to receive activation funding from the Activations Office. Finance officials for one of the selected facilities said that activation funding is provided for up to 5 years, while officials from several other facilities said that activation funding is available until operational expenses are covered by VERA. Activations Office officials said that the latter interpretation is accurate and that this transition to ongoing VERA support should take place within approximately 2 years after opening day.[26] However, an official from the Activations Office said that a few facilities have received funding from the Activations Office for more than 2 years after opening because there was no clear definition for when activation funding should cease.

The lack of clear definitions regarding what constitutes allowable activation expenses and when activation funding should end limits VHA's ability to consistently and accurately estimate and track activation costs. For example, similar facilities could develop varying total cost estimates due to different understandings of what expenses are allowable. VA management priorities include making data-driven decisions to improve

[25] While VHA has a decision tree to help officials determine if an expense should be categorized as a construction expense, the document does not clearly identify what non-construction expenses are activation-related.

[26] An official from the Activations Office said that the appropriate endpoint for activation funding may vary based on the circumstances of the individual facility—such as size and complexity of services. However, VHA officials noted that moving forward, it would be valuable to define the appropriate parameters for activation funding.

resource planning, budgeting, and allocation.[27] In addition, Standards for Internal Control in the Federal Government states that management should use quality information to achieve the entity's objectives.[28] Clear definitions on what expenses facilities should charge to activation accounts, and for how long, would improve the Activations Office's ability to monitor activation costs and improve resource stewardship.

Conclusions

As VHA undertakes the process of replacing facilities to better reflect its focus on outpatient and specialized care, it is poised to spend hundreds of millions of dollars per year to equip and staff these new sites. However, VHA does not have a clear understanding of total costs and whether individual activation projects are spending funds effectively. Because VHA does not have a process for developing an estimate for the entire activation cost of a project, the agency lacks a critical baseline that can inform future spending decisions. In addition, because VHA lacks a process that describes how officials should compare actual expenses to that estimate, the agency has no mechanism to regularly identify and respond to unplanned differences in activation costs. Furthermore, defining allowable activation expenses would better position VHA to ensure total cost estimates are consistent from facility to facility. Lastly, additional clarification on how to estimate activation costs and compare them against actual expenses would help VHA to more effectively manage the activations process. Without processes and clear definitions associated with activation cost measurement, VHA does not have reasonable assurance that it will be able to effectively manage the resources associated with activation.

Recommendations for Executive Action

We are making the following four recommendations to VA:

- The Assistant Deputy Under Secretary for Health for Administrative Operations should develop and document a process for estimating total activation costs for major medical facility projects. This process should

[27]Department of Veterans Affairs, 2019.

[28]GAO-14-704G

reflect the 12 steps for developing a reliable cost estimate outlined in the GAO Cost Guide. (Recommendation 1)

- The Assistant Deputy Under Secretary for Health for Administrative Operations should develop and document a process for comparing actual activation costs for major medical facility projects to estimates. This process should identify the personnel responsible for comparing the estimated costs to the actual expenses and document their responsibilities. (Recommendation 2)
- The Assistant Deputy Under Secretary for Health for Administrative Operations should define and document what items and services officials can purchase with activation funds. (Recommendation 3)
- The Assistant Deputy Under Secretary for Health for Administrative Operations should define and document when facilities should cease to spend activation funds. (Recommendation 4)

Agency Comment

We provided a draft of our report to VA for review and comment. VA provided written comments, which are reprinted in appendix II. VA concurred with all of our recommendations. VA further provided information on how it intends to address our recommendations, with target dates for completion in December 2020.

We are sending this report to the appropriate congressional committees and to the Secretary of the Department of Veterans Affairs. In addition, this report is available at no charge on the GAO website at http://gao.gov.

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

Andrew Von Ah
Director, Physical Infrastructure

Appendix I: Reported Activation Costs at Selected VHA Medical Facilities

To understand the costs of the activations of the eight selected facilities, we asked activation officials at each facility to provide a breakdown of the activation costs by the following categories: (1) Furniture, Fixtures, and Equipment; (2) Staffing; (3) Supplies; (4) Other; and (5) Total Cost. We used these cost categories because these are the categories in the template that facilities complete to estimate activation costs.

Table 2: Reported Activation Costs for Selected Medical Facilities at the Veterans Health Administration (VHA)

Location	New or replacement	Furniture, fixtures, and equipment	Staffing	Supplies	Other	Total[a]
Austin, Texas	New	$15,625,133	$23,736,655	$2,669,010	$1,678,838	**$43,709,636**
Gilbert, Arizona	Replacement	$2,306,428	$13,571,645	$103,584	$158,489	**$16,140,146**
Golden, Colorado	New	$1,715,709	$4,998,188	$0	$110,765	**$7,952,624**
Greenville, North Carolina	Replacement	$10,664,082	$83,090,791	$2,695,758	$11,651,332	**$108,101,964**
Montgomery, Alabama	New	$3,331,432	$5,518,388	$1,378,334	$6,568,595	**$16,796,749**
Salem, Oregon[b]	Replacement	$3,850,021	Cannot be determined	Unknown	Cannot be determined	**Cannot be determined**
Tampa, Florida[c]	New	$8,223,214	$8,513,810	Unknown	$0	**$16,737,024**
Wyoming, Michigan	Replacement	$15,802,297	$15,759,456	$0	$46,928	**$31,608,681**

Source: GAO analysis of data provided by the selected facilities. | GAO-20-169.

[a]Officials from each of the eight selected facilities provided us with the actual costs of the activation and documentation supporting those costs. We reviewed this documentation for consistency and mathematical errors; however, the accuracy of these data was not fully evaluated by GAO. As discussed in our report, VA policy does not sufficiently define which costs should be considered activation costs or when facilities should cease to spend activation funds. These issues may have affected the activation cost information provided by the facilities.

[b]Officials from the facility in Salem, Oregon, stated that they were unable to provide certain cost information due to staff turnover and the length of time that had passed since the facility became operational. Officials were not able to separate the costs of Supplies from the costs for Furniture, Fixtures, Equipment. As a result, the Furniture, Fixtures, and Equipment amount includes Supplies costs as well.

[c]Officials from the facility in Tampa, Florida, said that they were unable to separate Staffing and Supplies costs. As a result, the Staffing costs figure for Tampa accounts for both Staffing and Supplies costs.

Appendix II: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

DEC 11 2019

Mr. Andrew Von Ah
Director
Physical Infrastructure
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Von Ah:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: ***VA REAL PROPERTY: VHA Should Improve Activation Cost Estimates and Oversight*** (GAO-20-169).

The enclosure sets forth the actions to be taken to address the draft report recommendations.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

Pamela Powers
Chief of Staff

Enclosure

Enclosure

The Department of Veterans Affairs (VA) Comments to the
Government Accountability Office Draft Report
VA REAL PROPERTY: VHA Should Improve Activation Cost Estimates and Oversight
(GAO-20-169)

Recommendation 1: The Assistant Deputy Under Secretary for Health for Administrative Operations should develop and document a process for estimating total activation costs for major medical facility projects. This process should reflect the 12 steps for developing a reliable cost estimate outlined in the GAO Cost Guide.

VA Comment: Concur. The Veterans Health Administration's (VHA) Office of Capital Asset Management and Support (OCAMS) is currently developing a policy to document its process for estimating total life cycle activation costs for major medical facility projects. The policy under development will include a timeline that requires several important considerations and collaboration with necessary stakeholders for formal development and implementation. Target Completion Date: December 2020.

Recommendation 2: The Assistant Deputy Under Secretary for Health for Administrative Operations should develop and document a process for comparing actual activation costs for major medical facility projects to estimates. This process should identify personnel responsible for comparing the estimated costs to the actual expenses and document their responsibilities.

VA Comment: Concur. The policy that OCAMS is currently developing to document its process for estimating total activation costs for major medical facility projects will include guidance on comparison of actual costs to project estimates and responsible parties for comparing estimated costs to actual expenses. Target Completion Date: December 2020.

Recommendation 3: The Assistant Deputy Under Secretary for Health for Administrative Operations should define and document what items and services officials can purchase with activation funds.

VA Comment: Concur. There is currently a policy under development by OCAMS that will define and document the items and services that officials can purchase with activation funds. Target Completion Date: December 2020.

Recommendation 4: The Assistant Deputy Under Secretary for Health for Administrative Operations should define and document when facilities should cease to spend activation funds.

VA Comment: Concur. There is currently a policy under development by OCAMS that will define and document when facilities cease to spend activation funds. Target Completion Date: December 2020.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Andrew Von Ah, 202-512-2834 or vonah@gao.gov

Staff Acknowledgments

In addition to the contact above, Heather Halliwell (Assistant Director); Alison Snyder (Analyst-in-Charge); Rose Almoguera; Brian Bothwell; Geoffrey Hamilton; Jason Lee; Terence Lam; Ethan Levy; Josh Ormond; Daniel Setlow; Laurel Voloder; Mary Weiland; and Elizabeth Wood made key contributions to this report.

Appendix IV: Accessible Data

Data Table

Accessible Data for Figure 4: Planned and Actual Length of Time to Provide Medical Services after Building Acceptance at Seven Selected Veterans Health Administration (VHA) Facilities

Timeframe	Actual number of services offered within timeframe	Number of services planned to be offered within timeframe
2 months or less	53	80
3 to 6 months	23	6
More than 6 months	11	1

Agency Comment Letter

Accessible Text for Appendix II Comments from the Department of Veterans Affairs

Page 1

DEC 11 2019

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Director

Physical Infrastructure

U.S. Government Accountability Office

441 G Street, NW

Washington, DC 20548

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Enclosure

Page 2

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