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Report to Congressional Requesters

February 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

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GAO Highlights

Accountability * Integrity * Reliability

Highlights of GAO-13-220, a report to congressional requesters

Why GAO Did This Study

VA operates about 1,000 medical facilities—such as hospitals and outpatient clinics—that provide services to more than 6 million patients annually. The operation and maintenance of its facilities, including NRM, is funded from VA's Medical Facilities appropriations account, one of three accounts through which Congress provides resources for VA health care services.

In prior work, GAO found that VA's spending on NRM has consistently exceeded its estimates. GAO recommended that VA ensure that its NRM estimates fully account for this long-standing pattern, and VA agreed to implement this recommendation. GAO was asked to conduct additional work on NRM spending. In this report, GAO examines, for fiscal years 2006 through 2012, (1) what accounted for the pattern of NRM spending exceeding VA's budget estimates; (2) VA's allocation of resources for NRM to its health care networks; and (3) VA's process for prioritizing NRM spending and the extent to which NRM spending was consistent with these priorities. GAO reviewed VA's budget justifications and VA data and interviewed officials from headquarters and selected networks.

What GAO Recommends

GAO recommends that VA determine why it has overestimated spending for non-NRM and use the results to improve future, non-NRM budget estimates. GAO also recommends that VA provide networks with written guidance for prioritizing below-threshold NRM projects. VA concurred with GAO's recommendations.

View GAO-13-220. For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov.

What GAO Found

During fiscal years 2006 through 2012, the Department of Veterans Affairs (VA) had higher than estimated resources available for facility maintenance and improvement—referred to as non-recurring maintenance (NRM); these resources accounted for the $4.9 billion in VA's NRM spending that exceeded budget estimates. The additional resources came from two sources. First, VA spent less than it estimated on non-NRM, facility-related activities such as administrative functions, utilities, and rent, which allowed VA to spend over $2.5 billion more than originally estimated. Lower spending for administrative functions, utilities, and rent accounted for most of the resources estimated but not spent on non-NRM activities. Given that VA has consistently overestimated the costs of such activities in recent years, VA's budget estimates for its non-NRM activities may not be reliable. Second, more than $2.3 billion of the higher than estimated spending on NRM can be attributed to VA having higher than estimated budget resources available. In some years VA received higher appropriations from Congress than requested and supplemental appropriations for NRM—such as those included in the American Recovery and Reinvestment Act of 2009. The additional budget resources VA used for NRM also included transfers of funds from the agency's appropriations account that funds health care services.

VA allocated about $7.5 billion in resources for NRM to its 21 health care networks from fiscal year 2006 through fiscal year 2012. VA allocated about $4.6 billion of these resources at the beginning of each fiscal year through the Veterans Equitable Resource Allocation—its national, formula-driven system. In addition, VA allocated $2.9 billion during this period from higher than requested annual appropriations and its national reserve account, which is maintained to address contingencies that may develop each fiscal year. In anticipation of such resources, networks typically identify projects that can be implemented if additional funds become available. VA officials told us that they do this to better address the backlog of identified building deficiencies most recently estimated to cost over $9 billion.

To prioritize NRM spending more centrally, VA established a new process for projects above a minimum threshold, and from fiscal years 2006 through 2012 spending on NRM was generally consistent with VA priorities. Prior to fiscal year 2012, VA provided oral guidance to networks for prioritizing NRM spending and relied on its 21 health care networks to prioritize NRM projects to maintain medical facilities in good working condition and address deficiencies. Beginning in fiscal year 2012, as part of VA's Strategic Capital Investment Planning (SCIP) process, VA headquarters assumed responsibility for prioritizing more costly NRM projects using a set of weighted criteria. For fiscal year 2012, the threshold for NRM projects to be included in this centralized process was $1 million, while networks remain responsible for prioritizing "below-threshold" NRM projects. NRM spending during fiscal years 2006 through 2012 was generally consistent with VA priorities: at least 85 percent of the projects funded in each year were identified by networks as priorities. However, VA has not provided written policies for networks on how to apply SCIP criteria to below-threshold projects, which represented over 40 percent of VA's fiscal year 2012 NRM spending. Without such written policies, VA does not have reasonable assurance that network spending for below-threshold NRM projects will be consistent with SCIP criteria.

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Abbreviations

FCA	Facility Condition Assessment
NRM	non-recurring maintenance
Recovery Act	American Recovery and Reinvestment Act of 2009
SCIP	Strategic Capital Investment Planning
VA	Department of Veterans Affairs
VERA	Veterans Equitable Resource Allocation
VHA	Veterans Health Administration

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
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Congressional Requesters

The Department of Veterans Affairs (VA) is one of the nation's largest health care systems. VA operates more than 150 hospitals, 130 nursing homes, and 800 outpatient clinics providing health care services to more than 6 million patients in fiscal year 2012. Many of the buildings in which VA's medical facilities are housed, however, were built more than 50 years ago and may not be suitable for providing accessible, high-quality, and cost-effective health care in the 21st century. One way in which VA addresses these building deficiencies and modernizes its medical facilities is by performing various maintenance and improvement projects—referred to as non-recurring maintenance (NRM).[1] NRM projects include remodeling space used to deliver mental health or other clinical services; replacing roofing, windows, and doors; upgrading heating, ventilation, and air conditioning systems; and repaving roads and parking lots. VA spent about $1.5 billion on NRM in fiscal year 2012 and estimates the cost of addressing all existing building deficiencies—known as the NRM backlog—to be over $9 billion.[2]

While the amount of funding VA receives for its health care services—which includes resources for NRM—is determined by Congress in the annual appropriations process, VA has flexibility as to how the agency allocates its resources. In preparation for the appropriations process, VA develops estimates of the resources needed to provide health care services to veterans. These estimates are subsequently used to help inform the President's budget request to Congress for VA health care appropriations.[3] In particular, VA's estimates for NRM help inform the

[1]In general, NRM projects are repairs and renovations within the existing square footage of a facility that total more than $25,000. NRM projects that are strictly meant to ensure facilities are in good working condition are limited to $10 million. NRM projects may include expansion of new space, but associated costs may not exceed $500,000.

[2]Specifically, the NRM backlog represents a cumulative total of the estimated costs to address all deficiencies identified during facility condition assessments conducted at VA medical facilities.

[3]VA prepares an annual budget justification for congressional deliberation during the appropriations process. The budget justification provides Congress and stakeholders with estimates and other information that support the policies and spending decisions represented in the President's budget request.

President's request for VA's Medical Facilities appropriations account—one of three appropriations accounts used for VA health care services. At the beginning of each fiscal year, VA performs an initial allocation of most of its health care appropriations to its 21 health care networks. During the course of a fiscal year, however, VA and its networks have the flexibility to increase or decrease the amounts available for a specific program or activity, such as NRM, within applicable authority.

In recent years, we have highlighted VA's higher than estimated spending on NRM, and the agency's budget estimates. In June 2011 we reported that VA's spending for NRM exceeded its budget estimates for fiscal years 2006 through 2010.[4] Similarly, in June 2012, we reported that this pattern for NRM spending continued in fiscal year 2011 and, according to VA officials, was the result of VA medical facilities spending more on NRM using resources that were originally intended for other, non-NRM activities funded from the Medical Facilities account, such as utilities and janitorial services.[5] Furthermore, in fiscal year 2012, VA's spending on NRM again exceeded its estimates. In our June 2012 report, we recommended that VA ensure that its NRM estimates fully account for the long-standing pattern of medical facilities spending more on NRM than VA estimated. VA agreed with our recommendation, noting that future annual estimates of resources needed for NRM will be consistent with policy decisions and will account for past spending levels on NRM.

In light of our previous findings, you asked us to further review VA's spending for NRM. In this report we examine, for fiscal years 2006 through 2012, (1) what accounted for the pattern of NRM spending exceeding VA's budget estimates; (2) VA's allocation of resources for NRM to its health care networks; and (3) VA's process for prioritizing NRM spending and the extent to which NRM spending was consistent with these priorities.

[4]See GAO, *Veterans' Health Care Budget: Changes Were Made in Developing the President's Budget Request for Fiscal Years 2012 and 2013*, GAO-11-622 (Washington, D.C.: June 14, 2011). We have also issued other reports on VA's budget process. See the Related GAO Products page at the end of this report.

[5]See GAO, *Veterans' Health Care Budget: Transparency and Reliability of Some Estimates Supporting President's Request Could Be Improved*, GAO-12-689 (Washington, D.C.: June 11, 2012). This spending is consistent with VA's authority to increase or decrease the amounts VA allocates from the Medical Facilities account for NRM and with congressional committee report language. See, for example, S. Rep. No. 111-40 (2009), at 57; H.R. Rep. No. 111-188 (2009), at 43-44.

To examine the factors that accounted for the pattern of NRM spending exceeding VA's budget estimates in fiscal years 2006 through 2012, we reviewed and analyzed data related to VA's Medical Facilities appropriations account.[6] In particular, we compared estimated and actual amounts for VA's spending for NRM and non-NRM activities, and estimated and actual amounts for annual appropriations and other budget resources. We also reviewed VA's congressional budget justifications for fiscal years 2006 through 2012. We interviewed knowledgeable officials from VA's Veterans Health Administration's (VHA) Office of Finance and Office of Capital Asset Management Engineering and Support. We also interviewed officials from 2 of VA's 21 health care networks—Network 4 (Pittsburgh, Pennsylvania) and Network 16 (Jackson, Mississippi) to inquire about networks' effect on VA's NRM spending. We selected these networks because they were among the networks whose spending on NRM exceeded their initial allocation the most in fiscal years 2006 through 2012. While our selection allowed us to obtain additional insight into how networks manage spending related to estimates, the information is not representative of VA's 21 networks. As part of these interviews, we explored with VA officials why VA's NRM spending exceeded the agency's estimates based on experience in their networks regarding initial allocations for NRM and the amounts spent for NRM during the fiscal year.

To determine how, for fiscal years 2006 through 2012, VA allocated NRM resources to its 21 networks, we analyzed detailed NRM allocation data. We also reviewed relevant documentation, including manuals for VA's Veterans Equitable Resource Allocation (VERA), congressional budget justifications, and applicable laws and regulations.[7] We interviewed knowledgeable officials from VHA's Office of Finance and Office of Capital Asset Management Service to inquire about VA's allocation of resources to networks for NRM.

[6]For purposes of our work, we used data on VA's obligations to report the agency's annual spending for NRM and other activities. Obligations refer to a definite commitment creating a legal liability to make payments immediately or in the future. An obligation is incurred, for example, when an agency awards a contract to a private entity.

[7]VERA is a national, formula-driven system used by VA to allocate most of its health care appropriations to its 21 health care networks.

To examine VA's process for prioritizing NRM spending for fiscal years 2006 through 2012, we reviewed VA's policies for its NRM program, including VHA *Directive 1002.1, Non-Recurring Maintenance Program and VA Handbook 0011, Strategic Capital Investment Planning Process*, and other related documentation.[8] We also interviewed knowledgeable officials from VHA's Office of Finance and Office of Capital Asset Management Engineering and Support and from our two selected health care networks to inquire about VA's process for prioritizing NRM projects and request relevant documentation. We assessed to what extent VA established formal written policies documenting its guidance for prioritizing NRM spending.[9] To determine the extent to which funded NRM projects were consistent with VA's NRM priorities, we analyzed data on planned and funded NRM projects for fiscal years 2006 through 2012. We interviewed officials from our two selected networks to corroborate information we received from VA headquarters officials and to inquire about VA's NRM priorities and spending at the network level. We also reviewed documentation related to VA's current process for monitoring NRM spending and interviewed knowledgeable officials from VHA's Office of Capital Asset Management Engineering and Support.

To assess the reliability of VA's estimated and actual spending for its Medical Facilities appropriations account, we verified the consistency of the data we received from VA with amounts contained in VA's congressional budget justifications for fiscal years 2006 through 2012. To assess the reliability of VA's allocation of NRM resources, we verified the consistency of the data with information and amounts reported in the VERA manuals for fiscal years 2006 through 2012 and applicable laws. We discussed these data as well as the data on planned and funded NRM projects with VA officials. We also relied on our prior work to compare data and check for internal consistency. We found the data reliable for the purposes of this report.

[8]VA implemented its Strategic Capital Investment planning (SCIP) process in fiscal year 2012 to prioritize more costly NRM projects and other capital investment projects.

[9]The federal standards of internal control specify that agency policies should be documented and that all documentation should be properly managed and maintained. See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

We conducted this performance audit from July 2012 through February 2013 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

In support of the President's annual budget request for VA health care services, which includes a request for advance appropriations,[10] VA develops a budget estimate of the resources needed to provide such services for 2 fiscal years.[11] Typically, VHA starts to develop a health care budget estimate approximately 10 months before the President submits the budget request to Congress in February. This is approximately 18 months before the start of the fiscal year to which the request relates and about 30 months prior to the start of the fiscal year to which the advance appropriations request relates. VA's health care budget estimate includes estimates of the total cost of providing health care services as well as costs associated with management, administration, and maintenance of facilities. VA develops most of its budget estimate for

[10]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. For example, Congress provided annual appropriations for VA health care of about $51.2 billion for fiscal year 2012 and advance appropriations of $52.6 billion for fiscal year 2013. Pub. L. No. 112-10, div. B, title X, § 2015, 125 Stat. 38, 175 (2011); Pub. L. No. 112-74, div. H, title II, 125 Stat. 786, 1149-50 (2011).

[11]VA provides health care 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. 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.

health care services using the Enrollee Health Care Projection Model.[12] VA uses other methods to estimate needed resources for long-term care, other services, and health-care-related initiatives proposed by the Secretary of Veterans Affairs or the President.[13]

After determining the amount of VA's appropriations, Congress provides VA resources for health care through three accounts:

- **Medical Services**, which funds 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;
- **Medical Facilities**, which funds the operation and maintenance of the VA health care system's capital infrastructure, including costs associated with NRM[14] and non-NRM activities, such as utilities, facility repair, laundry services, and grounds keeping; and
- **Medical Support and Compliance**, which funds the management and administration of the VA health care system, including financial management, human resources, and logistics.

VA allocates most of its health care resources for these three accounts through VERA—a national, formula-driven system—at the beginning of each fiscal year and allocates additional resources throughout the year. VA allocates about 80 percent of the health care appropriations to its 21 health care networks through VERA. VA uses methods other than VERA to allocate the remaining resources to networks and medical centers for such programs as prosthetics, homeless grants, and state nursing homes. VA may also use methods other than VERA to allocate

[12]See GAO, *VA 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.: Jan. 31, 2011).

[13]The estimates for long-term care and other services are based on factors such as recent data on the costs and the amount of care VA provided to veterans, VA's policy goals for providing such services, and projections of the number of users.

[14]NRM is one of four types of capital investment programs used by VA. The remaining three types of capital investment programs are major construction, minor construction, and leasing. The major construction program funds construction projects estimated to cost more than $10 million, and the minor construction program funds construction projects estimated to cost $10 million or less. See 38 U.S.C. § 8104(a)(3)(A).

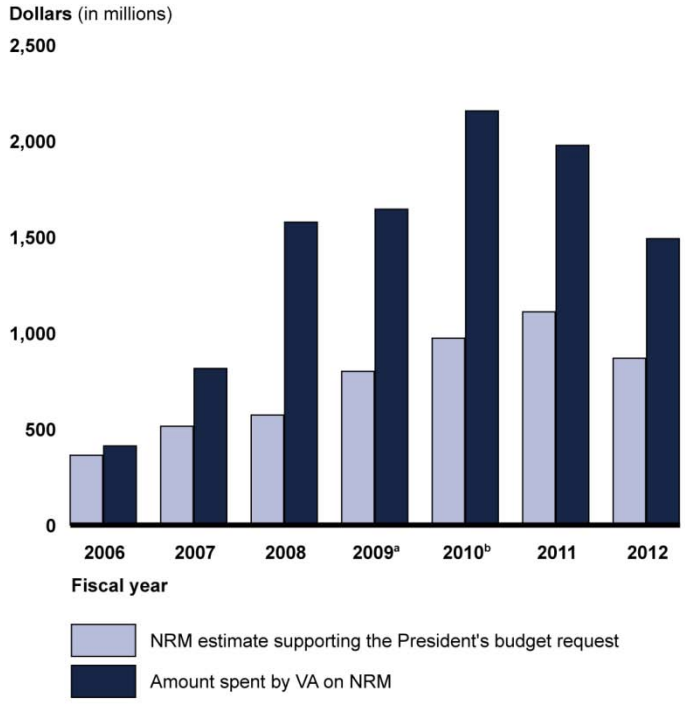
any additional resources it may receive from Congress during the year. The networks in turn allocate resources received through VERA and other methods to their respective medical facilities, as part of their role in overseeing all medical facilities within their networks. In addition to amounts allocated to networks and medical facilities at the beginning of the fiscal year, VA also sets aside resources from each of VA's three health care appropriations accounts—in what is known as a national reserve—so that resources are available for contingencies that may arise during the year. In general, VA allocates resources from the national reserve to match network spending needs for each appropriations account.

Within each appropriations account, VA also has flexibility as to how the resources are used. For example, within the Medical Services account, VA has the authority to use resources for outpatient services instead of hospital services, should the demand for hospital services be lower than expected and demand for outpatient services be higher. In a similar manner, VA has the authority to use resources in the Medical Facilities account for NRM instead of non-NRM activities—such as utilities—should spending for those activities be less than estimated.

In June 2012, we reported that VA's NRM spending has consistently exceeded the estimates reported in VA's budget justifications from fiscal years 2006 to 2011.[15] This pattern continued in fiscal year 2012 when VA spent about $1.5 billion for NRM, which was $622 million more than estimated. (See fig. 1.)

[15]GAO-12-689.

Figure 1: Non-Recurring Maintenance (NRM) Budget Estimates and Actual Spending, Fiscal Years 2006 through 2012



Source: GAO analysis of VA data.

Notes: NRM spending reflects obligated amounts.

[a]VA was provided $1 billion for NRM—in addition to the fiscal year 2009 appropriations for the Medical Facilities account—as part of the American Recovery and Reinvestment Act of 2009 (Recovery Act). The Recovery Act funding was outside the scope of the President's fiscal year 2009 budget request. VA spent about $260 million of this Recovery Act funding in fiscal year 2009.

[b]The NRM amount reflected in the President's fiscal year 2010 budget request included $510 million from the Recovery Act. However, VA had about $740 million in Recovery Act funding available for fiscal year 2010, and VA spent all of the remaining Recovery Act funding in fiscal year 2010.

To help inform its budget estimates for NRM, VA collects information on facility repair and maintenance needs as part of an ongoing process to evaluate the condition of its medical facilities. VA conducts facility condition assessments (FCA) at each of its medical facilities at least once every 3 years. VA uses contractors to conduct FCAs, and these contractors are responsible for inspecting all major systems (e.g., structural, mechanical, plumbing, and others) and assigning each a grade of A (for a system in like-new condition) through F (for a system in critical condition that requires immediate attention). As part of this assessment, the contractors use an industry cost database to estimate

the correction costs for each system graded D or F. According to VA officials, the agency's reported NRM backlog represents the total cost of correcting these FCA-identified deficiencies.

Availability of Higher Than Estimated Resources Accounted for NRM Spending That Exceeded Budget Estimates

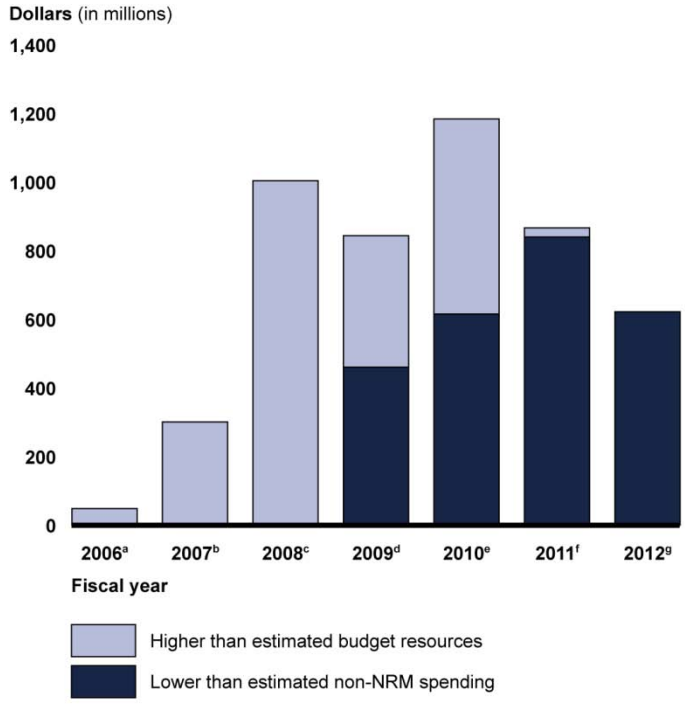
Our analysis of data for fiscal years 2006 through 2012 found that in each of these years VA had higher than estimated resources available in its Medical Facilities account, which VA used to increase NRM spending by about $4.9 billion. These resources derived from two sources: (1) lower than estimated non-NRM spending, which made more resources available for NRM, and (2) higher than estimated budget resources, which included annual appropriations, supplemental appropriations, reimbursements,[16] transfers,[17] and unobligated balances.[18] As figure 2 shows, after fiscal year 2008, lower than estimated spending on non-NRM activities accounted for most of VA's spending on NRM that exceeded VA's budget estimates.

[16]VA's reimbursements include amounts VA receives for services provided under service agreements with the Department of Defense.

[17]In each of the fiscal years we reviewed, Congress provided VA authority to move funds among its three health care appropriations accounts subject to congressional notification or approval. Any transfers to or from the Medical Facilities account require approval from the House and Senate Committees on Appropriations. See, for example, Pub. L. No. 112-74, div. H, tit. II, § 202, 125 Stat. 786, 1154 (2011). This transfer authority provides flexibility to respond to changing circumstances.

[18]VA's unobligated balances include resources VA has not spent that it is authorized to carry over into the following fiscal year from the previous one.

Figure 2: Non-Recurring Maintenance (NRM) Spending That Exceeded Budget Estimates, by Funding Source, Fiscal Years 2006 through 2012



Source: GAO analysis of VA data.

Notes: NRM spending reflects obligated amounts. Lower than estimated non-NRM spending refers to the difference between estimated and actual obligations for other, non-NRM activities funded through VA's Medical Facilities account. Higher than estimated budget resources included annual appropriations and supplemental appropriations as well as transfers, reimbursements, and unobligated balances.

[a]For fiscal year 2006, VA had $89 million in higher than estimated budget resources available, which it used to increase spending for both NRM and non-NRM activities beyond the amounts estimated.

[b]For fiscal year 2007, VA had $549 million in higher than estimated budget resources available, which it used to increase spending for both NRM and non-NRM activities beyond the amounts estimated.

[c]For fiscal year 2008, VA had $1.1 billion in higher than estimated resources available, which it used to increase spending for both NRM and non-NRM activities beyond the amounts estimated.

[d]For fiscal year 2009, VA had $461 million in resources from lower than estimated non-NRM spending available, which it used to increase spending for NRM beyond the amounts estimated. VA also used $383 million of higher than estimated budget resources to increase spending for NRM beyond the amounts estimated.

[e]For fiscal year 2010, VA had $616 million in resources from lower than estimated non-NRM spending available, which it used to increase spending for NRM beyond the amounts estimated. VA also used $569 million of higher than estimated budget resources to increase spending for NRM beyond the amounts estimated.

[f]For fiscal year 2011, VA had $840 million in resources from lower than estimated non-NRM spending, which it used to increase spending for NRM beyond the amounts estimated. VA also used $27 million of higher than estimated budget resources to increase spending for NRM beyond the amounts estimated.

[g]For fiscal year 2012, VA had $724 million in resources from lower than estimated non-NRM spending available. VA used $102 million to fund estimated NRM spending and $622 million to increase spending for NRM beyond the amounts estimated.

Lower than estimated non-NRM spending. VA spent fewer resources from the Medical Facilities account on non-NRM activities than it estimated, which allowed the agency to spend over $2.5 billion more on NRM than it originally estimated in fiscal years 2009 through 2012. When we asked why VA spent more on NRM projects than estimated, VA officials said one reason was that the agency spent less than it estimated on non-NRM activities and that the most practical use of these unspent resources was to increase spending on NRM because of the large backlog of FCA-identified deficiencies. VA officials further explained that VA spent less for non-NRM activities than anticipated because of a decrease in the demand for utilities and other weather-dependent non-NRM activities because of mild weather patterns during the last four winters. However, lower spending on these weather-dependent activities only accounted for $460 million—18 percent—of the resources eventually used for NRM. The remaining 82 percent eventually used for NRM came from resources originally intended to be used for various other activities, including administrative functions and rent.[19] VA has consistently overestimated spending for these non-NRM activities, and if the agency continues to determine estimates for such activities in the same way, its future budget estimates of spending for non-NRM may not be reliable.

Higher than estimated budget resources. VA had more budget resources available in its Medical Facilities account than the agency estimated it would have, and this allowed VA to spend over $2.3 billion more on NRM than it originally estimated. When we asked why VA spent more on NRM projects than estimated, VA officials said that in addition to spending less on non-NRM activities the agency also received higher annual appropriations than requested and unanticipated supplemental appropriations from Congress. For example, in fiscal year 2009 VA received $300 million more than it requested in annual appropriations as well as $1 billion in supplemental appropriations included in the American

[19]Less than estimated spending for administrative functions and rent accounted for about $1.3 billion of the total $2.5 billion in resources eventually used for NRM.

Recovery and Reinvestment Act of 2009 (Recovery Act).[20] VA also received $550 million in supplemental appropriations as part of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007.[21] All of these supplemental appropriations were specifically for NRM.

In addition to higher annual appropriations and supplemental appropriations, we also found that VA used other budget resources to increase NRM spending. The budget resources included transfers from VA's other appropriations accounts, reimbursements for services provided under service agreements with the Department of Defense, and unobligated balances carried over from prior fiscal years. While, according to VA officials, the agency did not track the use of specific resources used to increase NRM spending, data provided by VA suggests that more than $1.8 billion from higher than requested appropriations and about $762 million from other budget resources were available for this spending in fiscal years 2006 through 2012.

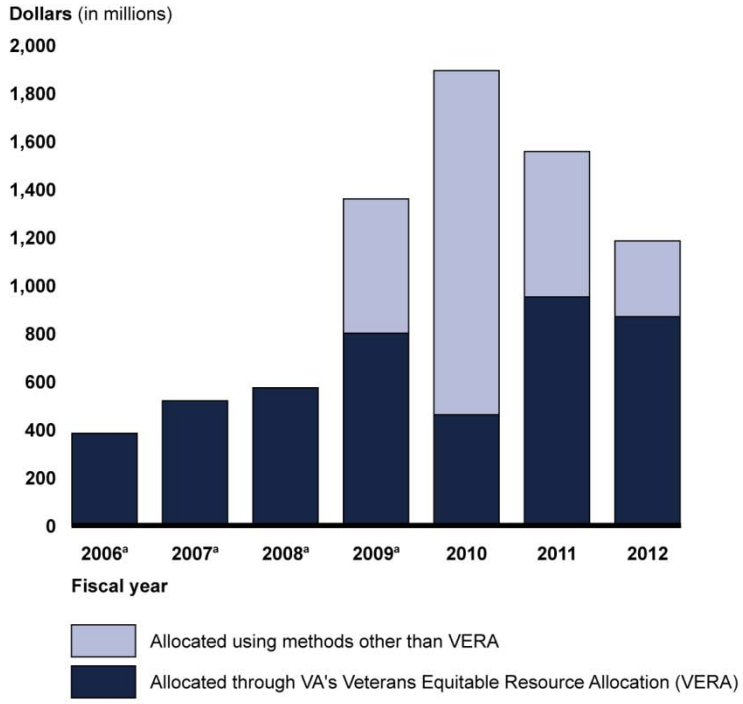
VA Used VERA to Allocate Most NRM Resources at the Start of a Fiscal Year and Network Requests to Allocate Additional NRM Resources Later

VA used VERA to perform an initial allocation of resources for NRM at the beginning of each fiscal year for fiscal years 2006 through 2012, allocating a total of about $4.6 billion over this time frame. In addition, for fiscal years 2009 through 2012, VA allocated $2.9 billion in total for NRM from higher than requested appropriations and its reserve account. Figure 3 shows the nearly $7.5 billion allocated for NRM using VERA and other methods, which included network estimated costs to maintain medical facilities in good working condition—that is for sustainment—and costs to address the NRM backlog of FCA-identified deficiencies for fiscal years 2006 through 2012.

[20]In February of 2009, Congress appropriated $1 billion for NRM as part of the Recovery Act, which remained available for obligation through fiscal year 2010. See Pub. L. No. 111-5, 123 Stat. 115, 199 (2009). VA spent $259 million in fiscal year 2009 and carried over the remaining $731 million into fiscal year 2010. Because of the timing of the act, VA was able to include an estimate of the carry over in its budget justification for fiscal year 2010 and a corresponding budget estimate for NRM. However, the $259 million VA spent in fiscal year 2009 was $231 million less than anticipated. As a result, VA carried over $231 million more than estimated. This contributed to NRM spending that exceeded budget estimates in fiscal year 2010.

[21]See Pub. L. No. 110-28, 121 Stat. 112, 168 (2007).

Figure 3: Resources Allocated for Non-Recurring Maintenance (NRM), by Allocation Method, Fiscal Years 2006 through 2012



Source: GAO analysis of VA data.

Notes: VERA is a national, formula-driven system used by VA to allocate most of the health care appropriations to its 21 health care networks. Other methods include network estimated costs to maintain medical facilities in good working condition—that is for sustainment—and costs to address the NRM backlog of identified deficiencies and requests for reserve amounts

[a]According to VA officials, prior to fiscal year 2010, VA did not track amounts allocated for NRM from its reserve amounts and therefore was unable to provide data on these allocations for fiscal years 2006 through 2009

Over the course of allocating about $4.6 billion for NRM using VERA between fiscal years 2006 and 2012, VA changed VERA's NRM allocation formula from one being based primarily on patient workload in the networks to one that primarily considers both sustainment of buildings and the NRM backlog in each network. Prior to fiscal year 2009, VA used VERA to allocate nearly $1.5 billion of NRM resources on the basis of patient workload and adjusting the cost of construction.[22] Under this

[22]VA adjusted the cost of construction by using an annually adjusted trade index of construction costs for various types of buildings, to adjust network workload.

formula, networks that treated the largest number of patients received the most resources for NRM, according to VA officials. Beginning in fiscal year 2009, VA used VERA to allocate resources for NRM primarily based on each network's estimated cost for sustainment and the cost for addressing the NRM backlog. VA used VERA to allocate about $2.6 billion from fiscal year 2009 through 2012—which according to VA officials resulted in more resources being allocated to networks with a higher proportion of more expensive building space. In addition, since fiscal year 2009, VA has also used VERA to allocate about $512 million to NRM projects that improve access or provide accommodations for specific health care services, such as research, women's health, and mental health, and certain other NRM projects.[23]

In fiscal years 2009 and 2010, VA allocated more than $1.4 billion of higher than requested Medical Facilities appropriations using methods other than VERA. Over the course of both fiscal years, VA allocated $1 billion of supplemental appropriations included in the Recovery Act mostly on the basis of each network's estimated cost of addressing FCA-identified deficiencies, according to VA officials. In both fiscal years, Congress also provided higher appropriations in the Medical Facilities account than the President requested, in part, to fund additional NRM projects. In providing these higher appropriations for NRM, Congress required VA to allocate a specific amount using methods other than VERA. In fiscal year 2009, VA allocated $300 million based on each network's estimated cost of addressing the NRM backlog of FCA-identified deficiencies.[24] In fiscal year 2010, VA allocated $130 million on the basis of networks' estimated sustainment costs and their cost to address the NRM backlog.[25]

In addition, VA allocated, in fiscal years 2010 through 2012, about $1.4 billion for NRM from VA's national reserve for the Medical Facilities account primarily based on sustainment costs and the cost of addressing

[23]For fiscal year 2012, VA used VERA to allocate a total of $68.6 million to its 21 networks for the design phase of NRM projects prioritized through its Strategic Capital Investment Planning process.

[24]See Pub. L. No. 110-329, div. E, tit. II, 122 Stat. 3574, 3705 (2008).

[25]See Pub. L. No. 111-117, div. E, tit. II, 123 Stat. 3034, 3299-300 (2009).

the backlog of FCA-identified deficiencies.[26] According to VA officials, Medical Facilities appropriations in the reserve that are not used for non-NRM purposes are available for NRM. The Under Secretary for Health determines whether funds in the reserve are available and recommends allocations of those funds to the Secretary of Veterans Affairs, who approves the allocations. VA officials explained that the allocation of funds from the reserve for NRM were typically based on sustainment costs as well as the cost of addressing FCA-identified deficiencies and other VA NRM priorities, such as VA's energy investment "Green" initiatives. These allocations are also subject to the networks' ability to award the projects and obligate the additional funds prior to their expiration. In anticipation of the availability of such resources, networks typically identify in advance projects that can be implemented if additional funds become available, according to VA officials. Officials explained further that the networks do this to better address the NRM backlog.

VA Relied on Networks to Prioritize NRM Spending before Centralizing Prioritization Recently for More Costly Projects, and Spending Was Generally Consistent with Priorities

VA relied on its networks to prioritize all NRM spending until centralizing this process for more costly projects in fiscal year 2012. NRM projects VA funded were generally consistent with VA priorities.

[26]According to VA officials, prior to fiscal year 2010, VA did not track amounts allocated for NRM from its reserve amounts and therefore was unable to provide data on these allocations for fiscal years 2006 through 2009.

VA Relied on Networks to Prioritize NRM Spending before Centralizing This Process for More Costly Projects in Fiscal Year 2012

For fiscal years 2006 through 2011, VA relied on its networks to prioritize projects for NRM spending. Each fiscal year, networks provided VA headquarters with a list of prioritized NRM projects, known as NRM operating plans.[27] According to officials from headquarters and the two selected networks, NRM operating plans represented all of the NRM projects that a network plans to fund and carry out in a given year. VA officials told us that to prioritize NRM projects during this period, the networks used oral guidance communicated to the networks during management meetings with VA headquarters that encouraged the networks to prioritize projects addressing critical FCA-identified deficiencies and sustainment.

Beginning in fiscal year 2012, VA changed its process for prioritizing more costly NRM projects. Specifically, VA headquarters assumed responsibility for prioritizing these NRM projects as part of VA's newly established Strategic Capital Investment Planning process, known as SCIP. Through SCIP, VA headquarters evaluates these more costly NRM projects and other types of capital investment projects using a set of weighted criteria in order to develop a list of prioritized projects to guide the agency's capital planning decisions.[28] For fiscal year 2012, the threshold for including NRM projects in this centralized prioritization process was $1 million. VA used this process to identify 190 projects as the agency's highest NRM priorities for fiscal year 2012. Under SCIP, VA prioritizes NRM projects based on the extent to which they meet the following six criteria:

1. improve the safety and security of VA facilities by mitigating potential damage to buildings facing the risk of damage from natural disaster,

[27]Operating plans include information about the networks' prioritized NRM projects, including whether a project addresses FCA-identified deficiencies and the total estimated cost of the project.

[28]The SCIP process begins approximately 23 months before the start of the fiscal year with VA headquarters' providing a set of SCIP guidelines to the networks and facilities for the fiscal year. As part of this SCIP process, analyses are conducted with facility-level data to determine "gaps" between current and future needs and VA's agency-wide targets. Facilities then develop a 10-year action plan, which identifies NRM and other capital improvement projects to address identified gaps within a 10-year period. A panel evaluates NRM projects with estimated costs of $1 million or more and scores them based on the extent to which they address the six SCIP criteria using the assigned weights. Ultimately, VA headquarters selects and ranks a national list of NRM projects to receive funding during the year.

improving compliance with safety and security laws and regulations, and ensuring that VA can provide service in the wake of a catastrophic event;

2. address selected key major initiatives and supporting initiatives identified in VA's strategic plan;[29]
3. address existing deficiencies in its facilities that negatively affect the delivery of services and benefits to veterans;
4. reduce the time and distance a veteran has to travel to receive services and benefits, increase the number of veterans utilizing VA's services, and improve the services provided;
5. right-size VA's inventory by building new space, converting underutilized space, or reducing excess space; and
6. ensure cost-effectiveness and the reduction of operating costs for new capital investments.

While VA uses SCIP to prioritize more costly NRM projects, the networks remain responsible for prioritizing all other or "below-threshold" NRM projects. However, VA has not provided its networks with written policies on how to prioritize these projects. According to a VA official, in fiscal year 2012, below-threshold projects accounted for over $625 million or 42 percent of VA's NRM spending. According to officials, instead of providing written guidance, VA officials have orally encouraged the networks to apply the same criteria included in SCIP when prioritizing below-threshold NRM projects.

VA's lack of written policies for prioritizing below-threshold NRM projects is inconsistent with federal internal control standards,[30] which specify that agency policies should be documented and that all documentation should be properly managed and maintained. Without written policies that clearly document VA's guidance to networks for prioritizing these less costly NRM projects, there is an increased risk that networks may not apply, or may inconsistently apply, the criteria included in SCIP.

[29]VA's major initiatives include eliminating veteran homelessness, improving veterans' mental health, enhancing veterans' access to health care, and improving VA's human-capital management, among others. The supporting initiatives provide more detailed goals, delegated to specific programs within VA, that are meant to help the agency meet its major initiatives and other strategic goals.

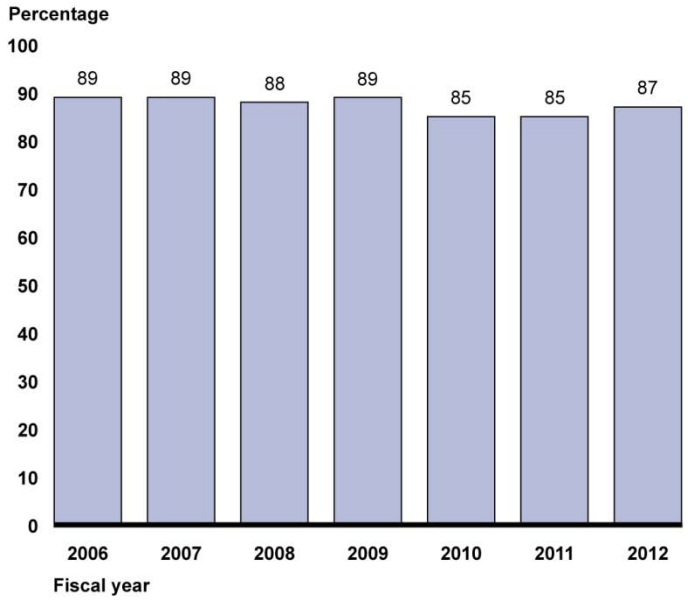
[30]GAO/AIMD-00-21.3.1.

Funded NRM Projects Were Generally Consistent with VA Priorities

Our review of VA data shows that for fiscal years 2006 through 2011 the majority of the NRM projects that were funded by the networks were projects that the networks had prioritized in their operating plans. Specifically, in each year during this period, at least 85 percent of the NRM projects the networks funded were listed in the networks' operating plans. For example, of the 2,905 NRM projects that networks funded in fiscal year 2011, over 2,400 projects (85 percent) were listed on the operating plans. When asked about funded projects that were not listed on networks' operating plans, VA officials told us that networks may fund NRM projects in response to emerging needs during the course of the year.

For fiscal year 2012, our analysis of VA data also shows that NRM projects funded that year were generally consistent with projects prioritized using SCIP and those prioritized by the networks in their operating plans. Specifically, in fiscal year 2012, 189 NRM projects that were prioritized through the SCIP process received funding. Moreover, as figure 4 shows, of the 1,909 NRM projects that were funded by the networks outside of the SCIP process in fiscal year 2012, 1,668 (87 percent) were listed on the networks' 2012 operating plans. This consistency notwithstanding, because VA has not provided its networks with written policies for prioritizing below-threshold projects, the agency faces an ongoing risk that NRM projects could be funded in a manner inconsistent with the SCIP criteria.

Figure 4: Percentage of Funded Non-Recurring Maintenance (NRM) Projects Listed in VA Health Care Networks' Operating Plans, Fiscal Years 2006 through 2012



Source: GAO analysis of VA data.

Note: According to VA officials, the network's NRM operating plans represented all of the NRM projects that a network plans to fund and carry out in a given year, and the remaining projects not listed in NRM operating plans were funded in response to emerging needs that arose during the course of each year.

Officials at VA headquarters have taken several steps in recent years to better monitor NRM spending to ensure that funded projects were consistent with the agency's priorities. In fiscal years 2009 and 2010, in compliance with congressional requirements, VA tracked and reported spending on NRM projects that used funding provided through the Recovery Act. Recognizing the value of such monitoring, VA headquarters officials decided to expand efforts tracking NRM spending by project on a monthly basis. Since fiscal year 2011, VA has used what it calls its capital assets database to manage and monitor NRM spending on a monthly basis. As part of these efforts, VA has instructed its project managers to update the information on each project on a monthly basis and review tracking reports to ensure that spending for each project is within its estimated cost. VA officials told us that there are new efforts under way to improve the data reliability of the capital assets database and to incorporate its tracking reports into the SCIP process.

Conclusions

Our work shows that VA has consistently spent more on NRM than estimated because of the availability of higher than estimated resources in its Medical Facilities account. These additional resources derived from lower than estimated spending for non-NRM activities and higher than requested appropriations. Further, our work shows that spending for administrative functions, utilities, and rent accounted for most of the lower than estimated non-NRM spending in recent years. Thus, given the underestimates for these activities, VA's future budget estimates for non-NRM activities in its budget justification may not be reliable if the agency continues to determine its estimates in the same way.

VA has taken important steps in establishing a centralized process for prioritizing more costly NRM projects through SCIP, and during the period we reviewed, VA's funded NRM projects were generally consistent with agency priorities. However, VA does not have reasonable assurance that spending on NRM will be consistent with criteria included in SCIP. Our work shows that while networks remain responsible for prioritizing below-threshold NRM projects, VA has not provided its networks with written policies for prioritizing these less costly NRM projects. Spending on these projects is not insignificant: in fiscal year 2012, spending on projects below the threshold was over $625 million or 42 percent of VA's spending on NRM. Without written policies that clearly document VA's guidance to networks for prioritizing below-threshold NRM projects, VA faces a continued risk that its networks may not apply, or may inconsistently apply, the criteria included in SCIP when funding these projects.

Recommendations for Executive Action

We recommend the Secretary of Veterans Affairs take the following actions:

- to improve the reliability of information presented in VA's congressional budget justifications that support the President's budget request for VA health care, determine why recent justifications have overestimated spending for non-NRM activities and incorporate the results to improve future budget estimates for such activities; and

- to provide reasonable assurance that VA's networks prioritize NRM spending consistent with VA's overall NRM priorities, establish written policies for its networks for applying SCIP criteria when prioritizing the funding of NRM projects that are below the threshold for inclusion in VA's centralized prioritization process.

Agency Comments

We provided a draft of this report to the Secretary of Veterans Affairs for comment. In the agency's comments—reprinted in appendix I—VA concurred with both of our recommendations. In concurring with our first recommendation regarding improvements needed in its estimates for non-NRM activities, VA noted that the budget formulation process has been modified to include a better synchronization of events that play a significant role in the overestimated spending for non-NRM activities. VA stated that this modification has been incorporated in the fiscal year 2014 President's budget. In concurring with our second recommendation regarding written guidance on the application of SCIP criteria to prioritization of below-threshold NRM projects, VA noted that the NRM handbook and related guidance will be updated to direct facilities and networks to apply SCIP criteria when prioritizing below-threshold NRM projects. In addition, networks' Capital Asset Managers, who are responsible for monitoring and evaluating each network's NRM program, will be required to review below-threshold NRM projects included in a network's operating plan. VHA's Office of Capital Asset Management Engineering and Support will also review networks' operating plans to ensure compliance.

We are sending copies of this report to the Secretary of Veterans Affairs and appropriate congressional committees. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff 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

List of Requesters

The Honorable Patty Murray
Chairman
Committee on the Budget
United States Senate

The Honorable Bernie Sanders
Chairman
The Honorable Richard Burr
Ranking Member
Committee on Veterans' Affairs
United States Senate

The Honorable Jeff Miller
Chairman
The Honorable Michael Michaud
Ranking Member
Committee on Veterans' Affairs
House of Representatives

Appendix I: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

February 4, 2013

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

Dear Mr. Williamson:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***"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), and generally agrees with GAO's conclusions and concurs with GAO's two recommendations to the Department.

The enclosure specifically addresses GAO's two recommendations and provides an action plan for each. VA appreciates the opportunity to comment on your draft report.

Sincerely,

John R. Gingrich
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
"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)

Recommendation 1: To improve the reliability of information presented in VA's congressional budget justifications that support the President's budget request for VA health care, we recommend the Secretary of VA determine why recent justifications have overestimated spending for non-NRM activities and incorporate the results to improve future budget estimates for such activities.

VA Comment: Concur. The Veterans Health Administration (VHA) CFO has modified the budget formulation process to include better synchronization of events such as activations that have been found to play a significant role in the overestimated spending for non-NRM activities. The changes are incorporated in the FY2014 President's Budget. At this time the FY 2014 budget does not have a publication date.

Recommendation 2: To provide reasonable assurance that VA's networks prioritize NRM spending consistent with VA's overall NRM priorities, we recommend the Secretary of VA establish written policies for its networks for applying SCIP criteria when prioritizing the funding of NRM projects that are below the threshold for inclusion in VA's centralized prioritization process.

VA Comment: Concur. The Deputy Under Secretary for Health for Operations and Management (DUSHOM) will update the NRM handbook and guidance and will provide directions to facilities and networks to apply Strategic Capital Investment Planning and other criteria when prioritizing the funding of NRM projects that are below the threshold for inclusion in VA's centralized prioritization process.

Anticipated completion date: February 28, 2013.

The DUSHOM will communicate the above-mentioned change to the Network Directors (ND), Deputy NDs, Medical Center Directors, and Associate Directors, via LiveMeeting during the capital training to be conducted at the end of January 2013, as well as during the ND Thursday call upon approval of this action.

Anticipated completion date: January 31, 2013.

Veterans Integrated Service Network (VISN) Capital Asset Managers will conduct VISN Prioritization reviews for under threshold NRMs prior to the NRM operating plan being finalized. VHA's Office of Capital Asset Management Engineering and Support will review the VISN Prioritization results to ensure compliance with policy.

Anticipated completion date: August 15, 2013.

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, James C. Musselwhite, Assistant Director; Krister Friday; Aaron Holling; Lisa Motley; and Said Sariolghalam made key contributions to this report.

Related GAO Products

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.

Veterans' Health Care Budget: Transparency and Reliability of Some Estimates Supporting President's Request Could Be Improved. GAO-12-689. Washington, D.C.: June 11, 2012.

VA Health Care: Estimates of Available Resources Compared with Actual Amounts. GAO-12-383R. Washington, D.C.: March 20, 2012.

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

Veterans' Health Care Budget: Changes Were Made in Developing the President's Budget Request for Fiscal Years 2012 and 2013. GAO-11-622. Washington, D.C.: June 14, 2011.

VA Health Care: Need for More Transparency in New Resource Allocation Process and for Written Policies on Monitoring Resources. GAO-11-426. Washington, D.C.: April 29, 2011.

VA Real Property: Realignment Progressing, but Greater Transparency about Future Priorities Is Needed. GAO-11-521T. Washington, D.C.: April 5, 2011.

VA Real Property: Realignment Progressing, but Greater Transparency about Future Priorities Is Needed. GAO-11-197. Washington, D.C.: January 31, 2011.

Veterans' Health Care: VA Uses a Projection Model to Develop Most of Its Budget Estimate to Inform President's Budget Request. GAO-11-205. Washington, D.C.: January 28, 2011.

VA Health Care: Overview of VA's Capital Asset Management. GAO-09-686T. Washington, D.C.: June 9, 2009.

VA Health Care: Challenges in Budget Formulation and Issues Surrounding the Proposal for Advance Appropriations. GAO-09-664T. Washington, D.C.: April 29, 2009.

VA Health Care: Challenges in Budget Formulation and Execution. GAO-09-459T. Washington, D.C.: March 12, 2009.

VA Health Care: Long-Term Care Strategic Planning and Budgeting Need Improvement. GAO-09-145. Washington, D.C.: January 23, 2009.

VA Health Care: VA Should Better Monitor Implementation and Impact of Capital Asset Alignment Decisions. GAO-07-408. Washington, D.C.: March 21, 2007.

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

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