



June 2016

VA'S HEALTH CARE BUDGET

In Response to a
Projected Funding
Gap in Fiscal Year
2015, VA Has Made
Efforts to Better
Manage Future
Budgets

Accessible Version

GAO Highlights

Highlights of [GAO-16-584](#), a report to the Committee on Veterans Affairs, House of Representatives

Why GAO Did This Study

VA projected a funding gap of about \$3 billion in its fiscal year 2015 medical services appropriation account, which funds VA health care services except for those authorized under the Veterans Choice Program. To close this gap, VA obtained temporary authority to use up to \$3.3 billion from the \$10 billion appropriated to the Veterans Choice Fund in August 2014.

GAO was asked to examine VA's fiscal year 2015 projected funding gap and any changes VA has made to prevent potential funding gaps in future years. This report examines (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 VA obligations data 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 officials to identify the steps taken to address the projected funding gap. GAO also examined changes VA made to prevent future funding gaps and reviewed the implementation of these changes at the VAMCs within six VISNs, selected based on geographic diversity.

What GAO Recommends

GAO is not making any recommendations. After reviewing a draft of this report, VA agreed with what GAO found.

View [GAO-16-584](#). For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov.

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VA'S HEALTH CARE BUDGET

In Response to a Projected Funding Gap in Fiscal Year 2015, VA Has Made Efforts to Better Manage Future Budgets

What GAO Found

GAO found that two areas accounted for the Department of Veterans Affairs' (VA) fiscal year 2015 projected funding gap of \$2.75 billion.

- Higher-than-expected obligations for VA's longstanding care in the community (CIC) programs—which allow veterans to obtain care from non-VA providers—accounted for \$2.34 billion or 85 percent of VA's projected funding gap. VA officials expected that the Veterans Choice Program—which is a relatively new CIC program implemented in fiscal year 2015 that allows veterans to access care from non-VA providers under certain conditions—would absorb veterans' increased demand for more timely care after public disclosure of long wait times. However, administrative weaknesses slowed enrollment into this program, and use of the Veterans' Choice Fund was far less than expected. Moreover, as utilization of CIC programs overall increased, VA's weaknesses in estimating costs and tracking obligations for CIC services resulted in VA facing a projected funding gap.
- Unanticipated obligations for hepatitis C drugs accounted for the remaining \$408 million of VA's projected funding gap. VA did not anticipate in its budget the obligations for these costly, new drugs 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.

To help prevent future funding gaps, VA has made efforts to better estimate costs and track obligations for CIC services and better project future utilization of VA's health care services. Specifically,

- VA implemented new policies directing VA medical centers (VAMC) and Veterans Integrated Service Networks (VISN) to better estimate costs for CIC authorizations—by using historical data and correcting for obvious errors—and to better track CIC obligations by comparing estimated costs with estimated obligations, correcting discrepancies, and certifying each month that these steps were completed. These policies are necessary, in part, because deficiencies in VA's financial systems make tracking obligations challenging. The VISNs and associated VAMCs GAO reviewed have implemented these policies.
- VA also allocated funds to each VAMC for CIC and hepatitis C drugs and began comparing VAMCs' obligations in these areas to the amount of funds allocated to help ensure that obligations do not exceed budgetary resources.
- VA updated the projection it uses to inform budget estimates 3 to 4 years in the future, adding fiscal year 2015 data reflecting increased CIC utilization.

While VA has made these efforts to better manage its budget, uncertainties remain regarding utilization of VA's health care services. For example, utilization of the Veterans Choice Program in fiscal years 2016 and 2017 is uncertain because of continued enrollment delays affecting the program. Moreover, even with improvements to its projection, VA, like other federal agencies, must make tradeoffs in formulating its budget estimate that requires it to balance the expected demand for health care services against other competing priorities.

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Abbreviations

AFR	Agency Financial Report
CIC	care in the community
EHCPM	enrollee health care projection model
FBCS	Fee Basis Claims System
FMS	Financial Management System
IFCAP	Integrated Funds Distribution, Control Point Activity, Accounting, and Procurement
OMB	Office of Management and Budget
VA	Department of Veterans Affairs
VAMC	VA medical center
VISN	Veterans Integrated Service Network

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June 3, 2016

The Honorable Jeff Miller
Chairman
The Honorable Corrine Brown
Ranking Member
Committee on Veterans Affairs
House of Representatives

The Department of Veterans Affairs' (VA) Veterans Health Administration operates one of the largest health care delivery systems in the nation—serving about 6.7 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 the agency projected a funding gap in fiscal year 2015 of about \$3 billion in its medical services appropriation account.¹ To address this projected funding gap, 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 until October 1, 2015.² 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.³

¹In this report, 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 budget 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. An evaluation of whether an Antideficiency Act violation occurred in fiscal year 2015 is outside the scope of this work.

²Pub. L. No. 114-41, Tit. IV, § 4004, 129 Stat. 443, 463-464 (2015).

³To 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).

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. 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.⁴ 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.⁵

In light of these challenges, coupled with VA's fiscal year 2015 projected funding gap, you asked us to examine VA's efforts to accurately estimate its budgetary needs for future years and track its obligations for medical services.⁶

In this report, we examine

1. the activities or programs that accounted for VA's fiscal year 2015 projected funding gap in its medical services appropriation account, and

⁴See 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, along with the information the agency 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.

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

⁶In February 2016, we issued a statement based on our preliminary observations of VA's fiscal year 2015 projected funding gap. See GAO, *VA's Health Care Budget: Preliminary Observations on Efforts to Improve Tracking of Obligations and Projected Utilization*, [GAO-16-374T](#) (Washington, D.C.: Feb. 10, 2016).

2. changes VA has made to prevent potential funding gaps in future years.

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 supporting documents for the President's fiscal year 2015 and 2016 budget requests for VA; VA's requests to Congress for authority to use other appropriations to address the projected funding gap; 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 VA's 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 the reasons that each activity or program contributed to the projected funding gap. We also interviewed officials from VA and staff from the Office of Management and Budget (OMB) to identify the steps taken to address the projected funding gap. 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 we interviewed officials from the Office of Finance within the Veterans Health Administration, who are knowledgeable about the data.⁷ As a result of these steps, we determined that the data were sufficiently reliable for our objectives.

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, internal reports, and supporting documents for the President's fiscal year 2017 budget request and the fiscal year 2018 advance appropriations request for VA, and we interviewed VA officials. We analyzed this information to identify new or updated policies or processes for tracking and estimating VA's obligations and for developing VA's future budget estimates. We examined the implementation of VA's new or updated processes at six Veterans Integrated Service Networks (VISN), which we selected based on geographic diversity.⁸ The six VISNs we selected were the Sierra Pacific

⁷VA's Veterans Health Administration is responsible for managing VA's health care system.

⁸VA's VISNs oversee the day-to-day functions of VAMCs that are within their network. At the start of fiscal year 2016, there were 21 VISNs, but VA is in the process of consolidating some VISNs so that by the end of fiscal year 2018, there will be 18.

Network (VISN 21), the South Central VA Health Care Network (VISN 16), the VA Health Care Network—VISN 4, the VA Midwest Health Care Network (VISN 23), the VA Southwest Health Care Network (VISN 18), and the VA Sunshine Health Care Network (VISN 8). The findings from our analysis are not generalizable beyond the VISNs we reviewed.

We conducted this performance audit from August 2015 to June 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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 typically receive care in VAMCs and community-based outpatient clinics, but VA may also authorize care through community providers to meet the needs of the veterans it serves. For example, VA may provide care through its Care in the Community (CIC) programs, such as when a VA facility is unable to provide certain specialty care services, like cardiology or orthopedics.⁹ CIC services must generally be authorized by a VAMC provider prior to a veteran receiving care.

In addition to its longstanding CIC programs, VA may also authorize veterans to receive care from community providers through the Veterans Choice Program, a new CIC program which was established through the

⁹VA has purchased health care services from community providers since as early as 1945. Before 2015, VA referred to its CIC programs as "non-VA medical care" or "fee basis care."

Veterans Access, Choice, and Accountability Act of 2014 (Choice Act), enacted on August 7, 2014.¹⁰ 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, scheduling appointments for veterans, and paying providers for their services.

The Choice Act also created a separate account, known as the Veterans Choice Fund, which can only be used to pay for VA obligations incurred for the Veterans Choice Program.¹¹ The use of Choice funds for any other program requires legislative action. 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 August 7, 2017 or until the funds in the Veterans Choice Fund are exhausted, whichever occurs first.¹²

VA's Budget Process

As part of the President's request for funding to provide medical services to veterans, VA develops an annual estimate detailing the amount of services the agency 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 elements of the department's budget estimate to meet the expected demand for VA medical services.¹³ Like many other agencies, VA begins to develop these estimates

¹⁰Pub. L. No. 113-146, 128 Stat. 1754 (2014).

¹¹Pub. L. No. 113-146, § 802, 128 Stat. 1754, 1802-1803 (2014). It was outside the scope of our review to evaluate VA's determinations to authorize an episode of care by non-VA providers under the Veterans Choice Program as opposed to another CIC program.

¹²Pub. L. No. 113-146, §§ 101(p)(2) and 802(d), 128 Stat. 1754, 1763, 1802-1803 (2014).

¹³The 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.

approximately 18 months before the start of the fiscal year for which the funds are provided. Unlike 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 for the advance appropriations 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 appropriations 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 the 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 to respond to successively higher levels of review in VA and OMB.

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

- 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 the costs associated with nonrecurring maintenance, utilities, facility repair, laundry services, and groundskeeping.¹⁴
- 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

¹⁴Nonrecurring maintenance is designed to correct, replace, upgrade, and modernize existing infrastructure and utility systems.

homes, and CIC services.¹⁵ With the exception of the Veterans Choice Program, which is funded through the Veterans Choice Fund, medical services furnished by community providers have been, and will continue to be, funded through this appropriation account through fiscal year 2016.

- Starting in fiscal year 2017 and thereafter, with the exception of the Veterans Choice Program, it is anticipated that Congress will fund medical services that VA authorizes veterans to receive from community providers through a new appropriations account—Medical Community Care—which the VA Budget and Choice Improvement Act requires VA to include in its annual budget submission.

¹⁵In this report, 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 in relation to the nearly \$51 billion in total budgetary resources available in this account.

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

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

Higher-than-expected obligations identified by VA in April 2015 for VA's CIC programs accounted for \$2.34 billion (or 85 percent) of VA's projected funding gap of \$2.75 billion in fiscal year 2015.¹⁶ These higher-than-expected obligations for VA's CIC programs 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. 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 in the program, such as provider networks that had not been fully established and VAMC staff who lacked guidance on when to refer veterans to the program, both of which slowed enrollment in the program. Instead of relying on its Choice Program, VA provided a greater amount of services through its CIC programs, resulting in total obligations of \$10.2 billion in fiscal year 2015, which VA officials stated were much higher than expected.

¹⁶At 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.

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. VA officials 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 following issues as contributing to a material weakness in estimating costs for CIC services and tracking CIC obligations:¹⁷

- 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.¹⁸ 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 the estimated costs associated with authorizations for CIC services in FBCS 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, VA does not perform centralized, consolidated, and consistent monitoring of CIC authorizations.

¹⁷See VA, *2015 Agency Financial Report* (Washington, D.C.: Nov. 16, 2015).

¹⁸A 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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- FBCS is not fully integrated with FMS, VA's system for recording and tracking the department's obligations. As a result, the obligations for CIC services recorded in the former system may not match the obligations recorded in the latter. 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 information on obligations, to FMS. According to VA officials, because FBCS and IFCAP are not integrated, at the beginning of each month, VAMC staff typically record in IFCAP estimated obligations for outpatient CIC services, and they typically use historical obligations to make these estimates.¹⁹ 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.

A key factor contributing to the weaknesses identified in VA's AFR was the absence of standard policies across VA for estimating and monitoring the amount of obligations associated with authorized CIC services. Specifically, in fiscal year 2015, the Chief Business Office within the Veterans Health Administration had not developed and implemented standardized and comprehensive policies for VAMCs, VISNs, and the

¹⁹To ensure the integrity and reliability of agencies' obligational accounting records, the Recording Statute, 31 U.S.C. § 1501, requires agencies to record an obligation when supported by documentary evidence that a legal liability for the government has been incurred. VA officials acknowledge that VA's legal liability occurs when services are authorized, but that VA does not record an obligation at this time for outpatient CIC authorizations. 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.

office itself to follow when estimating costs for CIC authorizations and for monitoring these obligations.²⁰ The AFR and VA officials we interviewed explained that because oversight of the CIC programs was consolidated under the Chief Business Office in fiscal year 2015 pursuant to the Choice Act, this office 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 appropriations for amounts obligated for medical services from non-VA providers—regardless of whether the obligations were authorized under the Veterans Choice Program or CIC—for the period from May 1, 2015 until October 1, 2015.²¹ 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) Programs 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. ^a
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 and were projected to exceed the programs’ budgetary resources as currently allotted. VA estimated this would result in a projected funding gap. ^b
April – May 2015	VA submitted a request to the Office of Management and Budget (OMB) to reappropriation about \$831 million in the Medical Services appropriation account from the fourth quarter of fiscal year 2015 to the third quarter of fiscal year 2015 to help address the projected funding gap. OMB approved this request.

²⁰VA’s Chief Business Office is responsible for developing administrative processes, policy, regulations, and directives associated with VA’s CIC programs.

²¹Of 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, Tit. IV, § 4004(a)(2), 129 Stat. 443, 463-464 (2015).

Date	Action taken
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 OMB 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 VA attributed \$2.5 billion to its CIC programs—and requested temporary authority to use Veterans Choice Program funds for other purposes, specifically to cover the projected funding in VA's medical services appropriation account. ^c According to VA officials, VA also requested permission from the Senate and House Committees on Appropriations to transfer about \$349 million from the Medical Facilities appropriation to provide additional resources for CIC, but the committees did not act upon this request.
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 programs. 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-16-584.

^aVA 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.

^bAccording to VA officials, VAMCs typically record obligations for outpatient CIC in IFCAP monthly, and most use 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.

^cIn 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 programs 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 VA's CIC programs. VA officials were unable to fully reconcile the difference between the two amounts.

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

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 2015.²² 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. According to VA, the new drugs cost between \$25,000 and \$124,000 per treatment regimen, and demand for the treatment was high.²³ 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 than expected by year's end, due to higher-than-expected demand for the drugs. 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 use amounts from the Veterans Choice Fund to address the projected funding gap.

²²In addition, in fiscal year 2015, VA faced unanticipated construction costs totaling \$875 million for the new Aurora, Colorado VAMC. Based on a grant of statutory authority enacted on June 15, 2015, VA transferred funds from the medical services account and other VA appropriation accounts to cover these unanticipated construction costs. See Pub. L. No. 114-25, 129 Stat. 317 (2015).

²³VA officials told us that they were not aware of the cost of these drugs until after their approval by the Food and Drug Administration.

VA Has Made Efforts to Prevent Future Funding Gaps, but Uncertainties about Future Utilization of Health Care Services Remain

To help prevent future funding gaps, VA has made efforts to improve its cost estimates for CIC services and the department's tracking of associated obligations. VA has also taken steps to more accurately estimate future utilization of VA health care services, though uncertainties about utilization of VA health care services and emerging treatments remain.

VA Has Made Efforts to Improve Cost Estimates and Tracking of Obligations for CIC Services

Faced with a projected funding gap in fiscal year 2015, VA made efforts to improve its cost estimates for CIC services as well as the department's tracking of associated obligations.

First, in August 2015, VA issued a policy to VAMCs for recording estimated costs for inpatient and outpatient CIC authorizations in FBCS. This policy, among other things, stipulates that VAMCs are to base estimated costs on historical cost data provided by VA. These data, which represent average historical costs for a range of procedures, are intended to help improve the accuracy of VAMCs' cost estimates. To help implement this policy, in December 2015 VA updated its FBCS software so that the system automatically generates estimated costs for CIC authorizations based on historical CIC claims data. As a result, in many cases, VAMC staff will no longer need to individually estimate costs using various methods and manually record these estimates in FBCS.²⁴ Officials we interviewed at six selected VISNs shortly after the implementation of the software update told us that the update sometimes produces inaccurate cost estimates or no cost estimates at all. VA officials told us that the problems affecting the software update were largely due to VA's adoption of a revised medical classification system in

²⁴VA officials told us that, in some cases, such as for uncommon medical procedures, the FBCS software may be unable to automatically generate a cost estimate. In these cases, staff at some VAMCs told us they use other methods, including historical data or cost estimation tools provided previously by VA, to estimate the cost.

October 2015.²⁵ The change in the classification system meant that there were relatively few paid claims with the new codes to inform FBCS's automated cost estimates for CIC services. VA officials told us they anticipate this problem diminishing throughout fiscal year 2016 as more CIC claims using the new codes are paid and as the amount of data used to inform the cost estimates increase.

Second, in November 2015, VA issued a policy requiring VAMCs to systematically review and correct potentially inaccurate estimated costs for CIC authorizations recorded in FBCS, a step which was previously not required. VA officials told us this policy was created to detect and correct obvious errors in the cost estimates, such as data entry errors that fall outside of the range of reasonable cost estimates. Additionally, this policy requires VISNs to certify monthly to VA's Chief Business Office that the appropriate review and corrective actions have been completed. We found that all six VISNs certified that they had implemented this policy.²⁶

Third, in November 2015, VA issued a policy requiring VAMCs to identify any discrepancies between the estimated costs for CIC authorizations recorded in FBCS and the amount of estimated obligations recorded in FMS. VA's policy also requires VAMCs to correct discrepancies they identify—such as increasing unreasonably low estimated obligations to make the estimates more accurate—and document the corrections they make. This policy also requires VISNs to certify monthly to VA's Chief Business Office that the appropriate review and corrective actions have been taken and appropriately documented. As we previously stated, in part because FBCS is not fully integrated with FMS, VA officials concluded this policy was necessary to detect and address discrepancies between the two systems. According to VA officials, if estimated costs for CIC authorizations recorded in FBCS are higher than estimated obligations recorded in FMS, it may leave VA at risk of potentially being unable to pay for authorized care. Alternatively, if estimated costs for CIC authorizations recorded in FBCS are lower than estimated obligations

²⁵In October 2015, VA adopted the tenth revision of the International Statistical Classification of Diseases and Related Health Problems, a medical classification system developed by the World Health Organization. This is the standard code set used in the United States for documenting patient medical diagnoses and inpatient medical procedures.

²⁶One of the VAMCs we reviewed reported that it was not in full compliance with this policy but has implemented corrective actions to address existing deficiencies.

recorded in FMS, VA may be dedicating more resources than needed for this care.

While we found that all six selected VISNs and the VAMCs they manage certified that they had implemented this new policy, the methods used to identify and correct discrepancies between estimated costs for CIC authorizations in FBCS and the amount of estimated obligations in FMS varied. Moreover, in some cases, we found that discrepancies VAMCs identified and associated corrections were not documented or that documentation lacked specificity, making it difficult to determine whether appropriate corrections were made. To achieve greater consistency in how VAMCs implement this new policy, VA officials reviewed VAMCs' reports and in February 2016, provided VISNs and VAMCs with additional guidance and best practices for identifying discrepancies and documenting corrections. For example, VA instructed VAMCs to be as specific as possible in documenting corrections they make to the estimated obligations. VA officials also told us that they are developing additional guidance that would define an acceptable level of variation between estimated costs for CIC authorizations and the amount of estimated obligations in FMS. This guidance, once implemented, would require that VAMCs ensure that estimated costs and estimated obligations were no more than \$50,000 or 10 percent apart, whichever is less.

Finally, to better track that VAMCs' obligations for CIC do not exceed available budgetary resources for fiscal year 2016, VA allocated funds specifically for CIC to each VAMC.²⁷ VA officials, including some VISN officials we interviewed, told us that they identify VAMCs that may be at risk for exhausting their funds before the end of the fiscal year by reviewing monthly reports comparing each VAMC's obligations for CIC to the amount of funds allocated for that purpose to the VAMC. Officials from the Office of Finance within the Veterans Health Administration told us that once a VAMC had obligated all of its CIC funds, it would have to request realignment of funds from other VA programs, assuming additional funds could be made available. VA would, in turn, evaluate the validity of a VAMC's request. VA is employing a similar process to track VAMCs' use of funds for hepatitis C drugs. Officials told us that these

²⁷VA officials told us that they initially allocated funds to VAMCs in November 2015 and, after VA received its fiscal year 2016 appropriations in December 2015, VA increased the funds allocated to VAMCs.

steps are intended to reduce the risk of VAMCs obligating more funds than VA's budgetary resources allow.

Despite these efforts, VA still faces challenges accurately estimating CIC costs and tracking associated obligations, in large part because of the uncertainty inherent in predicting the CIC services veterans will actually receive. According to VA Chief Business Office and VISN officials, 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. Furthermore, system deficiencies also complicate both the development of accurate CIC cost estimates and the tracking of related obligations. Chief Business Office and VISN officials told us that due to systems limitations, cost estimates for inpatient CIC authorizations are estimated in FBCS based on a veteran's diagnosis at the time the care is authorized and cannot be adjusted if a veteran's diagnosis—and associated treatment plan—changes.²⁸ For example, a veteran may be authorized to obtain inpatient care to treat fatigue and nausea, but may be subsequently diagnosed as having a heart attack and receive costly surgery that was not included in the cost estimate. Chief Business Office officials told us that while the cost estimate cannot be adjusted in FBCS, VAMC officials should adjust the estimated obligation that corresponds to the authorization in IFCAP to reflect the cost difference; they should also document why they made the adjustment.

To better align cost estimates for CIC authorizations with associated obligations, in the long term, VA officials told us that VA is exploring options for replacing IFCAP and FMS, which officials describe as antiquated systems based on outdated technology. 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 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. Moreover, as we have previously reported, VA has made previous attempts to update IFCAP and FMS that were unsuccessful. In October 2009, we reported that

²⁸Unlike cost estimates for inpatient CIC authorizations, cost estimates for outpatient CIC authorizations can be adjusted as needed.

these failures could be attributed to the lack of a reliable implementation schedule and cost estimates, among other factors.²⁹

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

To more accurately project future health care utilization of VA services given the implementation of the Veterans Choice Program, in November 2015 VA took steps to update its EHCPM projection to better inform future budget estimates.³⁰ Officials told us that the updated EHCPM projection in November 2015 included available data from fiscal year 2015 to inform the department's budget estimate for fiscal years 2017 and 2018. Without the updated projection, VA would have relied on the EHCPM projection from April 2015 using actual data from fiscal year 2014. The updated EHCPM projection using fiscal year 2015 data showed increased utilization of CIC services in that year. According to VA officials, this increase was an unexpected result of implementing the Veterans Choice Program. Specifically, because of administrative weaknesses affecting the Veterans Choice Program, veterans seeking services through this program were generally provided care through other VA CIC programs instead.³¹ Additionally, according to VA, analysis of fiscal year 2015 data showed that the implementation of the Veterans Choice Program resulted in veterans relying on VA services rather than on services provided by other health care benefit programs for a greater share of their health care needs.³² VA officials told us that they plan to continue relying on the EHCPM projection from April of each year using data from the most recently completed fiscal year and updating the EHCPM later in the year using more current data.

²⁹Previous 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).

³⁰The 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 had a projected funding gap for its medical services appropriation account in fiscal year 2015.

³¹According to the updated EHCPM projection, the implementation of the Veterans Choice Program increased the overall utilization of CIC services by 17 percent in fiscal year 2015.

³²In addition to VA health care, veterans may have access to other health care benefit programs, such as Medicare or private health insurance. In many cases, cost sharing under these programs is higher than cost sharing under VA's health care program.

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 VA policy decisions and the President's priorities, and will not necessarily match the EHCPM projection in any given year.³³ Historically, the final budget estimate for VA has consistently been lower than the amount projected by the EHCPM. For example, in December 2015, to develop the budget estimates for fiscal year 2017 and advance appropriations for fiscal year 2018, VA officials made a policy decision to use a previous EHCPM projection that does not take into account the increased utilization of CIC services by veterans in fiscal year 2015. VA officials told us that if demand for VA services exceeds the amount requested for VA's Medical Services Account in the President's budget request for fiscal year 2017, the difference can be made up by greater utilization of the Veterans Choice Program. VA officials also told us that VA will likely request an increase in funding for health care services in the President's budget request for fiscal year 2018, which is expected to be submitted to Congress in February 2017.³⁴

To help increase utilization of the Veterans Choice Program, VA issued policy memoranda to VAMCs in May and October 2015, requiring them to refer veterans to the Veterans Choice Program if timely care cannot be delivered by a VAMC, rather than authorizing care through VA's other CIC programs. In addition, on July 31, 2015, the VA Budget and Choice Improvement Act eliminated the requirement that veterans must be enrolled in the VA health care system by August 2014 in order to receive care through the program.³⁵ While data from January 2016 indicate that utilization of care under the Veterans Choice Program has begun to increase, VA officials, including at the VISNs we interviewed, expressed concerns whether existing contracts were sufficient to address veterans' needs in a timely manner.³⁶ For example, officials we interviewed from

³³See GAO, *Veterans Health Care Budget: Improvements Made, But Additional Actions Needed to Address Problems Related to Estimates Supporting Requests*, [GAO-13-715](#) (Washington, D.C.: Aug. 8, 2013).

³⁴VA will include an updated budget request for fiscal year 2018 in the President's budget request for fiscal year 2018 and advance appropriations request for fiscal year 2019.

³⁵Pub. L. No. 114-41, Tit. IV, § 4005(b), 129 Stat. 443, 464 (2015).

³⁶According to data provided to VA by its contractors, appointments scheduled through the Veterans Choice Program increased from about 61,000 in July 2015 to about 106,000 in January 2016.

five of the six selected VISNs cited inadequate provider networks, delays in scheduling appointments, and delays in providers receiving payment for services delivered, as factors limiting program utilization. To address these concerns, VA is granting VAMCs the authority to establish agreements directly with providers to deliver services through the Veterans Choice Program and schedule appointments for veterans if VA's contractors are unable to schedule them in a timely manner.³⁷ These efforts have the potential to increase Veterans Choice Program utilization beyond the levels VA estimated for fiscal year 2016, which, according to VA officials, may limit the funds available to the program in fiscal year 2017. Conversely, some of these officials told us that if VA does not succeed in increasing Veterans Choice Program utilization in fiscal years 2016 and 2017, veterans may have to seek care through other CIC programs, which may not have the funds available to meet the demand for services. In either case, according to VA officials, veterans may face delays in accessing VA health care services.

In addition to the challenges associated with the Veterans Choice Program, VA, like other health care payers, faces uncertainties estimating the utilization—and associated costs—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 utilization and costs for health care services or these treatments with reasonable accuracy. Moreover, even with improvements to its projection, VA, like other federal agencies, must make tradeoffs in formulating its budget estimate that requires it to balance the expected demand for health care services against other competing priorities.

Close scrutiny and careful monitoring in all these areas should assist VA in managing its available resources and better protect against a reoccurrence of budgetary circumstances similar to those that existed in fiscal year 2015.

³⁷ According to VA officials, under the new authority, VA's contractors will be given 3 days to schedule appointments for emergent care and five days for non-emergent care, before VAMCs are allowed to schedule the appointments.

Agency Comments and Our Evaluation

VA provided written comments on a draft of this report, which we have reprinted in appendix I. While we are not making any recommendations in this report, in its comments, VA agreed with our findings and reiterated the uncertainty the department faces in estimating the cost of emerging health care treatments. VA also provided technical comments on the draft report, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees and the Secretary of Veterans Affairs. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>. If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs are on the last page of this report. GAO staff who made major contributions to this report are listed in appendix II.



Randall B. Williamson
Director, Health Care

Appendix I: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

May 17, 2016

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

Dear Mr. Williamson:

The Department of Veterans Affairs (VA) has reviewed the U.S. Government Accountability Office's (GAO) draft report, ***"VA'S HEALTH CARE BUDGET: In Response to a Projected Funding Gap in Fiscal Year 2015, VA Has Made Efforts to Better Manage Future Budgets"*** (GAO-16-584).

In the enclosure, VA provides a general comment and technical comments to the draft report.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

A handwritten signature in black ink, appearing to read "Gina S. Farrisee".

Gina S. Farrisee
Deputy Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***“VA’S HEALTH CARE BUDGET: In Response to a Projected Funding Gap in
Fiscal Year 2015, VA Has Made Efforts to Better Manage Future Budgets”***
(GAO-16-584)

General Comment:

The Veterans Health Administration (VHA) is committed to improving financial stewardship by developing and maintaining consistently applied policies and procedures to account for and project future spending. This report identifies many of the challenges and uncertainties that VHA faces to provide world-class health care for our Veterans. We will continue to review processes to compensate for automated system deficiencies as we work to select a modern replacement system for accounting and financial management.

VHA appreciates the thoroughness of GAO’s review and the integration of the significant improvements VHA has made in a relatively short period of time, especially the inclusion of:

- a. Changes to policy to improve Care in the Community (CIC) cost estimating and certification of monthly system reconciliations to ensure that funding is available to support the CIC health care demand;
- b. Allocation of funds to each VA Medical Center for CIC and Hepatitis C drugs, with updated policies and daily/weekly tracking of demand and spending, to improve accountability and projection of budget needs; and
- c. Updating the methodology used in the Enrollee Health Care Projection Model to include prior year data in order to more quickly recognize and react to shifts in demand for health care.

It is extremely difficult for VHA to predict the potential impact of blockbuster drugs. Should a new blockbuster drug be introduced, VHA plans to implement the same procedures that we are currently using for Hepatitis C to ensure budget solvency. We believe that the situation encountered with new treatments for Hepatitis C, (i.e., new treatments that are both dramatically more expensive and effective than existing treatments), is likely to become more common in all health care systems. We look forward to working with GAO and Congress to develop more timely approaches to ensure that Veterans receive world-class treatment when such a circumstance recurs.

VHA is strongly committed to developing long-term solutions that mitigate risks to the timeliness, cost-effectiveness, quality, and safety of the VHA health care system. VHA is using the input from GAO, Inspectors General, audits, and other advisory groups to identify root causes and to develop critical actions. VHA is dedicated to sustained improvement.

Enclosure

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Government Accountability Office (GAO) Draft Report
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The topics reviewed in this report apply to the following high-risk areas: 1 (ambiguous policies and inconsistent processes), 2 (inadequate oversight and accountability), and 5 (unclear resource needs and allocation priorities). The changes we have made to policies and procedures, including leadership certifications of accomplishments at every level have already begun to ensure consistency, oversight, and accountability.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

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

Staff Acknowledgments

In addition to the contact named above, Rashmi Agarwal, Assistant Director; Luke Baron; Krister Friday; Jacquelyn Hamilton; and Michael Zose made key contributions to this report.

Appendix III: Accessible Data

Agency Comment Letter

Text of Appendix I:
Comments from the
Department of Veterans
Affairs

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Health Care

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Gina S. Farrisee

Deputy Chief of Staff

Enclosure

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Enclosure

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Enclosure

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Related GAO Products

VA's Health Care Budget: Preliminary Observations on Efforts to Improve Tracking of Obligations and Projected Utilization. [GAO-16-374T](#). Washington, D.C.: February 10, 2016.

Veterans' Health Care Budget: Improvements Made, but Additional Actions Needed to Address Problems Related to Estimates Supporting President's Request. [GAO-13-715](#). Washington, D.C.: August 8, 2013.

Veterans' Health Care: Improvements Needed to Ensure That Budget Estimates Are Reliable and That Spending for Facility Maintenance Is Consistent with Priorities. [GAO-13-220](#). Washington, D.C.: February 22, 2013.

Veterans' Health Care Budget: Better Labeling of Services and More Detailed Information Could Improve the Congressional Budget Justification. [GAO-12-908](#). Washington, D.C.: September 18, 2012.

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VA Health Care: Estimates of Available Budget Resources Compared with Actual Amounts. [GAO-12-383R](#). Washington, D.C.: March 30, 2012.

VA Health Care: Methodology for Estimating and Process for Tracking Savings Need Improvement. [GAO-12-305](#). Washington, D.C.: February 27, 2012.

Veterans Affairs: Issues Related to Real Property Realignment and Future Health Care Costs. [GAO-11-877T](#). Washington, D.C.: July 27, 2011.

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Veterans' Health Care: VA Uses a Projection Model to Develop Most of Its Health Care Budget Estimate to Inform the President's Budget Request. [GAO-11-205](#). Washington, D.C.: January 31, 2011.

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