

September 2006

VA HEALTH CARE

Budget Formulation and Reporting on Budget Execution Need Improvement





Highlights of [GAO-06-958](#), a report to congressional requesters

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Budget Formulation and Reporting on Budget Execution Need Improvement

Why GAO Did This Study

The Department of Veterans Affairs (VA) estimates it will serve 5.4 million patients in fiscal year 2006. Medical services for these patients are funded with appropriations, after consideration by Congress of the President's budget request. VA formulates the medical programs portion of that request. VA is also responsible for budget execution—using appropriations and monitoring their use for providing care. For fiscal years 2005 and 2006, the President requested additional funding for VA medical programs, beyond what had been originally requested.

GAO was asked to examine for fiscal years 2005 and 2006 (1) how the President's budget requests for VA medical programs were formulated, (2) how VA monitored and reported to Congress on its budget execution, and (3) which key factors in the budget formulation process contributed to requests for additional funding. To do this, GAO analyzed budget documents and interviewed VA and Office of Management and Budget (OMB) officials.

What GAO Recommends

GAO recommends that VA better explain cost savings from proposed policy changes in budget formulation and provide more comprehensive reporting on budget execution to Congress. VA stated that it substantially agreed with GAO's findings and concurred with the recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-06-958.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Laurie E. Ekstrand at (202) 512-7101 or ekstrandl@gao.gov.

What GAO Found

The formulation of the President's budget requests for VA medical programs for fiscal years 2005 and 2006 was informed by VA's comparison of its cost estimate of projected demand for medical services to its anticipated resources. VA projected about 86 percent of its costs using an actuarial model that estimated veterans' demand for health care. To project the costs of long-term care (about 10 percent of the funds for VA medical programs in each of these years) and the remaining medical care costs (about 4 percent), separate estimation approaches were used that did not rely upon an actuarial model but used other methods instead. The agency anticipated resources based on prior year appropriations, guidance from OMB, and other factors. For both fiscal years, VA officials told GAO that projected costs—calculated from the actuarial model and other approaches—exceeded anticipated resources and that they addressed the difference in budget requests for those years with cost-saving policy proposals and management efficiencies.

Although VA staff closely monitored budget execution and identified problems for fiscal years 2005 and 2006, VA did not report this information to Congress in a sufficiently informative manner. VA closely monitored the fiscal year 2005 budget as early as October 2004, anticipating challenges managing within its resources. However, Congress did not learn of these challenges until April 2005. VA initially planned to manage within its budget for fiscal year 2005 by delaying some spending on equipment and nonrecurring maintenance and drawing on funds it had planned to carry over into 2006. Instead, the President requested additional funds from Congress for both fiscal years 2005 (a \$975 million supplemental appropriation in June 2005) and 2006 (a budget amendment of \$1.977 billion in July 2005). Congress included in the 2006 appropriations act a requirement for VA to submit quarterly reports regarding the medical programs budget status during this fiscal year. These reports have not included some of the measures that would be useful for congressional oversight, such as patient workload measures to capture costs and the time required for new patients to be scheduled for their first primary care appointment.

Unrealistic assumptions, errors in estimation, and insufficient data were key factors in VA's budget formulation process that contributed to the requests for additional funding for fiscal years 2005 and 2006. Unrealistic assumptions about how quickly cost savings could be realized from proposed nursing home policy changes contributed to the additional requests, as did computation errors measuring the estimated effect of one of these changes. Insufficient data in VA's initial budget projections also contributed to the additional funding requests. For example, VA underestimated the cost of serving veterans returning from Iraq and Afghanistan, in part because estimates for fiscal year 2005 were based on data that largely predated the Iraq conflict and because according to VA, the agency had challenges for fiscal year 2006 in obtaining data from the Department of Defense.

Contents

Letter		1
	Results in Brief	4
	Background	6
	Formulation of President's Budget Request for VA Medical Programs Informed by Comparing Cost of Projected Demand and Anticipated Resources	8
	VA Closely Monitored Budget Execution and Identified Problems, but Did Not Report Them in a Timely and Sufficiently Informative Manner	13
	Unrealistic Assumptions, Estimation Errors, and Insufficient Data Contributed to VA's Requests for Additional Funding	19
	Conclusions	22
	Recommendations for Executive Action	23
	Agency Comments	24
Appendix I	Objectives, Scope, and Methodology	25
Appendix II	Comments from the Department of Veterans Affairs	28
Appendix III	GAO Contact and Staff Acknowledgments	31
Related GAO Products		32
Table		
	Table 1: VA Cost-saving Policies Proposed in the President's Budget Requests for Fiscal Years 2005 and 2006 (Dollars in Millions)	12

Figures

Figure 1: Percentage of Projected Costs for VA's Medical Programs Using Various Estimation Approaches	9
Figure 2: VA's March 2006 Monthly Report to VA Senior Management Indicating Number of New Patients Waiting for First Appointment to be Scheduled	18

Abbreviations

CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
DOD	Department of Defense
NCA	National Cemetery Administration
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OMB	Office of Management and Budget
VA	Department of Veterans Affairs
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration

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United States Government Accountability Office
Washington, DC 20548

September 20, 2006

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

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

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

The Department of Veterans Affairs (VA) operates one of the largest health care delivery systems in the nation. For fiscal year 2006, VA estimates it will treat 5.4 million patients with appropriations of \$31.5 billion.¹ During the past decade the number of patients served by VA has increased rapidly, due in part to an expansion of the number of veterans eligible to receive care. The Veterans' Health Care Eligibility Reform Act of 1996 simplified eligibility standards for veterans in need of hospital and outpatient care and made available services that previously had not been made available to veterans without service-connected disabilities or low incomes.² The act required VA to provide a uniform set of medical benefits, including hospital and outpatient care, to veterans who are eligible and who enroll in its health care system. In addition to the uniform set of medical benefits, VA is required to provide certain other services—such as

¹Total includes medical care collections, but does not include certain other amounts, such as appropriations for construction.

²Pub. L. No. 104-262, §§ 101, 104, 110 Stat. 3177, 3178-81 and 3182-84. Veterans with low incomes are those veterans with annual incomes below a certain threshold. In 2006, the income threshold was \$26,902 for veterans without dependents.

nursing home care—to some veterans, but not to others.³ If sufficient resources are not available to provide hospital and outpatient care that is timely and acceptable in quality, VA is required to restrict enrollment based on veterans' eligibility priorities.⁴

For VA, like other agencies, formulation of a budget request begins 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. For this purpose, the Veterans Health Administration (VHA),⁵ within VA, develops estimates of its medical program budget for agency review and approval. In preparing budget estimates, VA and its component organizations—such as VHA—use policy and technical guidance from the Office of Management and Budget (OMB), while preparing a budget submission to OMB that reflects VA priorities. OMB is the office responsible for assisting the President in overseeing the preparation of the federal budget and supervising its administration. OMB reviews VA's and other agencies' budget requests from their submission in September through November and then notifies agencies at the end of November on the level of funding and policy proposals that will be included in the President's budget request. Agencies have very limited time to appeal these decisions to OMB before they start preparing a congressional budget justification—a more detailed presentation of the President's budget request—for their appropriations subcommittees' consideration. Congressional budget justifications are submitted to appropriations subcommittees following transmission of the President's budget request.

³The Veterans Millennium Health Care and Benefits Act required VA to provide nursing home care to veterans requiring such care with a service-connected disability rated at 70 percent or greater, those requiring nursing home care because of a condition related to their military service who do not have a service-connected disability rating of 70 percent or greater, and those who were receiving care in VA nursing homes on the enactment date of the act and continue to need that care. Pub. L. No. 106-117, § 101, 113 Stat. 1545, 1547-51 (codified at 38 U.S.C. § 1710A). The Veterans' Health Care, Capital Asset, and Business Improvement Act of 2003 extended this requirement through 2008. Pub. L. No. 108-170, § 106(b), 117 Stat. 2042, 2046. VA provides most of its nursing home care to veterans who receive it on a discretionary basis rather than as required by these acts.

⁴Veterans' eligibility priority categories are generally determined on the basis of service-connected disability and/or income. There are currently eight priority categories.

⁵The VA also provides a comprehensive benefits program, administered by the Veterans Benefits Administration (VBA), and maintains national cemeteries, administered by the National Cemetery Administration (NCA).

After the President submits his budget request, he may request further changes in one of two ways, depending on the timing of the additional request. If Congress has not completed action on an appropriations act, the President can transmit a budget amendment. If an appropriations act has already been enacted, the President can request a supplemental appropriation; this is typically done in cases where the need for funds is too urgent to postpone until enactment of the following year's appropriations bill.

Once an appropriations bill becomes law, OMB apportions the funds, allowing an agency to obligate and expend the funds as authorized. Each agency is responsible for obligating and expending funds efficiently and effectively to carry out the programs and activities for which funds were appropriated. Carrying out this responsibility is referred to as budget execution and requires monitoring throughout the fiscal year to ensure that funds are being used as authorized for agency program objectives—in the case of VA medical programs to provide quality care to veterans—and to ensure compliance with provisions of fiscal law. For example, the Antideficiency Act prohibits VA and other agencies from making or authorizing obligations⁶ or expenditures in excess of the available appropriations.⁷

Congress provided additional funds beyond those initially requested by the President for VA medical programs for both fiscal years 2005 and 2006. In 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 fiscal year 2006. These additional requests raised concerns in Congress and among stakeholders regarding the reasons for the additional requests for funding. At your request, we examined for fiscal years 2005 and 2006 (1) how the President's budget requests for VA medical programs were formulated, (2) how VA monitored and reported to Congress on its budget execution, and (3) which key factors in the budget formulation process contributed to the requests for additional funding.

⁶An obligation is generally a definite commitment that creates a legal liability of the government for a payment immediately or in the future. Agencies incur obligations when they place orders, award contracts, receive services, and carry out similar transactions during a given period that will require payments by an agency during the same or future periods.

⁷See 31 U.S.C. § 1341(a)(1)(A).

To perform this work, we interviewed VA officials responsible for the agency's medical programs budget issues, and for developing budget projections. We also interviewed OMB officials. We analyzed and reviewed budget documents including VA's budget justifications for medical programs for fiscal years 2005 and 2006. We also reviewed VA budget estimates and other information VA reported that it used either to formulate its submissions to OMB for fiscal years 2005 and 2006 or to monitor the use of appropriated funds for those fiscal years. Our review of how VA monitored its use of funds in the fiscal year 2006 budget includes the first 11 months of the fiscal year.⁸ This work expands upon the preliminary findings that we reported in February 2006.⁹ We conducted our review from October 2005 through September 2006 in accordance with generally accepted government auditing standards. For additional details of our scope and methodology, see appendix I.

Results in Brief

The formulation of the President's budget requests for VA medical programs for fiscal years 2005 and 2006 was informed by VA's comparison of its estimation of the cost of projected demand for its medical services to its anticipated resources. VA projected about 86 percent of its costs using an actuarial model that estimated veterans' demand for health care. In addition, VA projected the costs of long-term care, which accounts for about 10 percent of the funds requested for VA medical programs in each of these fiscal years, and remaining costs for other medical care, about 4 percent, using separate estimation approaches that did not rely upon an actuarial model. VA anticipated its resources to provide medical programs for fiscal years 2005 and 2006 based on its prior year appropriations, guidance published by OMB that outlined the President's budget priorities, and other factors. For both fiscal years, VA officials told us that projected costs—calculated from the actuarial model and other approaches—exceeded anticipated resources. VA officials told us they addressed the difference in budget requests for those years with cost-saving policy proposals and management efficiency savings, which were included in the President's budget requests for fiscal years 2005 and 2006.

⁸Fiscal year 2006 will not be complete until September 30, 2006.

⁹See GAO, *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.: Feb. 6, 2006). See Related GAO Products at the end of this report.

Although VA staff closely monitored budget execution and identified problems for fiscal years 2005 and 2006, VA did not report this information to Congress in a timely and sufficiently informative manner. VA closely monitored the fiscal year 2005 budget as early as October 2004, because the agency anticipated significant challenges to providing care to veterans with its appropriations. However, Congress did not learn of these challenges until April 2005. VA initially planned to manage within its budget for fiscal year 2005 by delaying some spending on equipment and nonrecurring maintenance and drawing on funds it had planned to carry over into 2006. Instead, in June 2005, with 3 months remaining in the fiscal year, the President requested a \$975 million supplemental appropriation from Congress for VA medical programs for that fiscal year. In July 2005, the President requested \$1.977 billion for fiscal year 2006 through the budget amendment process. The appropriations act for fiscal year 2006 included a requirement that VA submit quarterly reports on VHA's financial status. However, VA's reports have not included some of the measures that would assist Congress in its oversight, such as measures of patient workload that would capture the costliness of patient care, and the time required for new patients to be scheduled for their first health care appointment. Moreover, while VA has 12 months to execute its budget, it did not submit its first two quarterly reports to Congress until nearly 2 months after the end of each quarter, using patient workload data that were as much as 3 months old at the time of submission. These data included a combination of actual and estimated number of patients seen. However, VA submitted its third quarterly report about 1 month after the end of the quarter, using estimated data for the number of patients seen.

Unrealistic assumptions, errors in estimation, and insufficient data were key factors in VA's budget formulation process that contributed to the requests for additional funding in fiscal years 2005 and 2006. One factor that contributed to these requests was a set of unrealistic assumptions about the expected time frame in which cost savings could be realized from proposed nursing home policy changes. Computational errors in measuring the estimated effect of one of these changes also contributed to the additional funding request. Furthermore, insufficient data in VA's initial budget projections contributed to the additional funding requests. For example, VA underestimated the cost of serving veterans returning from Iraq and Afghanistan, in part because estimates for fiscal year 2005 were based on data that largely predated the Iraq conflict and because, according to VA, the agency did not have sufficient data for fiscal year 2006 due to challenges obtaining data needed to identify these veterans from the Department of Defense (DOD).

To help improve VA's formulation of its medical programs budget and facilitate congressional oversight, we recommend that the Secretary of Veterans Affairs take several actions. We recommend that VA improve its budget formulation processes by explaining the relationship between implementation of proposed policy changes and the expected timing of cost savings to be achieved and by strengthening its internal controls to better ensure the accuracy of calculations it uses in preparing budget requests. We also recommend 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 to schedule veterans' first primary care appointment for new patients.

VA stated that it substantially agreed with our findings and conclusions, and concurred with our recommendations. VA also described steps it has taken and plans to take to respond to our recommendations.

Background

VA, as part of its mission to provide benefits and services to America's veterans, administers one of the nation's largest health care systems through the VHA. As part of a uniform set of medical benefits provided to eligible veterans who enroll, VA provides a range of services including preventive and primary health care, a full range of outpatient and inpatient services, and prescription drugs. VA also provides additional services, such as nursing home and dental care and other services, as required by law, for some veterans and makes these services available to other veterans on a discretionary basis as resources permit. One of the largest of these programs is VA's nursing home care program, which provides care in three settings. VA operates its own nursing homes in 134 locations; it pays for care under contract in non-VA nursing homes, referred to as community nursing homes; and it pays about one-third of the costs per day for veterans in state veterans' nursing homes.¹⁰ In its three settings, nursing home services are provided to veterans, ranging from short-stay post-acute care for patients recovering from a condition such as a stroke to long-stay

¹⁰VA also supports state veterans' nursing homes through grants for construction, acquisition, or renovation of existing structures. See 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) and GAO, *VA Long-Term Care: Oversight of Nursing Home Program Impeded by Data Gaps*, [GAO-05-65](#) (Washington, D.C.: Nov. 10, 2004).

care for patients who cannot be cared for at home because of severe, chronic physical or mental limitations.¹¹

To manage access to hospital and outpatient care in relation to available resources, VA established an enrollment system with priority categories, as required by the Veterans' Health Care Eligibility Reform Act of 1996.¹² The act called for seven priority categories; subsequent legislation provided for eight categories.¹³ Priority categories are generally determined by a veteran's degree of service-connected or other disability or on financial need. VA gives veterans in Priority category 1 (with 50 percent or more service-connected disability) the highest preference for services and gives lowest preference to those in Priority category 8 (no disability, with income exceeding certain thresholds, and who were enrolled as of January 16, 2003).

The act also required VA to restrict enrollment consistent with its priority categories if sufficient resources are not available to provide care that is timely and acceptable in quality.¹⁴ In January 2003, VA restricted enrollment by no longer allowing Priority 8 veterans, those in the lowest priority category, to enroll.¹⁵ However, Priority 8 veterans who were already enrolled as of January 16, 2003, would continue to receive service. This policy remained in effect as of August 2006.

In the mid-1990s, VA began to change the way it delivered health care to veterans to increase the efficiency of its health care system and to improve access to medical services. Applying lessons learned from the private sector's experiences with managed health care, VA began emphasizing certain managed care practices, such as primary, outpatient, and preventive care, and deemphasizing its reliance on inpatient care. Over the 10-year period from 1995 through 2004, for example, the ratio of outpatient

¹¹VA nursing home care is part of a continuum of long-term care services that VA provides, including services to veterans in the community and in veterans' own homes.

¹²Pub. L. No. 104-262, § 104(a)(1) 110 Stat. 3177, 3182-83 (codified at 38 U.S.C. § 1705). Enrollment is not required to receive nursing home care in any of VA's three nursing home settings.

¹³Department of Veterans Affairs Health Care Programs Enhancement Act of 2001, Pub. L. No. 107-135, § 202(a), 115 Stat. 2446, 2457.

¹⁴See 38 U.S.C. § 1705(b)(1).

¹⁵VA announced this change through the publication of an interim final rule in the Federal Register. See 68 Fed. Reg. 2670-73 (Jan. 17, 2003).

visits to inpatient hospital stays at VA increased from 29 to 1, to 92 to 1, reflecting the change in how VA delivers medical care. To support its health care reform efforts, VA decentralized the management structure of the agency to coordinate the organization of hospitals, outpatient clinics, and other facilities into 21 regional health care networks. These networks have budget and management responsibilities that include allocating resources to facilities, clinics, and programs within their networks and ensuring access to appropriate health care services.

Formulation of President's Budget Request for VA Medical Programs Informed by Comparing Cost of Projected Demand and Anticipated Resources

The formulation of the President's budget requests for VA medical programs for fiscal years 2005 and 2006 was informed by VA's comparison of its estimation of the cost of projected demand and anticipated resources. Estimated costs for medical care exceeded anticipated resources in both fiscal years 2005 and 2006, and, in formulating the budget, VA addressed the difference with cost-saving policy proposals and estimated savings from management efficiencies.

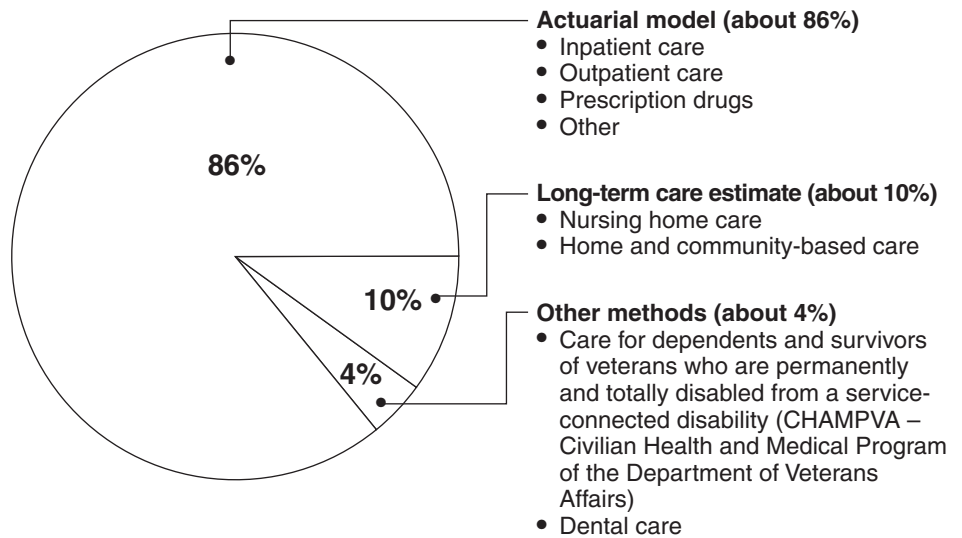
VA Estimated Costs of Medical Programs Based on Projected Demand for Medical Care

VA used an actuarial model¹⁶ to project demand and costs for about 86 percent of its medical programs budget estimate for fiscal years 2005 and 2006. (See fig. 1.) For this part of the medical programs budget estimate, the model was used to project enrollment in the VA health care system and then to estimate VA's total health care services utilization by estimating the proportion of enrollees' total health care that was expected to come from VA. The actuarial model used cost estimates associated with particular health care services in conjunction with the enrollment and utilization projections to project VA health care costs. The actuarial model provided utilization projections for 55 health care services including inpatient acute surgery, outpatient care, prescription drugs, and prosthetics. The model used private sector benchmarks but made allowances for the special characteristics of the VA enrollee population, adjusting for age, sex, morbidity of enrollee population, and veterans' use

¹⁶VA's actuarial model was developed under contract by Milliman USA, Inc.

of other health care providers reimbursed by payers such as Medicare and Medicaid.

Figure 1: Percentage of Projected Costs for VA's Medical Programs Using Various Estimation Approaches



Source: VA.

VA used a separate estimation approach, rather than an actuarial model, to project long-term care demand and costs,¹⁷ which accounted for about 10 percent of the funds requested for medical programs for each of the fiscal years 2005 and 2006. The long-term care estimation approach projected demand by using historical expenditures to calculate the costs of treating veterans and multiplying these estimates by projected workload, which was calculated based on historical trends and policy proposals. VA officials told us that they are working on incorporating the projection of long-term care demand and costs into the actuarial model, but could not provide a date when this would be completed. Similarly, VA used other approaches, rather than an actuarial model, to project demand and costs for the remaining 4 percent of the medical programs budget request for fiscal years 2005 and 2006. These other methodologies included

¹⁷VA long-term care includes nursing home care provided in VA-operated, state, and community nursing homes, and home and community-based care such as in-home care services and adult day health care centers.

adding inflation to actual expenditures and projecting trends based on workload, expenditure, and other data provided by program officials. The majority of these expenditure projections were for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)¹⁸ and dental care.

The actuarial model projections and the other estimation approaches for the fiscal year 2005 budget were developed in March 2003. To estimate costs for VA's medical programs for fiscal year 2005, VA used fiscal year 2002 data, which were the most current fiscal year data available in the spring of 2003. Similarly, VA used fiscal year 2003 data, in the spring of 2004, to project costs for fiscal year 2006.

VA Anticipated Resources Based on Prior Appropriation Levels, OMB Guidance, Collections, Reimbursements, and Projected Carryover of Unobligated Funds

VA anticipated its resources for fiscal years 2005 and 2006 based on its prior year appropriations, guidance published by OMB that outlined the President's budget priorities, and other factors. For example, OMB's annual planning guidance for fiscal year 2005, published in April 2003, directed executive agencies, including VA, to develop a budget for fiscal year 2005 that was within the levels included in the fiscal year 2004 budget. The guidance noted, for example, that any increases or amounts for new initiatives should be offset by reductions in lower priority or ineffective programs.

In addition, VA anticipated its funding based on resources it expected from collections, reimbursements,¹⁹ and the projected carryover of unobligated funds into the next fiscal year. VA may carry over from one fiscal year to the next unobligated balances of funds made available without fiscal year limitation and other funds appropriated for multiple fiscal years. In fiscal year 2004, for example, VA collected \$1.7 billion from veterans and third-party insurers,²⁰ which was available without fiscal year

¹⁸CHAMPVA provides medical care for dependents and survivors of veterans who are permanently and totally disabled from a service-connected disability.

¹⁹VA receives reimbursements from services it provides to other government entities, such as DOD, or other private or nonprofit entities. For example, VA laundries receive reimbursements from other entities by selling laundry services.

²⁰VA has the authority to collect payments for treatment of veterans' nonservice-connected conditions, that is, injuries or illnesses that were not incurred or aggravated during military service. VA collects first-party payments from veterans, such as copayments for outpatient medications and third-party payments from veterans' private health insurers, including those companies that self-insure.

limitation. VA carried over about \$600 million from fiscal year 2004 into fiscal year 2005; this amount consisted of collections from prior years and multiyear funds that had not been obligated during fiscal year 2004.

Adjustments Were Made to Address the Difference Between Projected Costs for VA Medical Programs and Anticipated Resources

According to VA officials, for both fiscal years 2005 and 2006, projected costs exceeded anticipated resources. VA officials stated that differences between projected costs and anticipated resources in budget requests for those years were addressed in two ways: (1) cost-saving policy proposals and (2) management efficiency savings.

To develop a budget request consistent with anticipated resources, VA officials told us they addressed the difference with cost-saving policy proposals which were included in the President's budget requests for fiscal years 2005 and 2006. These cost-saving policy proposals totaled \$494 million and \$734 million in fiscal years 2005 and 2006, respectively, and were proposed to reduce the total appropriation requested. (See table 1.) More specifically, a proposed long-term care policy was designed to reduce costs by reducing patient workload, while a proposed \$250 enrollment fee and an increase in pharmacy copayments for Priority 7 and 8 veterans—primarily, those veterans with incomes or net worths above applicable thresholds and no service-connected disability—would have generated additional resources. The projected savings from these policy proposals, which were designed to enhance revenue as a means of protecting resources, were used to adjust projected costs. VA used the actuarial model and long-term care estimates to project savings from these proposals.

Table 1: VA Cost-saving Policies Proposed in the President’s Budget Requests for Fiscal Years 2005 and 2006 (Dollars in Millions)

Policy proposals	Fiscal year 2005	Fiscal year 2006
Long-term care policy proposals to reduce average daily census ^a	\$270	\$502
Assess \$250 annual enrollment fee for Priority 7 and 8 veterans ^b	141	206
Increase pharmacy copayment from \$7 to \$15 for Priority 7 and 8 veterans ^b	83	26
Total cost-saving policy proposals	\$494	\$734

Source: GAO analysis of VA data.

^aAverage daily census is a patient workload measure, which represents the total number of days of nursing home care provided in a year divided by the number of days in the year.

^bPriority 7 and 8 veterans are veterans who have either incomes or net worths above applicable thresholds, no service-connected disability that results in monetary benefits from VA, and no other recognized statuses, such as former prisoners of war.

In addition to cost-saving policy proposals, VA developed estimates of management efficiency savings of \$340 million and \$590 million in fiscal years 2005 and 2006, respectively, which were included in the President’s budget request. According to VA, these management efficiency savings were initiatives designed to reduce costs without reducing quality. In a February 2006 report,²¹ we reported that VA’s total projected management efficiency savings in the President’s budget request for fiscal years 2003 through 2006 were used to fill the gap between the costs associated with VA’s projected demand for health care services and anticipated resources. In addition, we reported that VA lacked a methodology for measuring the dollar effect of the health care management efficiency savings it had detailed for fiscal years 2003 through 2006.

OMB and VA officials told us they did not include management efficiency savings in the fiscal year 2007 budget request and do not have plans for doing so in the future. However, they will continue to include other efficiency savings, which VA calls clinical efficiencies, projected by its actuarial model. Each year, a workgroup of VA officials and staff from the developer of the actuarial model review VA and health care industry trends and evaluate specific VA practices expected to affect health care service utilization and cost and incorporate these expectations into the

²¹See GAO, *Veterans Affairs: Limited Support for Reported Health Care Management Efficiency Savings*, [GAO-06-359R](#) (Washington, D.C.: Feb. 1, 2006).

actuarial model. For example, VA's Advanced Clinical Access initiative is intended to reduce the need for veterans to visit clinics to receive care by implementing certain health care practices such as using follow-up telephone calls by practitioners to reduce the number of in-person office visits. VA officials told us that to calculate the savings from such an initiative, the assumptions of reducing patient utilization are built into the actuarial model. The actuarial model then produces estimates of the effect of these efficiencies on the cost of health care services, according to VA officials.

VA Closely Monitored Budget Execution and Identified Problems, but Did Not Report Them in a Timely and Sufficiently Informative Manner

Anticipating challenges in managing its medical care programs within available resources, VA closely monitored its medical programs budget execution from the beginning of fiscal year 2005. Similarly, in early fiscal year 2006, the agency tracked how well it was managing to provide care to veterans with available resources during the 12-month time period. However, in fiscal years 2005 and 2006, VA reporting of budget execution to Congress could have been more timely and informative.

VA Monitored Budget Execution Early, Anticipating Challenges in Providing Medical Care with Available Resources

Recognizing that fiscal year 2005 would be a tight budget year, VA closely monitored budget execution from the beginning of the fiscal year. In early fiscal year 2005, VA formed a workgroup, the Budgetary Challenges workgroup, to develop a strategy the agency could take to manage within its budget. This six-member workgroup was comprised of selected network directors and an official from VA headquarters. In December 2004, in internal briefings to VA's National Leadership Board, the Deputy Under Secretary for Health for Operations and Management, and the Deputy Secretary, the workgroup recommended that the agency consider a number of budget options to manage within its fiscal year 2005 budget, including limiting the implementation of new initiatives and shifting resources from equipment and nonrecurring maintenance into direct patient care.

VA officials told us that in the middle of fiscal year 2005, it became clear that demand for health care services was increasing rapidly—confirming what they had anticipated at the beginning of the fiscal year—and that spending would have to be carefully controlled to manage within its fiscal year 2005 budget for the remainder of the year. VA staff identified these trends by analyzing the monthly reports they generate for VA senior management. In its March 2005 report to senior management, VA found

that through January 2005 unique patient workload²² was about 4.1 million, 5.2 percent above what VA had expected by that time of the fiscal year, suggesting a potential challenge to managing care with available resources.

On the basis of this close monitoring which began as early as October 2004, VA took actions to shift resources it had originally allocated for equipment and nonrecurring maintenance into direct patient care. VA initially planned to manage within its budget for fiscal year 2005 by deferring \$600 million for equipment and nonrecurring maintenance and reducing the fiscal year 2006 carryover balance by \$375 million. However, with a few months remaining in the fiscal year, in June and July 2005, the President requested additional VA medical programs funds for fiscal years 2005 and 2006, asking for \$975 million and \$1.977 billion, respectively.

In June 2005, the President submitted a request for supplemental funding for fiscal year 2005 that totaled \$975 million. VA reported to Congress²³ that the following activities contributed to the request:

- \$273 million for medical care services provided to veterans returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF),²⁴
- \$226 million for long-term care,
- \$200 million for an increase in the number of Priority 1 through 6 veterans using VA medical care,
- \$179 million for a greater-than-expected increase in the utilization of medical services and intensity of patient workload,
- \$58 million to reduce the number of veterans on waiting lists to receive medical care, and

²²Unique patient workload is a measure that represents an unduplicated count of the number of patients that used VA within the fiscal year. Therefore, patients are counted only once regardless of the number of times they use VA medical services within a fiscal year.

²³*Emergency Hearing to Examine the Shortfall in VA's Medical Care Budget Before the Senate Comm. on Veterans' Affairs*, 109th Cong. (June 28, 2005) (statement of R. James Nicholson, Secretary, Department of Veterans Affairs); *Hearing on the Department of Veterans Affairs Health Care Budget Before the House Comm. on Veterans' Affairs*, 109th Cong. (June 30, 2005) (statement of R. James Nicholson, Secretary, Department of Veterans Affairs).

²⁴Those who have served, or are now serving, in Operation Iraqi Freedom and Operation Enduring Freedom may receive care from VA for conditions that are or may be related to their combat services for a 2-year period following the date of their separation from active duty without copayment requirements. See 38 U.S.C. § 1710(e)(1)(C) and (e)(3)(C).

-
- \$39 million to provide medical care for the health care needs of dependents of veterans who are rated as having 100 percent service-connected disability.

In July 2005, the President submitted a budget amendment adding \$1.977 billion to his fiscal year 2006 request for VA Medical Services appropriations. VA testified before the House Committee on Veterans Affairs, in July 2005,²⁵ that the following activities contributed to the requests for additional funding:

- \$677 million for a 2 percent increase in the number of veterans using VA medical care,
- \$600 million to correct an error in VA's estimate of long-term care costs included in the President's budget,
- \$400 million to cover an unexpected 1.2 percent increase in the average cost per patient, and
- \$300 million to replace funds VA planned to carry over from fiscal year 2005 to fiscal year 2006.

To support these requests for additional funding for VA medical programs, VA officials told us that they chose to highlight activities for fiscal years 2005 and 2006 that were of high programmatic priority to the administration and Congress and could be supported by workload and expenditure data (e.g., veterans returning from Iraq and Afghanistan). They told us that there were a number of other ways the agency could have presented the data in the President's request for additional funding. For example, additional funding requested by the President could have been categorized by budget object code, which would have listed expenditures by broad cost categories including personnel and travel. However, VA officials believed that presenting the information primarily by programmatic activity would be the most useful for Congress.

²⁵*Hearing on the Department of Veterans Affairs Proposed Health Care Budget Amendment for Fiscal Year 2006 Before the House Comm. On Veterans' Affairs*, 109th Cong. (July 21, 2005) (statement of Jonathan B. Perlin, Under Secretary for Health, Department of Veterans Affairs).

VA's Reporting of Budget Execution Progress and Problems to Congress Could Have Been More Timely and Informative

Despite VA's identification of potential fiscal year 2005 budget challenges as early as October 2004, Congress did not learn of these challenges until April 2005, when VA reported to Congress that it intended to use funds allocated for equipment and nonrecurring maintenance to fund patient care. It was not until June 2005, with 3 months remaining in the fiscal year, that VA reported in congressional testimonies²⁶ that it had greater-than-anticipated workload levels, likely to result in greater-than-anticipated costs. It notified Congress at that time that it would not be able to manage by using nonrecurring maintenance funds as planned, but rather that the President planned to request additional funds from Congress.

OMB officials told us that they have taken a more active role in monitoring VA's execution of its fiscal year 2006 budget than they did in fiscal year 2005. VA and OMB officials now meet monthly to discuss the budget situation. Further, in fiscal year 2006, VA began preparing a special monthly report for OMB. The data in VA's monthly status reports have enabled OMB to help monitor VA's budget execution during the fiscal year. VA's monthly status reports to OMB provide measures of financial and workload data. For example, the report includes information on obligations and patient workload such as patients by priority category, outpatient visits, and nursing home average daily census.

Following the supplemental appropriation requested in fiscal year 2005 and the budget amendment requested for fiscal year 2006, Congress included a provision in the fiscal year 2006 Military Quality of Life and Veterans Affairs Appropriations Act requiring the Secretary of Veterans Affairs to submit to the Committees on Appropriations of the U.S. Senate and U.S. House of Representatives a quarterly report on the financial status of the Veterans Health Administration.²⁷ In addition, the conference

²⁶*Emergency Hearing to Examine the Shortfall in VA's Medical Care Budget Before the Senate Comm. on Veterans' Affairs*, 109th Cong. (June 28, 2005) (statement of R. James Nicholson, Secretary, Department of Veterans Affairs); *Hearing on the Department of Veterans Affairs Health Care Budget Before the House Comm. on Veterans' Affairs*, 109th Cong. (June 30, 2005) (statement of R. James Nicholson, Secretary, Department of Veterans Affairs).

²⁷Pub. L. No. 109-114, § 222, 119 Stat. 2372, 2391 (2005). A provision contained in an annual appropriation act is not considered permanent legislation unless the language or the nature of the provision makes it clear that Congress intended it to be permanent. Because this provision does not use any language indicating future application, it is not permanent and applies only to fiscal year 2006. The bill providing for the fiscal year 2007 Department of Veterans Affairs appropriations, H.R. 5385, would continue the quarterly report for that fiscal year. As of August 1, 2006, the bill had been reported out of the House and Senate appropriation committees, and had been passed by the House.

report accompanying the appropriations act directed VA to include waiting list performance measures and whether equipment or nonrecurring maintenance funds have been used to pay for operating expenses, among other things.²⁸

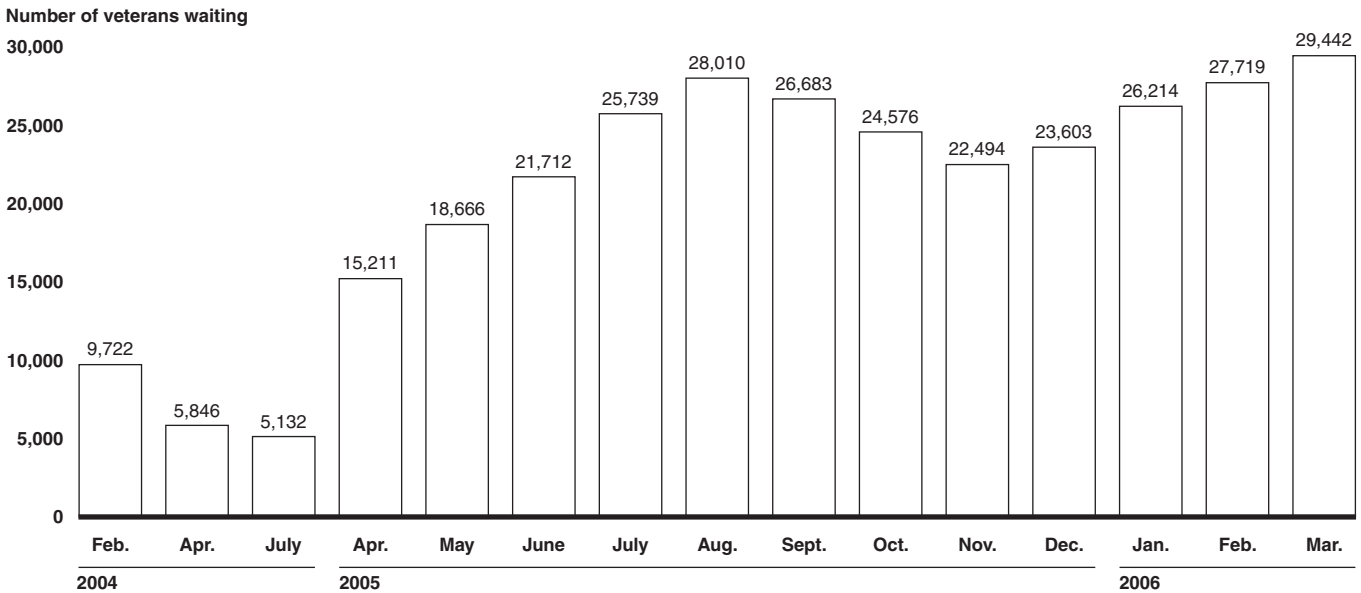
VA has provided three congressional quarterly reports beginning with a report on the first quarter of fiscal year 2006. While VA has 12 months to execute its budget, it did not submit its first two quarterly reports to Congress until nearly 2 months after the end of each quarter, using patient workload data that were as much as 3 months old at the time of submission. These data included a combination of actual and estimated number of patients seen. The third quarterly report was submitted in August, about 1 month after the end of the quarter, which was 1 month faster than VA provided the first two quarterly reports. The third quarterly report used estimated data for the number of unique patients seen.

We also found that these three quarterly reports did not include information identified in the conference report that would be useful for congressional oversight. Among measures identified in the conference report and not provided by VA in the quarterly report was a particular access measure—the time required for new patients to get their first appointment. Although not the same measure, a similar measure produced in one of VA's monthly reports to its own senior management for use in internal budget formulation showed the number of new patients waiting for their first appointment to be scheduled almost doubled over 11 months, from April 2005 to March 2006, indicating a potential problem in the first quarter of fiscal year 2006.²⁹ (See fig. 2.) However, the quarterly report for that period shows only the more favorable access measures for existing patients—percent of primary care and percent of specialty care appointments scheduled within 30 days of desired date—where VA is actually exceeding its performance goals. VA did not provide other measures requested, such as the status of equipment or nonrecurring maintenance funds and whether these funds have been used to pay for operating expenses.

²⁸See H.R. Conf. Rep. No. 109-305, at 50 (2005).

²⁹VA provided us with more recent data through July 1, 2006, that showed that the number of new patients waiting for first appointments had returned to about 15,000 or the same level as in April 2005. However, VA has not included these data in its first three quarterly reports.

Figure 2: VA's March 2006 Monthly Report to VA Senior Management Indicating Number of New Patients Waiting for First Appointment to be Scheduled



Source: Adapted from VA's March 2006 report presented to senior management on April 3, 2006.

Note: New patients are those who have enrolled in the past 12 months and have not been seen in VA during the past 24 months. VA officials told us the report reflects 50 outpatient clinics that account for about 95 percent of VA's outpatient visits. Data from 2004 are reported from the middle of the month (the 15th) and data for 2005 and 2006 are reported from first day of the month.

Additionally, we found that information VA provides on patient workload in its quarterly reports to congressional committees contrasted with the more detailed program and clinical information VA uses to inform the President's budget request for VA medical programs—such as the patient workload measures used to estimate costs in the actuarial model. The information in the quarterly congressional reports also contrasts with the more detailed patient workload information that VA provides in its monthly reports to OMB. In its quarterly reports, VA uses a patient workload measure, “unique patients,” that counts patients only once no matter how many times they use VA services within the fiscal year. (For example, a patient who used VA health care services in October would not be counted again in the patient workload totals for November, December, or January, even if that patient used VA medical services again during each of those months.) However, the unique patient measure does not capture the difference between patients predominately using low-cost services, such as primary care outpatient visits, at an average \$245 each, and patients using more high-cost services, such as acute inpatient hospital

care, which costs about \$1,500 a day, on average. In contrast, VA now provides in its monthly reports to OMB other patient workload measures—in addition to the number of unique patients—that provide a more complete picture of whether new patients are receiving low- or high-cost services. Some of the patient workload measures VA provides to OMB include nursing home patient workload, as measured by average daily census, number of outpatient visits, and patient workload by priority category.³⁰

Unrealistic Assumptions, Estimation Errors, and Insufficient Data Contributed to VA's Requests for Additional Funding

The requests for additional funding for VA medical programs in fiscal years 2005 and 2006 were caused, in part, by unrealistic assumptions, errors in estimation, and insufficient data in its budget formulation process. Unrealistic assumptions about the expected time frame in which the cost savings could be realized from proposed nursing home cost-saving policies contributed to the subsequent request for additional funding. Further, computational errors in measuring the estimated effect of one of these cost-saving policies led VA to underestimate resources needed in fiscal year 2006. Moreover, insufficient data in VA's initial budget projections contributed to the additional funding requests. For example, VA underestimated the cost of serving veterans returning from Iraq and Afghanistan, in part because estimates for fiscal year 2005 were based on data that largely predated the Iraq conflict and because VA did not have sufficient data for fiscal year 2006 due to challenges in obtaining data needed to identify these veterans from DOD, according to VA officials.

Unrealistic Assumptions and Errors in Estimating the Effect of Nursing Home Policies Contributed to Requests for Additional Funding

An unrealistic assumption about the expected time frame in which VA could implement a fiscal year 2005 proposed nursing home cost-saving policy contained in the President's budget request—a reduction in nursing home patient workload in VA-operated nursing homes—contributed to \$226 million of the request for supplemental funding for that fiscal year, VA officials said. The President's fiscal year 2005 budget request for VA medical programs included a proposal to reduce patient workload on a daily basis—average daily census—from about 12,000 to 8,500 in VA-operated nursing homes. In retrospect, agency officials told us this

³⁰Senior-level managers at managed care organizations typically use a number of measures to monitor on a recurring basis changes in patient workload. See Peter R. Kongstvedt, ed., *The Managed Health Care Handbook* (Aspen Publishers, Inc., Gaithersburg, Maryland, Fourth ed. 2001), pp. 298-299.

assumption was particularly unrealistic because of its accelerated time frame. VA projected the savings from this reduction in workload would be realized on the first day of the fiscal year, a change which would have required transferring or discharging, in an extremely compressed time frame, potentially thousands of veterans, many of whom had severe, chronic, physical or mental impairments. These veterans would have had to seek financing from other sources, such as Medicaid or private health insurance, or paid for their care out of pocket. Moreover, achievement of substantial savings from this policy would have also likely required reducing the number of VA employees. However, VA included no discussion in its budget formulation on how this cost-saving policy was to be implemented. Furthermore, VA officials told us that because VA had established a precedent for providing care to veterans who receive nursing home care on a discretionary basis, changing the policy on short notice would be difficult.

Similarly, the fiscal year 2006 President's budget request for VA medical programs included unrealistic assumptions and computational errors in estimating savings of a proposed nursing home policy. The assumption and estimation errors contributed to \$600 million of the budget amendment requesting additional funding in fiscal year 2006. The President's fiscal year 2006 budget request for VA medical programs included a policy proposal to reduce patient workload and costs by prioritizing the veterans³¹ who would receive long-stay nursing home care in its VA-operated nursing homes, community nursing homes, and state veterans' nursing homes. 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 qualify for long-stay care.

An unrealistic assumption about the expected time frame in which VA could implement the proposed policy contributed to \$152 million of the \$600 million request for additional funding for nursing home care in that fiscal year, according to VA officials. While VA had originally assumed the savings could be realized in April 2005, before the start of the 2006 fiscal

³¹VA planned to limit long-stay nursing home care to those veterans with higher priority status—i.e., those veterans who had a priority status of 1 through 3 and those priority 4 veterans who were catastrophically disabled.

year, VA staff said they later recognized with OMB that this date had been unrealistic. In addition, VA said that the policy assumed a 90 percent reduction in patient workload in state veterans' nursing home workload for patients requiring long-stay nursing home care but that the correct estimate was a 20 percent reduction in workload per year. For VA-operated nursing homes, the policy assumed an 80 percent reduction in patient workload over 1½ years; however, VA later stated the correct estimate was closer to 30 percent.

Computation errors in estimating the effect of this proposed fiscal year 2006 policy contributed to about \$445 million of the \$600 million request for additional funding for nursing home care in that fiscal year, according to VA officials. In particular, VA underestimated patient workload—average daily census—and costs in all three nursing home settings. Specifically, VA incorrectly estimated that the average daily census in VA-operated nursing homes was 9,795, when the correct estimated patient count was 11,151. Similarly, while VA estimated that the per diem rate for its homes was \$471.16, it was actually \$567.52. VA officials said that the errors in estimating the effect of the proposed nursing home policy resulted from calculations being made in haste during the OMB appeal process,³² and that a more standardized approach to long-term care calculations could provide stronger quality assurance to help prevent future mistakes.

Insufficient Data on Certain Activities Contributed to the Requests for Additional Funding in Fiscal Years 2005 and 2006

Insufficient data on veterans returning from Iraq and Afghanistan—OIF and OEF—accounted for \$273 million of the request for supplemental funding in fiscal year 2005. According to VA officials, the original cost projections for providing care to OIF and OEF veterans were understated for fiscal year 2005 in part because they were based on data from fiscal year 2002 that predated the Iraq conflict, which began in March 2003. While VA originally projected, in its fiscal year 2005 budget formulation, that it would need to provide care to about 23,500 returnees from Iraq and Afghanistan, revised projections indicated that it would serve about four times that number of OIF and OEF veterans, nearly 100,000 returnees for fiscal year 2005.

³²In 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.

Insufficient data on returning OIF and OEF veterans continued to be a problem in fiscal year 2006 budget formulation, accounting for \$276 million of the budget amendment requesting additional funding for that year, according to VA officials. VA officials told us they did not have sufficient data for fiscal year 2006 due to challenges obtaining data needed to identify these veterans from DOD. VA later determined in late fiscal year 2005, after the President submitted the fiscal year 2006 budget request, that it expected to provide care to approximately 87,000 patients beyond what it had initially projected. According to VA officials, VA now receives the DOD data it requires to identify OIF/OEF veterans on a monthly basis rather than the quarterly reports it used to receive. However, VA has a 2-month lag in projecting costs associated with treating these veterans at VA.

Insufficient data on whether VA achieved management efficiency savings may have also contributed to the requests for additional funding. However, VA's calculations of management efficiencies obtained in fiscal year 2005 were based on the same approach we found to be inadequate in our earlier work and therefore are not reliable. Data on whether management efficiency savings were achieved for fiscal year 2006 were not available during our work because the fiscal year was not complete. Because we could not determine if the efficiency savings were achieved, we could not conclude whether the estimation of savings was incorrect and therefore may have contributed to the request for additional funding.

Conclusions

VA, like other federal agencies, faces fiscal challenges as demand for its services increases while federal resources are constrained. Until recently, VA had more options to meet this challenge because it could redirect resources from more expensive inpatient care to less expensive outpatient care to serve more veteran patients as it modernized the delivery of its health care services. However, VA's success in transforming its system to emphasize outpatient care means that it will have fewer such options to meet future fiscal challenges. In this context, sound budget formulation, anticipatory monitoring of budget execution, and the reporting of informative and timely information to Congress for oversight will become increasingly important in order to provide high-quality, accessible, and cost-efficient health care to veterans. Even with these actions, the challenge of balancing veterans' access to health care and the availability of federal resources is likely to be more difficult in the future.

The lessons of the last few years show what can happen when budget formulation is affected by calculation errors, unrealistic assumptions, and insufficient data. Whether due to errors in calculating long-term care patient workloads and costs, unrealistic assumptions about the expected time frame in which long-term care policies can be changed and lack of discussion in budget formulation on how such policies would be implemented, or insufficient data on the number of people who will need health care, such problems can result in mismatches in projecting service provision and available resources. Although budget formulation is, by its nature, based on assumptions and imperfect information, these assumptions and information can be improved based on experience, and complemented by reasonable projections for known events that will affect the agency. Additional measures in VA's quarterly reports, such as the time new patients waited for their first health care appointments and measures of patient workload in addition to unique patients, might help alert Congress to potential problems VA may face in managing within its budget in future years. VA's budget execution and monitoring in fiscal years 2005 and 2006 were perhaps more vigilant than in prior years because VA expected, from the beginning of fiscal year 2005, that it might experience difficulties in managing its medical program within available resources. When, as a result of this monitoring, VA found potential problems in providing medical care programs within its appropriations, its reporting of the information to Congress was not sufficiently timely or informative. More recently, however, VA improved the timeliness of its reporting. VA submitted its third quarterly report for fiscal year 2006 more quickly after the end of the quarter than it had the first two quarterly reports.

Recommendations for Executive Action

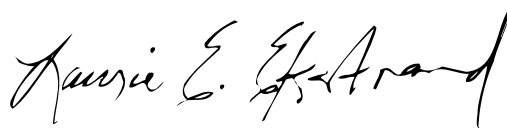
To help improve VA's budget formulation of its medical programs budget and facilitate congressional oversight, we recommend that the Secretary of Veterans Affairs take three actions:

- Explain the relationship between implementation of proposed policy changes and the expected timing of when cost savings would be achieved.
- Improve its internal controls to provide stronger assurance that calculations used to formulate policy projections in the President's budget submissions are accurate.
- Incorporate into VA's reporting to Congress (1) measures of patient workload, in addition to unique patients, that would capture the costliness of patient care; and (2) a measure of waiting times to schedule veterans' first primary care appointment for new patients.

Agency Comments

We received comments on a draft of this report from VA (reproduced in app. II). In commenting on the draft, VA stated that it substantially agreed with our findings and conclusions and concurred with our recommendations. VA also described steps it has taken and plans to take to respond to our recommendations, including steps it took in developing information for the President's fiscal year 2007 budget request and in monitoring the execution of its fiscal year 2006 resources.

We are sending copies of this report to the Secretary of Veterans Affairs and the Director of the Office of Management and Budget, appropriate congressional committees, and other interested parties. We will also make copies available to others upon request. 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) 512-7101 or at ekstrandl@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.



Laurie E. Ekstrand
Director, Health Care

Appendix I: Objectives, Scope, and Methodology

For fiscal years 2005 and 2006, we examined: (1) how the President's budget requests for the Department of Veterans Affairs (VA) medical programs were formulated, (2) how VA monitored and reported to Congress on its budget execution, and (3) which key factors in the budget formulation process contributed to the requests for additional funding. Our review of how VA monitored its fiscal year 2006 budget includes the first 11 months of the fiscal year because the fiscal year was not over when we completed our work.

For each of our reporting objectives, we interviewed senior officials in VA and the Office of Management and Budget (OMB) to determine how the President's budget request for VA medical programs for fiscal years 2005 and 2006 was formulated, and how VA monitored and reported on its budget execution. We interviewed VA officials in Washington, D.C. from three primary offices responsible for budget issues related to VA's medical programs: (1) VA's Office of the Deputy Assistant Secretary for Budget, (2) Veterans Health Administration's (VHA) Office of the Chief Financial Officer, and (3) VHA's Office of the Assistant Deputy Under Secretary for Health for Policy and Planning. We also interviewed senior officials from OMB responsible for VA budget issues to obtain their perspective on the President's budget request for VA's medical programs and the subsequent requests for additional funding for fiscal years 2005 and 2006.

For the purposes of our analysis, the President's budget request for VA medical programs primarily concerned four appropriation accounts: (1) medical services, for direct patient care; (2) medical administration, for administrative oversight and all information technology; (3) medical facilities, for the maintenance and operation of hospitals and other structures; and (4) medical research. VA funded nonrecurring maintenance, for items such as roof repair, through the appropriations for VA medical programs, and funds for these activities are included in our analysis. However, we did not include more general construction funding—i.e., for major construction and minor construction—in our analysis, as these funds are provided in separate appropriations.

We obtained and analyzed documents and interviewed VA officials about how each of the three primary projection methods was used in formulating the budget: (1) an actuarial model; (2) a long-term care approach; and (3) other methodologies, including adding inflation to actual expenditures. For each method, we verified information VA officials told us in interviews by analyzing the documents VA provided. For example, we confirmed that the actuarial model accounted for about 86 percent of the President's

budget request for VA medical programs for fiscal year 2005 through our analysis of documents VA provided.

To determine how VA monitored and reported to Congress on its budget execution, we conducted interviews and reviewed copies of monthly reports prepared internally for VA senior managers, monthly reports prepared for OMB, and quarterly reports prepared for the House and Senate Appropriations Committees. For monthly reports prepared for VA senior managers, we reviewed both the March 2005 and the March 2006 monthly reports. We reviewed a monthly report VA prepared for OMB for the month of April 2006. For the quarterly reports, we reviewed the first, second, and third quarterly reports VA prepared on the fiscal year 2006 budgets. We analyzed these documents to assess the comprehensiveness of the reporting information included in these reports.

To identify key factors in the budget formulation process that contributed to the requests for additional funding, we obtained and analyzed a number of documents detailing estimated savings from various policy proposals, calculation errors, and data gaps in the budget formulation process for fiscal years 2005 and 2006. For example, we analyzed documents obtained from VA showing calculation errors made in estimating the impact of a proposed long-term care policy in fiscal year 2006. We also obtained and analyzed revised estimates of veterans returning from Iraq and Afghanistan and compared these to data available during the fiscal years 2005 and 2006 budget formulation process. In addition, we reviewed publicly available documents such as transcripts of VA testimony to the Senate and House Veterans' Affairs Committees, the VA's Medical Programs Budget Submissions for fiscal years 2005 and 2006, and the President's formal requests to Congress for additional funding for VA medical programs for fiscal years 2005 and 2006.

We assessed the reliability of the information we obtained about how VA formulated, monitored, and reported on the President's budget request for medical programs in several ways. First, we checked the internal consistency of documents VA provided detailing various budget estimates for fiscal years 2005 and 2006 and information contained in the President's budget request in those years. Second, we interviewed agency officials knowledgeable about the data used to formulate, monitor, and report on the budget. We determined that the actuarial model appeared reasonable for formulating the budget but we did not conduct a separate, detailed audit of all data inputs into the actuarial model. Third, we relied on our prior work to identify potential issues about data reliability. For example, we determined that the assumptions used to project management

efficiencies were inaccurate, based on a report we had previously issued.¹ We determined that the data we used in our analyses were sufficiently reliable for the purposes of this report.

We performed our review from October 2005 through September 2006 in accordance with generally accepted government auditing standards.

¹See [GAO-06-359R](#).

Appendix II: Comments from the Department of Veterans Affairs



THE DEPUTY SECRETARY OF VETERANS AFFAIRS
WASHINGTON

September 5, 2006



Commemorating 75 Years of Service

Ms. Laurie E. Ekstrand
Director
Health Care Team
U. S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Ekstrand:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, **VA HEALTH CARE: Budget Formulation and Reporting on Budget Execution Need Improvement** (GAO-06-958). VA substantially agrees with your findings and conclusions as they pertain to the formulation of the fiscal year (FY) 2005 and FY 2006 budgets. VA has also taken steps to incorporate these improvements into the FY 2007 budget and will continue to do so in future budget requests.

VA is committed to ensuring that budget estimates accurately reflect mission requirements and are based on valid assumptions in providing timely, high-quality health care to veterans.

The enclosure details actions taken and planned to implement GAO's recommendations. VA appreciates the opportunity to comment on your draft report.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Gordon H. Mansfield".

Gordon H. Mansfield

Enclosure

Enclosure

THE DEPARTMENT OF VETERANS AFFAIRS' (VA) COMMENTS
TO THE GOVERNMENT ACCOUNTABILITY OFFICE (GAO)
DRAFT REPORT

***VA HEALTH CARE: Budget Formulation and Reporting on
Budget Execution Need Improvement***
(GAO-06-958)

- **To help improve VA's budget formulation of its medical programs budget and facilitate congressional oversight. GAO recommends that the Secretary of Veterans Affairs take three actions:**

Explain the relationship between implementation of proposed policy changes and the expected timing of when cost savings would be achieved.

Concur – VA employed the approach of critically evaluating policy changes and assumptions, realistic implementation timelines, and resulting savings in the development of the FY 2007 budget request and will continue to do so in future budgets. The relationship between the implementation of the policy and the expected timing of the budgetary impact will be determined and explained in the budget by VA. All changes in health care policy were appropriately identified in the FY 2007 budget and will continue to be clearly identified in future budgets. This will enable all stakeholders to clearly recognize any policy changes that are proposed, along with the rationale to support them and their financial impact. This includes the date of expected approval of the policy, the timing of the implementation in the field, and the initial and future cost impacts. VA will provide more comprehensive explanations regarding the timing of the complex relationship between respective policy changes and realization of cost, or cost savings, in future budget requests to Congress.

Improve its internal controls to provide stronger assurance that calculations used to formulate policy projections in the President's budget submissions are accurate.

Concur - VA has taken steps to improve its overall quality control and made technical changes to strengthen the accuracy of its formulation methodologies and assessments of cost savings in the FY 2007 and future budgets. Assumptions and calculations have been verified independently to assure the fundamental quality of estimates. Additionally, VA has contracted with the RAND Corporation to independently evaluate its actuarial projection model for the purpose of identifying potential improvements. During the execution year, VA is also monitoring budget performance with monthly reports to VA senior leaders and to OMB, and with quarterly reports to the four congressional committees.

Enclosure

THE DEPARTMENT OF VETERANS AFFAIRS' (VA) COMMENTS
ON THE GOVERNMENT ACCOUNTABILITY OFFICE (GAO)
DRAFT REPORT

***VA HEALTH CARE: Budget Formulation and Reporting on
Budget Execution Need Improvement***
(GAO-06-958)

Incorporate into VA's reporting to Congress (1) measures of patient workload, in addition to unique patients, that would capture the costliness of patient care, and (2) a measure of waiting times to schedule veterans' first primary care appointment for new patients.

Concur - The Secretary personally briefed the first FY 2006 quarterly report to the congressional committees as requested and has provided quarterly reports for the two subsequent quarters. The Secretary and VA have responded to all requests from the committees for performance information and will continue to provide workload data as well as financial and program performance information to Congress as requested. VA will provide Congress with a measure of waiting times to schedule veterans' first primary care appointments for new patients in its quarterly reports to Congress.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Laurie E. Ekstrand, (202) 512-7101 or ekstrandl@gao.gov.

Acknowledgments

James Musselwhite, Assistant Director; Jennie Apter; Denise Fantone; Michael Kendix; Dean Koulouris; Tiffany Tanner; Thomas Walke; and Greg Whitney made key contributions to this report.

Related GAO Products

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.

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

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

VA Health Care: Resource Allocations to Medical Centers in the Mid South Healthcare Network. [GAO-04-444](#). Washington, D.C.: April 21, 2004.

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

Managing for Results: Efforts to Strengthen the Link Between Resources and Results at the Veterans Health Administration. [GAO-03-10](#). Washington, D.C.: December 10, 2002.

VA Health Care: Allocation Changes Would Better Align Resources With Workload. [GAO-02-338](#). Washington, D.C.: February 28, 2002.

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