



Statement for the Record  
to the Committee on Veterans Affairs,  
House of Representatives

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# VA'S HEALTH CARE BUDGET

## Preliminary Observations on Efforts to Improve Tracking of Obligations and Projected Utilization

Statement for the Record by Randall B. Williamson,  
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# GAO Highlights

Highlights of [GAO-16-374T](#), a statement for the record to the Committee on Veterans Affairs, House of Representatives

## Why GAO Did This Study

VA projected a funding gap in its fiscal year 2015 medical services appropriation account and obtained temporary authority to use up to \$3.3 billion in Veterans Choice Program funding to close this gap. GAO was asked to examine VA's fiscal year 2015 projected funding gap and changes VA has made to help prevent potential funding gaps in future years.

This statement is based on GAO's ongoing work and provides preliminary observations on (1) the activities or programs that accounted for VA's fiscal year 2015 projected funding gap in its medical services appropriation account and (2) changes VA has made to prevent potential funding gaps in future years. GAO reviewed data VA provided on its obligations and related documents to determine what activities accounted for the projected funding gap in its fiscal year 2015 medical services appropriation account, as well as the factors that contributed to the projected funding gap. GAO interviewed VA and Office of Management and Budget officials to identify the steps taken to address the projected funding gap. GAO also examined changes VA made to better track obligations and project future budgetary needs.

GAO shared the information provided in this statement with VA and incorporated its comments as appropriate.

View [GAO-16-374T](#). For more information, contact Randall B. Williamson at (202) 512-7114 or [williamsonr@gao.gov](mailto:williamsonr@gao.gov).

February 10, 2016

## VA'S HEALTH CARE BUDGET

### Preliminary Observations on Efforts to Improve Tracking of Obligations and Projected Utilization

## What GAO Found

GAO's ongoing work indicates that two areas accounted for the Department of Veterans Affairs' (VA) fiscal year 2015 projected funding gap of \$2.75 billion. Specifically,

- Higher-than-expected obligations for VA's longstanding care in the community (CIC) program—which allows veterans to obtain care from providers outside of VA facilities—accounted for \$2.34 billion or 85 percent of VA's projected funding gap. VA officials expected that the new Veterans Choice Program—which was implemented in fiscal year 2015 and also allows veterans to access care from non-VA providers under certain conditions—would absorb veterans' increased demand for care after public disclosure of long wait times. However, administrative weaknesses slowed enrollment into this new program. The unexpected increase in CIC obligations also exposed VA's weaknesses in estimating costs for CIC services and tracking associated obligations. VA officials did not determine that VA faced a projected funding gap until April 2015—6 months into the fiscal year, after they compared estimated authorizations with estimated obligations for CIC.
- Unanticipated obligations for hepatitis C drugs accounted for the remaining portion—\$408 million—of VA's projected funding gap. VA did not anticipate in its budget the obligations for these costly, new drugs, which can help cure the disease, because the drugs did not gain approval from the Food and Drug Administration until fiscal year 2014—after VA had already developed its budget estimate for fiscal year 2015. VA officials told GAO that in fiscal year 2015 about 30,000 veterans received these drugs, which cost between \$25,000 and \$124,000 per treatment regimen.

GAO's ongoing work indicates that VA has taken steps to better track obligations and project future healthcare utilization, but systems deficiencies and budgetary uncertainties remain. Specifically, GAO's preliminary results indicate that VA has taken the following steps:

- VA issued a standard operating procedure to help VA medical centers (VAMC) more accurately estimate the costs associated with authorizations for CIC.
- VA directed VAMCs to compare their estimated costs for CIC authorizations with estimated obligations for CIC on a monthly basis.
- VA allocated funds to each VAMC for CIC and hepatitis C drugs and began tracking VAMCs' obligations with monthly reports. Officials told GAO that once a VAMC has obligated its funds, it would have to request additional funds. VA would determine whether additional funds may be made available. These processes are necessary because continued deficiencies in VA's financial systems present challenges in tracking of obligations.
- VA updated the model it uses to inform most of its budget estimates for medical services. It now includes more recent data that reflect increased healthcare utilization among veterans in fiscal year 2015. However, VA officials noted uncertainties remain about the forecasted utilization of the Veterans Choice Program and emerging health care treatments, which could affect the accuracy of the health care budget estimates.

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Chairman Miller, Ranking Member Brown, and Members of the Committee,

I am pleased to submit this statement on preliminary observations from our ongoing work examining the Department of Veterans Affairs' (VA) projected funding gap in its fiscal year 2015 medical services appropriation account. As you know, VA's Veterans Health Administration operates one of the largest health care delivery systems in the nation—serving about 6.6 million patients—and had total budgetary resources of nearly \$51 billion for medical services in fiscal year 2015. In June 2015, VA requested additional amounts from Congress because it projected a funding gap of about \$3 billion in its medical services appropriation account.<sup>1</sup> On July 31, 2015, the VA Budget and Choice Improvement Act provided VA temporary authority to use up to \$3.3 billion from the Veterans Choice Program appropriation for obligations incurred for other specified medical services, starting May 1, 2015 and ending October 1, 2015, to address its fiscal year 2015 projected funding gap.<sup>2</sup> The Veterans Choice Program, which was established by statute in 2014, generally allows veterans to obtain care from a network of providers when their local VA medical centers (VAMC) cannot provide the services due to long wait times or the distance from veterans' homes.<sup>3</sup>

We and others have reported on past challenges VA has faced regarding the reliability, transparency, and consistency of its budget estimates for medical services used to support the President's budget request, as well as the agency's ability to accurately track obligations for medical services.

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<sup>1</sup>In this statement, the projected funding gap refers to the period in fiscal year 2015 when VA's obligations for medical services were projected to exceed its available budgetary authority for that purpose for that year. The Antideficiency Act prohibits agencies from incurring obligations in excess of available budget authority. 31 U.S.C. § 1341(a). An obligation is defined as a "definite commitment that creates a legal liability of the government for the payment of goods and services ordered or received, or a legal duty on the part of the United States that could mature into a legal liability by virtue of actions on the part of the other party beyond the control of the United States." GAO, *A Glossary of Terms Used in the Federal Budget Process*, GAO-05-734SP (Washington, D.C.: September 2005), p. 70. We did not determine whether an Antideficiency Act violation occurred, as such an evaluation was beyond the scope of our ongoing work.

<sup>2</sup>Pub. L. No. 114-41, §§ 4001, 4004, 129 Stat. 443, 463-464 (2015).

<sup>3</sup>To address concerns about long wait times for care, in 2014, the Veterans Access, Choice, and Accountability Act of 2014 was enacted to, among other things, establish the Veterans Choice Program. Pub. L. No. 113-146, § 101, 128 Stat. 1754, 1755-1765 (2014).

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For example, in February 2012, we reported that VA's estimated savings from operational improvements for providing medical services—used to support both the President's budget request for fiscal year 2012 and VA's advance appropriations request for fiscal year 2013—lacked analytical support or were flawed, raising questions regarding the reliability of the estimated savings.<sup>4</sup> In addition, according to VA's 2014 Performance and Accountability Report, VA has financial system deficiencies and lacks an adequate process to validate its reported obligations.<sup>5</sup> In light of these challenges, coupled with VA's fiscal year 2015 projected funding gap, members of Congress have questioned VA's ability to accurately estimate its budgetary needs for future years and track its obligations for medical services.

My statement today will discuss our preliminary observations on

1. the activities or programs that accounted for VA's fiscal year 2015 projected funding gap in its medical services appropriation account, and
2. changes VA has made to prevent potential funding gaps in future years.

My statement today is based on our ongoing work examining VA's fiscal year 2015 projected funding gap in its medical services appropriation account. To examine the activities or programs that accounted for this projected funding gap, we reviewed fiscal year 2015 obligation data and documents provided by VA, including requests for VA's fiscal year 2015 and 2016 budgets; VA's requests to Congress for the authority to transfer

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<sup>4</sup>See GAO, *VA Health Care: Methodology for Estimating and Process for Tracking Savings Need Improvement*, [GAO-12-305](#) (Washington, D.C.: Feb. 27, 2012). Proposed savings included savings from operational improvements and management initiatives that are included in VA's budget justifications. The Veterans Health Care Budget Reform and Transparency Act of 2009 provided that VA's annual appropriations for health care also include advance appropriations that become available 1 fiscal year after the fiscal year for which the appropriations act was enacted. Pub. L. No. 111-81, § 3, 123 Stat. 2137, 2137–38 (2009), codified at 38 U.S.C. § 117. The act provided for advance appropriations for VA's Medical Services, Medical Support and Compliance, and Medical Facilities appropriations accounts and directed VA to include with information it provides Congress in connection with the annual appropriations process detailed estimates of funds needed to provide its health care services for the fiscal year for which advance appropriations are to be provided.

<sup>5</sup>See VA, *2014 Performance and Accountability Report* (Washington, D.C.: Nov. 12, 2014).

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funds between its appropriations; internal memos and communications; and documents related to the projection model used by VA to estimate the utilization of and associated costs for activities funded through its medical services appropriation account. We analyzed this information to examine the activities or programs in VA's medical services budget that accounted for the projected funding gap in fiscal year 2015, as well as the extent to which and reasons that each activity or program contributed to the projected funding gap. We also interviewed officials from VA and the Office of Management and Budget (OMB) to identify the steps taken to address the projected funding gap.

To examine the changes VA has made or is planning to make to help prevent potential funding gaps in future years, we obtained and reviewed VA documents, including VA policy memoranda and internal reports, and interviewed VA officials. We analyzed this information to identify new or updated processes for projecting future budgetary needs and tracking obligations. We conducted a data reliability assessment of VA's fiscal year 2015 obligation data that we used, which included checks for missing values and outliers, and interviewed officials from the Office of Finance within the Veterans Health Administration, who are knowledgeable about the data. As a result of these steps, we determined that the data were sufficiently reliable for our objectives. We obtained the views of VA officials on the information provided in this statement and incorporated their comments, as appropriate.

The work upon which this statement is based is being conducted in accordance with generally accepted government auditing standards.

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## Background

VA provides medical services to various veteran populations—including an aging veteran population and a growing number of younger veterans returning from the military operations in Afghanistan and Iraq. VA operates approximately 170 VAMCs, 130 nursing homes, and 1,000 outpatient sites of care. In general, veterans must enroll in VA health care to receive VA's medical benefits package—a set of services that includes a full range of hospital and outpatient services, prescription drugs, and long-term care services provided in veterans' own homes and in other locations in the community.

The majority of veterans enrolled in the VA health care system receive care in VAMCs and community-based outpatient clinics, but VA may authorize care through community providers to meet the needs of the

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veterans it serves. For example, VA may provide care through its Care in the Community (CIC) program, such as when a VA facility is unable to provide certain specialty care services, like cardiology or orthopedics.<sup>6</sup> CIC services must generally be authorized by a VAMC provider prior to a veteran receiving care. In addition to the CIC program, VA may also provide care to veterans through the Veterans Choice Program, which was established through the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act), enacted on August 7, 2014.<sup>7</sup> Implemented in fiscal year 2015, the program generally provides veterans with access to care by non-VA providers when a VA facility cannot provide an appointment within 30 days or when veterans reside more than 40 miles from the nearest VA facility. The Veterans Choice Program is primarily administered using contractors, who, among other things, are responsible for establishing nationwide provider networks and scheduling appointments for veterans. The Choice Act created a separate account known as the Veterans Choice Fund, which cannot be used to pay for VA obligations incurred for any other program, such as CIC, without legislative action.<sup>8</sup> The Choice Act appropriated \$10 billion to be deposited in the Veterans Choice Fund. Amounts deposited in the Veterans Choice Fund are available until expended and are available for activities authorized under the Veterans Choice Program. However, the Veterans Choice Program activities are only authorized through fiscal year 2017 or until the funds in the Veterans Choice Fund are exhausted, whichever occurs first.<sup>9</sup>

As part of the President's request for funding to provide medical services to veterans, VA develops an annual budget estimate detailing the amount of services it expects to provide as well as the estimated cost of providing those services. VA uses the Enrollee Health Care Projection Model (EHCPM) to develop most of the agency's estimates of the budgetary

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<sup>6</sup>VA has purchased health care services from community providers since as early as 1945. Before 2015, VA referred to its CIC program as "non-VA medical care" or "fee basis care."

<sup>7</sup>Pub. L. No.113-146, 128 Stat. 1754 (2014).

<sup>8</sup>Pub. L. No.113-146, § 802, 128 Stat. 1754, 1802-1803 (2014). It was outside the scope of our ongoing review to evaluate VA's determinations to authorize an episode of care by non-VA providers under the Veterans Choice Program as opposed to CIC.

<sup>9</sup>Pub. L. No.113-146, § 802(d), 128 Stat. 1754, 1802 (2014).

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needs to meet the expected demand for VA medical services.<sup>10</sup> Like many other agencies, VA begins to develop these estimates approximately 18 months before the start of the fiscal year for which funds are provided. Different from many agencies, VA's Veterans Health Administration receives advance appropriations for health care in addition to annual appropriations. VA's EHCPM makes these projections 3 or 4 years into the future for budget purposes based on data from the most recent fiscal year. In 2012, for example, VA used actual fiscal year 2011 data to develop the budget estimate for fiscal year 2014 and the advance appropriation estimate for fiscal year 2015. Similarly, in 2013, VA used actual fiscal year 2012 data to update the budget estimate for fiscal year 2015 and develop the advance appropriation estimate for fiscal year 2016. Given this process, VA's budget estimates are prepared in the context of uncertainties about the future—not only about program needs, but also about future economic conditions, presidential policies, and congressional actions that may affect the funding needs in the year for which the estimate is made—which is similar to budgeting practices of other federal agencies. Further, VA's budget estimates are typically revised during the budget formulation process to incorporate legislative and department priorities as well as in response to successively higher level of reviews in VA and OMB.

Each year, Congress provides funding for VA health care primarily through the following appropriation accounts:

- Medical Services, which funds, among other things, health care services provided to eligible veterans and beneficiaries in VA's medical centers, outpatient clinic facilities, contract hospitals, state homes, and outpatient programs on a fee basis.<sup>11</sup> The CIC program is funded through this appropriation account.

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<sup>10</sup>The EHCPM's estimates are based on three basic components: the projected number of veterans who will be enrolled in VA health care, the projected quantity of health care services enrollees are expected to use, and the projected unit cost of providing these services. Unit costs are the costs to VA of providing a unit of service, such as a 30-day supply of a prescription or a day of care at a medical facility.

<sup>11</sup>In this statement, when we refer to medical services provided by VA, we are referring only to the services funded through its Medical Services appropriation account, which is where VA projected its fiscal year 2015 funding gap.

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- Medical Support and Compliance, which funds, among other things, the administration of the medical, hospital, nursing home, domiciliary, construction, supply, and research activities authorized under VA's health care system.
  - Medical Facilities, which funds, among other things, the operation and maintenance of the Veterans Health Administration's capital infrastructure, such as costs associated with nonrecurring maintenance, utilities, facility repair, laundry services, and groundskeeping.<sup>12</sup>

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## Higher-than-Expected Obligations for the CIC Program and Hepatitis C Drugs Accounted for VA's Fiscal Year 2015 Projected Funding Gap

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<sup>12</sup>Nonrecurring maintenance is designed to correct, replace, upgrade, and modernize existing infrastructure and utility systems.



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## Higher-than-Expected Obligations for the CIC Program Accounted for 85 Percent of VA's Projected Fiscal Year 2015 Funding Gap

Our preliminary work suggests that the higher-than-expected obligations identified by VA in April 2015 for VA's CIC program accounted for \$2.34 billion (or 85 percent) of VA's projected funding gap of \$2.75 billion in fiscal year 2015.<sup>13</sup> These higher-than-expected obligations for the CIC program were driven by an increase in utilization of VA medical services across VA, reflecting, in part, VA's efforts to improve access to care after public disclosure of long wait times at VAMCs. VA officials expected that the Veterans Choice Program would absorb much of the increased demand from veterans for health care services delivered by non-VA providers. However, veterans' utilization of Veterans Choice Program services was much lower than expected in fiscal year 2015. VA had estimated that obligations for the Veterans Choice Program in fiscal year 2015 would be \$3.2 billion, but actual obligations totaled only \$413 million. Instead, VA provided a greater amount of services through the CIC program, resulting in total obligations of \$10.1 billion, which VA officials stated were much higher than expected for that program in fiscal year 2015.<sup>14</sup> According to VA officials, the lower-than-expected utilization of the Veterans Choice Program in fiscal year 2015 was due, in part, to administrative weaknesses, such as provider networks that had not been fully established, that slowed enrollment in the program and that VAMC staff lacked guidance on when to refer veterans to the program.

The unexpected increase in CIC obligations in fiscal year 2015 exposed weaknesses in VA's ability to estimate costs for CIC services and track associated obligations. While VA officials first became concerned that CIC obligations might be significantly higher than projected in January 2015, they did not determine that VA faced a projected funding gap until April 2015—6 months into the fiscal year. They made this determination after they compared authorizations in the Fee Basis Claims System (FBCS)—VA's system for recording CIC authorizations and estimating costs for this care—with obligations in the Financial Management System (FMS)—the centralized financial management system VA uses to track all of its obligations, including those for medical services. In its 2015 Agency Financial Report (AFR), VA's independent public auditor identified the

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<sup>13</sup>At the end of the fiscal year, VA determined that the projected funding gap was lower than it had initially projected, because VA reduced or halted funding for non-essential projects to mitigate an initial \$3 billion projection.

<sup>14</sup>The total obligations of \$10.1 billion in fiscal year 2015 for the CIC program do not include the \$413 million in obligations for the Veterans Choice Program in that year.

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following issues as contributing to a material weakness in estimating costs for CIC services and tracking CIC obligations:<sup>15</sup>

- VAMCs individually estimate costs for each CIC authorization and record these estimates in FBCS. This approach leads to inconsistencies, because each VAMC may use different methodologies to estimate the costs they record.<sup>16</sup> Having more accurate cost estimates for CIC authorizations is important to help ensure that VA is aware of the amount of money it must obligate for CIC services.
- VAMCs do not consistently adjust estimated costs associated with authorizations for CIC services in a timely manner to ensure greater accuracy, and they do not perform a “look-back” analysis of historical obligations to validate the reasonableness of estimated costs. Furthermore, centralized, consolidated, and consistent monitoring of CIC authorizations is not performed.
- FBCS is not fully integrated with VA’s systems for recording and tracking the department’s obligations. Notably, the estimated costs of CIC authorizations recorded in FBCS are not automatically transmitted to VA’s Integrated Funds Distribution, Control Point Activity, Accounting, and Procurement (IFCAP) system, a procurement and accounting system used to send budgetary information, such as obligations, to FMS. According to VA officials, because FBCS and IFCAP are not integrated, at the beginning of each month, VAMC staff must record in IFCAP estimated obligations for outpatient CIC services, and they use historical obligations for this

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<sup>15</sup>See VA, *2015 Agency Financial Report* (Washington, D.C.: Nov. 16, 2015).

<sup>16</sup>A recent VA Office of Inspector General report found that the methods used to calculate estimated costs included Medicare rates, historical costs, and an optional cost estimation tool provided by the Chief Business Office within the Veterans Health Administration. This office is responsible for developing administrative processes, policy, regulations, and directives associated with the CIC program. The accuracy of estimates varied widely among these methodologies. See VA Office of Inspector General, *Audit of the Veterans Health Administration’s Non-VA Medical Care Obligations* (Washington, D.C.: Jan. 12, 2015).

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purpose.<sup>17</sup> Depending on the VAMC, these estimated obligations may be entered as a single lump sum covering all outpatient care or as separate estimated obligations for each category of outpatient care, such as radiology. Regardless of how they are recorded, the estimated obligations recorded in IFCAP are often inconsistent with the estimated costs of CIC authorizations recorded in FBCS. In fiscal year 2015, the estimated obligations that VAMCs recorded in IFCAP were significantly lower than the estimated costs of outpatient CIC authorizations recorded in FBCS. VA officials told us that they did not determine a projected funding gap until April 2015, because they did not complete their analysis of comparing estimated obligations with estimated costs until then.

In addition, the Chief Business Office (CBO) within the Veterans Health Administration, which is responsible for developing administrative processes, policy, regulations, and directives associated with the CIC program, had not developed and implemented standardized and comprehensive policies for VAMCs, regional networks, and the office itself to follow when estimating costs for CIC authorizations and for monitoring authorizations and associated obligations.<sup>18</sup> This contributed to the material weaknesses the independent public auditor identified in the AFR. The AFR and VA officials we interviewed stated that because CIC was consolidated under CBO in fiscal year 2015 pursuant to the Choice Act, CBO did not have adequate time to implement efficient and effective procedures for monitoring CIC obligations.

To address the fiscal year 2015 projected funding gap, on July 31, 2015, VA obtained temporary authority to use up to \$3.3 billion in Veterans Choice Program funds for obligations incurred for medical services from non-VA providers, whether authorized under the Veterans Choice Program or CIC, starting May 1, 2015 and ending October 1, 2015.<sup>19</sup>

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<sup>17</sup>In contrast, obligations corresponding to inpatient CIC authorizations are automatically recorded into IFCAP when the authorization is entered into FBCS. Officials told us that the high volume of outpatient CIC authorizations compared to the relatively lower volume of inpatient CIC authorizations, among other issues, makes it impossible to automate the process for recording outpatient CIC obligations using the existing systems.

<sup>18</sup>VA's regional networks manage VAMCs within their network.

<sup>19</sup>Of this amount, not more than \$500 million could be used to pay for drug expenses relating to the treatment of hepatitis C. Pub. L. No. 114-41, § 4004, 129 Stat. 443, 463 (2015).

Based on our preliminary work, Table 1 shows the sequence of events that led to VA's request for and approval of additional budget authority for fiscal year 2015.

**Table 1: Timeline of Actions Taken to Address the Department of Veterans Affairs' (VA) Higher-than-Expected Obligations for Care in the Community (CIC) Program in Fiscal Year 2015**

Date	Action taken
January 2015	VA officials stated that they first became concerned that CIC obligations might be significantly higher than projected. Officials discovered that authorizations for CIC, which are recorded in the Fee Basis Claims System (FBCS), had increased between 30 and 40 percent compared to the same period in the prior year, while obligations recorded in the Integrated Funds Distribution, Control Point Activity, Accounting, and Procurement (IFCAP) system and transmitted to the Financial Management System (FMS) had not increased correspondingly. <sup>a</sup>
January – April 2015	VA officials told us that, upon discovering the discrepancy between authorizations and obligations, VA undertook efforts to determine the cause of the discrepancy by comparing its authorizations in FBCS with obligations in FMS. VA officials stated that this process involved analyzing millions of transactions and was complicated by the lack of interoperability between FBCS and FMS.
April 2015	VA officials determined that CIC obligations were underreported in FMS, were projected to exceed the program's budgetary resources as currently allotted, and estimated this would result in a projected funding gap. <sup>b</sup>
May 2015	VA explored whether it had other budgetary resources available to address its projected funding gap and reduced or halted funding for non-essential projects.
May – June 2015	Officials stated that VA asked the Office of Management and Budget whether unobligated balances from prior years in other appropriation accounts could be used to address the projected funding gap. VA was informed that this was not possible.
June 2015	VA notified the Senate and House Committees on Veterans Affairs of its projected funding gap of about \$3 billion—of which it attributed \$2.5 billion to its CIC program—and requested temporary authority to use Veterans Choice Program funds for other purposes, specifically to cover the projected funding gap in VA's medical services appropriation account. <sup>c</sup>
July 2015	VA obtained temporary authority to use up to \$3.3 billion in Veterans Choice Program funding to cover the projected funding gap.
September 30, 2015	At the end of the fiscal year, VA determined that its projected funding gap was \$2.75 billion—of which VA attributed \$2.34 billion to its CIC program. This amount was lower than VA had initially projected, because VA reduced or halted funding for non-essential projects.

Source: GAO analysis based on VA documentation and interviews. | GAO-16-374T.

<sup>a</sup>VA medical centers (VAMC) use FBCS to record CIC authorizations and estimate costs for this care. IFCAP is a decentralized procurement, funds control, and front-end accounting system. IFCAP transmits obligations to VA's FMS. VA uses FMS to track all of its obligations, including those for medical services.

<sup>b</sup>According to VA officials, VAMCs record obligations for outpatient CIC in IFCAP monthly, using historical obligations in each category of care, such as radiology. In contrast, obligations associated with inpatient CIC are automatically transmitted to IFCAP at the time the care is authorized in FBCS.

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<sup>9</sup>In June 2015, VA officials provided the House Committee on Veterans Affairs with a spreadsheet outlining its expected obligations for CIC through the end of fiscal year 2015 compared to the amount budgeted for CIC at the beginning of the fiscal year. The amount budgeted for CIC, as reported to the committee, did not match the amount allocated for CIC in VA's budget justification, which was presented to Congress as part of the President's budget request in February 2015. VA officials told us that the amounts did not match because VA had made changes in how it defined its CIC program between the time the budget justification was developed and the beginning of fiscal year 2015, including reorganizing certain programs as a result of the Veterans Access, Choice, and Accountability Act of 2014 under the Chief Business Office, which is responsible for developing administrative processes, policy, regulations, and directives associated with the CIC program. VA officials were unable to fully reconcile the difference between the two amounts.

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### Unanticipated Obligations for Hepatitis C Drugs Contributed to the Remaining Portion of VA's Projected Fiscal Year 2015 Funding Gap

Our preliminary work also suggests that unexpected obligations for new hepatitis C drugs accounted for \$0.41 billion of VA's projected funding gap of \$2.75 billion in fiscal year 2015.<sup>20</sup> Although VA estimated that obligations in this category would be \$0.7 billion that year, actual obligations totaled about \$1.2 billion.

VA officials told us that VA did not anticipate in its budget the obligations for new hepatitis C drugs—which help cure the disease—because the drugs were not approved by the Food and Drug Administration until fiscal year 2014, after VA had already developed its budget estimate for fiscal year 2015. The new drugs costs between \$25,000 and \$124,000 per treatment regimen, and according to VA officials demand for the treatment was high.<sup>21</sup> Officials told us that about 30,000 veterans received these drugs in fiscal year 2015.

In October 2014, VA reprogrammed \$0.7 billion within its medical services appropriation account to cover projected obligations for the new hepatitis C drugs, after VA became aware of the drugs' approval. However, in January 2015, VA officials recognized that obligations for the new hepatitis C drugs would be significantly higher by year end than they expected. VA officials told us that they assessed next steps and then limited access to the drugs to those veterans with the most severe cases of hepatitis C. In June 2015, VA requested statutory authority to transfer

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<sup>20</sup>In addition, VA faced unanticipated construction costs totaling \$875 million for the new Aurora, Colorado VAMC. VA reprogrammed funds in its medical services account, and with statutory authority, transferred funds from other VA appropriation accounts to cover these unanticipated construction costs.

<sup>21</sup>VA officials told us that they were not aware of the cost of these drugs until after their approval.

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funds dedicated to the Veterans Choice Program to VA's medical services appropriation account to cover the projected funding gap.

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## VA has Taken Steps to Better Track Obligations and Project Health Care Utilization, but Systems Deficiencies and Budgeting Uncertainties Remain

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### VA Has Taken Steps to Better Track Obligations, but Deficiencies Remain in the Systems for Tracking Obligations

Our preliminary work indicates that VA has developed new processes to prevent funding gaps for fiscal year 2016 and future years by improving its ability to track obligations for CIC services and hepatitis C drugs.

- In August 2015, VA issued a standard operating procedure to all VAMCs for recording estimated costs for inpatient and outpatient CIC in FBCS. The procedure, among other things, stipulates that VAMCs are to base estimated costs on historical cost data provided by VA. In addition, VA developed a software patch—released in December 2015 to all VAMCs—that automatically generates estimated costs for CIC authorizations, thereby eliminating the need for VAMC staff to individually estimate costs and record them in FBCS. According to VA officials, these changes should result in more accurate estimated costs for CIC authorizations. However, VA officials told us that accurately estimating the cost of CIC authorizations is challenging because of several unknown factors, such as the number of times a veteran may seek treatment for a recurring condition.<sup>22</sup>

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<sup>22</sup>A single authorization may allow for multiple episodes of care, such as up to 10 visits to a physical therapist. Alternatively, a veteran may choose not to seek the care that was authorized.

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- In November 2015, VA allocated funds for CIC and hepatitis C drugs to each VAMC.<sup>23</sup> In addition, VA officials told us that to identify VAMCs that may be at risk for exhausting their funds before the end of the fiscal year, VA began tracking VAMCs' obligations for CIC and hepatitis C drugs through monthly reports. Officials from the Office of Finance within the Veterans Health Administration told us that once a VAMC had obligated its CIC and hepatitis C drug funds, it would have to request additional funds from VA. VA would, in turn, evaluate the validity of a VAMC's request and determine whether additional funds may be made available. This practice could limit veterans' access to CIC services or hepatitis C drugs in some locations. Officials told us that these steps are intended to reduce the risk of VAMCs obligating more funds than VA's budgetary resources allow.
  - In November 2015, VA also issued a policy requiring VAMCs to identify and report on potentially inaccurate estimated costs for CIC authorizations recorded in FBCS and any discrepancies between estimated costs for CIC authorizations recorded in FBCS and the amount of estimated obligations recorded in FMS. According to VA officials, these discrepancies may signal a risk of VA under obligating funds for CIC, leaving VA potentially unable to pay for authorized care. VA's policy also requires VAMCs to address concerns identified by VAMCs in these reports—such as adjusting unreasonably low estimated costs for CIC authorizations and unreasonably low estimated obligations, to make the estimates more accurate. Under VA's new policy, network directors are required to certify monthly that the reports have been reviewed and concerns addressed.

VA officials told us that these new processes are necessary to help prevent future funding gaps because of the deficiencies in VA's systems for tracking obligations, which we have described previously.

Officials also told us that VA is exploring options for replacing IFCAP and FMS, which officials describe as antiquated systems based on outdated technology, and the department has developed a rough timeline and estimate of budgetary needs to make these changes. Officials told us that the timeline and cost estimate would be refined once concrete plans for replacing IFCAP and FMS are developed. Officials told us that replacing

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<sup>23</sup>VA officials told us that, after VA received its fiscal year 2016 appropriations in December 2015, VA increased the funds allocated to VAMCs.

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IFCAP and FMS is challenging due to the scope of the project and the requirement that the replacement system interface with various VA legacy systems, such as the Veterans Health Information Systems and Technology Architecture, VA's system containing veterans' electronic health records. However, as we have previously reported, VA has made previous attempts to update IFCAP and FMS that were unsuccessful. In October 2009, we attributed these failures to the lack of a reliable implementation schedule and cost estimates, among other factors, and made several recommendations aimed at improving program management.<sup>24</sup>

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### VA is Using More Recent Data to More Accurately Project Future Health Care Utilization, but Budgetary Uncertainties Remain

Our preliminary work indicates that VA updated its EHCPM to include data from the first 6 months of fiscal year 2015, reflecting increased health care utilization in that year, which VA officials told us will inform VA's budget estimate for fiscal year 2017 and advance appropriations request for fiscal year 2018.<sup>25</sup> Without this change, VA would have used actual data from fiscal year 2014 to make its budget estimate and inform the President's budget request for fiscal years 2017 and 2018.

However, as we have previously reported, while the EHCPM projection informs most of VA's budget estimate, the amount of the estimate is determined by several factors, including the President's priorities. Historically, the final budget estimate for VA has consistently been lower than the amount projected for modeled services. VA officials told us that they expect any difference between the fiscal year 2017 budget estimate and the amount projected by VA's model to be made up by greater utilization of the Veterans Choice Program. However, VA's authority to use Veterans Choice Program funds is only available through fiscal year 2017 or until the funds are exhausted, whichever occurs first.

VA has also taken steps to help increase utilization of the Veterans Choice Program. VA issued policy memoranda to VAMCs in May and

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<sup>24</sup>Previous unsuccessful attempts to update FMS include the Core Financial and Logistics System in 2004. See GAO, *Information Technology: Actions Needed to Fully Establish Program Management Capability for VA's Financial and Logistics Initiative*, [GAO-10-40](#) (Washington, D.C.: Oct. 26, 2009).

<sup>25</sup>The President's Budget request for fiscal year 2016 and VA's fiscal year 2016 congressional budget justification had been submitted by the time officials realized that VA faced a projected funding gap for its medical services appropriation account in fiscal year 2015.



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October 2015, requiring them to refer veterans to the program if timely care cannot be delivered by a VAMC, rather than authorizing care through the CIC program. With statutory authority, VA has also loosened restrictions on veterans' use of the Veterans Choice Program, eliminating the requirement that veterans must be enrolled in the VA health care system by August 2014 in order to receive care through the program.<sup>26</sup> While data from November 2015 indicate that utilization of care under the Veterans Choice Program has increased, VA officials expressed concerns that utilization would not reach the levels projected for fiscal year 2016 because of continuing weaknesses in implementing the program. For example, in November 2015, VA's Office of Compliance and Business Integrity identified extensive noncompliance among VAMCs with VA's policies for implementing the Veterans Choice Program and recommended training for VAMC staff responsible for implementing the program.<sup>27</sup> The office also recommended that VA establish internal controls to ensure compliance with VA's policies. As of January 2016, VA had not completed a plan for establishing these internal controls.

Like other health care payers, VA faces uncertainties estimating the cost of emerging health care treatments—such as costly drugs to treat chronic diseases affecting veterans. VA, like other federal agencies, prepares its budget estimate 18 months in advance of the start of the fiscal year for which funds are provided. At the time VA develops its budget estimate, it may not have enough information to estimate the likely costs for health care services or these treatments with reasonable accuracy. However, by establishing appropriate internal controls, VA can help reduce the risks associated with the weaknesses in its budgetary projections and monitoring.

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Chairman Miller, Ranking Member Brown, and Members of the Committee, this concludes my statement for the record.

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<sup>26</sup>Pub. L. No. 114-41, § 4005(b), 129 Stat. 443, 464 (2015).

<sup>27</sup>This office provides internal oversight of the VAMCs' revenue and CIC operations.

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## GAO Contacts & Staff Acknowledgments

If you or your staff members have any questions concerning this statement, please contact Randall B. Williamson, Director, Health Care, at 202-512-7114 or [williamsonr@gao.gov](mailto:williamsonr@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this statement include Rashmi Agarwal, Assistant Director; Luke Baron; Krister Friday; Jacquelyn Hamilton; and Michael Zose.

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