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VA HEALTH CARE

Challenges in Budget
Formulation and Execution

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss the Department of Veterans Affairs' (VA) health care programs and consider the President's budget request for fiscal year 2010. These programs form one of the largest health care delivery systems in the nation and provide, for eligible veterans, a range of services, including preventive and primary health care, outpatient and inpatient services, and prescription drugs. For example, VA provides a variety of outpatient and inpatient mental health services for veterans with conditions such as depression, post-traumatic stress disorder, and substance abuse disorders. VA also provides a range of long-term care services—including nursing home care and noninstitutional care provided in veterans' homes or in the community—for veterans needing assistance due to chronic illness or physical or mental disability. VA estimated that in fiscal year 2009, its health care programs would serve 5.8 million patients with appropriations of \$41.2 billion. The President recently proposed an increase in VA's health care budget for fiscal year 2010 to expand health care services for veterans.

VA formulates its health care budget by developing annual estimates of its likely spending for all of its health care programs and services, and includes these estimates in its annual congressional budget justification to the appropriations subcommittees. VA's formulation of its budget is by its very nature challenging, as it is based on assumptions and imperfect information on the health care services VA expects to provide. For example, VA is responsible for anticipating the service needs of two very different populations—an aging veteran population and a growing number of veterans returning from the military operations in Afghanistan and Iraq, known as Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), respectively—calculating the future costs associated with providing VA services, and using these factors to develop the department's budget request submitted to the Office of Management and Budget (OMB).¹ VA uses an actuarial model to develop the annual budget estimates for most, but not all, of its health care programs, including inpatient acute surgery, outpatient care, and prescription drugs. This model estimates future VA health care costs by using projections of veterans' demand for VA's health care services as well as cost estimates associated with particular health care services.² In fiscal

¹VA begins to formulate its own 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.

²The actuarial model reflects factors such as the age, sex, and morbidity of the veteran population as well as the extent to which veterans are expected to seek care from VA rather than health care providers reimbursed by other payers such as Medicare and Medicaid.

year 2006, VA used the actuarial model to estimate about 86 percent of its projected health care spending for that year. VA uses other approaches to develop its spending estimates for its remaining health care services, such as long-term care. Long-term care accounted for about 10 percent of VA's estimated health care spending for fiscal year 2006.

VA is also responsible for executing its budget—a responsibility that includes spending appropriated funds efficiently and effectively and monitoring the use of funds throughout the fiscal year to ensure that those funds are used to provide health care services as authorized. VA typically receives appropriations that support all its health care services rather than appropriations specifically for certain types of services. As a result, VA has considerable discretion in how it allocates its resources among its various health care services. VA allocates most of the appropriations for its health care services to VA's 21 health care networks, which in turn allocate funds to the medical centers within their networks.³

In 2006 and 2009, we issued three reports that examined some of the challenges VA faces in budget formulation and execution; these reports pertained to VA's overall health care budget as well as portions of its budget that pertain to long-term care and to specific mental health initiatives.⁴ You asked us to discuss budget challenges VA faces related to its health care programs, and today my remarks are based on our issued work on this subject.⁵ Specifically, I will discuss (1) challenges VA faces formulating its health care budget, and (2) challenges VA faces executing its health care budget.

For our 2006 report on VA's overall health care budget for fiscal years 2005 and 2006, we analyzed and reviewed budget documents, including VA's budget justifications for health care programs for fiscal years 2005 and 2006, and interviewed VA officials responsible for VA health care budget issues and for developing budget projections. In addition, from August to September 2008, we reviewed VA documents to determine whether VA had implemented the

³VA delegates decision making regarding health care financing and service delivery to its health care networks, including most budget and management responsibilities concerning medical center operations.

⁴See GAO, *VA Health Care: Budget Formulation and Reporting on Budget Execution Need Improvement*, [GAO-06-958](#) (Washington, D.C.: Sept. 20, 2006); GAO, *VA Health Care: Long-Term Care Strategic Planning and Budgeting Need Improvement*, [GAO-09-145](#) (Washington, D.C.: Jan. 23, 2009); and GAO, *VA Health Care: Spending for Mental Health Strategic Plan Initiatives Was Substantially Less Than Planned*, [GAO-07-66](#) (Washington, D.C.: Nov. 21, 2006).

⁵We currently have work underway on other VA health care related issues, including aspects of VA's mental health programs.

recommendations we made in our 2006 report. For our other 2006 report, on VA's budget for specific mental health initiatives, we reviewed documents related to the funding of these initiatives. We interviewed VA headquarters officials responsible for VA's mental health services and budget functions. We also conducted site visits and phone interviews with officials from selected VA health care networks and VA medical centers. In September 2008, we reviewed VA documents to determine whether VA had implemented the recommendations we made in that report. For our 2009 report on VA's long-term care budget, we reviewed VA's fiscal year 2009 congressional budget justification and related documents. We also interviewed VA officials. We conducted our work for these performance audits in accordance with generally accepted government auditing standards.⁶ 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.

VA Faces Challenges in Formulating Its Health Care Budget

Our prior work highlights some of the challenges VA faces in formulating its budget. As we reported in 2006, these challenges include making realistic assumptions about the budgetary impact of some of its policies, making accurate calculations, and obtaining sufficient data for useful budget projections. In 2009, we again reported on VA's budget formulation challenges—specifically, VA's challenges projecting the amount of long-term care it will provide and estimating the costs of this care.

⁶We conducted our work on VA's overall health care budget from October 2005 through September 2006, our work on VA's mental health initiative funding from January through November 2006, and our work on VA's long-term care budget from November 2007 through January 2009.

Challenges Making Realistic Assumptions Related to Proposed Policy Changes, Making Accurate Calculations, and Obtaining Sufficient Data

Our 2006 report on VA's overall health care budget illustrated that in formulating its budget, VA faces challenges making realistic assumptions about the budgetary impact of its proposed policies. We reported that the President's requests for additional funding for VA's medical programs for fiscal years 2005 and 2006⁷ were in part due to unrealistic assumptions VA made about how quickly the department would realize savings from proposed changes in its nursing home policy.⁸ Specifically, we found that:

- VA's fiscal year 2005 budget justification included a proposal to reduce the amount of care VA provides—known as workload—in VA-operated nursing homes, one of three settings which provide VA nursing home services.⁹ VA assumed that savings from this reduction in workload would be realized on the first day of fiscal year 2005. VA officials later told us that this assumption had been unrealistic because of the accelerated time frame of the planned policy change. The change would have required transferring or discharging veterans from the nursing homes in an extremely compressed time frame; moreover, achievement of substantial savings from this policy would have also likely required reducing the number of VA employees.
- VA's fiscal year 2006 budget justification included a policy proposal to reduce patient workload and costs by prioritizing the veterans who would receive a certain type of VA nursing home care.¹⁰ VA assumed that savings resulting from the policy change could be realized before the start of the 2006 fiscal year; however, VA officials said they later realized that time frame was unrealistic.

In our 2006 report, we recommended that VA improve its budget formulation processes by explaining in its budget justifications the relationship between the implementation of proposed policy changes and the expected timing of cost

⁷In June 2005, the President requested a \$975 million supplemental appropriation for fiscal year 2005, and in July 2005, the President submitted a \$1.977 billion budget amendment for the fiscal year 2006 appropriation.

⁸See [GAO-06-958](#).

⁹VA also provides nursing home services through community nursing homes and state veterans' nursing homes.

¹⁰This policy proposal was related to long-stay nursing home care provided in all three of VA's nursing home settings. Long-stay care includes nursing home care needed by veterans who cannot be cared for at home because of severe, chronic physical or mental impairments such as the inability to independently eat or the need for supervision because of dementia. Under the proposed policy, many veterans receiving VA nursing home care would no longer have qualified for long-stay care.

savings to be achieved. VA agreed with this recommendation and acted on this recommendation in VA's fiscal year 2009 budget justification.

Our 2006 report also illustrated that VA faces challenges making accurate calculations during budget formulation. As we reported, VA made computation errors when estimating the effect of its proposed fiscal year 2006 nursing home policy, and this contributed to requests for supplemental funding that year. We found that VA underestimated workload and the costs of providing care in all three of its nursing home settings. VA officials said that the errors resulted from calculations being made in haste during the OMB appeal process,¹¹ and that a more standardized approach to long-term care calculations could provide stronger quality assurance to help prevent future mistakes. In 2006, we recommended that VA strengthen its internal controls to better ensure the accuracy of calculations it uses in preparing budget requests. VA agreed with and implemented this recommendation and had the savings estimates from proposed policy changes in its fiscal year 2009 budget justification validated by an outside actuarial firm.

In formulating its budget, VA also faces the challenge of obtaining sufficient data for useful workload projections, as illustrated in our 2006 report. We reported that the President's requests for additional funding for VA health care programs in fiscal years 2005 and 2006 were, in part, due to the lack of sufficient data on how many OEF/OIF veterans VA would care for in those fiscal years. In its fiscal year 2005 budget justification, VA projected that it would need to provide care to about 23,500 returning OEF/OIF veterans. VA subsequently revised its projections to indicate that VA would serve nearly 100,000 OEF/OIF veterans. According to VA officials, the original projections for providing care to OEF/OIF veterans had been understated for fiscal year 2005 in part because the projections were based on insufficient data on veterans returning from Iraq and Afghanistan. Insufficient data on returning OEF/OIF veterans continued to be a challenge in formulating VA's fiscal year 2006 budget justification. VA officials told us they did not have sufficient data for that fiscal year due to challenges obtaining data needed to identify these veterans from the Department of Defense (DOD). After the President submitted the fiscal year 2006 budget request, VA determined that it expected to provide care to approximately 87,000 more veterans than initially projected for fiscal year 2006. According to VA officials, the agency subsequently began receiving the DOD data it requires to identify

¹¹In late November, OMB "passes back" budget decisions to the agencies on the President's budget requests for their programs, a process known as "passback." These decisions may involve, among other things, funding levels, program policy changes, and personnel ceilings. The agencies may appeal decisions with which they disagree.

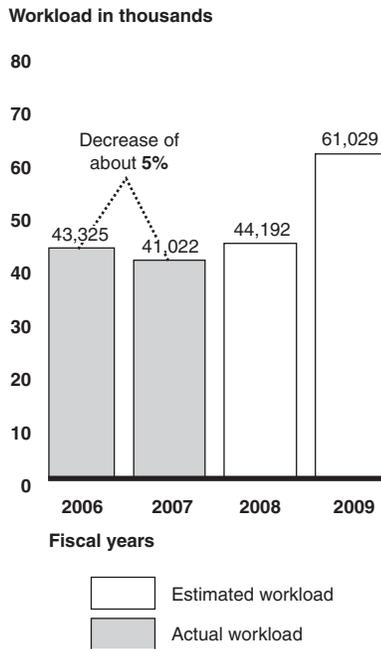
OEF/OIF veterans on a monthly basis rather than the quarterly reports it used to receive.

Challenges Projecting the Amount and Cost of Long-Term Care Services

Our recent work on VA's budget showed how VA continued to face challenges formulating its budget for long-term care services.¹² In January 2009, we reported on VA's challenges developing realistic assumptions to project the amount of noninstitutional long-term care services it would provide to veterans. We found that, in its fiscal year 2009 budget justification, VA included a spending estimate for noninstitutional long-term care services that appeared unreliable, in part because this spending estimate was based on a workload projection that appeared to be unrealistically high, given recent VA experience providing these services. Specifically, in an effort to help meet veterans' demand for noninstitutional services, VA projected that it would increase its noninstitutional workload 38 percent from fiscal year 2008 to fiscal year 2009. VA included this projection in the budget despite the fact that from fiscal year 2006 to fiscal year 2007—the most recent year for which workload data are available—VA's actual workload for these services decreased about 5 percent, rather than increasing as projected. (See fig. 1.) In its fiscal year 2009 budget justification, VA did not provide information regarding its plans for how it will increase noninstitutional workload 38 percent from fiscal year 2008 to fiscal year 2009.

¹²See [GAO-09-145](#).

Figure 1: 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.

To strengthen the credibility of the estimates of long-term care spending in VA's budgeting proposals and increase transparency for Congress and stakeholders, we recommended that in future budget justifications VA 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. In commenting on a draft of our report, VA did not indicate whether it agreed with this recommendation, but stated it would complete an action plan that responds to the recommendation by the end of March 2009.

In addition to having difficulty developing reliable projections on the amount of long-term care services it will provide, VA also faces challenges developing realistic assumptions about the cost of providing these services when formulating its budget. In January 2009, we reported that VA may have underestimated its nursing home spending for fiscal year 2009 because it used a cost assumption that appeared unrealistically low, given both recent VA experience and economic forecasts of increases in health care costs. To formulate its nursing home

spending estimate, VA assumed that the cost of providing a day of nursing home care would increase

2.5 percent from fiscal year 2008 to fiscal year 2009. However, from fiscal year 2006 to fiscal year 2007—the most recent year for which actual cost data are available—the cost to provide this care increased approximately 5.5 percent. Similarly, for fiscal year 2007 to fiscal year 2008, VA estimated that its nursing home costs would increase approximately 11 percent. In addition to its recent experience, VA’s 2.5 percent cost increase is also less than the rate provided in OMB guidance to VA to help with its budget estimates—which forecasted a rate of inflation for medical services of 3.8 percent for the same time period.

In our January 2009 report, we also found that VA’s estimate of the amount it would spend for noninstitutional long-term care services in fiscal year 2009 appeared to be unreliable—in part because VA based this estimate on a cost assumption that appeared unrealistically low, when compared to VA’s recent experience and to economic forecasts of increases in health care costs. Specifically, VA assumed that the cost of providing a day of noninstitutional long-term care would not increase from its fiscal year 2008 level. VA used this assumption to formulate its noninstitutional long-term care spending estimate despite the fact that from fiscal year 2006 to fiscal year 2007—the most recent year for which actual cost data are available—the cost of providing these services increased 19 percent. VA’s cost assumption is also inconsistent with the OMB guidance provided to VA. In its fiscal year 2009 budget justification, VA did not provide information regarding its nursing home or noninstitutional cost assumptions. However, VA officials told us that they made these assumptions in order to be conservative in VA’s fiscal year 2009 budget estimates.

To strengthen the credibility of the estimates of long-term care spending in VA’s budgeting proposals and increase transparency for Congress and stakeholders, we recommended that VA, in future budget justifications, use cost assumptions for estimating both nursing home and noninstitutional long-term care spending that are consistent with VA’s recent experience or report the rationale for using cost assumptions that are not. In commenting on a draft of our report, VA did not indicate whether it agreed with these recommendations, but stated it would complete an action plan that responds to the recommendations, again by the end of March 2009.

VA Faces Challenges in Executing Its Budget for Health Care Services

Our prior work highlights some of the challenges VA faces in executing its health care budget. These challenges include spending and tracking funds designated by VA for specific health care initiatives as well as providing timely and useful information to Congress regarding budget execution progress and problems.

Challenges Spending and Tracking Funds Designated for VA Health Care Initiatives

After formulating its estimates of likely spending on its health care services, VA is also responsible for executing its budget efficiently and effectively. However, our 2006 report on VA's funding for specific mental health initiatives¹³ showed that in executing its budget, VA faces challenges spending and tracking the use of funds designated by VA for specific VA health care initiatives, in particular funds that VA intends to use to expand services to improve access to care for its veteran population. For example, in 2006, we reported that in fiscal years 2005 and 2006, VA had difficulty spending and tracking funds it had designated for new initiatives included in VA's mental health strategic plan, which were to expand mental health services in order to address gaps previously identified by VA. These initiatives—which were to be funded by \$100 million in fiscal year 2005 and \$200 million in fiscal year 2006—were intended to enhance VA's larger mental health program.¹⁴ In both fiscal years, VA allocated funds to VA medical centers and offices that were to be used for mental health strategic plan initiatives during those fiscal years, as part of VA's efforts to expand these services. As we reported in 2006, VA faced challenges in both spending the funds and tracking their use in fiscal years 2005 and 2006:

- Challenges in spending funds—We found that, by the end of fiscal years 2005 and 2006, some VA medical centers had not spent all of the funds they had received for mental health strategic plan initiatives for those fiscal years, according to VA medical center officials and other available information. In fiscal year 2005, this was due to factors such as the length of time it took the medical centers to hire new staff and locate or renovate space for new mental health programs.
- Challenges in tracking the use of funds—In both fiscal years, VA did not have an adequate method in place for tracking spending for its new mental health strategic plan initiatives. VA did not track how funds allocated for plan initiatives

¹³See [GAO-07-66](#).

¹⁴These funds represented a small portion of the overall funds available to support VA mental health services in those two fiscal years. For example, VA expected to spend more than \$2 billion on mental health services in fiscal year 2006.

were spent, and as a result, VA could not determine to what extent the funds for plan initiatives were spent on those initiatives.

To provide information for improved management and oversight, we recommended that VA track the extent to which the funds allocated for mental health strategic plan initiatives are spent for those initiatives. Since we reported on this issue in November 2006, VA has implemented a tracking system to monitor spending on mental health strategic plan initiatives and help determine the extent to which funds allocated for mental health strategic plan initiatives are spent for those initiatives.

Although VA took steps to address its challenges tracking its spending on mental health initiatives, our more recent work in 2009 shows how VA continues to face spending challenges when the department undertakes efforts to expand services for veterans. In January 2009 we reported that VA's fiscal year 2009 budget justification included plans to increase VA's spending on noninstitutional long-term care services, in order to partially close previously identified gaps in the provision of these services. VA assumed it would be able to increase its noninstitutional workload by 38 percent from fiscal year 2008 to fiscal year 2009. However, in our report we raised questions about VA's ability to achieve this increase in workload. As we noted in our report, VA officials stated that increasing noninstitutional workload is challenging. Similar to VA's prior mental health initiatives, many of VA's noninstitutional services are provided by VA personnel, and as a result, VA must take the time to hire and train more personnel before it has the capacity to serve an increased workload. These factors suggest that VA may have difficulty spending its resources as planned. In its budget justification, VA did not explain how it plans to achieve this increase in noninstitutional workload.

Challenges Providing Timely and Useful Information to Congress Regarding Budget Execution Progress and Problems

As VA executes its budget, VA also faces the challenge of providing timely information to Congress about the agency's progress and any problems the agency encounters during this process. For example, in our 2006 report on VA's overall health care budget, we reported that although VA staff had closely monitored its budget execution and identified problems for fiscal years 2005 and 2006, VA did not report this information to Congress in a timely manner. For example, anticipating challenges in managing within its resources, VA had closely monitored the fiscal year 2005 budget as early as October 2004. However, Congress did not learn of the budget challenges facing VA until April 2005.

In addition, VA faces a challenge in providing information to Congress that would be useful for congressional oversight of VA's budget. For example, in 2006, we also found that VA's reporting of its budget execution progress and problems to Congress could have been more informative. In the appropriations act for fiscal year 2006, Congress included a requirement for VA to submit quarterly reports regarding the status of the medical programs budget during that fiscal year.¹⁵ In addition, the conference report accompanying the appropriations act directed VA to include waiting list performance measures, among other things.¹⁶ We found that VA did not include in its quarterly reports certain types of information that would have been useful for congressional oversight. For example, in its reports to Congress, VA used a patient workload measure that counted patients only once no matter how many times they used VA services within the fiscal year. This measure did not capture the difference between patients predominantly using low-cost services such as primary care outpatient visits and those using high-cost services such as acute inpatient hospital care. In contrast, VA provided in its reports to OMB other workload measures that provided a more complete picture of whether new patients were receiving low- or high-cost services. Some of those measures provided to OMB included a measure of one type of inpatient care—nursing home workload—and the number of outpatient visits.

In addition, in one of its quarterly reports to Congress, VA reported access measures for existing VA patients—the percentage of primary care and percentage of specialty care appointments scheduled within 30 days of the desired date—where VA was exceeding its performance goals. However, VA did not provide one access measure identified in the conference report: the time required for new patients to get their first appointment. Although not the same measure, a similar measure VA produced for other purposes showed the number of new patients waiting for their first appointment to be scheduled. This measure showed that the number of new patients waiting for their first appointment to be scheduled almost doubled from April 2005 to March 2006, indicating a potential problem in the first quarter of fiscal year 2006.

We recommended that VA improve its reporting of budget execution progress to Congress by incorporating measures of patient workload to capture the costliness of care and a measure of waiting times. These measures might help alert Congress to potential problems VA may face in managing within its budget in future years. VA implemented part of this recommendation in the quarterly report

¹⁵Pub. L. No. 109-114, § 222, 119 Stat. 2372, 2391 (2005).

¹⁶See H.R. Conf. Rep. No. 109-305, at 50 (2005).

it submitted to Congress in May 2008, in which VA reported two measures related to waiting times. Although the inclusion of these measures in VA's quarterly reports can help facilitate congressional oversight, VA could provide additional information to inform Congress about the costliness of VA care.

Concluding Observations

Sound budget formulation, monitoring of budget execution, and the reporting of informative and timely information to Congress for oversight continue to be essential as VA addresses budget challenges we have identified in recent years. While the budget process inevitably involves imperfect information and uncertainty about future events, VA has the opportunity to improve the credibility of its budgeting process by continuing to address problems that we have identified in recent years. Doing so can increase the credibility and usefulness of information that VA provides to Congress and affected stakeholders on its annual budget plans and the progress it makes in spending appropriated funds as planned. This is particularly the case for long-term care services, where budget workload assumptions and cost projections, as highlighted by our work for several years, raise questions regarding the credibility and usefulness of projected spending estimates. In addition, our prior report on new VA mental health initiatives to address identified gaps in services may provide a cautionary lesson regarding the expansion of new VA health care programs more generally. Namely, that the availability of funding for new health care initiatives does not in itself mean that these initiatives will be fully implemented within a given fiscal year—in part because new initiatives can bring challenges in hiring and training new staff—or that monitoring and tracking of such funding will be adequate to report the extent to which new initiatives are being implemented as planned.

Mr. Chairman, this concludes my prepared remarks. I would be happy to answer any questions you or other members of the Subcommittee may have.

Contact and Acknowledgments

For more information regarding this testimony, please contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. In addition, James C. Musselwhite, Assistant Director; Deirdre Brown; Robin Burke; and Krister Friday made key contributions to this testimony.
