STATEMENT OF
MR. SLOAN D. GIBSON
DEPUTY SECRETARY,
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS

April 24, 2015

Good morning, Mr. Chairman and Members of the Committee. Thank you for the opportunity to update the Committee on the status of the construction of the replacement medical center in Denver. I am accompanied today by Ms. Stella Fiotes, Executive Director, and Mr. Dennis Milsten, Director of Operations, of the VA Office of Construction and Facilities Management.

The Department's main priority regarding the Denver project is to complete the facility without further delay, and to do that while delivering the best possible value to taxpayers given the difficult circumstances. Our commitment to completing this project, which is intended to serve over 390,000 Colorado Veterans and their families, has never wavered, and current VA medical facilities and programs in the area continue to ensure that no Veterans or their families go unserved.

BACKGROUND

I think it is important to review the events that brought us to where we are today. I would like to highlight some key events that directly shaped the current status of the project.

The replacement of the existing Denver VA Medical Center began as an idea between the University of Colorado and VA to construct a shared facility. The project went through a protracted development period that included a concept to build a shared facility with the Department of Defense. VA requested design funds in fiscal year (FY) 2004, with an estimated project budget of $328.5 million. In 2004, then VA Secretary Principi set forth the requirement for a stand-alone VA facility on the Fitzsimmons campus. VA developed a plan for a 1.4 million square foot facility in 2006, then revised that plan to 945 thousand square feet, and subsequently requested appropriations for an $800 million project in 2010 with final funding being requested and received in 2012.

VA retained the services of an architect engineer firm (AE) to complete a design with an Estimated Construction Cost at Award (ECCA) of $582 million. The original acquisition strategy for the project was to complete 100 percent design and then solicit construction proposals to build the project. This strategy was changed to use a different contract mechanism, known in the Industry as “Early Contractor Involvement,” to bring the contractor onboard early to participate in the design. This change in acquisition strategy, intended to expedite project delivery by overlapping early phases of construction with completion of the design, was a decisive moment in the life of the project. The timing and appropriateness of this specific delivery method underlie many of the ensuing issues with the management of the project. VA entered into a contract in August 2010 with Kiewit-Turner (KT) to perform design, constructability, and cost reviews. This contract also provided an option to award the construction of the facility to the contractor.

At the time of the 2010 contract award, the design had progressed to a point that limited the opportunity for the contractor to influence the design and cost. The contractor provided pre-construction services and amid attempts at cost reconciliation with the designer, the contractor maintained that the project was over budget and could not be built for the established ECCA. The parties negotiated for a period of approximately six months to arrive at a construction contract price but differences remained. Feeling the need to finally get to construction award for the project, VA and the contractor executed an option on November 11, 2011, to build the replacement hospital, which became known as Supplemental Agreement 07 (SA-07). The total design was not 100 percent complete at the time; it was at what was deemed an "enhanced design development or roughly 65% stage." SA-07 stated that VA would ensure that the design produced would meet the ECCA of $582.8 million and that the contractor, KT, would build the project at the firm target price of $604 million, which included pre-construction services and additional items. This was the next and probably most critical point in the project's evolution. VA's promise to ensure that the design produced met the ECCA became the centerpiece of diverging interpretation and conflicts between VA and the contractor. Course correction opportunities were missed because of the fundamentally different interpretation of SA-07, poor project and contract management, and the increasingly strained relationships among the parties.

KT filed a complaint with the Civilian Board of Contract Appeals (CBCA) in July 2013 that further cemented the differing perspectives on the interpretation of the contract and ultimately the cost of the project. Despite the less-than-optimal business environment during the year-and-a-half of litigation, construction quality and progress

were maintained. In December 2014, VA was found in breach of contract for failure to provide a design that met the ECCA, and KT began to demobilize from the project site. VA entered into immediate negotiations with KT to stop the demobilization, recognizing the hospital was approximately 50 percent complete. Subsequently, VA entered into an interim agreement with KT to continue the project, and with the United States Army Corps of Engineers (USACE) to assess the project, and to manage all the pre-award activity related to the follow-on contract. VA intends to enter into a separate agreement with USACE to execute a new construction contract and to complete the facility once we have obtained the necessary authorization and funding.

OPTIONS AND COSTS FOR COMPLETION OF PROJECT

After the decision by the CBCA, VA identified two primary courses of action. The first was to allow KT to continue demobilizing and have VA assume maintenance of the site, update the construction contract documents, and re-compete the contract for the remaining work. The second option was to re-establish a contractual relationship with KT for continued construction of the medical center. The option to re-compete the project represented a potential 18- to 22-month delay, involving closeout of the existing contract and development and award of a new contract to finish the job. While this work was ongoing, VA would also need to engage several contractors to maintain the site and preserve the work accomplished to date. In addition, VA would have to recognize the bidding climate for this project would not be advantageous, and a premium would be

applied by subcontractors to cover perceived risk. These factors would have served to increase both the length of time to complete the project and its ultimate cost.

The second option of retaining KT leveraged their current knowledge of the project, presence on the site, and existing relationships with subcontractors. It reduced delays that could have impacted construction warranties and provided the best option for protecting the existing construction. Finally, resuming work with KT put over 600 workers back on the job, and also best protected the significant investment already made in this project. In the days immediately following the demobilization, this option represented the clearest path to achieving the two main goals stated above. For this reason, it is the path that VA chose.

On March 17, 2015, VA notified Congress that the total estimated cost for the Denver Replacement Medical Center project would be $1.73 billion. This is an authorization increase of $930 million to complete the project and requires additional funding of $830 million. The new authorization level reflects input from USACE on the required cost to complete the project. USACE has had access to all design documents and VA staff relative to the Denver project. The USACE team included subject matter experts in cost contracting, acquisition, construction management, design management, and cost engineering. The team also looked at the cost to administer the construction. USACE was provided access to all estimates of construction, cost paid to-date, and modifications executed. USACE also examined the original contract as well as the interim contract to assess cost and completion progress.

USACE used all this information to form their assessment of the cost to complete the effort. Their estimate included a contingency and cost to manage the construction.

USACE estimates a need for an additional $700 million following the close out of the original and interim contracts. USACE has established a June 2015 target to award a new contract for the completion effort.

VA added the cost necessary to continue the interim contract through June 2015, additional funds for closing out the original contract and funds for completing the post-traumatic stress disorder residential treatment facility. This totaled $130 million in addition to USACE's construction completion estimate. The money currently on the project of $899.8 million, plus the $700 million and the $130 million, drive the $1.73 billion estimate for the project.

Now, we must work with this Committee and others to secure funding. We have proposed funding the increased cost by requesting authority to use funds provided to VA in The Veterans Access, Choice, and Accountability Act.

The Act provided $5 billion in mandatory funding to increase health care staffing and improve physical infrastructure. We propose adjusting that language to enable VA to redirect a portion of this funding toward the remaining requirements to complete the Denver project. We will forward to the committee an updated spend plan for the $5 billion that shows how this proposed change would impact the allocations for other VA programs. We believe this is the best approach among the difficult choices before us.

This hospital complex is an important part of VA infrastructure, and completing it will improve access to care for over 390,000 Colorado veterans. The development of this new, state-of-the-art medical center will enhance Veteran health care capabilities in the Eastern Rockies by ensuring every patient receives the fullest complement of clinical services. The expansion of Mental Health services will meet a projected

workload increase of 16% over the next 20 years support VA's targeted goal of improving Veteran wellness and economic security. Clinical education will also be significantly enhanced by increasing space to match clinical need and patient demand.

ACCOUNTABILITY

VA established an Administrative Investigation Board to look at the actions and processes that resulted in the current situation and the employees responsible for those actions and decisions. At this juncture, while the investigation is ongoing, it is premature for VA to identify who may be subject to appropriate disciplinary action. VA intends to hold any individuals found to have acted negligently accountable for their actions. As previously discussed during the hearing in January 2015, USACE is also conducting a broader, detailed examination of VA's major construction program to identify gaps and improve management processes, structures, and controls in project oversight and delivery. We expect USACE to complete their review and report their findings in May 2015. In the interim, we changed the reporting structure within the Department so that the Office of Construction and Facilities Management reports directly to me to ensure continued visibility and accountability in real time.

In addition to the review of the four large hospital projects by USACE, an independent third-party organization is conducting a comprehensive assessment of the entire VA construction program as part of the Choice Act legislation and will report their findings to Congress by September 2015.

THE FUTURE OF VA CONSTRUCTION

Over the past two years, VA has significantly changed the way it conducts business, but more work remains to be done. Unfortunately, many of these changes were too late to affect the Denver project.

To help ensure that previous challenges are not repeated and to lead improvements in the management and execution of our capital asset program as we move forward, VA will continue to adopt best-management practices and controls including :

- Incorporating integrated master planning is essential to ensure that the planned acquisition closes the identified gaps in service and corrects facility deficiencies.
- Requiring major medical construction projects must achieve at least 35-percent design prior to cost and schedule information being published and construction funds requested.
- Implementing a deliberate requirements control process, where major acquisition milestones are identified to review scope and cost changes based on the approved budget and scope. Any significant changes in project scope or cost need to be approved by the Secretary prior to submission to Congress.
- Institutionalizing a Project Review Board (PRB). VA worked with USACE to establish a PRB for VA that is similar to the structure at the USACE District Offices. The PRB regularly provides management with metrics and insight to indicate if/when a project requires executive input or guidance.

- Using a Project Management Plan to outline a plan for accomplishing the acquisition from planning to activation to ensure clear communication throughout the project.
- Establishing of VA Activation Office to ensure the integration of the facility activation into the construction process for timely facility openings.
- Conducting pre-construction reviews – Major construction projects must undergo a “constructability” review by a private construction management firm to evaluate design and engineering factors that facilitate ease of construction and ensure project value.
- Integrating Medical Equipment Planners into the construction project teams – Each major construction project will employ medical equipment planners on the project team from concept design through activation.

These improvements are being applied to our ongoing and upcoming major construction projects. Depending on the stage of development, some projects like the Denver Replacement Medical Center did not benefit from many of these improvements.

In the past five years, VA has delivered 75 major construction projects valued at over $3 billion that include the new medical center complex in Las Vegas; cemeteries; polytrauma rehabilitation centers; spinal cord injury centers; a blind rehabilitation center; and community living centers. The New Orleans replacement facility is currently on schedule, and is anticipated to be completed in the fall of 2016. This is not to diminish our serious concerns over the mistakes that led to the current situation on the Denver project, but only to emphasize that we have successfully managed numerous projects through our major construction program. VA takes full responsibility for the situation in

Denver, and we will continue to review our major construction program and the details of this project to improve our performance. We must ensure these mistakes never happen again. Not only will we rigorously apply the best practices above and those included in the Corps' report, we look forward to receiving the independent study directed by The Choice Act. We will work with the Independent Commission established by Congress under the Choice act to provide a comprehensive proposal for the future of VA's construction program.

In closing, each day, VA is moving toward its goal of improving and streamlining our processes to increase access to our Veterans and their families. I am personally committed to doing what is right for Colorado veterans, and completing the Denver project without further delay and to do that while delivering the best possible value to taxpayers given the difficult circumstances.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to testify before the Committee today. My colleagues and I would be pleased to respond to questions from you and Members of the Committee.