

GAO

Report to the Chairman, Committee on
Veterans' Affairs, House of
Representatives

January 2009

VA HEALTH CARE

Long-Term Care Strategic Planning and Budgeting Need Improvement



GAO

Accountability * Integrity * Reliability



Highlights of [GAO-09-145](#), a report to the Chairman, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

In fiscal year 2007, the Department of Veterans Affairs (VA) spent about \$4.1 billion on long-term care for veterans. VA provides—through VA or other providers—institutional care in nursing homes and noninstitutional care in veterans' homes or the community. In response to a statute, VA published in 2007 a long-term care strategic plan through fiscal year 2013. VA includes long-term care spending estimates in its annual budget justifications for Congress. These estimates are based on workload projections—the amount of care to be provided—and cost assumptions. VA has discretion in allocating appropriated funds among its medical services, such as long-term care. GAO examined (1) VA's reporting of planned workload in its 2007 long-term care strategic plan and (2) VA's long-term care spending estimates, including its cost assumptions and workload projections, in VA's fiscal year 2009 budget justification. GAO analyzed budget and planning documents and interviewed VA officials.

What GAO Recommends

GAO recommends that VA add certain workload information to its next long-term care strategic plan, and use, in its budget justifications, assumptions and projections in line with recent experience, or report why not. VA supports GAO's conclusion that its long-term care strategic planning and budgeting should be clarified. VA did not comment on the recommendations, but said it will provide an action plan in response to the final report.

To view the full product, including the scope and methodology, click on [GAO-09-145](#). For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov.

VA HEALTH CARE

Long-Term Care Strategic Planning and Budgeting Need Improvement

What GAO Found

In its 2007 long-term care strategic plan, VA reported planned increases for some long-term care workload, but the workload information VA provided for both nursing home and noninstitutional care was incomplete. With respect to nursing home care, VA reported plans to increase workload for certain veterans for whom VA is required to provide such care. However, VA did not report its nursing home workload plans for most veterans VA currently serves—veterans who receive such care from VA on a discretionary basis and who accounted for over three-fourths of VA's nursing home workload in fiscal year 2007. Although not reported in its strategic plan, VA's intention is to keep its total nursing home workload stable. Doing so while increasing workload for veterans VA is required to serve would reduce care provided on a discretionary basis. For noninstitutional care, VA reported plans to increase workload to close gaps in services—previously identified by GAO—for enrolled veterans, for whom those services are to be available. But VA's plan did not report the magnitude of this planned increase—167 percent between fiscal years 2007 and 2013—or VA's time frame for achieving this planned increase. Currently, VA is developing its next long-term care strategic plan.

In its fiscal year 2009 budget justification, VA estimated that it will increase its long-term care spending over its fiscal year 2008 level, but this estimate is based on cost assumptions and a workload projection that appear unrealistic. VA estimated that spending for both nursing home and noninstitutional care will increase in fiscal year 2009 by about \$108 million and \$165 million, respectively. However, VA may have underestimated its nursing home spending because it assumed nursing home costs would increase about 2.5 percent, an amount that appears unrealistically low compared to VA's recent experience and other indicators. For noninstitutional care, VA proposed a spending increase in order to partially reduce gaps in services. However, VA's estimated noninstitutional spending for fiscal year 2009 appears to be unreliable, because it is based on a cost assumption that appears unrealistically low and a workload projection that appears unrealistically high, given recent VA experience. The net effect of these two factors on VA's fiscal year 2009 noninstitutional spending estimate is unknown. VA's fiscal year 2009 budget justification did not explain the rationale behind its nursing home and noninstitutional cost assumptions or its plans for how it will increase noninstitutional workload.

Because the workload information reported in VA's long-term care strategic plan is incomplete, the plan is of limited usefulness to Congress and stakeholders for determining VA's strategic direction, the extent to which VA's priorities are consistent with congressional priorities, and the level of resources VA may need to achieve its strategic plan goals. In addition, in its fiscal year 2009 budget justification, VA's use, without explanation, of cost assumptions and a workload projection that appear to be unrealistic raises questions about both the reliability of VA's spending estimates and the extent to which VA is closing gaps in noninstitutional long-term care services.

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Abbreviations

CCHT	Care Coordination/Home Telehealth
CCT	care coordination/telehealth
CMS	Centers for Medicare & Medicaid Services
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OMB	Office of Management and Budget
VA	Department of Veterans Affairs

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United States Government Accountability Office
Washington, DC 20548

January 23, 2009

The Honorable Bob Filner
Chairman
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

The Department of Veterans Affairs (VA) operates one of the largest health care delivery systems in the nation. VA provides a range of health care services to veterans, including long-term care. In fiscal year 2007, VA spent about \$4.1 billion—about 12 percent of its total health care spending—to provide for veterans' long-term care needs. VA provides two types of long-term care: institutional long-term care, which is provided almost exclusively in nursing homes, and noninstitutional long-term care, which is provided in veterans' own homes and in other locations in the community. Most of VA's spending on long-term care is for nursing home care, which accounted for approximately 87 percent of VA's total long-term care spending in fiscal year 2007. VA is required by law to provide nursing home care to certain veterans needing such care.¹ However, VA provides the majority of its nursing home care to other veterans on a discretionary basis, as resources permit.² Many of those veterans require postacute short-stay care after being discharged from a VA hospital. In addition, VA provides nine noninstitutional long-term care services to veterans who need those services, two of which are required by law.³

¹VA is required by law to provide nursing home care that the Secretary of VA determines is needed to any veteran in need of such care for a service-connected disability and to any veteran who is in need of such care and who has a service-connected disability rated at 70 percent or greater. 38 U.S.C. § 1710A(a). These requirements will terminate on December 31, 2013. 38 U.S.C. § 1710A(d) (amended by the Veterans' Mental Health and Other Care Improvements Act of 2008, Pub. L. No. 110-387, § 805, 122 Stat. 4110, 4141). The statute states that these requirements may not be construed as authorizing or requiring that a veteran who was receiving nursing home care in a department nursing home on November 30, 1999, be displaced, transferred, or discharged from the facility. 38 U.S.C. § 1710A(b)(2).

²See 38 U.S.C. § 1710(a)(2), (3).

³The two services that VA is required by law to provide are adult day health care and respite care. 38 U.S.C. § 1710B.

VA's budgeting for long-term care has received increased scrutiny by Congress and others. The increased scrutiny has occurred, in part, because, as we have reported, VA underestimated its long-term care spending for fiscal years 2005 and 2006 due to unrealistic assumptions and projections.^{4,5} The underestimation was a key factor that led to the President requesting additional funding during those years. In June 2005, the President requested a \$975 million supplemental appropriation for fiscal year 2005, of which VA planned to use \$226 million for long-term care.⁶ Further, in July 2005, the President submitted a \$1.977 billion budget amendment for the fiscal year 2006 appropriation, of which VA planned to use \$600 million for long-term care. According to VA, \$445 million of this \$600 million was needed because VA underestimated both the workload—the amount of care provided—and the cost of providing nursing home care that year. To create its annual long-term care spending estimates, which are used for budgeting purposes, VA multiplies its projected long-term care workload by its assumed cost of providing long-term care. VA's most recent spending estimates for long-term care and all of its other medical services are in VA's 2009 budget justification.⁷ While VA includes spending estimates for long-term care in its budget justifications for planning purposes, VA typically receives appropriations that support all its medical services rather than one specifically for long-term care services. As a result, VA has considerable discretion in how it allocates appropriated funds between its various medical services, which have competing demands for resources.

Over the last decade, concerns have also been raised about VA's provision of and planning for its long-term care services. In 1998, a federal advisory

⁴Each year, VA develops annual spending estimates for its medical services, such as long-term care, and includes these estimates and supporting information in the budget justification that VA submits to Congress as part of the annual appropriations process.

⁵See GAO, *VA Health Care: Budget Formulation and Reporting on Budget Execution Need Improvement*, [GAO-06-958](#) (Washington, D.C.: Sept. 20, 2006).

⁶VA received a \$1.5 billion supplemental appropriation in fiscal year 2005. Department of the Interior, Environment, and Related Agencies Appropriations Act, 2006, Pub. L. No. 109-54, 119 Stat. 499, 563-64 (2005).

⁷In its fiscal year 2009 budget justification, VA included actual data on long-term care costs and workload for fiscal year 2007 and estimates of long-term care costs and workload for fiscal year 2008, based on the most recent data available at the time of the creation of its fiscal year 2009 budget justification. Department of Veterans Affairs, *FY 2009 Budget Submission, Medical Programs and Information Technology Programs, Volume 2 of 4* (Washington, D.C.: February 2008).

committee reviewing VA's long-term care services expressed concern that VA was not prepared to meet an increasing demand for long-term care services and recommended that VA develop plans to change its long-term care services, in part by increasing the availability of noninstitutional services.⁸ Since that time, VA has increased the availability of noninstitutional services and made other changes. However, despite VA's efforts, it has not provided the noninstitutional long-term care services it offers to all veterans who seek them from VA. In 2003, we reported that veterans' access to noninstitutional services was limited by service gaps and restrictions in several ways. For example, we found that some VA facilities did not offer two required noninstitutional services—adult day health care and respite care. We also found that some facilities had limits on the amount of particular services they offered and that these facilities used different criteria to determine which of the veterans enrolled in VA's health care system⁹ were served and what volume of services veterans could receive.¹⁰ In 2006, VA's Office of Inspector General reported similar findings.¹¹ In addition, we also reported, in 2004 and 2006, our concerns that VA cannot strategically plan how to best provide nursing home services without incorporating information on its current nursing home workload—and that not doing so hampers congressional oversight.¹² Incorporating workload for strategic planning projections includes taking into account nursing home workload for veterans whom VA is required to serve and nursing home workload for veterans to whom VA provides such care on a discretionary basis.

In the context of these concerns about VA's long-term care, the Veterans Benefits, Health Care, and Information Technology Act of 2006 required

⁸Department of Veterans Affairs, *VA Long-Term Care at the Crossroads: Report of the Federal Advisory Committee on the Future of VA Long-Term Care* (Washington, D.C.: June 1998).

⁹In general, veterans must enroll in VA's health care system in order to receive most of VA's medical services.

¹⁰See GAO, *VA Long-Term Care: Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care*, [GAO-03-487](#) (Washington, D.C.: May 9, 2003).

¹¹VA Office of Inspector General, *Review of Access to Care in the Veterans Health Administration*, Report Number 05-03-028-145 (Washington, D.C.: May 17, 2006).

¹²See GAO, *VA Long-Term Care: Data Gaps Impede Strategic Planning for and Oversight of State Veterans' Nursing Homes*, [GAO-06-264](#) (Washington, D.C.: Mar. 31, 2006). GAO, *VA Long-Term Care: Oversight of Nursing Home Program Impeded by Data Gaps*, [GAO-05-65](#) (Washington, D.C.: Nov. 10, 2004).

VA to publish a long-term care strategic plan.¹³ In August 2007, VA published a long-term care strategic plan, which covers the period through fiscal year 2013, and submitted it to Congress.¹⁴ VA is in the process of developing its next long-term care strategic plan, but as of November 2008 had not yet provided a release date. VA considers its long-term care strategic plan to be linked to VA's overall strategic plan for the department.¹⁵ A strategic plan can serve two purposes. First, a strategic plan is a tool an agency can use internally to set priorities and to guide the formulation and execution of the agency's budget.¹⁶ For example, an agency's requests made during budget formulation are expected to support an agency's strategic priorities. Second, a strategic plan is a formal means through which an agency can communicate its priorities and intended use of resources to Congress and outside stakeholders such as agency beneficiaries, the public, and others.¹⁷ For example, VA's long-term care strategic plan can inform Congress of VA's planned level of workload for its nursing home and noninstitutional long-term care services—thereby providing information on which veterans VA will serve and which long-term care services it will provide.

Given the concerns about VA's provision of and planning for long-term care services, it is especially important that VA's long-term care strategic plan provides Congress with comprehensive and reliable information. By providing such information VA can better inform Congress of VA's strategic direction, assist in its determination of whether VA's plans are aligned with congressional priorities, and enhance decisionmaking regarding the short- and longer-term levels of appropriations that may be required to meet VA's planned long-term care workload.

You expressed interest in VA's strategic planning and budgeting for long-term care, given developments on these issues in recent years. In this

¹³Pub. L. No. 109-461, § 206, 120 Stat. 3403, 3412.

¹⁴Department of Veterans Affairs, *Long-Term Care Strategic Plan, Response to Public Law 109-461, The Veterans Benefits, Health Care, and Information Technology Act of 2006* (Washington, D.C.: August 2007).

¹⁵Department of Veterans Affairs, *Strategic Plan FY 2006-2011* (Washington, D.C.: October 2006).

¹⁶Office of Management and Budget, *Circular No. A-11: Preparation, Submission, and Execution of the Budget* (Washington, D.C.: June 2008).

¹⁷See GAO, *Agencies' Strategic Plans Under GPRA: Key Questions to Facilitate Congressional Review*, [GAO/GGD-10.1.16](#) (Washington, D.C.: May 1997).

report, we examine (1) VA's reporting of planned long-term care workload in its 2007 long-term care strategic plan and (2) VA's long-term care spending estimates, including underlying cost assumptions and workload projections, in VA's fiscal year 2009 budget justification.

To examine VA's reporting of long-term care workload in its 2007 long-term care strategic plan, we reviewed the strategic plan and related documents and interviewed VA officials. Specifically, we reviewed the 2007 strategic plan and the workload projections reported in the plan to determine if the information was sufficiently comprehensive for use by Congress and stakeholders for assessing VA's strategic direction, determining if VA's plans are aligned with congressional priorities, and understanding whether planned workload will require significant changes in levels of appropriations. We compared planned workload information in the strategic plan to actual workload information in recent VA budget justifications and examined the extent to which VA's planned nursing home workload included both required care and care VA provides on a discretionary basis.¹⁸ To better understand the workload information reported in the strategic plan and to obtain information on workload not reported in the strategic plan, we interviewed officials in the Veterans Health Administration's Offices of Geriatrics and Extended Care, the Chief Financial Officer, and Policy and Planning.

To examine VA's long-term care spending estimates in VA's fiscal year 2009 budget justification, we reviewed the fiscal year 2009 budget justification and related documents, including VA's budget justifications for fiscal years 2007 and 2008, additional documents obtained from VA, and VA's Fiscal Year 2007 Performance and Accountability Report.¹⁹ To obtain information on the reasons for which particular cost assumptions and workload projections were used to develop the spending estimates in VA's fiscal year 2009 budget justification, we interviewed VA officials from the same offices as for our review of VA's long-term care strategic plan. In addition, we relied on our past work on VA's budgeting and long-term care

¹⁸During our work we focused on VA's planning and budgeting for nursing home care. We did not examine other types of institutional long-term care VA provides—state home domiciliary care and inpatient geriatric evaluation and management. Nursing home care accounted for almost all of VA's institutional long-term care workload in fiscal year 2007—the most recent year for which actual workload data is available.

¹⁹Department of Veterans Affairs, *Fiscal Year 2007 Performance and Accountability Report* (Washington, D.C.: Nov. 15, 2007).

service provision.²⁰ To examine VA's long-term care spending estimates, we compared fiscal year 2009 estimates to spending in prior years to determine the extent to which VA expected spending for these services to increase. To examine whether the cost assumptions VA used to develop spending estimates were realistic, we compared these assumptions to actual changes in the cost of providing a day of long-term care that VA has experienced in recent years. We also compared VA's cost assumptions to other assumptions of health care costs. To examine whether the workload projections that VA used to develop spending estimates were realistic, we compared VA workload projections in VA's fiscal year 2009 budget justification with VA's actual workload in recent years and examined the extent to which budget workload projections from recent years have been achieved.

In our work we examined VA's planning and budgeting for long-term care services for all veterans in general. We did not specifically review VA's long-term care services for the Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veteran population, many of whom have unique care needs. According to VA, the number of seriously disabled OEF/OIF veterans needing long-term care is small compared to the total number of veterans requiring long-term care services.

We assessed the reliability of the information we obtained about VA's spending estimates, cost assumptions, and workload projections in several ways. First, we checked the internal consistency of VA documents detailing VA's actual and estimated long-term care spending, workload, and cost data for fiscal years 2005 through fiscal year 2009. Second, we interviewed agency officials knowledgeable about the data and assumptions used to create VA's estimates and the reporting of these estimates in VA's 2009 budget justification and its long-term care strategic plan. Third, we relied on our prior work to identify potential issues about data reliability. For example, we have previously reported that VA's reported workload estimate for one noninstitutional program—home-based primary care—does not necessarily reflect care veterans receive.²¹ We determined that the data we used in our analyses were sufficiently reliable for the purposes of this report.

²⁰See the list of related GAO products at the end of this report.

²¹See GAO, *VA Long-Term Care: More Accurate Measure of Home-Based Primary Care Workload Is Needed*, [GAO-04-913](#) (Washington, D.C.: Sept. 8, 2004).

We conducted our work from November 2007 through January 2009 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.

Results in Brief

In its 2007 long-term care strategic plan, VA reported planned increases for some of its long-term care workload, but the workload information that VA's plan provided for both nursing home and noninstitutional care was incomplete. With respect to nursing home care, VA reported plans to increase its workload for certain veterans for whom VA is required to provide such care. However, VA did not report its nursing home workload plans for most of the veterans VA currently serves—veterans who receive such care on a discretionary basis, as resources permit. These veterans accounted for about three-fourths of VA's total nursing home workload in fiscal year 2007. According to VA officials, VA intends to keep its total nursing home workload relatively stable, but VA did not report this information in its long-term care strategic plan. To keep its total nursing home workload stable and also achieve its planned workload increase for certain veterans for whom VA is required to provide such care, VA would have to reduce its workload for veterans who receive VA nursing home care on a discretionary basis. For noninstitutional long-term care services, VA reported plans to increase its workload to close previously identified gaps in services for enrolled veterans, for whom noninstitutional services are to be available. However, VA's plan did not report the magnitude of VA's planned noninstitutional workload increase or VA's time frame for achieving this increase. Although not reported in the strategic plan, VA officials told us that when VA completed its strategic plan, its goal was to increase its noninstitutional workload in order to meet the estimated demand for noninstitutional services by fiscal year 2013. In order to meet its goal, VA would have to increase noninstitutional workload by 167 percent between fiscal years 2007 and 2013. According to VA officials, VA now plans to meet the full demand for noninstitutional services by fiscal year 2011.

In its fiscal year 2009 budget justification, VA estimated that it will increase its long-term care spending over its fiscal year 2008 level, but this estimate is based on cost assumptions and a workload projection that appear unrealistic. VA estimated that spending for both nursing home and noninstitutional care will increase in fiscal year 2009 by about \$108 million

and \$165 million, respectively. However, VA may have underestimated its nursing home spending because it used a cost assumption that appears unrealistically low compared to recent VA experience as well as economic forecasts of increases in health care costs from fiscal year 2008 to fiscal year 2009. For example, VA assumed that nursing home costs would increase 2.5 percent from fiscal year 2008 to fiscal year 2009 although these costs increased 5.5 percent from fiscal year 2006 to fiscal year 2007—the most recent year for which actual cost data are available. For noninstitutional long-term care, VA proposed a spending increase to reduce previously identified gaps in services for enrolled veterans seeking such care from VA. However, VA’s estimate of its noninstitutional long-term care spending for fiscal year 2009 appears to be unreliable, because it is based on a cost assumption that appears unrealistically low and a workload projection that appears unrealistically high, given recent VA experience providing these services. For example, VA assumed that the costs of providing noninstitutional care would not increase over fiscal year 2008 levels, despite the fact that these costs increased 19 percent from fiscal year 2006 to fiscal year 2007. In addition, in an effort to move toward partially meeting veterans’ demand for noninstitutional services, VA projected that it would increase its noninstitutional workload 38 percent from fiscal year 2008 to fiscal year 2009, despite the fact that VA’s actual workload for these services decreased about 5 percent from fiscal year 2006 to fiscal year 2007. The net effect of an apparently unrealistically low cost assumption and an apparently unrealistically high workload projection on VA’s fiscal year 2009 noninstitutional spending estimate is unknown. In its fiscal year 2009 budget justification, VA did not provide information regarding its nursing home or noninstitutional cost assumptions or its plans for how it will increase noninstitutional workload.

Because the workload information VA reported in its long-term care strategic plan is incomplete, the plan is of limited usefulness to Congress and stakeholders for determining VA’s strategic direction, the extent to which VA’s priorities are consistent with congressional priorities, and the level of resources VA may need to achieve plan goals. Regarding both nursing home and noninstitutional services, VA had additional information about its planned workload that it did not report in its plan. VA officials told us that VA’s plan did not report nursing home workload for all veterans because VA is not required to provide nursing home care to all veterans. VA officials also said that VA did not report additional information on noninstitutional workload in its plan because of ongoing VA deliberations about budgeting workload targets that were occurring as the plan was finalized. VA is currently developing its next long-term care

strategic plan, but has not yet determined a release date. In addition, in its fiscal year 2009 budget justification, VA's use, without explanation, of cost assumptions and a workload projection that appear unrealistic raises questions about both the reliability of VA's spending estimates and the extent to which VA is closing previously identified gaps in noninstitutional long-term care services. To improve VA's strategic planning, we are recommending that VA's next long-term care strategic plan include additional workload information. To improve VA's budgeting, we are recommending that VA use, in future budget justifications, assumptions and projections that are in line with VA's recent experience, or report the rationale for not doing so.

In its written comments on a draft of this report, VA stated that VA supports our overall conclusion that VA's long-term care strategic planning and budget justification process should be clarified so that the priorities of VA's long-term care program can be clearly understood by all stakeholders, including Congress. VA did not provide specific comments on the draft report or recommendations, including whether VA agrees with the recommendations. VA noted it would evaluate the final report and complete an action plan that responds to our recommendations.

Background

VA long-term care includes a continuum of services for veterans needing assistance due to chronic illness or physical or mental disability. VA's long-term care services include nursing home care, which is provided in three settings: VA-operated nursing homes, community nursing homes, and state veterans' nursing homes.²² In addition, VA provides noninstitutional long-term care services, which are in-home services and services provided in community-based settings, such as adult day care.²³ VA provides nine noninstitutional long-term care services (see app. I). VA provides these services using both VA providers and other providers it pays for the provision of such services. Veterans may prefer noninstitutional long-term care services because such services allow them to remain in their homes or in other settings that are less restrictive than nursing homes. For example, some veterans receive assistance with bathing and dressing in their homes by home health aides.

²²38 U.S.C. §§ 1710B, 1745.

²³VA also refers to noninstitutional long-term care services as "home and community based care" services.

VA is required by law to provide nursing home care and some types of noninstitutional long-term care to certain veterans.²⁴ VA is required by law to provide nursing home care to veterans needing such care and who have a service-connected disability rating of 70 percent or greater—referred to as Priority 1A veterans.²⁵ However, VA provides most of its nursing home care to veterans who receive it on a discretionary basis.²⁶ Many of those veterans require postacute short-stay care—care less than 90 days—such as rehabilitation care following hospitalization in a VA hospital. For example, VA may provide short-stay nursing home care to a veteran who has had a stroke and needs intensive, short-term rehabilitative services, once the veteran is medically stable. According to VA officials, VA’s usual clinical practice is to try to provide short-stay care to all veterans who need such care following discharge from a VA hospital, regardless of the veterans’ priority category.

By statute or the regulation defining VA’s medical benefits package, noninstitutional long-term care services are to be provided to enrolled veterans.^{27, 28} VA is required by law to provide two of its nine

²⁴Requirements for VA long-term care services—like other VA health care services—are effective in any fiscal year only to the extent and in the amount provided in advance in appropriations acts for such purposes. 38 U.S.C. § 1710(a)(4).

²⁵In addition to Priority 1A veterans, VA is also required to provide nursing home care that the Secretary of VA determines is needed for veterans in need of such care for a service-connected disability. 38 U.S.C. § 1710A(a). These requirements will terminate on December 31, 2013. 38 U.S.C. § 1710A(d) (amended by the Veterans’ Mental Health and Other Care Improvements Act of 2008, Pub. L. No. 110-387, § 805, 122 Stat. 4110, 4141). The statute states that these requirements may not be construed as authorizing or requiring that a veteran who was receiving nursing home care in a department nursing home on November 30, 1999, be displaced, transferred, or discharged from the facility. 38 U.S.C. § 1710A(b)(2).

²⁶See 38 U.S.C. § 1710(a)(2), (3).

²⁷In general, veterans must enroll in VA’s health care system in order to receive VA’s medical benefits package, which covers most of VA’s medical services. VA’s enrollment system includes eight categories for enrollment, with priority generally based on service-connected disability, low income, and other recognized statuses such as former prisoners of war. 38 U.S.C. § 1705; 38 C.F.R. § 17.36 (2008). Veterans do not have to be enrolled in VA’s health care system to receive VA nursing home care. 38 C.F.R. § 17.37(i) (2008).

²⁸VA is required to provide “medical services”—including adult day health care and respite care—to groups of veterans specified by law. 38 U.S.C. §§ 1710(a)(1), (2), 1701(6) (amended by the Veterans’ Mental Health and Other Care Improvements Act of 2008, Pub. L. No. 110-387, § 801, 122 Stat. 4110, 4140–41). VA is authorized to provide medical services to other veterans not identified in these groups. 38 U.S.C. § 1710(a)(3). The groups of veterans to whom VA is required to provide medical services coincide with most of VA’s enrollment categories. See 38 U.S.C. § 1705.

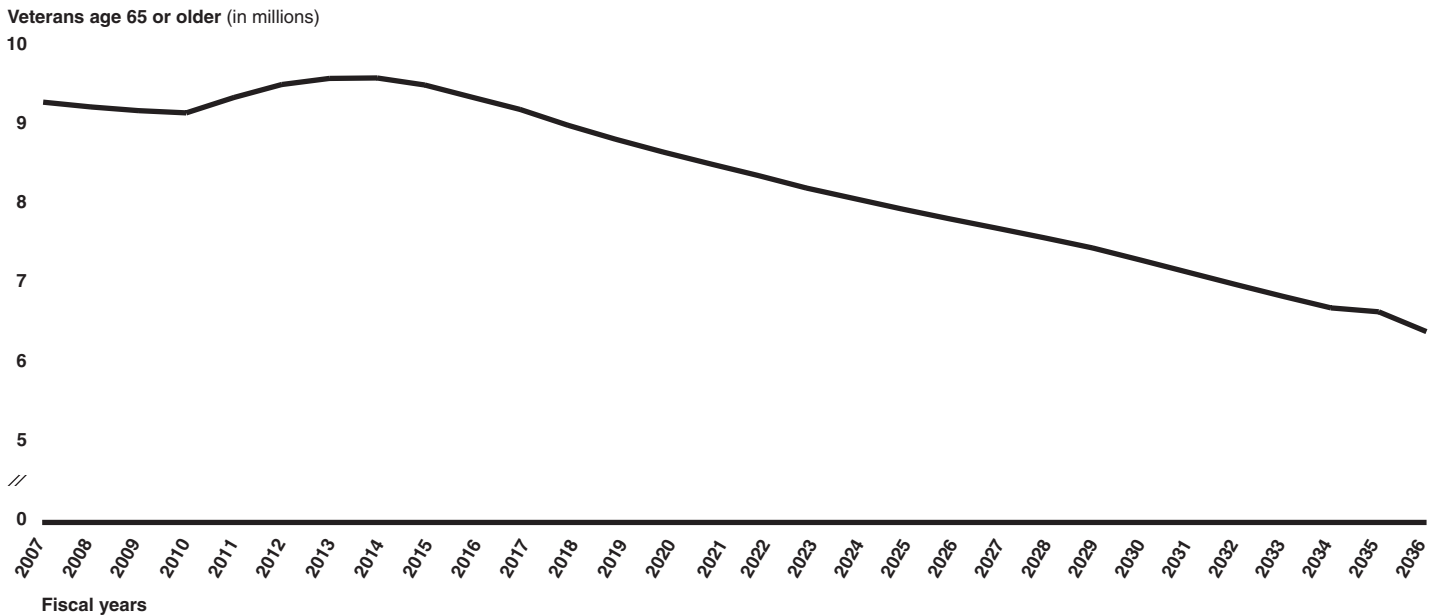
noninstitutional long-term care services: adult day health care and respite care.²⁹ Most of VA's other noninstitutional long-term care services—six of the other seven services³⁰—are provided as part of VA's medical benefits package, which is a uniform set of services that are to be available to all enrolled veterans. VA's policy is to provide the services required by law and the services provided as part of the medical benefits package to all enrolled veterans who need and seek these services from VA.

Veterans of all ages may need VA long-term care, but the need for long-term care increases with age. Long-term care is particularly important to VA, in part, because the veteran population is older than the general population. It is estimated that in 2007 about forty percent of the veteran population was age 65 or older, compared to about 13 percent of the general population. Moreover, the number of elderly veterans is expected to increase through 2014. However, the number of elderly veterans is expected to decline thereafter. (See fig. 1.)

²⁹38 U.S.C. § 1710B.

³⁰These six services are care coordination/telehealth; home-based primary care; homemaker/home health aide services; hospice and palliative care; purchased skilled home health care; and spinal cord injury home care. VA also provides community residential care to veterans, but not as part of its medical benefits package.

Figure 1: Projected Veteran Population Age 65 and Older, Fiscal Year 2007 through Fiscal Year 2036



Source: GAO analysis of VA data.

Note: This figure includes all veterans 65 and older whether they receive health care from VA or non-VA providers. It is based on VA's VetPop2007 data.

Many veterans who need long-term care do not receive it from VA but instead receive care from other providers that is financed by programs such as Medicaid, Medicare, private health or long-term care insurance, or self-financing by the patients.³¹ As a result, in VA's long-term care strategic planning, determining future workload is a multistep process. This process requires estimating the number of veterans who will need long-term care, the number of those veterans needing long-term care who will seek it from VA, and the number of veterans seeking such care that VA will serve.

VA funds its long-term care services with annual appropriations. Each year VA develops its annual budget request, which includes spending estimates for VA medical services, such as long-term care. VA begins to formulate its

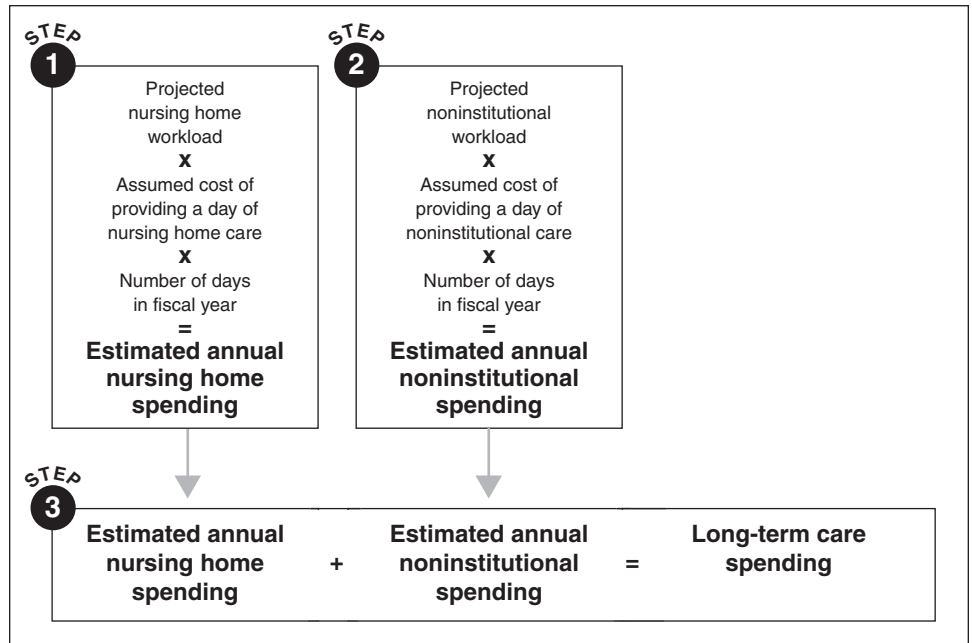
³¹VA is not authorized, in most cases, to bill and collect payments from Medicaid and Medicare, nor can VA bill other insurers for health care services that are related to a service-connected disability. However, a veteran's eligibility to participate in VA's nursing home program does not prohibit him or her from using these financing sources for nursing home care outside of VA's health care system, if eligible.

budget request approximately 18 months before the start of the fiscal year to which the request relates and about 10 months before transmission of the President's budget request, which usually occurs in early February.³²

The annual spending estimates VA develops for long-term care, as part of its annual budget request, are based on two factors: projected long-term care workload and the assumed cost of providing a day of care. Long-term care workload is measured in terms of average daily census, which reflects the average number of veterans in long-term care on any given day during the course of the year. The product of projected workload and assumed costs, multiplied by the number of days in the fiscal year, equates to VA's estimated annual spending for nursing home and noninstitutional care, respectively. (See fig. 2.)

³²Due to the timing of the budget preparation, VA's spending estimates are not based on VA's actual spending from the prior year since these data are not yet available.

Figure 2: Calculation of Estimated Annual Spending for Long-Term Care



Source: GAO analysis of VA information.

Notes: Workload is measured in terms of average daily census or the average number of veterans in VA long-term care on any given day during the course of a year. For noninstitutional long-term care, the “number of days in fiscal year” varies by noninstitutional service.

Nursing home care accounted for almost all of VA’s institutional long-term care workload in fiscal year 2007—the most recent year for which workload data are available. This figure does not reflect the institutional long-term workload from VA’s other institutional long-term care services—state home domiciliary care and inpatient geriatric evaluation and management.

VA has considerable discretion in how it allocates the resources that have been appropriated for its medical services. In general, VA is not required to allocate a specific level of funding for long-term care services. VA presents its plan for providing long-term care services and the resources required to implement this plan, along with similar information for other medical services, in its annual budget justification. However, the actual amount of long-term care services provided and resources spent may be different than planned. VA may, for example, spend more for long-term care services than planned in the budget justification by using resources originally planned for other medical services. Conversely, VA may spend less for long-term care services than originally planned by using resources planned for long-term care services for other medical services.

VA Reported Plans to Increase Some of Its Long-Term Care Workload, but Incomplete Information Limited Plan's Usefulness for Stakeholders

In its 2007 long-term care strategic plan, VA reported planned increases in some of its long-term care workload. However, VA's plan provided incomplete information on its planned long-term care workload, which limited the plan's usefulness for stakeholders. In particular, VA reported plans to increase its nursing home workload for certain veterans for whom VA is required to provide nursing home services, but did not report planned workload for veterans who receive VA nursing home care on a discretionary basis and account for the majority of care VA's nursing home program provides. For noninstitutional services, VA reported plans to increase its workload to close previously identified gaps in services for enrolled veterans, for whom noninstitutional services are to be available. However, VA's plan did not report the magnitude of the planned increase or VA's time frame for achieving the increase in noninstitutional workload. As a result, VA's plan does not provide information to Congress and stakeholders on VA's priorities and intended use of resources.

VA Reported Planned Nursing Home Workload Increases for Some Veterans VA Is Required to Serve, but Did Not Report Planned Discretionary Nursing Home Workload for Most Veterans VA Currently Serves

In its long-term care strategic plan, VA reported plans to increase the amount of nursing home care it provides for some veterans, but did not report the amount of care VA would provide for most of the veteran population VA currently serves. VA reported plans to increase its nursing home workload for a certain group of veterans for whom VA must provide nursing home care—a group known as Priority 1A veterans.³³ According to VA’s long-term care strategic plan, VA plans to increase its nursing home workload for these veterans from 9,300³⁴ in fiscal year 2007 to 11,000 in fiscal year 2013 to meet an estimated increase in demand for nursing home services by Priority 1A veterans.^{35,36} However, VA’s long-term care strategic plan did not report the amount of nursing home care VA plans to provide to veterans who receive VA nursing home care on a discretionary basis. These veterans account for the majority of care VA’s nursing home program provides. In contrast to Priority 1A veterans, who accounted for only about one-quarter of VA’s nursing home workload in fiscal year 2007 (9,300 of 34,579), veterans who receive VA nursing home care on a discretionary basis accounted for about three-fourths of VA’s nursing home workload that year. These veterans also accounted for the majority—roughly 65 percent—of VA’s total spending on long-term care that fiscal year.

³³VA is also required to provide nursing home care that the Secretary of VA determines is needed for veterans in need of such care for a service-connected disability. 38 U.S.C. § 1710A(a). These requirements will terminate on December 31, 2013. 38 U.S.C. § 1710A(d) (amended by the Veterans’ Mental Health and Other Care Improvements Act of 2008, Pub. L. No. 110-387, § 805, 122 Stat. 4110, 4141). The statute states that these requirements may not be construed as authorizing or requiring that a veteran who was receiving nursing home care in a department nursing home on November 30, 1999, be displaced, transferred, or discharged from the facility. 38 U.S.C. § 1710A(b)(2). According to VA officials, these two groups—veterans receiving nursing home care for a service-connected disability and veterans who were receiving nursing home care in a VA nursing home on November 30, 1999—are very small in relation to the number of Priority 1A veterans.

³⁴VA measures workload in terms of average daily census.

³⁵VA estimates of demand for its long-term care services—for both nursing home and noninstitutional services—are estimates of the number of veterans who are expected to seek long-term care from VA rather than seek such care through Medicare, Medicaid, private insurance, or TRICARE—the Department of Defense health care program for active-duty personnel, retirees, and their dependents. VA officials told us that VA expects to be able to meet the rising demand for nursing home services for Priority 1A veterans because VA’s planned workload for this population—11,000—is less than the capacity available in VA-operated nursing homes, one of the three settings through which VA provides nursing home care.

³⁶VA estimated the increase in demand for nursing home services by Priority 1A veterans using information on actual Priority 1A nursing home workload.

Although not reported in VA's long-term care strategic plan, VA has plans for the total amount of nursing home care it intends to provide in future years. VA officials told us that VA plans to keep its total nursing home workload relatively stable between fiscal years 2007 and 2013. To keep its total nursing home workload stable and also achieve its planned workload for Priority 1A veterans, VA would have to reduce its workload for veterans who receive VA nursing home care on a discretionary basis. VA officials told us that the long-term care strategic plan did not report VA's planned workload for all veterans receiving VA nursing home care because VA is not required to provide nursing home services to all veterans. These officials stated that the plan reported on planned workload for Priority 1A veterans because VA must ensure that it has adequate resources to provide nursing home care to this population.

Because VA's long-term care strategic plan does not report the total amount of nursing home care VA plans to provide in the future, including the care it will provide to veterans on a discretionary basis, the plan does not provide key information about VA's strategic direction and priorities for its nursing home program, and how VA intends to use its resources. In particular, VA's plan does not provide Congress with sufficient information about VA's strategic direction for the veterans who account for most of VA's long-term care spending—veterans who receive VA nursing home care on a discretionary basis—and whether VA will increase or decrease nursing home workload for these veterans. Furthermore, VA's plan provides limited information for Congress to determine (1) whether VA's plans for its nursing home program are aligned with congressional priorities and (2) the level of appropriations VA may need to achieve its nursing home workload plans in the short and longer term.

VA Reported a Planned Increase in Noninstitutional Workload to Close Gaps in Service, but Did Not Report the Magnitude or Time Frame of the Planned Increase

In its long-term care strategic plan, VA reported plans to increase noninstitutional workload to close gaps in service, but did not report the magnitude of VA's planned noninstitutional workload increase or VA's time frame for achieving this increase. VA's plan reported that it planned to increase its noninstitutional workload in order to continue closing previously identified gaps between the number of enrolled veterans who need and seek such services from VA—known as demand—and the amount of services VA provides. As noted in the plan, closing these gaps has been a key element of VA long-term care policy, particularly in the context of growing demand for long-term care among veterans and the desire to serve veterans in home and community-based settings, instead of caring for them in nursing homes. According to VA's plan, the demand for

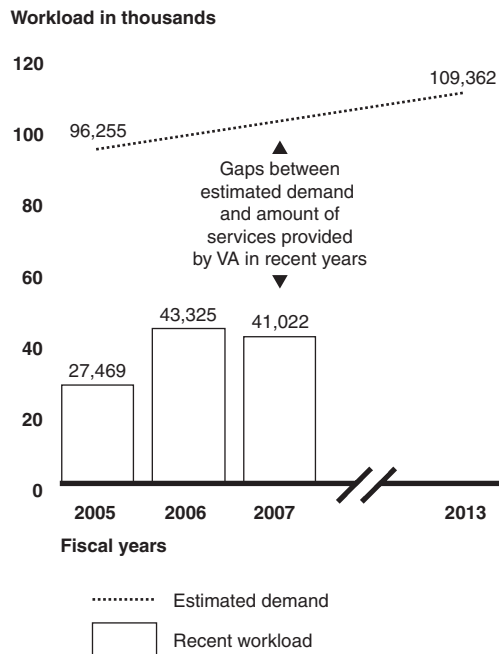
VA's noninstitutional long-term care services will increase an estimated 14 percent between fiscal years 2005 and 2013.³⁷

While VA's long-term care strategic plan reported that VA intended to increase its noninstitutional workload in the face of growing demand for such services, it did not specify how much VA would increase this workload. In fact, VA's plan did not report VA's noninstitutional workload plans for each of the years through fiscal year 2013, the last year covered by VA's long-term care strategic plan. Moreover, although VA's plan reported a 14 percent increase in estimated demand for noninstitutional care, it did not specify the estimates of demand that were used to calculate this estimated increase, compare VA's noninstitutional workload in recent years to the estimated demand for those services, or report the extent to which VA planned on meeting the estimated demand for those services. As a result, VA's plan did not provide information on the extent to which VA would have to increase its workload to meet the estimated demand for noninstitutional services.

Although not reported in VA's long-term care strategic plan, VA has specific estimates of the demand for its noninstitutional services. According to VA officials, the estimates of demand for noninstitutional services that were used to calculate the reported 14 percent increase in demand were 96,255 and 109,362 in fiscal years 2005 and 2013, respectively. Comparing these estimates of demand with VA's noninstitutional workload in recent years shows that there have been significant gaps between the estimated number of veterans who needed and sought noninstitutional services from VA and the amount of noninstitutional services that VA has provided. (See fig. 3.)

³⁷VA estimated the increase in demand for noninstitutional services by making projections based on data on enrolled veterans' utilization of noninstitutional services.

Figure 3: VA Noninstitutional Long-Term Care: Estimated Demand and Recent Workload



Source: GAO analysis of VA data.

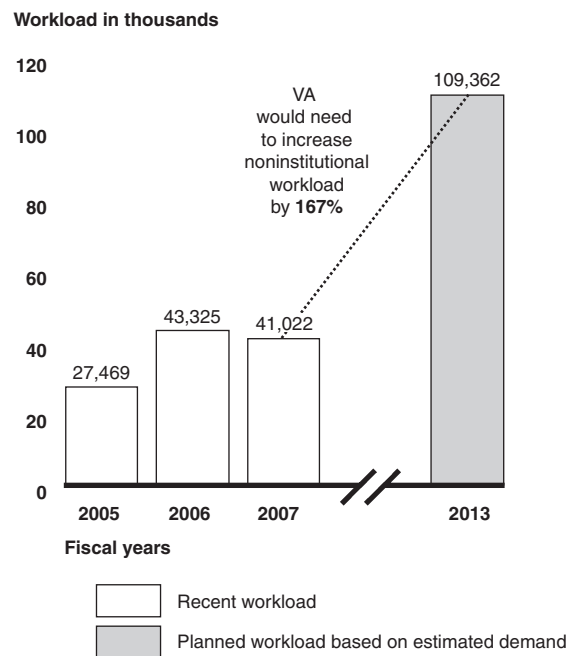
Notes: According to VA officials, VA estimated the demand for noninstitutional services using data on enrolled veterans' use of noninstitutional services.

Data on VA's recent noninstitutional workload are from VA budget submissions. Workload is measured in average daily census. Average daily census reflects the average number of veterans in VA noninstitutional long-term care services on any given day during the course of a year.

VA also did not report in its long-term care strategic plan that VA has a specific time frame for increasing noninstitutional workload in order to meet the estimated demand for noninstitutional services. VA officials told us that when VA completed its strategic plan, VA's goal was to increase its noninstitutional workload in order to meet the estimated demand for those services by fiscal year 2013. VA's planned noninstitutional workload for fiscal year 2013 of 109,362—as reported to us by VA officials—would represent a significant increase compared with VA's recent noninstitutional workload. Specifically, it would represent a 167 percent increase over VA's noninstitutional workload of 41,022 in fiscal year 2007, the most recent year for which information on the amount of noninstitutional services provided by VA is available. (See fig. 4.) According to VA officials, after VA issued its long-term care strategic plan, VA accelerated its timeline for increasing noninstitutional workload and

now plans to begin meeting the estimated demand for those services by fiscal year 2011. VA officials told us that VA did not compare estimated demand to recent workload or report information on planned noninstitutional workload in the strategic plan because VA did not want to publish those figures at the time the strategic plan was finalized. VA officials said this was because of ongoing VA deliberations about budgeting workload targets. Also, VA officials told us that achieving the planned increase in noninstitutional workload will be challenging because of the magnitude of the expanded capacity that VA would need to create to provide this level of increased services.

Figure 4: VA Noninstitutional Long-Term Care: Recent and Planned Workload



Source: GAO analysis of VA data.

Notes: Although not reported in the long-term care strategic plan, according to VA officials, when VA issued the plan in August 2007, VA intended to increase noninstitutional workload in order to meet the estimated demand for those services by fiscal year 2013. According to VA officials, after VA issued the plan, VA accelerated its timeline and now plans to begin meeting estimated demand for noninstitutional services by fiscal year 2011.

Data on VA's recent noninstitutional workload are from VA budget submissions. Workload is measured in average daily census. Average daily census reflects the average number of veterans in VA noninstitutional long-term care services on any given day during the course of a year.

The lack of information in VA's plan on how its noninstitutional workload will change in the future when compared to VA's recent workload limits the plan's usefulness to stakeholders in understanding VA's priorities and how VA plans to use its resources. In particular, the plan does not inform Congress about whether VA plans a substantial or modest increase in noninstitutional workload during the time period covered by the plan—and thus to what extent VA will close gaps in the noninstitutional services that are to be available for all enrolled veterans. Moreover, the lack of such workload information limits the plan's usefulness to Congress for considering the level of appropriations VA may need in the short or longer term to close such service gaps.

In Estimating Increases in Long-Term Care Spending, VA Used Cost Assumptions and a Workload Projection That Appear Unrealistic

In its fiscal year 2009 budget justification, VA estimated that it will increase its long-term care spending for both nursing home and noninstitutional care over its fiscal year 2008 level, but this estimate is based on cost assumptions and a workload projection that appear unrealistic. For nursing home care, VA may have underestimated the amount its nursing home spending will increase from fiscal year 2008 to fiscal year 2009, because it used a cost assumption that appears unrealistically low. Similarly, VA's estimated increase in noninstitutional long-term care spending for this period appears to be unreliable because it is based on a cost assumption that appears unrealistically low and a projected increase in workload that appears unrealistically high. The net effect of these two factors on VA's noninstitutional spending estimate is unknown.

VA Estimated an Increase in Long-Term Care Spending for Fiscal Year 2009

In its fiscal year 2009 budget justification, VA estimated a \$273 million increase in long-term care spending, from about \$4.5 billion in fiscal year 2008 to about \$4.8 billion in fiscal year 2009. Of this increase, approximately \$108 million is for increased spending on nursing home care and approximately \$165 million is for increased spending on noninstitutional long-term care (see table 1). VA's estimated increase in spending for nursing home care is based on (1) the assumption that the cost of providing a day of nursing home care will increase about 2.5 percent from its fiscal year 2008 level, and (2) a projection that workload will remain fairly stable during this period, increasing from 34,633 to 34,970.

Table 1: Estimated Increase in Fiscal Year 2009 Spending for Nursing Home and Noninstitutional Long-Term Care

Dollars in millions

	Fiscal year 2008 estimated spending ^a	Fiscal year 2009 estimated spending	Estimated increase in spending from fiscal year 2008
Nursing home care	3,895	4,003	108
Noninstitutional long-term care	597	762	165
Total long-term care^b	4,492	4,766^c	273

Source: VA.

Notes: Data are from VA, *FY 2009 Budget Submission, Medical Programs and Information Technology Programs, Volume 2 of 4* (Washington, D.C.: February 2008).

^aIn its fiscal year 2009 budget justification, VA included an updated estimate of fiscal year 2008 spending, based on the most recent long-term care spending data available at the time of the creation of the fiscal year 2009 budget justification.

^bTotal of nursing home and noninstitutional long-term care. VA provides other types of institutional long-term care but for the purposes of this report we refer to nursing home and noninstitutional services as long-term care because they comprise about 99 percent of VA's estimated long-term care spending for fiscal year 2009.

^cNumbers do not add due to rounding.

VA's estimated increase in spending for noninstitutional long-term care for fiscal year 2009 reflects VA's effort to partially close previously identified gaps in its provision of noninstitutional services.³⁸ VA's estimated increase in spending for this care is based on (1) the assumption that the cost of providing a day of noninstitutional care would remain at the same level it was in fiscal year 2008, and (2) that VA's noninstitutional workload will increase a projected 38 percent from fiscal year 2008. As a result, VA's estimated spending increase for noninstitutional long-term care is driven solely by VA's projected increase in noninstitutional workload. VA officials told us that in developing noninstitutional spending estimates for fiscal year 2009, VA focused on increasing workload in order to make progress towards accomplishing its plan of meeting all enrolled veterans' demand for these services by fiscal year 2011.

³⁸See [GAO-03-487](#).

VA May Have Underestimated Its Nursing Home Spending Because the Cost Assumption Used Appears Unrealistically Low

VA's fiscal year 2009 spending estimate for nursing home care may be underestimated because its assumption that the cost of providing a day of nursing home care will increase approximately 2.5 percent from its fiscal year 2008 level is substantially less than the increases in nursing home costs that VA has recently experienced. For example, from fiscal year 2006 to fiscal year 2007—the most recent year for which actual cost data are available—VA's cost of providing a day of nursing home care increased approximately 5.5 percent. Similarly, VA estimated that its nursing home costs from fiscal year 2007 to fiscal year 2008 will increase approximately 11 percent.³⁹ In addition to VA's recent experience, economic forecasts also predict increases in the cost of providing medical services that are greater than 2.5 percent. Office of Management and Budget (OMB) guidance provided to VA to help with its budget estimates forecasted a rate of inflation for medical services of 3.8 percent from fiscal year 2008 to fiscal year 2009. Similarly, in its annual estimate of national health care spending, the Centers for Medicare & Medicaid Services (CMS) predicted that this spending would increase about 6.7 percent from fiscal year 2008 to fiscal year 2009.⁴⁰ We determined that if VA had assumed a 5.5 percent increase in the cost of providing a day of nursing home care, which is consistent with VA's recent experience, VA's estimated nursing home spending for fiscal year 2009 would have increased approximately \$112 million more than VA reported in its budget justification.

In its fiscal year 2009 budget justification, VA did not report or explain the rationale behind its nursing home cost assumption. VA officials told us that information on this cost assumption was not included in the budget justification because VA wanted to keep the budget submission concise. VA officials also told us that VA made the decision to assume a 2.5 percent increase in the cost of providing a day of nursing home care to be conservative in its fiscal year 2009 appropriations request. The officials offered no further explanation as to why VA's assumption was lower than VA's previous experience and that recommended by OMB guidance. Without additional information, VA's 2.5 percent cost increase appears to be unrealistic.

³⁹In its fiscal year 2009 budget justification, VA included fiscal year 2007 actual data and an estimate of fiscal year 2008 data, based on the most recent nursing home data available at the time of the creation of its fiscal year 2009 budget justification.

⁴⁰Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of the Actuary, *National Health Expenditures Projections 2007-2017* (Washington, D.C.: January 2008).

VA's Estimate of Noninstitutional Spending Is Based on a Cost Assumption and Workload Projection That Appear Unrealistic, and Overall Effect Is Unknown

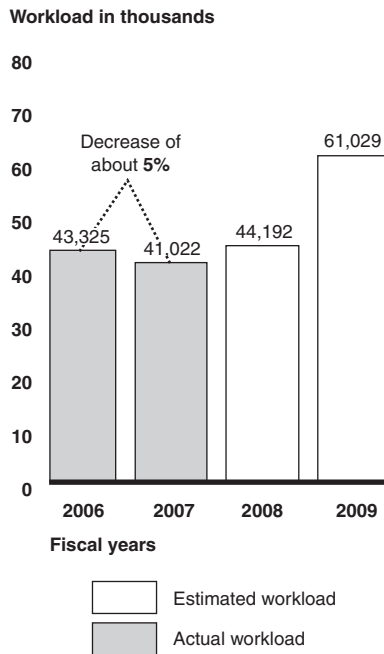
VA's estimate of noninstitutional long-term care spending for fiscal year 2009 is based on a cost assumption that appears unrealistically low and a workload projection that appears unrealistically high. The net effect of these two factors on VA's noninstitutional spending estimate for fiscal year 2009 is unknown. VA's assumption that the cost of providing a day of noninstitutional care will not increase from its fiscal year 2008 level appears unrealistically low, given both VA's recent experience and economic forecasts of increases in health care costs. From fiscal year 2006 to fiscal year 2007—the most recent year for which actual cost data are available—the cost of providing a day of noninstitutional care increased by 19 percent. VA's cost assumption for noninstitutional services for fiscal year 2009 is also inconsistent with OMB guidance, which forecasts inflation of 3.8 percent for medical services from fiscal year 2008, and with the 6.7 percent increase forecasted by CMS. If VA's costs for providing noninstitutional care increase from fiscal year 2008 to fiscal year 2009—and its workload projection is accurate—VA's estimates of fiscal year 2009 spending will be underestimated. For example, we determined that if VA had assumed a 19 percent increase in the cost of providing a day of noninstitutional care from fiscal year 2008 to fiscal year 2009—an amount consistent with VA's recent experience—and if VA achieved its projected workload, VA's estimated noninstitutional spending for fiscal year 2009 would be approximately \$144 million more than the amount VA reported in its fiscal year 2009 budget justification.

In its fiscal year 2009 budget justification, VA did not report or explain why it assumed that costs for providing a day of noninstitutional long-term care would not increase. As in the case for VA's nursing home cost assumption, VA officials told us that the reason VA did not provide information on its cost assumption for noninstitutional services was because VA wanted to keep its budget submission concise. While not reported in VA's 2009 budget submission, VA officials told us that to be conservative in VA's fiscal year 2009 budget estimates, they made the decision to base VA's spending estimates for noninstitutional long-term care on the assumption that costs would not rise. These officials also explained that VA's fiscal year 2009 budgeting priority was to increase noninstitutional workload to improve VA's ability to meet the needs of all enrolled veterans who need and seek such care, as envisioned in VA's long-term care strategic plan. In order to do this and stay within anticipated budgetary constraints, VA assumed that the cost of providing a day of noninstitutional care would not change from the fiscal year 2008 level.

Like its cost assumption, VA's noninstitutional workload projection for fiscal year 2009 appears unrealistic. Specifically, VA's projected 38 percent increase in noninstitutional workload appears unrealistically high given VA's recent experience providing this type of care. From fiscal year 2006 to fiscal year 2007—the most recent year for which workload data are available—VA's noninstitutional workload decreased about 5 percent, from 43,325 to 41,022, rather than increasing as projected.⁴¹ (See fig. 5.) VA officials told us that the reason workload decreased during this time period was because VA chose to focus on offering other medical services VA is required to provide veterans. VA officials also stated that increasing noninstitutional workload is challenging. Because many of VA's noninstitutional services are provided by VA personnel, VA must hire and train more personnel before it has the capacity to serve an increased workload. In its budget justification, VA did not explain how it plans to increase workload 38 percent from fiscal year 2008 to fiscal year 2009. If, as recent VA experience indicates, VA's actual workload for noninstitutional long-term care in fiscal year 2009 is less than VA projects—and if VA's noninstitutional costs remain at fiscal year 2008 levels as VA assumes—then VA's estimates of its fiscal year 2009 noninstitutional spending will be overestimated.

⁴¹In its fiscal year 2007 budget justification, VA projected workload to increase about 14 percent from fiscal year 2006 to fiscal year 2007. Department of Veterans Affairs, *FY 2007 Budget Submission, Medical Programs, Volume 1 of 4* (Washington, D.C.: February 2006).

Figure 5: VA Actual and Estimated Noninstitutional Workload, Fiscal Year 2006 through Fiscal Year 2009



Source: GAO analysis of VA data.

Note: Workload is measured in average daily census. Average daily census reflects the average number of veterans in VA noninstitutional long-term care services on any given day during the course of a year.

Although VA's workload projection appears unrealistically high and its cost assumption appears unrealistically low, the net effect of these two factors on VA's noninstitutional spending estimate for fiscal year 2009 is unknown. This is because these two factors have opposite effects on spending and could potentially offset each other. For example, it is possible that the effects of an unrealistically high workload estimate could be balanced out by the effects of an unrealistically low cost estimate, causing VA's actual spending in fiscal year 2009 to be close to its spending estimate. However, even if VA's spending estimate for fiscal year 2009 is accurate—due to VA's actual workload being lower than projected—VA would be serving fewer veterans than it budgeted for. As a result, VA would be further away from meeting its planned goal of meeting the total demand for noninstitutional services by fiscal year 2011.

During the course of our work, we identified another factor that could raise questions regarding VA's noninstitutional workload projection for

fiscal year 2009. In addition to VA's workload projection appearing to be unrealistically high, the projection may also overstate the amount of care veterans will receive. This is because the workload measure VA uses for home-based primary care⁴² does not accurately reflect the quantity of care veterans receive. VA projects that this service will account for about one-third of its noninstitutional workload increase from fiscal year 2008 to fiscal year 2009. Unlike the workload for most noninstitutional long-term care services—which VA measures by the number of individual visits from a care provider a veteran receives—VA measures workload for home-based primary care by the number of days a veteran is enrolled in the service, regardless of the number of visits from a care provider or other services that the veteran actually receives.⁴³ For example, if over a 2-week period a veteran was in home-based primary care and received two home visits, VA would calculate the workload as 14, based on the veteran's days of enrollment in the program, even though the veteran received two visits from a care provider. In contrast, if the veteran was in homemaker/home health aide care⁴⁴ and received four visits during the 2-week period, VA would calculate the workload as 4, based on the number of care provider visits the veteran received. Consequently, for home-based primary care, a reported increase in workload may reflect an increase in the number of veterans enrolled in these services, but does not necessarily reflect an increase in the quantity of care veterans receive.

VA did not indicate or explain, in its fiscal year 2009 budget justification, why it had calculated workload differently for home-based primary care than it had for most other noninstitutional long-term care services. According to VA officials, although VA for other purposes measures the

⁴²Home-based primary care provides primary care, delivered by a physician-directed interdisciplinary team of staff including nurses, in the homes of veterans with complex medical, behavioral, and psychosocial conditions who would be candidates for nursing home care in the absence of this service.

⁴³VA uses enrolled days to measure workload for three other noninstitutional services: (1) care coordination/telehealth, (2) community residential care, and (3) hospice and palliative care. We did not focus on these three services for several reasons. First, veterans have contact with VA each day they are enrolled in care coordination/telehealth services. Also, VA's contribution for community residential care services is limited to the cost of program administration and clinical services. Finally, VA projects that hospice and palliative care will account for less than 2 percent of its noninstitutional workload increase from fiscal year 2008 to fiscal year 2009.

⁴⁴Homemaker/home health aide services are personal care and related support services that may include assistance with activities of daily living that are essential for maintaining a safe and sanitary environment in the areas of the home used by the patient.

amount of care veterans receive in home-based primary care by the number of visits veterans receive, VA does not report this information in the budget justification. Instead, according to VA officials, VA reports workload based on enrolled days of care because this is the community standard used by CMS when reporting workload for similar services provided through Medicare's home health program.

The lack of disclosure regarding VA's different workload measure for home-based primary care limits the usefulness of the workload information in VA's budget justification for Congress and others. The information, as presented, hinders their ability to consider the extent to which VA's reported workload increase will result in additional services for veterans and to know the amount of care veterans are receiving with the resources VA is expending.

Conclusions

VA's strategic planning and budgeting for its long-term care programs have received considerable attention in recent years from Congress and stakeholders as VA has continued its efforts to provide these services to an aging veteran population in a continuum of long-term care services, from nursing home care to various noninstitutional services that provide care in veterans' homes or in the community. As part of VA's efforts to serve an aging veteran population and as required by law, VA developed a long-term care strategic plan. In this plan, VA stated its commitment to meeting the demand for noninstitutional long-term care services and the demand for nursing home services among veterans VA is required to serve. In addition, for a number of years VA has been implementing initiatives to make noninstitutional services available to all enrolled veterans who need and seek such care from VA—and for whom those services are to be available. However, as VA has acknowledged, VA has not yet provided a sufficient amount of these services to meet this demand.

In light of these ongoing challenges, VA's long-term care strategic plan is an important mechanism for providing Congress and stakeholders information on VA's strategic direction for its long-term care, including the level of resources VA may need to achieve its strategic priorities. However, VA's plan did not report key information on (1) whether VA intends to maintain, reduce, or increase its nursing home workload for all the veterans VA serves and (2) how much VA intends to increase the amount of noninstitutional long-term care services VA provides. In both cases, VA had more information about the strategic direction it intended to take with these services than it reported in its strategic plan. Such incomplete information in VA's strategic long-term care plan limits the usefulness of

the plan to Congress and stakeholders for determining VA's strategic direction, the extent to which VA's priorities are consistent with congressional priorities, and the level of resources required to achieve plan goals in the shorter and longer term.

Our work also shows that concerns about VA's long-term care spending estimates are still warranted. VA's fiscal year 2009 long-term care spending estimates justify continued concern because the estimates are based on cost assumptions that appear to be unrealistically low and on a noninstitutional workload projection that appears to be unrealistically high. Without further explanation, VA's use of the cost assumptions and workload projection raises questions about the reliability of VA's fiscal year 2009 spending estimate. Moreover, determining the net effect of these two apparently unrealistic factors on VA's spending estimate is not possible, because they tend to offset each other to an unknown degree. VA's budget justification also suffers from a lack of transparency in its reporting of workload information, as VA did not report its use of different measures of its noninstitutional long-term care services. These differences call into question the extent to which VA's reported increases in noninstitutional long-term care services result in commensurate increases in services veterans receive.

As a result of the apparently unrealistic cost assumptions and workload projection, as well as workload measures, that VA used in its fiscal year 2009 budget justification, VA's long-term care spending estimates are questionable benchmarks for congressional budget deliberations. Furthermore, the extent to which VA's proposed budget initiative to increase noninstitutional service workload will close service gaps is less clear than it could be. Given VA's past difficulties with long-term care services spending estimates, costs, and workload, it is especially important that VA strengthen the credibility of such estimates in its budget justification to inform congressional deliberations.

Recommendations for Executive Action

To make available more complete information for congressional oversight and use by stakeholders regarding VA's plans for the provision of long-term care, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to include three types of workload information in VA's forthcoming long-term care strategic plan:

- planned total nursing home workload, including care provided to veterans on a discretionary basis;

-
- estimated demand for noninstitutional services and VA's time frame for meeting this demand; and
 - a comparison of planned noninstitutional workload with recent noninstitutional workload to show the magnitude of the expected change in services provided.

To strengthen the credibility of VA's estimates of spending for its long-term care services budgeting proposals and increase transparency for Congress and stakeholders, we recommend that the Secretary of Veterans Affairs take the following four actions in future budget justifications:

- use cost assumptions for estimating nursing home spending that are consistent with VA's recent experience or report the rationale for using cost assumptions that are not;
- use cost assumptions for estimating noninstitutional long-term care spending that are consistent with VA's recent experience or report the rationale for using cost assumptions that are not;
- use workload projections for estimating noninstitutional long-term care spending that are consistent with VA's recent experience or report the rationale for using projections that are not; and
- if VA uses different measures of workload for noninstitutional long-term care services for estimating spending, report which measures are used for each service and how these measures reflect the volume of services received by veterans.

Agency Comments

We provided a draft of this report to VA for comment. In its written comments, VA stated that VA supports our overall conclusion that VA's long-term care strategic planning and budget justification process should be clarified so that the priorities of VA's long-term care program can be clearly understood by all stakeholders, including Congress. VA noted that the department was unable to provide specific comments on the draft report or recommendations, and did not indicate whether it agreed with the recommendations. However, VA stated that VA officials will evaluate the final report carefully. VA expects to complete its assessment of the final report—as well as a detailed action plan that responds to our recommendations—within 60 days of publication of the final report, and will share the assessment and action plan with us. VA's written comments

are provided in appendix II. VA also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Secretary of Veterans Affairs, appropriate congressional committees, and other interested parties. In addition, this report will be available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix III.

Sincerely,

A handwritten signature in black ink that reads "Randall B. Williamson". The signature is written in a cursive style with a large initial "R".

Randall B. Williamson
Director, Health Care

Appendix I: Description of the Department of Veterans Affairs' (VA) Nursing Home and Noninstitutional Long-Term Care Services

VA long-term care services	Description
Nursing home settings	
VA-operated nursing homes	Facilities owned and operated by VA and usually attached to or in close proximity to a VA medical center. Generally, rehabilitation and medically complex patients are placed in these homes.
State veterans' homes	Nursing homes owned and operated by individual states, which establish admission criteria. These homes allow delivery of nursing home care to a wider population of veterans who require care for life. VA pays states for these services based on a per diem amount that covers approximately one-third of the cost of providing these services to eligible veterans.
Community nursing home program	VA contracts with local non-VA nursing homes and typically uses these facilities for veterans with less intensive needs or for those who like to be located closer to home and family. VA covers the full cost of these services.
Noninstitutional services	
Adult day health care ^a	Adult day health care consists of health maintenance and rehabilitative services provided in a congregate outpatient setting by VA providers or other providers. VA pays for the provision of such services. Care is provided during part of a 24-hour day. Individualized programs of care are delivered by health professionals and support staff, with an emphasis on helping participants and their caregivers develop the knowledge and skills necessary to manage the patient's care requirements in the home. Therapy is the program's primary focus.
Care coordination/telehealth ^a	Care coordination/telehealth (CCT) involves the use of health informatics, telehealth, and disease management technologies to expand and enhance care and care management activities. Care Coordination/Home Telehealth (CCHT) is one of the Veterans Health Administration's enterprise-level CCT programs that supports the care of patients with chronic conditions in their home or place of residence. CCHT uses home telehealth and disease management technologies to monitor patients with chronic conditions each day, encourage self-management and initiate active care/care management, when this is required to prevent avoidable hospital admission/institutional care.
Community residential care	Community residential care is a form of enriched housing that provides health care supervision to eligible veterans not in need of hospital or nursing home care, but who, because of medical, psychiatric and/or psychosocial limitations as determined through a statement of needed care, are not able to live independently and have no suitable family or significant others to provide the needed supervision and supportive care. The veteran pays for the cost of this living arrangement. VA's contribution is limited to the cost of program administration and clinical services, which include inspection of the home and periodic visits to the veteran by VA health care professionals. Medical care is provided to the veteran primarily on an outpatient basis at VA facilities.
Home-based primary care ^a	A VA-operated home care service in which VA staff provide comprehensive longitudinal, interdisciplinary primary care in the homes of veterans with complex medical, behavioral, and psychosocial conditions who would be candidates for nursing home care in the absence of this program.
Homemaker/home health aide program ^a	Personal care and related support services provided in veterans' homes, which may include assistance with activities of daily living that are essential for maintaining a safe and sanitary environment in the areas of the home used by the patient. Only trained personnel who have successfully completed a competency evaluation and are employed by an agency may provide these services under the general supervision of a nurse.

**Appendix I: Description of the Department of
Veterans Affairs' (VA) Nursing Home and
Noninstitutional Long-Term Care Services**

VA long-term care services	Description
Hospice and palliative care ^{a, b}	Hospice is the final state of the care continuum in which the primary goals of treatment are comfort rather than cure for patients with advanced life-limiting disease. Community hospice agencies provide these services to patients in their homes through comprehensive management of the needs of the patient through state-VA partnership programs. The hospice program also provides support for the patient's caregivers including bereavement support. Hospice services are also available on an inpatient basis in several VA facilities.
Purchased skilled home health care ^{a, b}	Skilled home health care services are in-home services provided by qualified, contracted non-VA personnel that include skilled nursing, physical therapy, occupational therapy, speech therapy, and social work services. Care includes clinical assessment, treatment planning, treatment provision, patient and family education, health status monitoring, reassessment, referral, and follow-up. A VA primary care provider prescribes skilled home health care services when medically necessary and appropriate for enrolled veterans. Veterans with a spinal cord injury requiring home care services may employ a relative or other home health attendant when trained and certified as competent by VA personnel.
Spinal cord injury home care ^a	This program strives to maximize veterans' independence and ability to reside where they desire after discharge. Noninstitutional extended care options within VA include home health care (including bowel and bladder care), homemaker/home health aide, respite care services, medical foster homes, and community residential centers.
Respite care ^{a, c}	Respite care services are personal care and supportive services delivered in the home, nursing home adult day care center, or assisted-living facility for the purpose of temporarily relieving the unpaid caregiver of their duties. Respite care services may include various VA-provided services and non-VA purchased services. Respite care services are generally limited to 30 days per year from all settings in which respite is provided.

Source: GAO summary of VA information.

^aThese services are part of VA's medical benefits package, which is a uniform set of services that are to be available to all enrolled veterans.

^bIn its fiscal year 2009 budget justification, VA provided spending estimates and workload projections for hospice and palliative care and purchased skilled home health care under the heading "other home based programs."

^cIn its fiscal year 2009 budget justification, VA included spending estimates and workload projections for respite care in the estimates and projections it provided for the homemaker/home health aide program.

Appendix II: Comments from the Department of Veterans Affairs



THE SECRETARY OF VETERANS AFFAIRS

WASHINGTON

January 5, 2009

Mr. Randall Williamson
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Williamson:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***VA HEALTH CARE: Long-Term Care Strategic Planning and Budgeting Need Improvement*** (GAO-09-145). VA supports GAO's overarching conclusion that the long-term care strategic planning and budgeting justification process should be clarified so that the service priorities of our long-term care program are clearly understood by all stakeholders, including Congress.

At this time, the Department will be unable to provide specific comments to GAO's draft report and the seven recommendations (as currently structured). The program managers in the Offices of Patient Care Services, Policy and Planning, and the Veterans Health Administration's Office of Finance will evaluate GAO's final report carefully. The effort will be coordinated through the Office of the Principal Deputy Under Secretary for Health. The Department anticipates that the assessment and a detailed action plan that responds to GAO's recommendations will be completed within 60 days of the publication of the final report. At that point, we will provide this assessment and action plan to appropriate staff at GAO.

GAO's observations have been very beneficial to us and will form the basis of discussion and action. Enclosed are technical comments suggested by VA to provide clarification for the report's overall accuracy.

Sincerely yours,

A handwritten signature in black ink, appearing to read "James B. Peake".

James B. Peake, M.D.

Enclosure

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Randall B. Williamson, (202) 512-7114 or williamsonr@gao.gov

Staff Acknowledgments

James C. Musselwhite, Assistant Director; Susannah Bloch; Deirdre Brown; Robin Burke; Denise M. Fantone; Krister Friday; and Grace Materon made key contributions to this report.

Related GAO Products

VA Health Care: Budget Formulation and Reporting on Budget Execution Need Improvement. [GAO-06-958](#). Washington, D.C.: September 20, 2006.

VA Long-Term Care: Data Gaps Impede Strategic Planning for and Oversight of State Veterans' Nursing Homes. [GAO-06-264](#). Washington, D.C.: March 31, 2006.

VA Health Care: Preliminary Findings on the Department of Veterans Affairs Health Care Budget Formulation for Fiscal Years 2005 and 2006. [GAO-06-430R](#). Washington, D.C.: February 6, 2006.

VA Long-Term Care: Trends and Planning Challenges in Providing Nursing Home Care to Veterans. [GAO-06-333T](#). Washington, D.C.: January 9, 2006.

VA Long-Term Care: Oversight of Nursing Home Program Impeded by Data Gaps. [GAO-05-65](#). Washington, D.C.: November 10, 2004.

VA Long-Term Care: More Accurate Measure of Home-Based Primary Care Workload Is Needed. [GAO-04-913](#). Washington, D.C.: September 8, 2004.

VA Long-Term Care: Changes in Service Delivery Raise Important Questions. [GAO-04-425T](#). Washington, D.C.: January 28, 2004.

VA Long-Term Care: Veterans' Access to Noninstitutional Care Is Limited by Service Gaps and Facility Restrictions. [GAO-03-815T](#). Washington, D.C.: May 22, 2003.

VA Long-Term Care: Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care. [GAO-03-487](#). Washington, D.C.: May 9, 2003.

VA Long-Term Care: The Availability of Noninstitutional Services Is Uneven. [GAO-02-652T](#). Washington, D.C.: April 25, 2002.

VA Long-Term Care: Implementation of Certain Millennium Act Provisions Is Incomplete, and Availability of Noninstitutional Services Is Uneven. [GAO-02-510R](#). Washington, D.C.: March 29, 2002.

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