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United States Government Accountability Office
Washington, DC 20548

February 6, 2006

The Honorable Steve Buyer
Chairman
Committee on Veterans' Affairs
House of Representatives

The Honorable Daniel K. Akaka
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate

The Honorable Richard J. Durbin
The Honorable Patty Murray
The Honorable Ken Salazar
United States Senate

Subject: *VA Health Care: Preliminary Findings on the Department of Veterans Affairs Health Care Budget Formulation for Fiscal Years 2005 and 2006*

This report documents the information we provided to you in a briefing on February 2, 2006, in response to your request concerning the Department of Veterans Affairs (VA) internal budget formulation process. (See enclosure.) This includes information that VA develops for its budget submission to the Office of Management and Budget (OMB), but it does not include information on subsequent interactions that occur between VA and OMB. We will do additional work to incorporate information from OMB and complete our analysis in a report to be issued at a later date. You requested information on VA's budget formulation process because of your interest in ensuring that VA's budget forecasts are accurate and based on valid patient estimates.

As you know, VA provides a uniform set of medical benefits to eligible veterans. If sufficient resources are not available to provide care that is timely and acceptable in quality, VA is required to restrict medical benefits based on veterans' eligibility priorities.[1] VA also provides other services, such as nursing home care, to certain veterans. VA's provision of medical care is dependent upon the availability of appropriations. For fiscal year 2005, Congress appropriated $31.5 billion for all of VA's medical programs, and VA provided medical care to about 5 million veterans.

[1]Priority categories are generally determined on the basis of service-connected disability and income. There are currently eight priority categories. VA used this system to restrict enrollment in January 2003 to no longer allow Priority 8 veterans, those in the lowest priority category who generally do not have service-connected disabilities or low income, to enroll. This policy remains in effect.

During fiscal year 2005, the President requested a $975 million supplemental request for that fiscal year and a $1.977 billion amendment to the President's budget request for fiscal year 2006. In congressional testimonies in the summer of 2005, VA stated that its actuarial model understated growth in patient workload and services and the resources required to provide these services.[2]

In response to your request for information on VA's internal budget formulation process, this report provides the following for fiscal years 2005 and 2006:

- A description of VA's process for developing its budget submission to OMB for its medical programs, and the role of VA's actuarial model.
- A description of the medical program activities cited by VA as needing additional funding, and how VA identified these activities.
- Key factors in VA's budget formulation process that contributed to the requests for additional funding.

To conduct our work, we interviewed VA officials, including those in the Veterans Health Administration's Office of the Chief Financial Officer and Office of the Assistant Deputy Under Secretary for Health for Policy and Planning. We also interviewed officials in VA's Office of the Deputy Assistant Secretary for Budget. We also analyzed documents concerning VA's actuarial model, budgetary data, and workload and expenditure data and reviewed our past work. We tested the reliability of the data and determined they were adequate for our purposes. We have not yet met with OMB officials to discuss the budget formulation process for fiscal years 2005 and 2006 and the President's subsequent request for additional appropriations. We conducted our review from October 2005 through January 2006 in accordance with generally accepted government auditing standards.

Results in Brief

VA's internal process for formulating the medical programs funding requests was informed by, but not driven by, projected demand. VA projected costs based on projected demand for medical care under current policy. Throughout the process, VA compared projected costs to its anticipated request level for the OMB submission and made adjustments to address the difference. VA officials stated that this was done in two ways: through cost-saving policy proposals, such as assessing an annual health care enrollment fee, and management efficiencies.[3] After making adjustments to

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[2]Senate Committee on Veterans' Affairs, Statement of the Secretary, Department of Veterans Affairs, *Emergency Hearing to Examine the Shortfall in VA's Medical Care Budget*, 109th Congress, June 28, 2005; House Committee on Veterans' Affairs, Statement of the Secretary, Department of Veterans Affairs, *Full Committee Hearing on the Department of Veterans Affairs Health Care Budget*, 109th Congress, June 30, 2005; and House Committee on Veterans' Affairs, Statement of the Under Secretary for Health, Department of Veterans Affairs, *Full Committee Hearing on the Department of Veterans Affairs Proposed Health Care Budget Amendment for Fiscal Year 2006*, 109th Congress, July 21, 2005.

[3]See GAO, *Veterans Affairs: Limited Support for Reported Health Care Management Efficiency Savings*, GAO-06-359R (Washington, D.C.: Feb. 1, 2006).

address the difference between projected costs and its anticipated request level, VA developed its budget submission for OMB.

VA later cited a number of activities as needing additional funding based on programmatic priorities and an analysis of expenditure data. Among the activities that were cited for fiscal year 2005 was $273 million for veterans returning from Iraq and Afghanistan; $226 million for long-term care; and almost $400 million for increases in the number of patients, as well as increases in both utilization and intensity of care. For the fiscal year 2006 budget, VA cited $677 million to cover a 2 percent increase in the number of patients, $600 million to correct VA's estimate for long-term care costs, $400 million for an unexpected 1.2 percent increase in average cost per patient, and $300 million to replace funds VA planned to carry over from fiscal year 2005 to fiscal year 2006. VA officials said that they chose to highlight activities that were of high programmatic priority and could be supported by workload and expenditure data (e.g. veterans returning from Iraq and Afghanistan). They also reviewed spending and workload trends to determine whether spending trends were on target or whether adjustments were needed.

An unrealistic assumption, errors in estimation, and insufficient data were key factors in VA's budget formulation process that contributed to the requests for additional funding. According to VA, an unrealistic assumption about the speed with which VA could implement a policy to reduce nursing home patient workload in VA-operated nursing homes for fiscal year 2005 led to a need for additional funds. VA officials told us that errors in estimating the effect of a nursing home policy to reduce workload in all three of its nursing home settings—VA-operated nursing homes, community nursing homes, and state veterans' nursing homes—accounted for a request for additional funding for fiscal year 2006. VA officials said that the error resulted from calculations being made in haste during the OMB appeal process. Finally, VA officials told us that insufficient data on certain activities contributed to the requests for additional funds for both years. For example, inadequate data on veterans returning from Iraq and Afghanistan resulted in an underestimate in the initial funding request.

Agency Comments

We requested comments on a draft of the enclosed briefing slides from VA. VA provided us with technical comments on the briefing slides, which have been incorporated as appropriate.

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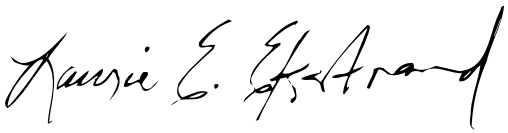
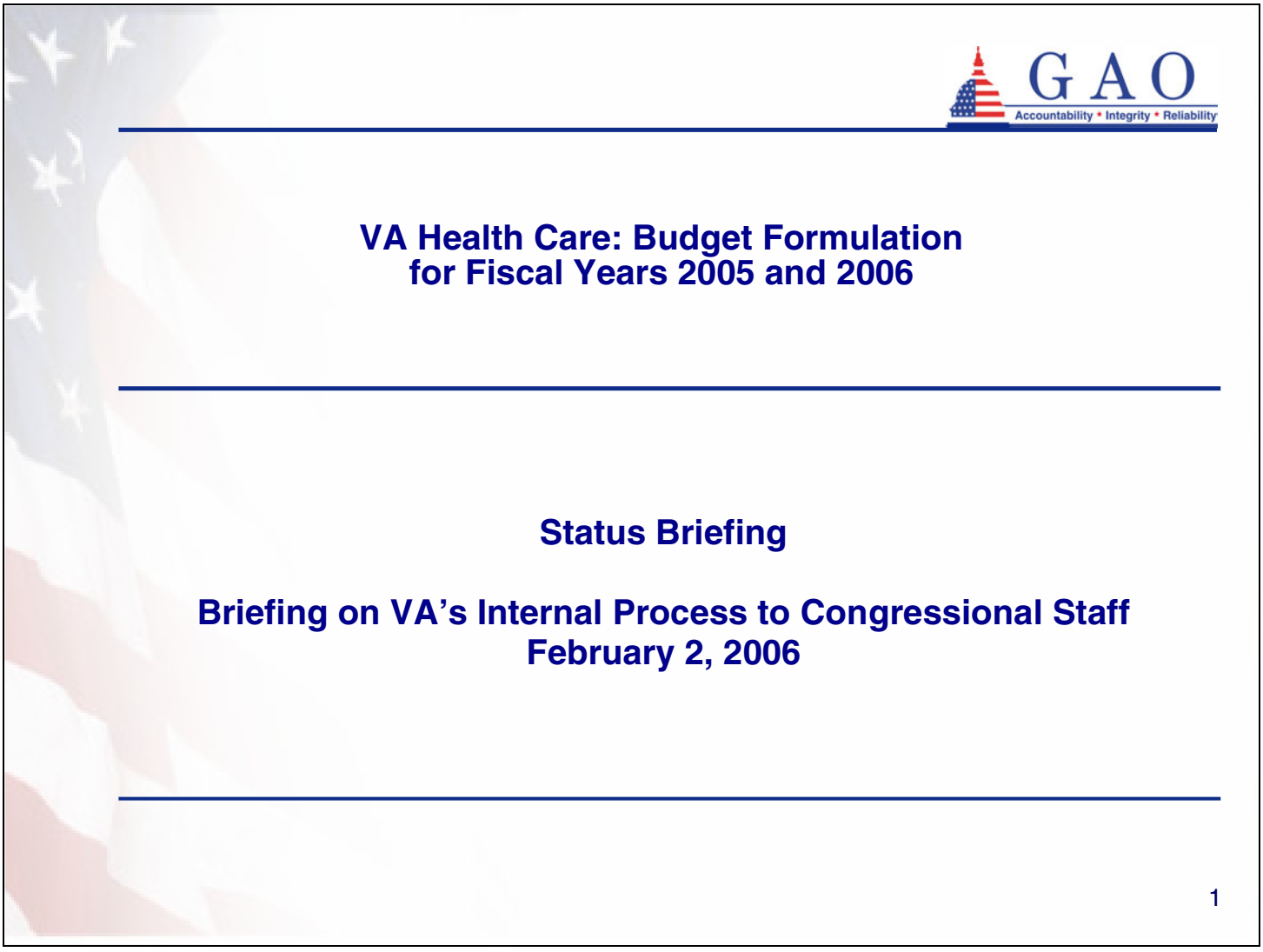
We are sending copies of this report to the Secretary of Veterans Affairs, the Director of the Office of Management and Budget, and appropriate congressional committees. We will also provide copies to others upon request. In addition, the report is available at no charge on GAO's home page at http://www:gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report.

If you and your staff have any questions or need additional information, please contact me at (202) 512-7101, or ekstrandl@gao.gov. Major contributors to this letter were James Musselwhite, Assistant Director; Denise Fantone; Michael Kendix; Dean Koulouris; Tiffany Tanner; Thomas Walke; and Greg Whitney.



Laurie E. Ekstrand
Director, Health Care

Enclosure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VA Health Care: Budget Formulation
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Status Briefing
Briefing on VA's Internal Process to Congressional Staff
February 2, 2006
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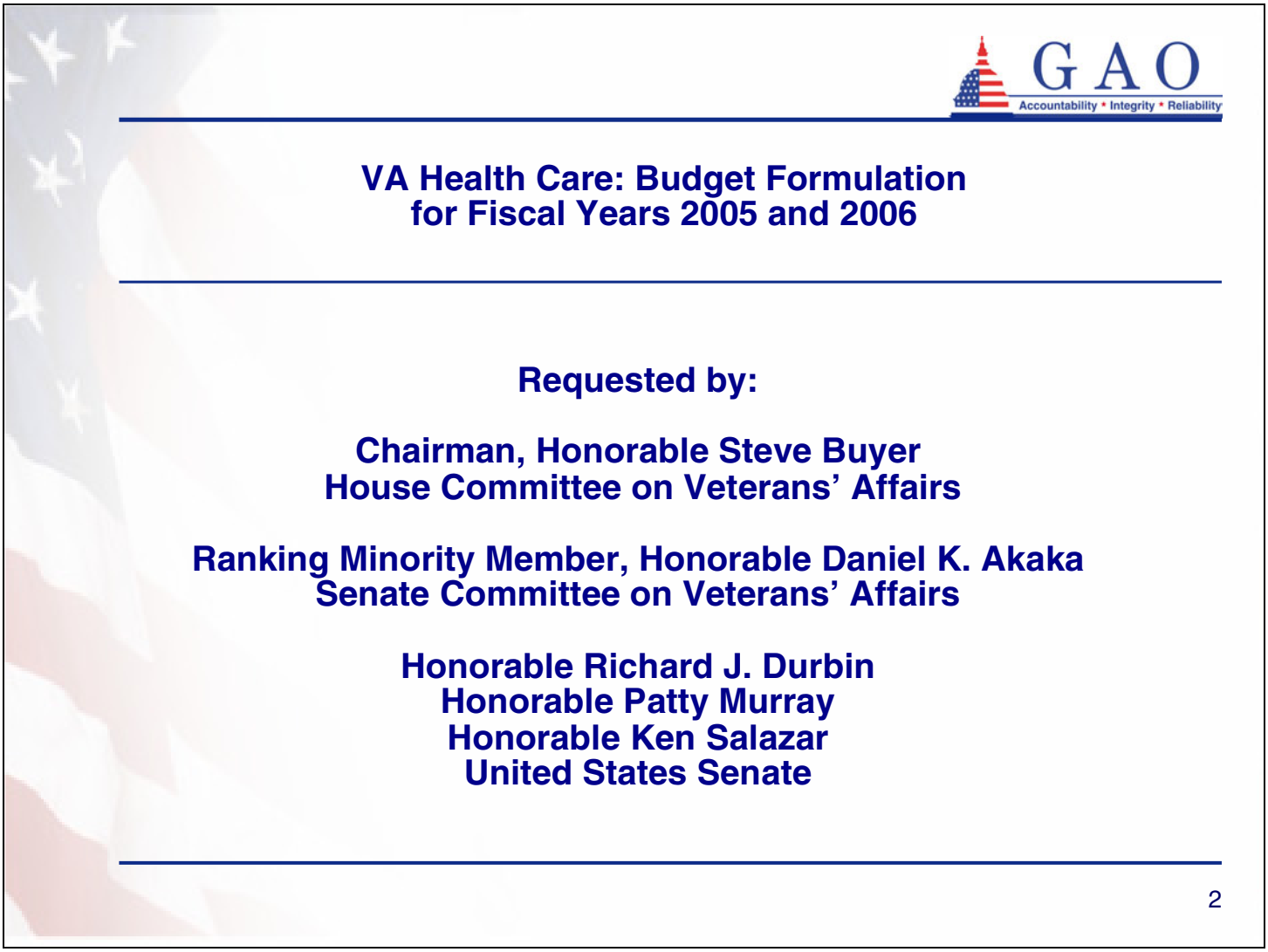
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Overview

- Introduction
- Objectives
- Scope and Methodology
- Findings

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Introduction

- The Department of Veterans Affairs (VA) provides a uniform set of medical benefits to eligible veterans. These benefits include preventive and primary health care, and a range of outpatient and inpatient services. In addition, VA provides other benefits, such as nursing home care, to certain veterans. The Veterans Health Administration (VHA) is responsible for operating VA's medical care system.

- VA's provision of medical care for veterans is dependent upon the availability of appropriations. For fiscal year 2005, Congress appropriated about $31.5 billion for all of VA's medical programs and VA provided medical care to about 5 million veterans.

- For each fiscal year since 1997, Congress has appropriated more for VA medical care than requested by the President. (See fig. 1.)

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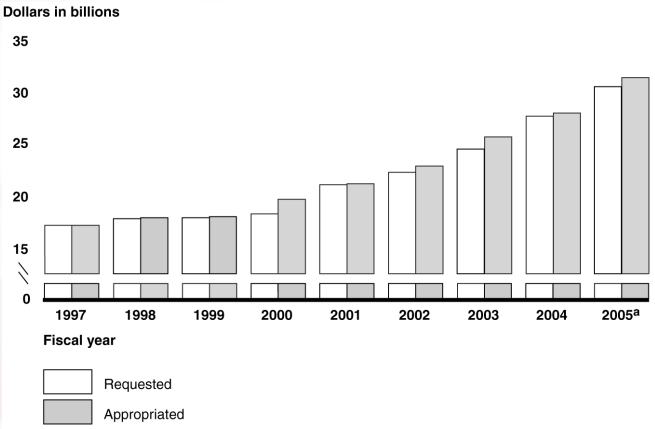
Introduction

Figure 1: President's Budget Request Compared to Appropriations for VHA Accounts, Fiscal Years 1997-2005



Sources: GAO analysis of VA Congressional Budget Justifications and appropriations acts for fiscal years 1997 through 2006.

[a]Fiscal year 2005 appropriation is estimated.

Note: Totals include medical care collections, but do not include VA construction accounts.

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Introduction

- Increased appropriations during this period coincided with the passage of the Veterans' Health Care Eligibility Reform Act of 1996, which simplified eligibility standards for veterans in need of hospital and outpatient care and made available services not previously available to veterans without service-connected disabilities or low incomes.[1]
- As required by this act, VA established an enrollment system with priority categories to manage access to hospital and outpatient care in relation to available resources.
- The act requires VA to restrict enrollment for purposes of these benefits consistent with its priority categories if sufficient resources are not available to provide care that is timely and acceptable in quality.[2] In January 2003, VA restricted enrollment by no longer allowing Priority 8 veterans, those in the lowest priority category, to enroll. This policy remains in effect.

[1]Pub. L. No. 104-262, §§ 101, 104, 110 Stat. 3177, 3178-81 and 3182-84.
[2]The act called for seven priority categories; subsequent legislation provided for eight categories. Priority categories are generally determined on the basis of service-connected disability and income.

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Introduction

- During fiscal year 2005, the President requested a $975 million supplemental for that fiscal year and a $1.977 billion amendment to the President's budget request for fiscal year 2006.
- In its congressional testimonies in June and July of 2005, VA stated that its actuarial model understated growth in patient workload and services and the resources required to provide these services.
- Congress is interested in ensuring that VA's budget forecasts are accurate and based on valid patient estimates.

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Objectives

1. To describe VA's process for developing its budget submission to the Office of Management and Budget (OMB) for its medical programs for fiscal years 2005 and 2006, and to describe the role of VA's actuarial model.

2. To describe medical program activities cited by VA as needing additional funding for fiscal years 2005 and 2006, and how VA identified these activities.

3. To identify key factors in VA's budget formulation process that contributed to the requests for additional funding for fiscal years 2005 and 2006.

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Scope and Methodology

- For this briefing, we focused our work on VA's process for formulating its funding request for its medical programs for fiscal years 2005 and 2006.
- Interviewed VA officials in:
  - VHA Office of the Chief Financial Officer
  - VHA Office of the Assistant Deputy Under Secretary for Health for Policy and Planning
  - VA's Office of the Deputy Assistant Secretary for Budget
- Analyzed data from publicly available documents and from VA including:
  - Actuarial model information
  - Budgetary data
  - Workload and expenditure data

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Scope and Methodology

- Past GAO work.
- In doing our work, we tested the reliability of the data and determined they were adequate for our purposes.
- We conducted our review from October 2005 through January 2006 in accordance with generally accepted government auditing standards.

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Summary of Findings to Date

- VA's Internal Process for Formulating the Medical Programs Funding Requests Was Informed by, but Not Driven by, Projected Demand
- VA Cited a Number of Activities as Needing Additional Funding Based on Programmatic Priorities and Analysis of Expenditure Data
- An Unrealistic Assumption, Errors in Estimation, and Insufficient Data Were Key Factors in VA's Budget Formulation Process that Contributed to the Requests for Additional Funding

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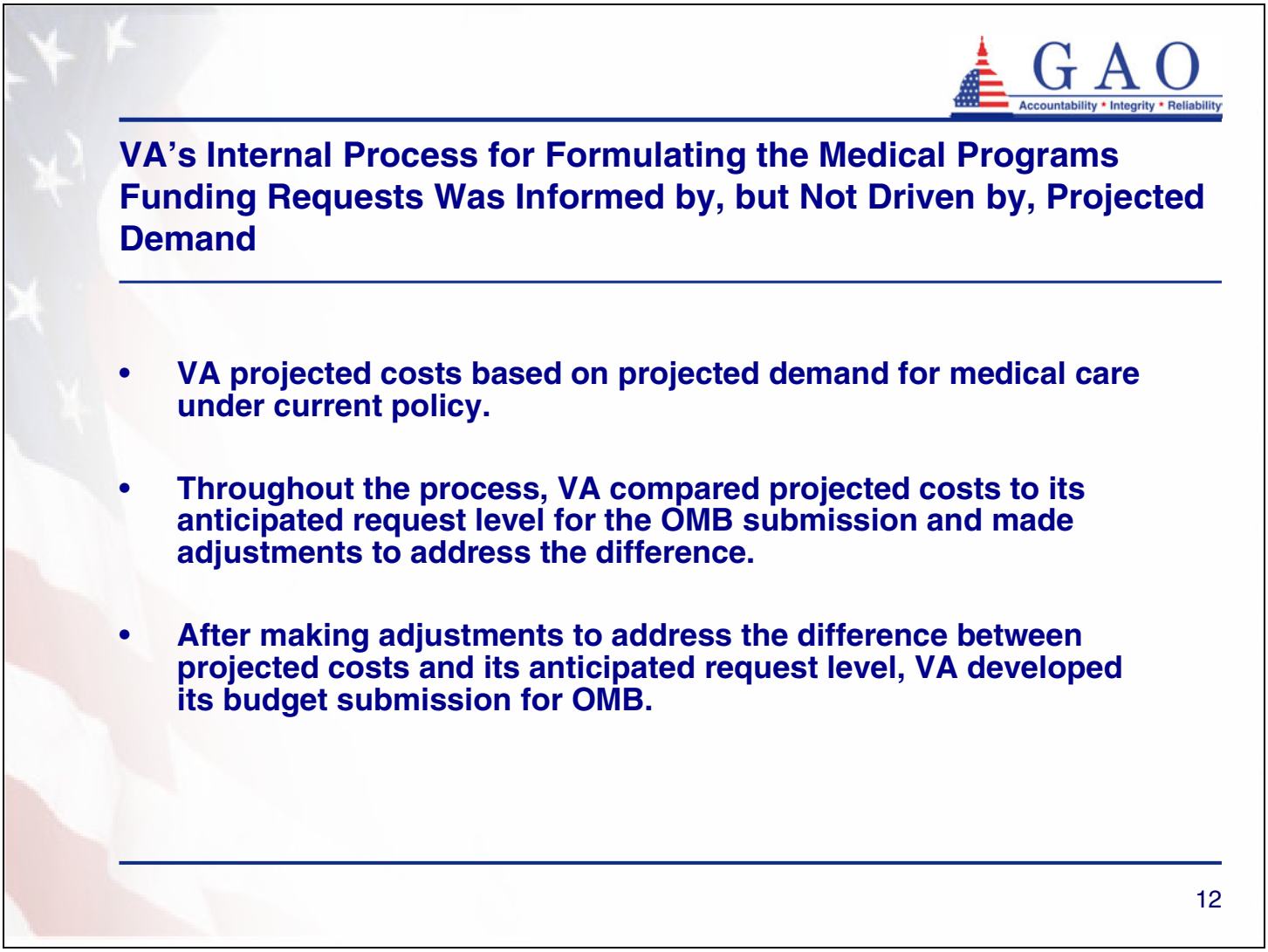
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VA's Internal Process for Formulating the Medical Programs Funding Requests Was Informed by, but Not Driven by, Projected Demand
• VA projected costs based on projected demand for medical care under current policy.
• Throughout the process, VA compared projected costs to its anticipated request level for the OMB submission and made adjustments to address the difference.
• After making adjustments to address the difference between projected costs and its anticipated request level, VA developed its budget submission for OMB.
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For fiscal years 2005 and 2006, VA projected costs based on projected demand for medical care under current policy.

According to VA officials:

- VA used an actuarial model to project workload and costs for about 86 percent of its medical programs funding request.[3]
- VA also used a separate model to project long-term care workload and costs, which account for about 10 percent of its medical programs funding request.
- For the remaining 4 percent, most projections were developed by adding inflation to actual expenditures. In some cases, VA used other methods, including projecting trends from workload and expenditure data.

[3]For fiscal year 2005, model projections were based on fiscal year 2002 data; for fiscal year 2006, the model projections were based on fiscal year 2003 data.

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Throughout the process, VA compared projected costs to its anticipated request level for the OMB submission and made adjustments to address the difference.

- VA officials stated that they developed a request that reflects OMB guidance and direction from VA senior management. This request included anticipated resources from reimbursements, collections, and unobligated balances.

- In both fiscal years 2005 and 2006 projected costs exceeded the anticipated request level. VA officials stated that the difference was addressed in two ways:

  (1) cost-saving policy proposals
  (2) management efficiencies

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Throughout the process, VA compared projected costs to its anticipated request level for the OMB submission and made adjustments to address the difference. (cont.)

- VA used several methods to estimate cost savings from various policy proposals.
  - VA used the actuarial model to estimate the impact of its cost-sharing proposals (e.g., increasing the copayment for prescriptions and assessing an annual enrollment fee).
  - VA used other methods to estimate the cost savings from proposed policy changes for nursing home care.
- GAO will issue a report shortly on VA's methodology for projecting management efficiency savings.

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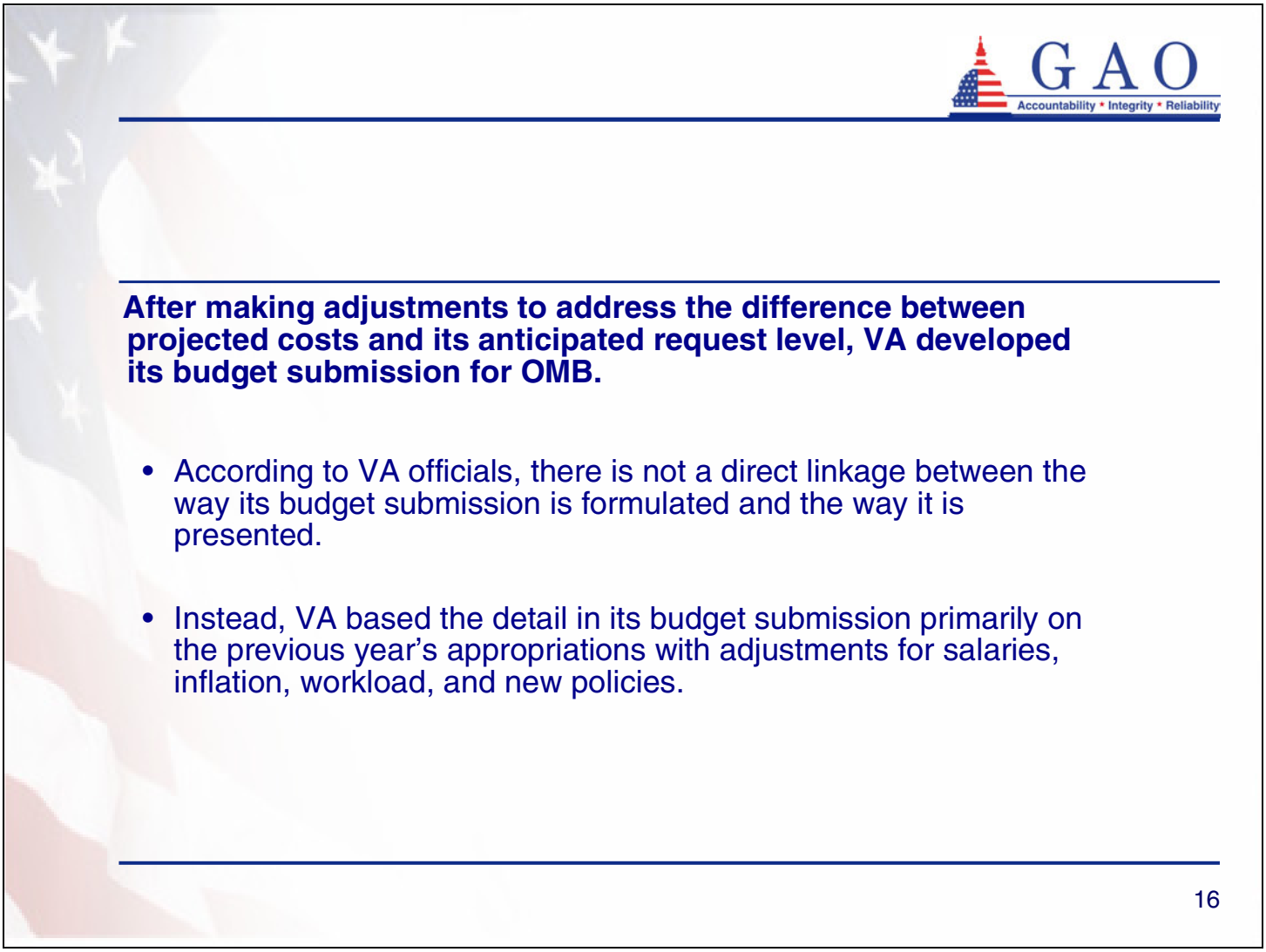
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After making adjustments to address the difference between projected costs and its anticipated request level, VA developed its budget submission for OMB.
• According to VA officials, there is not a direct linkage between the way its budget submission is formulated and the way it is presented.
• Instead, VA based the detail in its budget submission primarily on the previous year's appropriations with adjustments for salaries, inflation, workload, and new policies.
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VA Cited a Number of Activities as Needing Additional Funding Based on Programmatic Priorities and Analysis of Expenditure Data

- VA identified a number of activities that it said needed additional funding in fiscal years 2005 and 2006.
- VA described the processes for identifying the activities.

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In discussing the fiscal year 2005 supplemental request, VA identified a number of activities that it said needed additional funding that totaled $975 million:

- $273 million for veterans returning from Iraq and Afghanistan, Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF)
- $226 million for long-term care
- $200 million for Priority 1-6 patient workload
- $179 million for greater than expected increase in the utilization of services and intensity of patient workload
- $58 million for reducing patient backlog on waiting lists
- $39 million for health care needs of dependents of 100 percent service-connected veterans

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In discussing the fiscal year 2006 budget amendment request, VA identified a number of activities that it said needed additional funding that totaled $1.977 billion:

- $677 million to cover a 2 percent increase in number of patients, $276 million of which is for veterans returning from Iraq and Afghanistan (OIF/OEF)
- $600 million to correct VA's estimate of long-term care costs
- $400 million to cover an unexpected 1.2 percent increase in average cost per patient
- $300 million to replace funds VA planned to carry over[5] from fiscal year 2005 to fiscal year 2006

[5] Certain funds are available to VA for more than one fiscal year. For example, patient copayments and collections from third-party insurance are available to VA without fiscal year limitation.

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VA described the processes for identifying the activities that it said needed additional funding for fiscal years 2005 and 2006.

- VA officials told us that they chose to highlight activities for fiscal years 2005 and 2006 that were of high programmatic priority to the administration and Congress and could be supported by workload and expenditure data (e.g., veterans returning from Iraq and Afghanistan).

- VA reviewed spending and workload trends on a monthly basis with the Deputy Secretary to determine whether spending trends were on target or whether adjustments were needed. VA tracked:
  - Spending at a budget object level (e.g., personnel and travel) and
  - Patient workload, as measured by number of unique patients, by enrollment priority group (Priorities 1-8) with a 60-day lag in data availability.

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VA described the processes for identifying the activities that it said needed additional funding for fiscal years 2005 and 2006 (cont.).

- When VA management initially identified that the fiscal year 2005 actual workload was exceeding projections, rather than initiating a supplemental request, VA planned to address this difference by:
  - Reducing the fiscal year 2006 carryover balance by $375 million.
  - Deferring $600 million for equipment and nonrecurring maintenance.

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An Unrealistic Assumption, Errors in Estimation, and Insufficient Data Were Key Factors in VA's Budget Formulation Process that Contributed to the Requests for Additional Funding

- An unrealistic assumption about implementation of a proposal expected to result in cost savings contributed to the request for additional funding in fiscal year 2005.
- Errors in estimating the effect of a nursing home policy contributed to the request for additional funding in fiscal year 2006.
- Insufficient data on certain activities contributed to the requests for additional funding in fiscal years 2005 and 2006.

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An unrealistic assumption about implementation of a proposal expected to result in cost savings contributed to the request for additional funding in fiscal year 2005.

- According to VA, an unrealistic assumption about the speed with which VA could implement a policy to reduce nursing home patient workload in VA-operated nursing homes for fiscal year 2005 accounted for $226 million in the request for additional funding in fiscal year 2005.
- The President's fiscal year 2005 budget request included a policy to reduce patient workload, as measured by average daily census, in VA-operated nursing homes to 8,500.
- VA officials said this policy was "unrealistic," because the assumptions required an immediate reduction from an average daily census of about 12,000.

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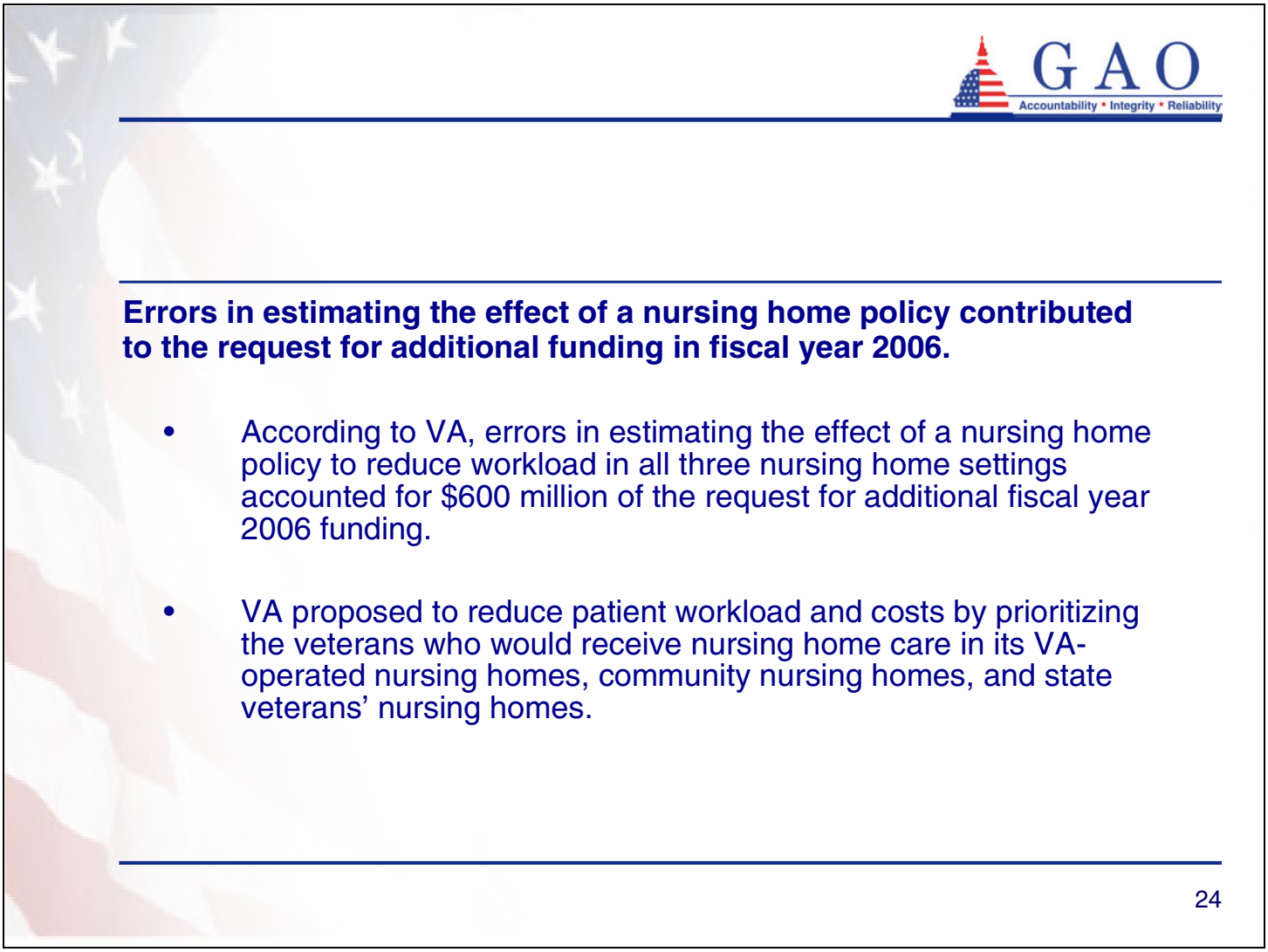
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Errors in estimating the effect of a nursing home policy contributed to the request for additional funding in fiscal year 2006.
• According to VA, errors in estimating the effect of a nursing home policy to reduce workload in all three nursing home settings accounted for $600 million of the request for additional fiscal year 2006 funding.
• VA proposed to reduce patient workload and costs by prioritizing the veterans who would receive nursing home care in its VA-operated nursing homes, community nursing homes, and state veterans' nursing homes.
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Errors in estimating the effect of a nursing home policy contributed to the request for additional funding in fiscal year 2006. (cont.)

- The estimated savings from this policy were understated in the fiscal year 2006 President's Budget request because of errors in estimation of average daily census, average costs, and rates of patient turnover in nursing homes.
- VA officials said that the error resulted from calculations being made in haste during the OMB appeal process.

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Insufficient data on certain activities contributed to the requests for additional funding in fiscal years 2005 and 2006

- VA officials stated, for example, that insufficient data on OIF/OEF veterans accounted for $273 million and $276 million of the requests for additional funding in fiscal years 2005 and 2006, respectively.

- According to VA officials, the projections for providing care were understated for fiscal years 2005 and 2006, because
  - Modeled projections were based on fiscal years 2002 and 2003 data, which did not include adequate data on OIF because this operation began in March 2003.[6]
  - VA also initially experienced delays in receiving Department of Defense (DOD) data on the identification of veterans returning from OIF/OEF.

[6]VA discovered the issue after submission of the fiscal year 2006 budget request.

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Insufficient data on certain activities contributed to the requests for additional funding in fiscal years 2005 and 2006 (cont.).

- Based on experience through the first 6 months of fiscal year 2005, VA revised its original workload and cost estimates for OIF/OEF returnees.
- According to revised projections for fiscal year 2005, VA expected to provide care to about an additional 76,000 patients for an additional cost of $273 million from estimates generated from the actuarial model.

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Agency Comments

- VA provided technical comments, which we incorporated as appropriate.
- VA said that it will provide written comments on a report on this topic, expected to be issued in the spring of 2006.

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Next Steps

- Discuss with OMB
- Conduct additional analysis

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Contact Information

- For questions about this briefing, please contact Laurie E. Ekstrand, Director, Health Care at (202) 512-7101 or ekstrandl@gao.gov

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