



June 2019

VA HEALTH CARE

Estimating Resources Needed to Provide Community Care

GAO Highlights

Highlights of [GAO-19-478](#), a report to congressional requesters

Why GAO Did This Study

VA continues to focus on the use of community care to address challenges with veterans' access to health care services at VA medical facilities. In fiscal year 2019, VA plans to consolidate the Veterans Choice Program and several other community care programs under a single new Veterans Community Care Program. GAO and others have previously reported on past challenges VA has faced regarding the reliability, transparency, and consistency of its budget estimates for health care.

GAO was asked to review VA's use of community care and efforts to develop budget estimates for this care. This report describes (1) trends in obligations for and utilization of VA's community care programs since fiscal year 2014, (2) how VA develops its community care budget estimate and any subsequent changes made to this estimate, and (3) how VA's actual obligations for community care compared with estimated obligations for fiscal years 2017 and 2018.

GAO reviewed actual obligation and utilization data for fiscal years 2014 through 2018, as well as estimated obligations for fiscal years 2019 through 2021. GAO also reviewed available VA documentation on the methods and data used to develop VA's community care budget estimate that informed the President's budget request for fiscal years 2017 through 2019. GAO also interviewed VA officials and contractors responsible for developing these estimates, and OMB staff responsible for the federal budget.

VA and OMB reviewed a draft of this report. VA's technical comments were incorporated as appropriate.

View [GAO-19-478](#). For more information, contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov.

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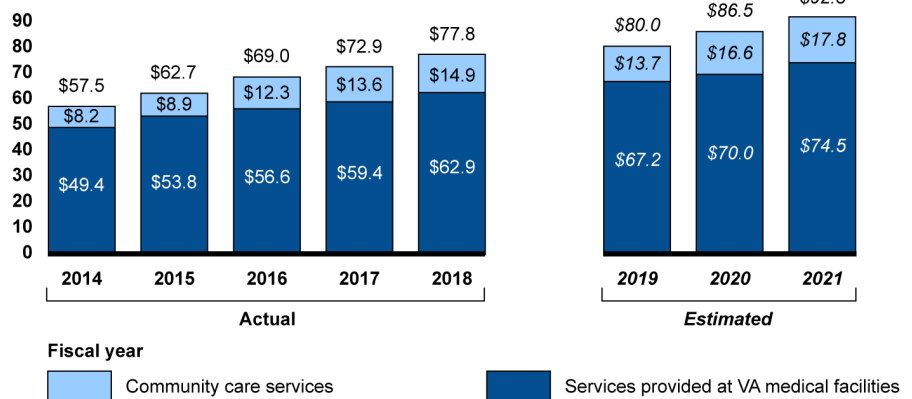
Estimating Resources Needed to Provide Community Care

What GAO Found

To help ensure that veterans are provided timely and accessible health care services, the Department of Veterans Affairs (VA) may purchase care from non-VA providers, known as community care. VA obligated \$14.9 billion for community care in fiscal year 2018, an increase of \$6.7 billion (about 82 percent) since fiscal year 2014. The number of veterans authorized to use community care increased from 1.3 million to 1.8 million during this period. By fiscal year 2021, VA estimated obligations to increase to \$17.8 billion, and officials estimate at least 1.8 million veterans will continue to use this care.

VA Health Care Obligations, Fiscal Years 2014 through 2021

Dollars in billions



Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-19-478

Note: VA estimated obligations for fiscal year 2019 to reflect \$1.8 billion in anticipated savings as a result of a VA policy change regarding the timing of certain community care obligations.

VA uses a projection model to estimate the majority of resources needed to provide health care services. Beginning with the President's fiscal year 2018 budget request, VA updated its model to estimate the resources needed to purchase over 40 community care services accounting for over 75 percent of VA's community care budget estimate. These services include outpatient and inpatient care, among others. For the remainder of its community care budget estimate, which includes nursing care in state-operated homes, VA uses other methods based on historical utilization. VA's budget estimate is successively reviewed at VA and the Office of Management and Budget (OMB) to inform the President's budget request. VA identified several changes made during the review process to its budget estimate for fiscal years 2018 and 2019 to reflect more current information related to utilization and costs, among other factors.

VA's actual obligations for community care for fiscal years 2017 and 2018 were \$1.2 billion and \$2.2 billion higher, respectively, than originally estimated. According to VA officials, this occurred for several reasons, including policy changes and increased costs for the Veterans Choice Program. To support higher obligations, VA requested and received additional funding for the Veterans Choice Program outside the annual appropriations process and used other funding sources, such as unobligated amounts from prior fiscal years.

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Abbreviations

CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
EHCPM	Enrollee Health Care Projection Model
OMB	Office of Management and Budget
VA	Department of Veterans Affairs
VHA	Veterans Health Administration

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June 12, 2019

The Honorable Jon Tester
Ranking Member
Committee on Veterans' Affairs
United States Senate

The Honorable Mark Takano
Chairman
The Honorable Phil Roe
Ranking Member
Committee on Veterans' Affairs
House of Representative

The Department of Veterans Affairs (VA) operates one of the nation's largest health care delivery systems. In fiscal year 2018, VA provided care to over 6.9 million patients—mostly, veterans—and obligated about \$78 billion for that care.¹ The majority of veterans utilizing VA health care services receive care in VA-operated medical facilities, including 170 VA medical centers and over 1,000 outpatient facilities. However, veterans may also obtain services from non-VA providers in the community—known as community care—through one of several community care programs aimed at helping ensure veterans receive timely and accessible care.²

In the last 5 years, Congress has taken steps to expand the availability of community care for veterans. The Veterans Access, Choice, and Accountability Act of 2014 created the temporary Veterans Choice Program (Choice Program) and provided \$10 billion in funding for

¹Veterans account for around 6.2 million of the 6.9 million VA patients. Patients are individuals treated at a VA medical facility or whose treatment is paid for by VA. Patients include veterans and their beneficiaries; active duty military; reserve personnel; and VA employees.

²For the purposes of this report, unless otherwise indicated, the terms “community care” and “community providers” refer, respectively, to the services the department purchases outside VA medical facilities for veterans and other eligible beneficiaries, and the non-VA providers who deliver the services. Other eligible beneficiaries include veterans' spouses and dependent children that receive care from community providers under certain VA health care programs. Additionally, for the purposes of this report, “community care programs” includes programs and activities that provide community care whether under statutory or under contractual authority.

veterans to obtain health care services from community providers when veterans faced long wait times or travel distances, or had other challenges accessing care at VA medical facilities.³ Implemented in fiscal year 2015, the temporary authority and funding of the Choice Program was separate from that of other previously existing programs through which VA has the option to purchase care from community providers.⁴ In 2018, the VA MISSION Act was enacted requiring VA to implement within one year a permanent community care program—the Veterans Community Care Program—that consolidates the Choice Program along with several other community care programs.⁵ The act, among other things, requires VA to ensure veterans can receive timely and accessible community care when certain criteria are met. The act also requires VA to issue regulations—including defining certain eligibility criteria—to carry out the Veterans Community Care Program.⁶

The amount of funding VA receives for community care and other health care services is predominately determined as part of the annual appropriations process. In preparation, VA must annually develop an estimate of the resources needed to provide community care and other health care services for two fiscal years—known as its health care budget estimate.⁷ This budget estimate is one step in a complex, multistep budget formulation process that culminates in an appropriations request for VA health care in the President’s annual budget request to Congress. Developing this estimate is inherently complex, as assumptions and imperfect information are used to project the likely quantity and cost of the health care services VA expects to provide. These projections are made 3 and 4 years into the future using data from the most recently completed fiscal year. As such, VA’s budget estimate is prepared in the context of

³Pub. L. No. 113-146, §§ 101, 802, 128 Stat. 1754, 1755-1765, 1802-1803 (2014).

⁴VA implemented the Choice Program in November 2014.

⁵John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018. Pub. L.No. 115-182, tit. I, 132 Stat. 1393 (2018) (VA MISSION Act).

⁶For example, in February 2019, VA proposed new access standards based on average drive times and wait times. For primary and mental health care services, VA is proposing a 30-minute average drive time standard and wait-time standard of 20 days. For specialty care, VA is proposing a 60-minute average drive time standard and wait-time standard of 28 days. 84 Fed. Reg. 5629 (Feb. 22, 2019).

⁷VA’s annual appropriations for health care include advance appropriations that become available one fiscal year after the fiscal year for which the appropriations act was enacted.

uncertainties about the future—not only about program and veterans’ needs, but also about future economic conditions, presidential policies, and congressional actions that may affect the funding needs in the year for which the request is made. As a result of these uncertainties, the amount of resources VA obligates during a fiscal year for health care services may be different than the amount it estimates it will obligate in its annual budget estimate.⁸

We and others have previously identified 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. 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.⁹ Due to these issues and other concerns related to veterans receiving timely care, we concluded that VA health care is a high-risk area and added it to our High Risk List in 2015.¹⁰

In light of these challenges and as VA looks to implement the VA MISSION Act to consolidate a number of its community care programs for veterans into a single program, you asked us to review VA’s use of

⁸An obligation is “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.” See GAO, *A Glossary of Terms Used in the Federal Budget Process*, [GAO-05-734SP](#) (Washington, D.C.: Sept. 1, 2005).

⁹See GAO, *VA Health Care: Challenges in Budget Formulation and Execution*, [GAO-09-459T](#) (Washington, D.C.: March 12, 2009); *VA Health Care: Methodology for Estimating and Process for Tracking Savings Need Improvement*, [GAO-12-305](#) (Washington, D.C.: Feb. 27, 2012); and *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](#) (Washington, D.C.: June 3, 2016). See also VA Office of Inspector General, *Veterans Health Administration: Audit of Non-VA Medical Care Obligations* (Washington, D.C.: Jan. 12, 2016).

¹⁰GAO maintains a high-risk program to focus attention on government operations that it identifies as high risk due to their greater vulnerabilities to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges. See GAO, *High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High Risk Areas*, [GAO-19-157SP](#) (Washington, D.C.: March 6, 2019).

community care, as well as its efforts to develop a budget estimate for this care. In this report, we describe

1. trends in obligations for and utilization of VA's community care programs since fiscal year 2014,
2. how VA develops its estimate of the resources needed for community care and any subsequent changes made to this estimate, and
3. how VA's actual obligations for community care compared to its estimated obligations for fiscal years 2017 and 2018.

To describe trends in obligations for VA's community care programs since fiscal year 2014, we reviewed data from VA's budget justifications and other data provided by VA on actual obligations for fiscal years 2014 through 2018—the most recently completed fiscal year for which these data were available.¹¹ We also reviewed the budget justification data on estimated obligations for fiscal years 2019 through 2021.¹² The community care data we reviewed reflected obligations for all VA community care programs for veterans and other eligible beneficiaries, such as spouses and dependent children. For comparison purposes, we reviewed data on VA's total obligations for health care services, including care provided in VA medical facilities and community care. We also reviewed data on actual obligations by service type—such as dental care, inpatient care, long-term care, outpatient care, and prosthetics.¹³ To describe trends in utilization of community care programs, we reviewed VA data on the number of veterans authorized to use community care services, and the types and number of community care services those

¹¹The budget justification provides Congress with estimates and other information that support the policies and spending decisions represented in the President's budget request, including information on what VA plans to achieve with the resources requested. In particular, VA's budget justification includes detailed information on estimates of funding needed for ongoing health care services and health-care-related initiatives proposed by the Secretary of Veterans Affairs and the President. As such, VA's budget justification is used to provide Congress with important information about agency priorities, as well as the implications of the requested amounts for VA's provision of health care services to veterans.

¹²Estimated obligations for fiscal year 2021 informed the advance appropriation request for that fiscal year.

¹³According to VA officials, the actual obligation amounts for certain service types for fiscal years 2016 through 2018 were understated due to the way certain adjustments were accounted for in VA's financial management system.

veterans actually used from fiscal years 2014 through 2018.¹⁴ We also reviewed data on the actual utilization of community care by other eligible beneficiaries from fiscal years 2014 through 2018.

To describe how VA develops its estimate of the resources needed for community care and any subsequent changes made to this estimate, we reviewed and analyzed the VA's budget justifications for the President's budget requests for fiscal years 2017 through 2019, which was the latest fiscal year for which complete information were available to support the President's budget request.¹⁵ VA documents we reviewed included those that describe the methods and types of data used to develop VA's community care budget estimates. VA data we reviewed included the community care budget estimates projected by those methodologies and changes made to those estimates that informed the President's budget request.

To describe how VA's actual obligations for community care compared to its estimated obligations for fiscal years 2017 and 2018, we reviewed data from VA's budget justifications and other data provided by VA on estimated and actual obligations for community care for those years. We chose this period because 2017 was the first fiscal year estimates of obligations for community care were reported separately in VA's budget justifications, and 2018 was the most recently completed fiscal year for which data were available. The community care data we reviewed reflected obligations for all VA community care programs for veterans and other eligible beneficiaries, including data by service type.

For all objectives, we spoke with officials from the Veterans Health Administration's (VHA) Office of Finance, Office of Community Care, and the Office of Enrollment and Forecasting within the Office of the Assistant Deputy Under Secretary for Health for Policy & Planning; VA's actuarial consultant for developing health care budget estimates; and the Office of Management and Budget (OMB). Additionally, we assessed the reliability

¹⁴Except for certain emergency and pharmacy care, all community care services for veterans must be authorized in advance of when veterans access the care in order for claims to be paid. Data we reviewed on veterans represents the number of individuals who had at least one authorization to receive community care during the fiscal year. Each authorization may result in multiple appointments, and a single veteran may have multiple authorizations under different community care programs.

¹⁵The President's budget request for fiscal year 2020 and advance appropriation for 2021 was released on March 11, 2019.

of the VA data, including data on obligations for and utilization of health care services, by checking for missing values and outliers, and interviewed relevant VA officials who are knowledgeable about these data. As a result of these steps, we determined that the data were sufficiently reliable for the purpose of our reporting objectives.

We conducted this performance audit from April 2018 through June 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform our work 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's Community Care Programs and Planned Consolidation

VA has purchased health care services from community providers since as early as 1945. In general, veterans may be eligible for community care when they are faced with long wait times or travel long distances for appointments at VA medical facilities, or when a VA medical facility is unable to provide certain specialty care services, such as cardiology or orthopedics. In general, community care services must be authorized in advance of when veterans access the care.¹⁶

Currently, there are several community care programs through which VA purchases hospital care and medical services for veterans, including the Choice Program. In implementing the VA MISSION Act, VA plans to consolidate four of its community care programs for veterans under the Veterans Community Care Program, which is expected to go into effect by June 2019. (See table 1.)

¹⁶Except for certain emergency and pharmacy care, all community care services for veterans must be authorized in advance of when veterans access the care in order for claims to be paid. Among other things, the authorization informs the community provider of the veteran's medical needs and the specific services that will be covered, as well as the period of validity (i.e., beginning and ending dates) for the episode of care. Each authorization may result in multiple appointments, and a single veteran may have multiple authorizations under different community care programs.

Table 1: Description of Four Department of Veterans Affairs Community Care Programs Expected to be Consolidated under the Veterans Community Care Program, beginning June 2019

VA Community Care Program	Program description
Dialysis contracts	In June 2013, VA awarded contracts to numerous community providers nationwide to deliver dialysis—a life-saving medical procedure for patients with end-stage renal disease (permanent kidney failure). When dialysis services are not feasibly available at VA medical facilities, veterans may be referred to one of VA’s contracted dialysis providers, and veterans may receive dialysis at local clinics on an outpatient basis, or at home (if the contractors offer home-based dialysis services).
Individually authorized care	Started in 1945, the program is the primary means by which VA has traditionally purchased community care. ^a Local VA medical center staff determine veteran eligibility, create authorizations, and assist veterans in arranging care with community providers that are willing to accept VA payment.
Patient-Centered Community Care	Created in 2013 under existing statutory authority and fully implemented in April 2014. VA awarded contracts to two, third-party administrators in September 2013 to develop regional networks of community providers to deliver specialty care, mental health care, limited emergency care, and maternity and limited newborn care when such care is not feasibly available from a VA medical facility.
Veterans Choice Program	Created by the Veterans Access, Choice, and Accountability Act of 2014, introduced in November 2014, and expanded in April 2015 and December 2015. ^b VA modified its contracts with the two Patient-Centered Community Care third-party administrators to establish networks of community providers, schedule appointments with community providers for veterans, and pay community providers for their services.

Source: GAO analysis of Department of Veterans Affairs (VA) information. | GAO-19-478

Note: In this table, “community care programs” includes programs and activities that provide community care whether under statutory or under contractual authority.

^a38 U.S.C. § 1703.

^bPub. L. No. 113-146, 128 Stat. 1754 (2014).

VA also provides health care services to veterans and other eligible beneficiaries through community providers under additional benefit programs. These benefit programs include the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and the Camp Lejeune Family Member Program, among others.¹⁷ After implementing the VA MISSION Act, VA will continue to operate the community care programs for other eligible beneficiaries, such as CHAMPVA and others, as it has historically done. Appendix I contains more information about VA’s community care programs.

¹⁷CHAMPVA is a comprehensive health care program that provides health care coverage for spouses and children of veterans who were permanently and totally disabled, or died, from a service-connected disability, or of those veterans who died in the line of duty. Camp Lejeune Family Member Program provides reimbursement to family members of certain veterans for health care costs associated with specific medical conditions.

Developing a Budget Estimate for VA Health Care

The amount of funding VA receives to provide its health care services is determined during the annual appropriations process. In preparation for the process, VA develops an estimate of the resources needed to provide its health care services—known as its health care budget estimate—for two fiscal years.¹⁸ This budget estimate is one step in a complex, multistep budget formulation process, which culminates in an appropriation request for VA health care that updates the earlier, advance appropriation request for the upcoming fiscal year and an advance appropriation request for the next fiscal year in the President's annual budget request to Congress.

VA's health care budget estimate includes the total cost of providing health care services, including direct patient costs, as well as costs associated with management, administration, and maintenance of facilities. VA uses its Enrollee Health Care Projection Model (EHCPM) to estimate the majority of resources needed to meet the expected demand for health care services, and uses other methods for the remaining services.¹⁹ VA uses the EHCPM to make projections 3 and 4 years into the future for budget purposes based on data from the most recent fiscal year. For example, in 2017, VA used data from fiscal year 2016 to develop its health care budget estimate for the fiscal year 2019 request and advance appropriation request for fiscal year 2020.²⁰ The EHCPM's estimates are based on three basic components: (1) the projected number of veterans who will be enrolled in VA health care, (2) the projected quantity of health care services enrollees are expected to use, and (3) the projected unit cost of providing these services.²¹ Each component is subject to a number of complex adjustments to account for the characteristics of VA health care and the veterans who access VA's health care services. (See fig. 1.)

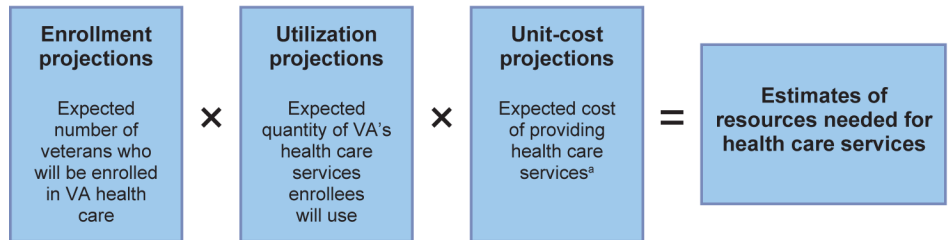
¹⁸VA's annual appropriations for health care include advance appropriations that become available one fiscal year after the fiscal year for which the appropriations act was enacted.

¹⁹The EHCPM was developed in 1998 by VA and its actuarial consultant. For the fiscal year 2019 request, the EHCPM estimated resources for 79 health care services available in VA medical facilities or through community care, which accounted for nearly 95 percent of VA's total health care budget estimate.

²⁰Similarly, VA used data from fiscal year 2015 to develop its health care budget estimate for the fiscal year 2018 request and advance appropriation request for fiscal year 2019.

²¹Unit 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.

Figure 1: Basic Components of VA's Enrollee Health Care Projection Model (EHCPM)



Source: GAO analysis of Department of Veterans Affairs (VA) information. | GAO-19-478

Notes: The EHCPM makes a number of complex adjustments to projections for VA's health care services to account for the characteristics of VA health care and enrolled veterans. For example, the EHCPM includes adjustments to account for reliance on VA health care, that is, the extent to which enrolled veterans will choose to access health care services through VA as opposed to other health care programs or insurers. Additionally, the EHCPM includes adjustments to incorporate the age, gender, priority level, and geographic location of enrolled veterans.

^aVA calculates the cost of providing a unit of service in different ways depending on the type of service provided. For example, unit costs for some pharmacy services reflect the cost of a 30-day supply of a prescription, and unit costs for inpatient services reflect the cost of a day of care at an inpatient facility.

VA uses other methods to estimate resources needed for the remaining portion of its budget estimate. This portion of the budget includes the state home per diem program, CHAMPVA, and other health care programs for veterans and other eligible beneficiaries, as well as health-care-related initiatives proposed by the Secretary of Veterans Affairs or the President.²² (See app. II for more information about the other methods VA uses in developing its health care budget estimate.)

VHA generally starts to develop a health care budget estimate approximately 10 months before the President submits the budget to Congress, which should occur no later than the first Monday in February.²³ The budget estimate changes during the 10-month budget formulation process, in part, due to successively higher levels of review in

²²Under the state home per diem program, veterans may receive nursing home, domiciliary, or adult day care in state veterans homes. These facilities are owned and operated by state governments. Each state establishes eligibility and admission criteria for its homes and VA provides payment on a per diem basis for eligible veterans.

²³31 U.S.C. § 1105(a). VHA administers VA's health care system. VHA is one of three administrations that comprise VA and are included in the President's budget request for VA: VHA, the Veterans Benefits Administration, and the National Cemetery Administration.

VA and OMB before the President’s budget request is submitted to Congress. (See table 2.) The Secretary of Veterans Affairs considers the health care budget estimate developed by VHA when assessing resource requirements among competing interests within VA, and OMB considers overall resource needs and competing priorities of other agencies when deciding the level of funding requested for VA’s health care services. OMB passes back decisions, known as a “passback,” to VA and other agencies on their budget estimate, along with funding and policy proposals to be included in the President’s budget request. VA has an opportunity to appeal the passback decisions before OMB finalizes the President’s budget request. Concurrently, VA prepares a congressional budget justification that provides details supporting the policy and funding decisions in the President’s budget request.

Table 2: Review Process Resulting in the President’s Budget Request for the Department of Veterans Affairs

Date	Budget formulation event
Year one	
April-September	<p>VA’s Office of Budget issues guidance, on behalf of the Secretary of Veterans Affairs, for preparing a budget submission.</p> <p>The Veterans Health Administration (VHA) develops most of its health care budget estimate using the Enrollee Health Care Projection Model based on data from the most recently completed fiscal year. VHA develops the remainder of its health care budget estimate using other methods.</p> <p>VHA uses the budget estimate to inform its budget submission for health care, which is subsequently reviewed by the VHA Undersecretary for Health.</p> <p>The Secretary reviews and approves the budget submission for health care along with the submissions from other components of VA.</p>
September	VA delivers the budget submission to the Office of Management and Budget (OMB).
October-December	OMB reviews VA’s budget submission and issues a decision on funding and policy priorities for VA. VA may appeal this decision.
Year two	
January	OMB prepares the President’s budget request, and VA concurrently prepares its budget justification, which supports the policies and funding decisions in the President’s budget request.
Early February	The President submits the budget request, which includes requested resources for VA health care, to Congress.
October 1	The fiscal year begins.

Source: GAO analysis and presentation of Department of Veterans Affairs (VA) and OMB information | GAO-19-478

Note: VHA administers VA’s health care system. VHA is one of three administrations that comprise VA and are included in the President’s budget request for VA: VHA, the Veterans Benefits Administration, and the National Cemetery Administration.

As of fiscal year 2017, VA primarily receives funding for all health care it provides or purchases through the following appropriation accounts:

-
- Medical Services: health care services provided to eligible veterans and other beneficiaries in VA facilities and non-VA facilities, among other things.
 - Medical Community Care: health care services that VA authorizes for veterans and other beneficiaries to receive from community providers.²⁴
 - Medical Support and Compliance: the administration of the medical, hospital, nursing home, domiciliary, supply, and research activities authorized under VA's health care system, among other things.
 - Medical Facilities: the operation and maintenance of VHA's capital infrastructure, such as the costs associated with nonrecurring maintenance, leases, utilities, facility repair, laundry services, and groundskeeping, among other things.²⁵

Separate from VA's health care appropriation accounts, the Veterans Access, Choice, and Accountability Act of 2014 provided \$10 billion in funding for the Choice Program, which was implemented in early fiscal year 2015 and authorized until funds were exhausted or through August 7, 2017, whichever occurred first.²⁶ However, VA received additional authority and funding to maintain the Choice Program through June 6, 2019, when the new Veterans Community Care Program is expected to go into effect.²⁷ VA expects that the new Veterans Community Care

²⁴The VA Budget and Choice Improvement Act required the inclusion of an appropriation account specifically for community care starting with the President's fiscal year 2017 budget request. Pub. L. No. 114-41, tit. IV, § 4003, 129 Stat. 443, 462-463 (2015).

²⁵Nonrecurring maintenance is designed to correct, replace, upgrade, and modernize existing infrastructure and utility systems.

²⁶Pub. L. No. 113-146, §§ 101(p), 802, 128 Stat. 1754, 1755-1765, 1802-1803 (2014).

²⁷Additional funding for the Choice Program was provided on three separate occasions. Legislation enacted in August and December of 2017 provided an additional \$4.2 billion for the Veterans Choice Fund. VA Choice and Quality Employment Act of 2017, Pub. L. No. 115-46, § 101, 131 Stat. 958, 959 (2017) (providing an additional \$2.1 billion for the Veterans Choice Fund); An Act to amend the Homeland Security Act of 2002 to require the Secretary of Homeland Security to issue Department of Homeland Security-wide guidance and develop training programs as part of the Department of Homeland Security Blue Campaign, and for other purposes, Pub. L. No. 115-96, Div. D, § 4001, 131 Stat. 2044, 2052-53 (2017) (providing an additional \$2.1 billion for the Veterans Choice Fund). In addition, the VA MISSION Act provided an additional \$5.2 billion for the Veterans Choice Fund and authorized VA, beginning March 1, 2019, to use remaining amounts in the Fund for the Community Care Program, along with any other available amounts in other appropriation accounts for such purposes. Pub. L. No. 115-182, §§142, 510, 132 Stat. 1393, ** (2018).

Program will be primarily funded through the Medical Community Care appropriation account.

VA Obligations for and Number of Veterans Authorized to Use Community Care Have Grown from Fiscal Year 2014 through Fiscal Year 2018

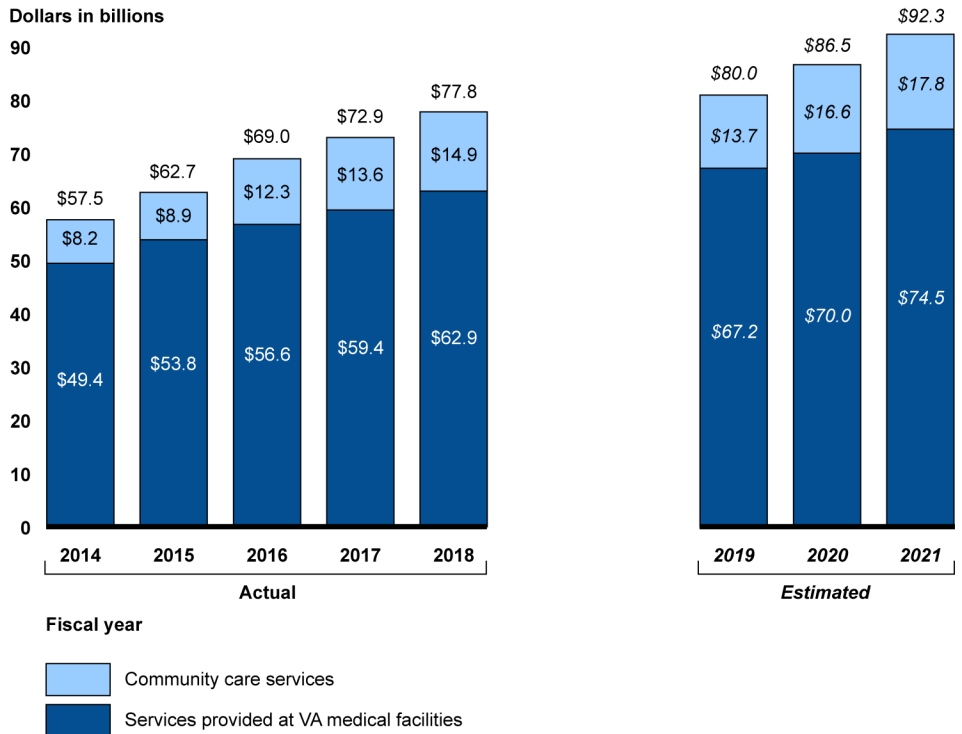
VA's Obligations for Community Care Increased by Over 80 Percent from Fiscal Years 2014 through 2018, and VA Estimates Obligations Will Grow an Additional 20 Percent through 2021

Our analysis of VA budget justification data shows that from fiscal year 2014 through fiscal year 2018, the total amount VA actually obligated for community care increased 82 percent, from \$8.2 billion to \$14.9 billion.²⁸ Since VA implemented the Choice Program in fiscal year 2015, the share of VA's obligations for community care relative to VA's total obligations for health care services increased through fiscal year 2018, from about 14 to 19 percent of VA's total obligations for health care services. By fiscal year 2021, VA estimates that the total amount obligated for community care will increase to \$17.8 billion, an increase of about 20 percent from the \$14.9 billion in actual obligations for fiscal year 2018.²⁹ (See fig. 2.)

²⁸For fiscal years 2014, 2015, and 2016, we examined data for community care obligations for the Veterans Choice Fund and the Medical Services Appropriation account. For fiscal years 2017 and 2018, we examined data for community care obligations for the Veterans Choice Fund and the Medical Community Care appropriation account.

²⁹For fiscal year 2019, we examined data for community care obligations for the Veterans Choice Fund and the Medical Community Care appropriation account. For fiscal years 2020 and 2021, we examined data for community care obligations for the Medical Community Care appropriation account.

Figure 2: Department of Veterans Affairs' Obligations for Community Care as a Share of Total Obligations for VA Health Care Services, Fiscal Years 2014 through 2021



Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-19-478

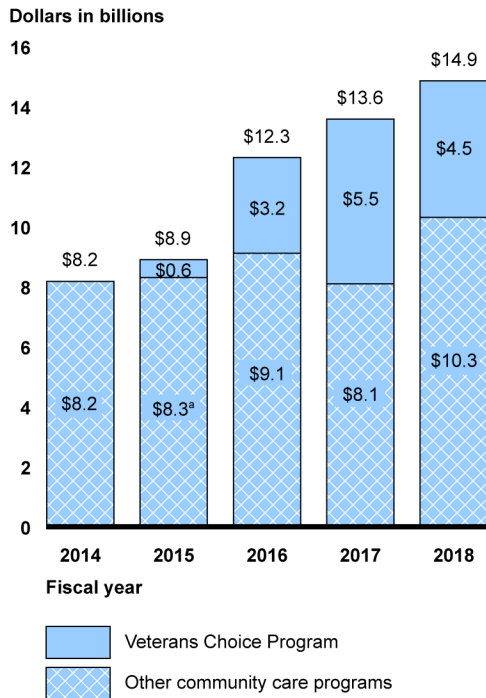
Notes: Numbers may not sum to totals due to rounding. Community care services refer to the services that VA purchases outside VA medical facilities for veterans and other eligible beneficiaries. Data reflect actual obligations from fiscal years 2014 through 2018, and estimated obligations from fiscal years 2019 through 2021. VA estimated obligations for fiscal year 2019 to reflect \$1.8 billion in anticipated savings as a result of a VA policy change regarding the timing of certain community care obligations.

As figure 2 shows, the largest increase in actual obligations for community care occurred from fiscal years 2015 through 2016, when they increased by \$3.4 billion, from \$8.9 billion to \$12.3 billion. According to VA officials, this increase in obligations during this period reflected veterans' expanded use of community care through the Choice Program, as more providers participated in the provider networks established by third-party administrators or entered into provider agreements with VA

facilities.³⁰ (Fig. 3 provides information on VA's obligations for community care by the Choice Program and by other community care programs.) The increase in actual obligations for community care from fiscal year 2016 through fiscal year 2017 was also largely due to expanded use of community care through the Choice Program. VA officials attributed this increase to efforts to obligate as much of the available Choice Program funding as possible before the anticipated end of the Choice Program in August of 2017. From fiscal years 2017 through 2018, obligations for community care continued to increase, but the increase was partially due to greater use of other community care programs, according to VA officials.

³⁰Provider agreements are agreements with community providers to provide health care services to veterans eligible under the Veterans Choice Program. VA establishes provider agreements, schedules veterans' appointments, and reimburses the providers directly (using Choice Program funds) when the third party administrators fail to schedule veterans' appointments within the time frames required by VA policy. See GAO, *Veterans' Choice Program: Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation of its Community Care Programs*, [GAO-18-281](#) (Washington, D.C.: June 4, 2018).

Figure 3: Department of Veterans Affairs' Actual Community Care Obligations for the Veterans Choice Program and Other Community Care Programs, Fiscal Years 2014 through 2018



Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-19-478

Notes: Amounts may not add up due to rounding. The Veterans Choice Program that was established to provide care in the community for veterans began in fiscal year 2015. "Other community care programs" include the Civilian Health and Medical Program of the Department of Veterans Affairs and other benefit programs under which VA provides care for veterans and other eligible beneficiaries, such as spouses and dependent children, through community providers. VA estimates that obligations for community care will total \$13.7 billion in fiscal year 2019, which reflects \$1.8 billion of anticipated savings as a result of a VA policy change regarding the timing of certain community care obligations.

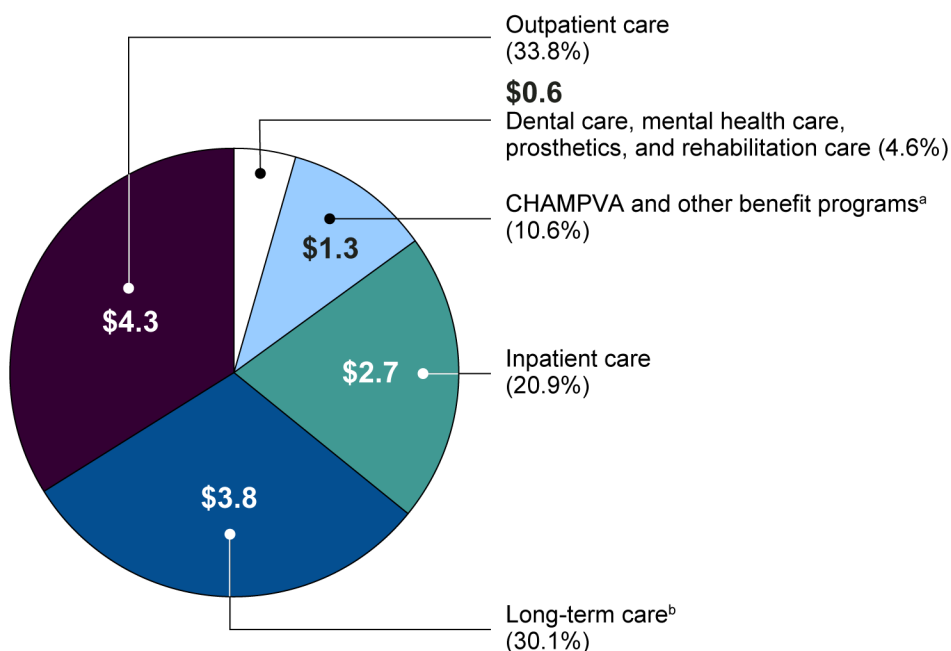
^aThis amount includes \$739 million in Veterans Choice Program funds obligated by VA between May 1, 2015, and September 30, 2015, for other VA community care programs. Congress granted VA authority to use Veteran Choice Program funds for this purpose in July 2015. See Pub. L. No. 114-41, § 4004(a), 129 Stat. 443, 463 (2015).

From fiscal years 2014 through 2018, the increases in total actual obligations for VA community care were driven largely by increases in obligations for outpatient and inpatient services.³¹ Over this time period,

³¹Outpatient services include services such as immunizations and vision exams, and inpatient services include services such as surgeries.

VA's actual obligations for outpatient services increased by \$2 billion, from \$2.3 billion to \$4.3 billion, and actual obligations for inpatient services increased by \$818 million, from \$1.8 billion to \$2.7 billion.³² Figure 4 illustrates how outpatient and inpatient services accounted for most of VA's total community care obligations for fiscal year 2018.

Figure 4: Department of Veterans Affairs' Actual Community Care Obligations by Service Type in Billions, Fiscal Year 2018



Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-19-478

Note: According to VA officials, the actual obligation amounts for certain service types were understated due to the way certain adjustments were accounted for in VA's financial management system. These adjustments were \$2.2 billion for fiscal year 2018.

^aIncludes the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and other benefit programs under which VA provides care for veterans and other eligible beneficiaries, such as spouses and dependent children, through community providers.

^bLong-term care includes community nursing home care, community non-institutional care, state adult day care, state home domiciliary care, and state home nursing care.

³²According to VA officials, the actual obligation amounts for certain service types for fiscal years 2016 through 2018 were understated due to the way certain adjustments were accounted for in VA's financial management system. These adjustments were \$1.2 billion for fiscal year 2016; \$700 million for fiscal year 2017; and \$2.2 billion for fiscal year 2018.

VA estimated that from fiscal years 2019 through 2021, obligations for community care will increase to \$17.8 billion, which VA officials said are attributable to the new eligibility criteria under the VA MISSION Act.³³ The authority for the Choice Program ends June 6, 2019, after which the new Veterans Community Care Program—which consolidates VA’s community care programs under the VA MISSION Act—will be expected to begin. For comparison purposes, the largest increase in obligations for services provided at VA medical facilities is estimated to occur between fiscal years 2020 and 2021. VA officials said this increase is attributable, in part, to efforts related to hiring and telehealth in response to the eligibility criteria under the VA MISSION Act.

The Number of Veterans Authorized to Use Community Care Increased about 40 Percent from Fiscal Years 2014 through 2018

Our analysis of VA data on authorizations for community care shows that the number of veterans authorized to use community care increased 41 percent from fiscal years 2014 through 2018.³⁴ (See fig. 5.) The approximately 1.8 million veterans authorized to use community care in 2018 represented about 30 percent of all veterans accessing VA health care services that year (approximately 6.2 million veterans).³⁵ By fiscal year 2021, VA officials told us that they estimate that at least 1.8 million veterans will still use community care.³⁶

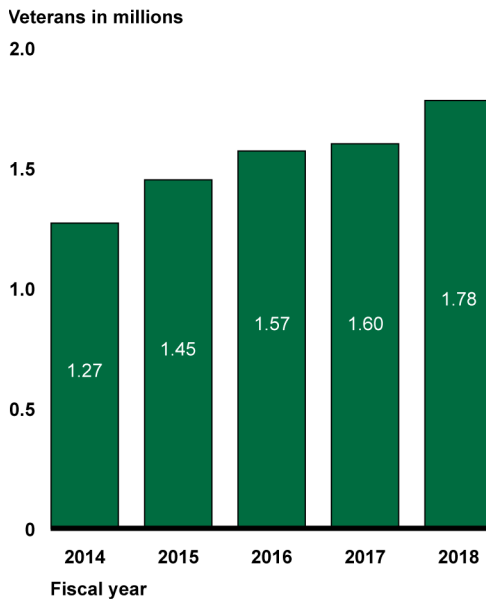
³³For example, in February 2019, VA proposed new access standards based on average drive times and wait times. For primary care, mental health, and non-institutional extended care services, VA is proposing a 30-minute average drive time standard and wait-time standard of 20 days. For specialty care, VA is proposing a 60-minute average drive time standard and wait-time standard of 28 days.

³⁴Data we reviewed on veterans represents the number of individuals who had at least one authorization to receive community care during the fiscal year. Among other things, the authorization informs the community provider of the veteran’s medical needs and the specific services that will be covered, as well as the period of validity (i.e., beginning and ending dates) for the episode of care. Each authorization may result in multiple appointments, and a single veteran may have multiple authorizations under different community care programs.

³⁵In addition to veterans, we found that the number of other eligible beneficiaries, such as spouses and dependents, that used community care increased from 342,000 to 404,000—an 18 percent increase—from fiscal years 2014 through 2018. Data we reviewed on other eligible beneficiaries represents the number of individuals who received community care through one of the benefits programs during the fiscal year.

³⁶VA officials said this estimate does not account for the new eligibility criteria under the VA MISSION Act.

Figure 5: Number of Veterans Authorized to Use Community Care, Fiscal Years 2014 through 2018



Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-19-478

Notes: Data reviewed included veterans who were authorized to use community care at least once in the fiscal year.

Our analysis of VA data also shows that after being authorized for care, veterans' utilization of certain community care services increased from fiscal years 2014 through 2018. Over this time period, a number of outpatient services experienced increases of more than 200 percent in utilization, especially chiropractic visits (418 percent, from 143,000 to 743,000 visits), physical therapy visits (252 percent, from 857,000 to 3 million visits), and non-mental health related office visits (243 percent, from 651,000 to 2.2 million visits). In comparison, our analysis found relatively smaller increases in veteran utilization for certain inpatient services. For example, the utilization for surgical inpatient stays increased about 39 percent—from 253,000 to 352,000 bed days.

VA Updated Its Projection Model to Develop Most of Its Community Care Budget Estimate; Subsequent Changes Reflect More Current Information and Other Factors

VA first developed a separate budget estimate for community care to inform the President's fiscal year 2017 budget request. Beginning with the President's fiscal year 2018 budget request, VA updated its EHCPM to develop over 75 percent of its community care budget estimate and used other methods to develop the remainder. Subsequent changes were made to the community care budget estimates developed by the EHCPM for fiscal years 2018 and 2019 through successively higher levels of review in VA and OMB.

VA First Developed a Separate Budget Estimate for Community Care as Part of the President's Fiscal Year 2017 Budget Request for VA

VA first developed a separate budget estimate of the resources it would need for community care—as distinct from the care provided in VA medical facilities—in order to inform the President's fiscal year 2017 budget request for VA. Prior to this fiscal year 2017 budget request, VA developed a single budget estimate of the resources needed to provide all VA health care services, regardless of whether these services were purchased from community providers or delivered in VA medical facilities, because all these services were to be funded through the same appropriation account.³⁷ According to VA officials, at the time a separate community care appropriation account and budget estimate were unnecessary, because community care accounted for a relatively small portion of VA's overall health care budget. However, once the medical community care appropriation account was established in fiscal year 2017, VA began developing a separate budget estimate for community care, as required by law.³⁸

To develop its first estimate of the resources needed for community care for fiscal year 2017, VA made adjustments to existing estimates for total demand for care—both in VA medical facilities and community care combined—developed by the EHCPM. At the time, VA used the EHCPM to estimate the resources needed to provide VA health care services to

³⁷Community care services were funded, in part, through the Veterans Choice Fund during fiscal years 2015 and 2016. VA's health care budget estimates for those fiscal years did not include estimates for the Choice Program due to the timing of the implementation of the Choice Program in relation timing to the budget process.

³⁸Pub. L. No. 114-41, § 4003, 129 Stat. 443, 462-463 (2015).

veterans, including inpatient, outpatient, and long-term care. However, the EHCPM did not make separate estimates for community care and care provided at VA facilities; according to VA officials, VA adjusted the EHCPM estimates by assuming that for each service, the share of total utilization and costs devoted to community care would be the same as they had been in the most recently completed fiscal year. In addition, after this adjustment, VA made additional changes to the community care budget estimate, which resulted in a net increase of \$2.5 billion. Nearly all of this increase reflected an anticipated impact of the expanded access under the Choice Program, according to VA officials. Overall, this approach accounted for about 75 percent of the \$12.3 billion community care budget estimate that informed the President's budget request for fiscal year 2017.

To develop the remaining portion of its community care budget estimate, VA used methods other than the EHCPM that, according to VA officials, were used historically to develop estimates of the resources needed for the state home per diem program and benefit programs. For example, VA develops budget estimates for certain services under the state home per diem program by creating projections of the amount of care to be provided using information about the size and demographic characteristics of the enrolled veteran population and projections of the unit cost of providing one day of care using recent cost experience. According to VA officials, VA was able to continue using these other methods, because the services under these programs have been provided through community providers and not VA medical facilities. While methods for each program vary, in general, these methods are based on each program's historical utilization and costs. (See app. II for additional information on the methods VA uses to develop the budget estimates for each of these community care programs.)

Beginning with the President's Fiscal Year 2018 Budget Request, VA Updated Its Projection Model to Develop over 75 Percent of Its Community Care Budget Estimate

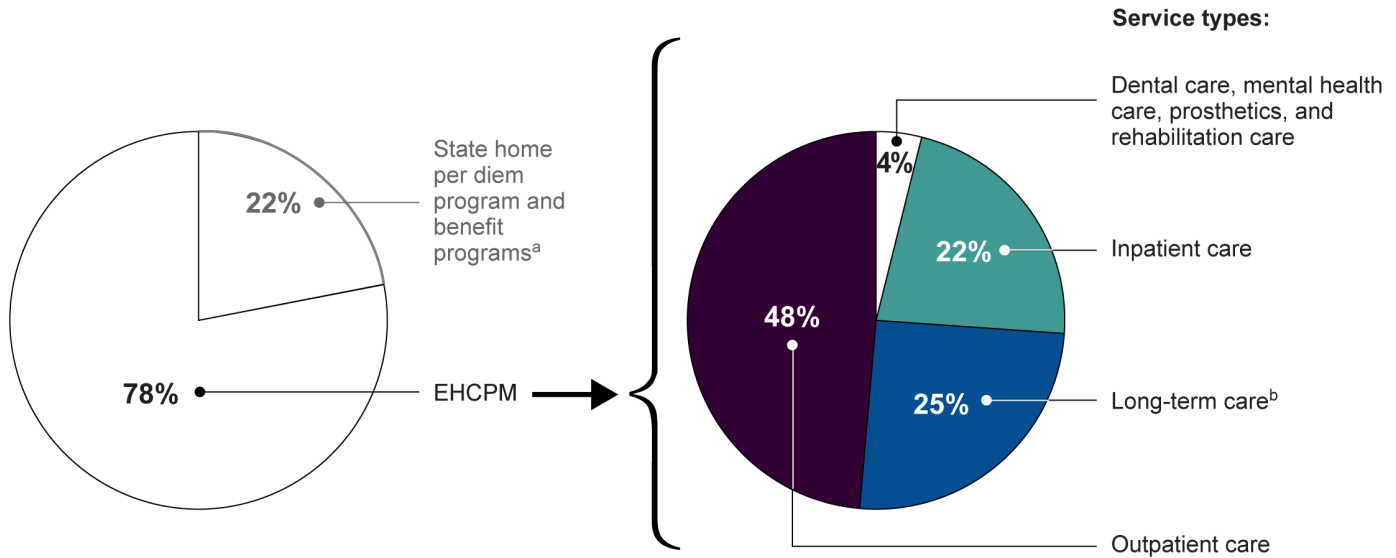
Beginning with the President's fiscal year 2018 budget request, VA updated its EHCPM directly to estimate most of the resources needed to purchase community care for veterans. Specifically, VA updated the EHCPM to estimate the amount of resources needed to purchase a set of more than 40 community care services that have accounted for over 75 percent of VA's total community care budget estimates of \$12.6 billion for fiscal year 2018 and \$12.4 billion for fiscal year 2019.³⁹ These health care services were grouped into seven service types and include outpatient care, inpatient care, and long-term care. (See app. III for a list of the health care services). Of these services, outpatient services typically accounted for the largest share of VA's community care budget estimate. For the remainder of community care services—including services provided under the state home per diem program and benefit programs—VA did not use the EHCPM and instead continued to use the other methods it has historically used to develop budget estimates for these services. (See fig. 6.)

³⁹According to VA officials, these approximately 40 services were the health care services that were available to veterans in the community.

Figure 6: Proportion of Department of Veterans Affairs (VA) Community Care Budget Estimate Developed Using VA's Enrollee Health Care Projection Model (EHCPM), by Service Type, Fiscal Year 2019

VA's community care budget estimate, fiscal year 2019
 VA used the EHCPM to estimate needed resources for 43 health care services purchased in the community

VA's EHCPM, by service type
 VA grouped the 43 health care services included in the EHCPM into seven service types



Source: GAO analysis of VA information. | GAO-19-478

Note: Percentages may not sum to 100 due to rounding.

^aState home per diem program includes adult day care, home domiciliary, and nursing care provided to veterans through state homes for eligible veterans. Benefit programs include the Civilian Health and Medical Program of the Department of Veterans Affairs, as well as other benefit programs that provide care for veterans and other eligible beneficiaries, such as spouses and dependent children, through community providers.

^bLong-term care includes nursing home care in community nursing homes and home and community-based care, such as, community adult day care, homemaker/home health aide, home hospice and palliative care; purchased skilled home care and respite care.

VA made several changes to the EHCPM to develop most of its community care budget estimate. Historically, the EHCPM estimated resources needed to meet the total expected demand for VA health care—a combination of care provided in VA medical facilities and through community care programs. VA updated the EHCPM to determine the proportion of demand met by community care by projecting enrolled veterans' expected utilization of community care and the expected costs

of purchasing these services.⁴⁰ In what follows, we describe five major changes made to the EHCPM allowing VA to estimate the budgetary resources needed for community care.

1. **Reliance on community care services.** The EHCPM has historically accounted for the extent to which enrolled veterans would be projected to obtain health care services through the VA as opposed to other health care programs or insurers—referred to as reliance on VA health care.⁴¹ VA updated the EHCPM so that it can further account for the extent to which enrolled veterans would be expected to use VA’s community care programs as opposed to using care in VA’s medical facilities. Each year, the EHCPM determines reliance on VA community care based on a combination of historical experience—or the extent to which community care was used in prior fiscal years—and on the projected impact of new VA policies and operational guidance. For example, for the fiscal year 2019 budget estimates, the EHCPM projected reliance on VA care to be about 38 percent, of which 14 percent would be met through community care. Thus, the EHCPM projected reliance on VA’s community care programs to be about 5.3 percent for all care enrolled veterans are projected to use in fiscal year 2019.⁴²
2. **Accounting for difference in community providers’ efficiency delivering inpatient services.** VA also updated the EHCPM so that community care utilization projections account for the fact that veterans receiving inpatient care through community providers generally have relatively shorter lengths of inpatient stays compared with veterans receiving care at VA medical facilities.⁴³ According to

⁴⁰To estimate likely utilization and costs of community care, the EHCPM relies on several different data sources, including claims data from the Choice Program and other community care programs. (See app. IV, which describes the various data sources used.)

⁴¹VA estimates that at least 80 percent of veterans that have enrolled in VA health care have some type of public or private health care coverage other than VA. Many enrolled veterans use VA for some of their health care needs, but choose their other health care coverage for the rest. Because VA does not provide for 100 percent of the health care needs of enrolled veterans, this reduces the number of services required from VA.

⁴²To project fiscal year 2019 budget estimates, VA used fiscal year 2016 data to determine reliance on community care. VA’s reliance on community care services may change once VA finalizes the new access standards under the VA MISSION Act, which bases eligibility on average drive times and wait times, among other factors.

⁴³Historically, EHCPM utilization projections have reflected a combination of the length of inpatient stays for community providers and VA facilities, according to VA officials.

officials from VA and its actuarial consultant, community providers on average have historically performed better than VA providers on national benchmarks measuring how well providers manage the length of inpatient stays, while not affecting quality of care. To account for this difference, VA uses an adjustment factor when projecting utilization of inpatient services based on potentially avoidable days of care for community providers.⁴⁴

3. **Comparing projected utilization with actual utilization for community care services.** VA developed an adjustment factor for the EHCPM's utilization estimates to account specifically for the differences between projected utilization and actual utilization of community care for the most recently completed fiscal year of data.⁴⁵ According to VA officials, the difference typically reflects utilization behavior among providers or patients that are difficult to estimate based solely on historical data—such as changes in local practice patterns (e.g., providers choosing to use magnetic resonance imaging versus x-rays).⁴⁶ To account for this behavior, VA compares projected and actual utilization and creates an “actual-to-expected” adjustment factor for each health care service to account for the difference.⁴⁷
4. **Projecting unit costs for community care services.** VA updated the EHCPM so that it could estimate what are known as the unit costs of purchasing community care services for veterans.⁴⁸ In general, the unit cost of a community care service comprises the payment made to the provider (known as direct patient costs), as well as the indirect costs associated with administration and overhead. Indirect costs

⁴⁴For example, if the national benchmark length of stay is 5 days of care for an inpatient surgery and 30 percent of those 5 days are avoidable, the length of a “well managed” stay is 3.5 days. The adjustment factor reflects the historical level of performance for community providers relative to a well-managed stay.

⁴⁵Historically, VA has compared the EHCPM's projected utilization of all VA health care services—both delivered in VA facilities and community care—with actual utilization in the most recently completed fiscal year.

⁴⁶This unexplained utilization is the net impact of a number of factors that often cannot be identified or quantified, including unique local practice patterns, evolving practice patterns or programs, coding issues, capacity constraints, and/or limitations in the data used to measure morbidity and reliance, or other model factors.

⁴⁷For example, if the actual utilization for a service was determined to be 5 percent lower than the projected, the factor used for the actual-to-expected adjustment would be 0.95.

⁴⁸Unit costs are costs to VA of purchasing a unit of service, such as an outpatient office visit or a day of care at an inpatient community facility.

include (1) the fees paid to the contractors for administrative responsibilities for the Choice Program, (2) VA billing and processing costs and care coordination costs associated community care programs, and (3) certain costs associated with the VA Central Office that support community care (e.g., the salaries for officials from the Office of Community Care and other VA Central Office officials).⁴⁹

5. **Accounting for community care service complexity and inflation.** VA made other changes to the EHCPM's unit cost projections for community care. For example, VA updated the EHCPM so that it accounts for costs associated with changes in the complexity—that is, the level of resources required to deliver—of health care services VA purchases from community providers. Officials from VA and its actuarial consultant noted that more complex services require relatively more resources to deliver, such as more expensive equipment (e.g., magnetic resonance imaging); more provider time; or higher-cost providers, such as surgeons. Officials anticipate that most services that VA purchases in the community will increase in complexity, leading to higher projected unit-costs for community care.⁵⁰ VA also updated the EHCPM so that its unit cost estimates for community care account for inflation in the cost of labor and equipment.

⁴⁹The Agency for Healthcare Research and Quality defines care coordination as the practice of organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer, more effective care. Participants may share clinical data using manual methods such as faxing paper records, but these methods can be time-consuming and costly. Information technology has the potential to improve the efficiency of care coordination by allowing VA, the Choice Program third-party administrators, community providers, and veterans to electronically exchange information for care coordination purposes.

⁵⁰According to officials from VA and its actuarial consultant, changes in the complexity of care can occur for a variety of reasons including the development of new drug therapies that replace less effective, less expensive therapies, such as the hepatitis C treatments that have become available in recent years; and changes in health care practices, such as greater use of magnetic resonance imaging to diagnose a condition.

VA's Community Care Budget Estimates Projected by the Model for Fiscal Years 2018 and 2019 Were Subsequently Changed to Reflect More Current Information, Among Other Factors

VA's community care budget estimates are reviewed at successively higher levels at VA and OMB to inform the President's budget request for VA. VA identified several changes made during the review process to its estimates projected by the EHCPM for fiscal years 2018 and 2019; these changes were due to the availability of more current information related to utilization and costs, among other factors.

For fiscal year 2018, changes resulted in a budget request for VA community care in the President's budget request that was approximately \$1 billion lower than VA's original EHCPM budget estimate of \$10.7 billion.⁵¹ These changes included the following:

- A \$996 million decrease reflecting the availability of more current information showing that an anticipated increase in utilization due to the Choice Program was too high.⁵²
- A \$600 million decrease reflecting the availability of more current information showing that overhead costs initially allocated to community care in the data used in the EHCPM were too high.
- A \$180 million decrease accounting for VA's implementation of a new law that reduces VHA's use of community care for examinations determining veterans' disability ratings.⁵³
- A \$500 million increase accounting for a court ruling that affected veteran eligibility for reimbursement of emergency community care, which was expected to increase utilization.⁵⁴
- A \$250 million increase reflecting the availability of more current information that indicated administrative costs for the Choice Program in the data used in the EHCPM were too low.

For fiscal year 2019, changes resulted in a budget request for VA community care in the President's budget request that was nearly \$1

⁵¹VA estimated \$12.6 billion in total community care obligations for fiscal year 2018.

⁵²According to VA officials, the anticipated increase in community care utilization was specifically related to veterans who were eligible for the Choice Program because the next available medical appointment with a VA provider was more than 30 days away.

⁵³See 38 U.S.C. § 5101 note.

⁵⁴Staab v. McDonald, 28 Vet. App. 50 (2016).

billion higher than VA's original EHCPM budget estimate of \$8.6 billion.⁵⁵ These changes included the following:

- A \$1.7 billion increase reflecting more current information indicating that community care administrative costs and the utilization levels in the data used in the EHCPM were too low.
- A \$1 billion increase accounting for a delay in the timing of the implementation of community care network contracts. According to VA officials, this resulted in the continued use of reimbursement rates in community care that were higher than Medicare reimbursement rates.⁵⁶
- A \$1.8 billion decrease that reflected VA's implementation of a new policy that changed the timing of community care obligations from when a veteran is authorized to use community care to the when a claim for actual services is paid.

VA's Actual Obligations for Community Care in Fiscal Years 2017 and 2018 Were Higher than Estimated and Included Additional Funding Received for the Choice Program

⁵⁵VA estimated \$12.4 billion in total community care obligations for fiscal year 2019.

⁵⁶According to officials, VA included in the EHCPM anticipated savings from VA transitioning to Medicare reimbursement rates.

VA's Actual Obligations for
Community Care in Fiscal
Years 2017 and 2018
Were \$1.2 Billion and \$2.2
Billion Higher than
Estimated, Respectively

Our analysis of data included in VA's budget justifications shows that in fiscal years 2017 and 2018, VA obligated \$1.2 billion and \$2.2 billion more for community care than originally estimated at the time of the President's budget requests for those years.⁵⁷ In both years, VA's actual obligations for both the Choice Program and other community care programs were higher than estimated. (See table 3.) According to VA officials, the higher-than-estimated obligations for the Choice Program for fiscal year 2017 were driven, in part, due to changes in Choice Program policies and a large increase in the cost per authorization for care.⁵⁸ In the case of other community care programs, VA officials told us that the higher-than-estimated obligations for both fiscal years 2017 and 2018 were driven, in part, by local practice patterns (e.g., providers choosing to use magnetic resonance imaging versus x-rays) and the capacity of VA medical facilities to provide services. As discussed later in this report, VA also received and reallocated additional funding to purchase community care in fiscal years 2017 and 2018, which contributed to actual obligations being higher-than-estimated obligations.⁵⁹

⁵⁷For fiscal years 2017 and 2018, we examined data for community care obligations for the Veterans Choice Fund and the Medical Community Care appropriation account. For comparison purposes, VA's budget justifications also show that in fiscal years 2017 and 2018, VA obligated \$2.5 billion and \$1.2 billion less for services provided in VA medical facilities than originally estimated at the time of the President's budget requests for those years. VA's actual obligations for these services totaled \$59.4 and \$62.9 billion for fiscal years 2017 and 2018, respectively.

⁵⁸For example, VA made a policy change in June 2017, by issuing a policy memorandum that directed VA medical facilities to refer veterans to the Choice Program only if they met wait-time, distance, and geographic eligibility criteria, and to instead use other VA medical facilities, other facilities with which VA has sharing agreements, and other community care programs to deliver care to veterans when services were not available at a VA medical facility and veterans did not qualify under the Veterans Access, Choice, and Accountability Act's eligibility criteria. In August 2017, VA changed its guidance and issued a fact sheet directing VA medical facilities to refer veterans to the Choice Program to the maximum extent possible. See Department of Veterans Affairs, *Extension of Veterans Choice Program Funding*, VA Fact Sheet (Washington, D.C.: August 2017).

⁵⁹In future work, we plan to review VA's development of its community care budget estimate, including how the department is incorporating lessons learned from its 2017 and 2018 estimates as it continues using the EHCPM for that purpose.

Table 3: Department of Veterans Affairs' Actual and Estimated Community Care Obligations, Fiscal Years 2017 and 2018

Program	Fiscal year 2017			Fiscal year 2018		
	Actual	Estimated	Difference	Actual	Estimated	Difference
Veterans Choice Program	5.5	4.8	0.7	4.5	3.5	1
Other community care programs	8.1	7.5	0.6	10.3	9.1	1.2
Total community care	13.6	12.3	1.2	14.9	12.6	2.2

Source: GAO analysis of Department of Veterans Affairs (VA) budget justification and VA data. | GAO-19-478

Notes: Numbers may not sum to totals or differences due to rounding. Estimated obligations are developed months prior to the start of a fiscal year. In addition to services for veterans, other community care programs include the community care services that VA purchases for other eligible beneficiaries, which may include a veteran's spouse or dependent child.

Our analysis of VA's obligations by service type shows that in fiscal year 2017, VA's higher-than-estimated obligations for community care were primarily for outpatient and inpatient services, as shown in table 4.⁶⁰ In fiscal year 2018, the higher-than-estimated obligations for community care were primarily for outpatient services, while there was an overall decrease in obligations for inpatient services. (See table 5.) Additionally, for some service types, VA's actual obligations were lower than estimated in fiscal years 2017 and 2018.⁶¹

⁶⁰According to VA officials, the actual obligation amounts for certain service types for fiscal years 2017 and 2018 were understated due to the way adjustments were accounted for in VA's financial management system. These adjustments were \$700 million for fiscal year 2017 and \$2.2 billion for fiscal year 2018. VA stated that they anticipate these adjustments to decrease starting in fiscal year 2019 as a result of a VA policy change regarding the timing of certain community care obligations.

⁶¹For fiscal years 2017 and 2018, we examined data for community care obligations for the Veterans Choice Fund and the Medical Community Care appropriation account.

Table 4: Comparison of Department of Veterans Affairs' Actual and Estimated Obligations for Selected Community Care Service Types, Fiscal Year 2017

Obligations (dollars in millions)			
Selected service type	Fiscal year 2017		
	Actual ^a	Estimated	Difference
Outpatient care	4,658	3,782	875
Inpatient care	3,016	2,656	360
CHAMPVA and other benefit programs' services ^b	1,290	1,697	(407)
Non-institutional care ^c	1,248	1,436	(188)
Community nursing home	870	1,012	(143)

Source: GAO analysis of Department of Veterans Affairs (VA) budget justification and VA data. | GAO-19-478

Notes: This table includes service types that had a difference of \$90 million or more between actual and estimated obligations. Differences reflect rounding. Estimated obligations are developed months prior to the start of a fiscal year. For fiscal year 2017, data reflect community care obligations for the Veterans Choice Fund and the Medical Community Care appropriation account.

^aAccording to VA officials, the actual obligation amounts for certain service types for fiscal year 2017 were understated due to the way adjustments were accounted for in VA's financial management system. The adjustment was \$700 million in fiscal year 2017.

^bThe Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), as well as other benefit programs provide care for veterans and other eligible beneficiaries, such as spouses and dependent children, through community providers.

^cNon-institutional care includes home and community-based long-term care programs, such as community adult day care, homemaker/home health aide programs, home hospice and palliative care, purchased skilled home care, and respite care.

Table 5: Comparison of Department of Veterans Affairs' Actual and Estimated Obligations for Selected Community Care Service Types, Fiscal Year 2018

Obligations (dollars in millions)			
Selected service type	Fiscal year 2018		
	Actual ^a	Estimated	Difference
Outpatient care	4,287	3,545	742
Dental care	238	146	91
Inpatient care	2,649	3,104	(455)
CHAMPVA and other benefit programs' services ^b	1,345	1,649	(305)
Community nursing home	937	1,032	(96)

Source: GAO analysis of Department of Veterans Affairs (VA) budget justification and VA data. | GAO-19-478

Notes: This table includes service types that had a difference of \$90 million or more between actual and estimated obligations. Differences reflect rounding. Estimated obligations are developed months prior to the start of a fiscal year. For fiscal year 2018, data reflect community care obligations for the Veterans Choice Fund and the Medical Community Care appropriation account.

^aAccording to VA officials, the actual obligation amounts for certain service types for fiscal year 2018 were understated due to the way adjustments were accounted for in VA's financial management system. These adjustments were \$2.2 billion for fiscal year 2018.

^bThe Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) as well as other benefit programs provide care for veterans and other eligible beneficiaries, such as spouses and dependent children, through community providers.

VA's Higher-Than-Estimated Obligations for Community Care Included Additional Funding VA Received for the Choice Program Outside of the Annual Appropriations Process

To obligate \$13.6 billion for community care in fiscal year 2017 and \$14.9 billion in fiscal year 2018—amounts that were \$1.2 billion and \$2.2 billion higher, respectively, than what VA originally estimated for its budget request, and what VA received in its annual appropriation—VA requested and received additional Choice Program funding outside of the annual appropriations process. VA also reallocated funding from other sources, including unobligated funding from a prior fiscal year and collections, to pay for the other community care programs.⁶²

Specifically, the \$13.6 billion and \$14.9 billion VA obligated for community care in fiscal years 2017 and 2018, respectively, came from the following sources:

- **Choice Program.** For both fiscal years, VA obligated from its remaining funding and prior-year recoveries from the previous fiscal years, and requested and received additional funding three times outside of the annual appropriations process.⁶³ (Table 6 below summarizes the time frames during which VA requested and received additional appropriations for the Choice Program outside of the annual appropriations process for fiscal years 2017 and 2018.)
- **Other community care programs.** For both fiscal years, VA obligated from its annual appropriation and transferred a portion of its overall collections from its Medical Care Collections Fund to the

⁶²Due to the nature of VA's multi-year authority in some of its appropriations, budget authority may be available from unobligated balances, which remain available for a fixed period of time in excess of one fiscal year. Collections refers to the resources VA expects to collect from health insurers of veterans who receive VA care for nonservice-connected conditions and other sources, such as veterans' copayments.

⁶³Prior-year recoveries refers to obligations that were estimated for authorizations for the previous fiscal year, but were never liquidated. For fiscal year 2017, VA de-obligated around \$700 million in Choice Program funds from fiscal year 2017 authorizations for use in 2018. For fiscal year 2018, this amount was around \$295 million.

medical community care account.⁶⁴ In addition, for fiscal year 2018, VA used unobligated funding and prior-year recoveries from fiscal year 2017.⁶⁵

Table 6: Department of Veterans Affairs' Veterans Choice Program Budget Timeline, Fiscal Years 2017 and 2018

Date	Budget event
2016:	
February	The President submitted the fiscal year 2017 budget request to Congress, which included requested resources for VA health care. As the Veterans Choice Program (Choice Program) was expected to end in August 2017, VA estimated it would use its remaining \$4.8 billion in Choice Program funding from fiscal year 2016. The Choice Program originally began with \$10 billion in funding. ^a
September	Fiscal year 2017 appropriations for VA enacted. ^b
2017:	
April	Legislation enacted allowing the Choice Program to continue until funding for the program is exhausted regardless of time. ^c
May	The President submitted the fiscal year 2018 budget request to Congress. VA estimated it would use its remaining \$626 million in available Choice Program funding from fiscal year 2017, and requested \$2.9 billion in new Choice Program appropriations for fiscal year 2018.
June	The Secretary of Veterans Affairs testified at a congressional subcommittee hearing regarding VA's fiscal year 2018 budget request. During the testimony, the Secretary informed Congress that due to an increase in utilization, Choice Program funding would run out prior to September, the end of fiscal year 2017.
August	Legislation enacted that provided \$2.1 billion in funding for the Choice Program. ^d According to VA, this amount was needed to maintain the program while the department worked to secure funding for the remainder of fiscal year 2018.
December	The Secretary informed Congress on December 12 that Choice Program funding would be exhausted in 3-to-5 weeks. Legislation enacted on December 22 provided \$2.1 billion in funding for the Choice Program. ^e

⁶⁴For fiscal years 2017 and 2018, VA was appropriated \$7.2 billion and \$419 million (in addition to advance appropriations of \$9.4 billion), respectively, for its medical community care account. For fiscal year 2017, VA transferred \$1.25 billion in collections from its Medical Care Collections Fund to its medical community care account, which was \$1 billion higher than what VA initially estimated it would transfer at the time of the President's budget request. For fiscal year 2018, VA transferred about \$272 million in collections.

⁶⁵For fiscal year 2018, VA had \$470 million in unobligated funding for its medical community care account from fiscal year 2017, and \$256 million in prior year recoveries from fiscal year 2017.

Date	Budget event
2018:	
March	The Secretary testified at a congressional subcommittee hearing regarding VA's fiscal year 2019 budget request. During the testimony, the Secretary informed Congress that as of March 16, about \$1.1 billion remained of the \$2.1 billion in funds appropriated in December 2017, and that funding would be exhausted before the end of fiscal year 2018.
	Fiscal year 2018 appropriations for VA enacted. ^f It did not include any additional appropriations for the Choice Program.
May	The Acting Secretary of Veterans Affairs sent a letter to Congress stating that the Choice Program would run out of funding by the end of the month.
June	Legislation enacted that provided \$5.2 billion in funding for the Choice Program. ^g This funding was expected to keep the Choice Program operating until VA's new community care program goes into effect, which was expected to be by June 2019.
October	Start of fiscal year 2019.

Source: GAO analysis. | GAO-19-478

^aAt the time of the Department of Veterans Affairs' (VA) fiscal year 2017 budget justification, VA estimated there was \$4.8 billion in funding for the Choice Program. However, VA's fiscal year 2019 budget justification shows only \$4.4 billion in Choice Program funding for fiscal year 2017. The Veterans Access, Choice, and Accountability Act of 2014 provided \$10 billion in funding for the Choice Program, which was implemented in early fiscal year 2015 and authorized until funds were exhausted or through August 7, 2017, whichever occurred first. Pub. L. No. 113-146, §§ 101(p), 802, 128 Stat. 1754, 1763, 1802-1803 (2014).

^bPub.L. No. 114-223, tit. II, 130 Stat. 857, 867 (2016).

^cPub.L. No. 115-26, § 1, 131 Stat. 129 (2017).

^dSee VA Choice and Quality Employment Act of 2017, Pub. L. No. 115-46, § 101, 131 Stat. 958, 959 (2017).

^eAn act to amend the Homeland Security Act of 2002 to require the Secretary of Homeland Security to issue Department of Homeland Security-wide guidance and develop training programs as part of the Department of Homeland Security Blue Campaign, and for other purposes, Pub. L. No. 115-96, Div. D, § 4001, 131 Stat. 2044, 2052-53 (2017).

^fPub. L. No. 115-141, 132 Stat. 348 (2018).

^gVA MISSION Act of 2018. Pub. L.No. 115-182, tit. I, 132 Stat. 1393 (2018).

Agency Comments

We provided a draft of this product to VA and OMB for comment. VA provided technical comments, which we incorporated as appropriate. OMB had no comments.

We are sending copies of this report to the Secretary of Veterans Affairs, the Director of the Office of Management and Budget, appropriate congressional committees, and other interested parties. This report is also available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or silass@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix V.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Sharon Silas". The signature is fluid and cursive, with the first name "Sharon" and the last name "Silas" clearly distinguishable.

Sharon M. Silas
Acting Director, Health Care

Appendix I: The Department of Veterans Affairs' Community Care Programs for Veterans and Other Eligible Beneficiaries

While the majority of veterans utilizing Department of Veterans Affairs' (VA) health care services receive care in VA-operated medical facilities, veterans may also obtain services from non-VA providers in the community—known as community care—through one of several community care programs aimed at helping to ensure that veterans receive timely and accessible care.¹ In implementing the VA MISSION Act, VA plans to consolidate four of its community care programs for veterans—dialysis contracts, individually authorized care, the Patient-Centered Community Care Program, and the Veterans Choice Program—under the Veterans Community Care Program, which is expected to go into effect by June 2019.² In addition, VA has several other community care programs that serve veterans and programs that provide health care services to other eligible beneficiaries, including a veteran's spouse or dependent child.

Community Care Programs for Veterans that VA Plans to Consolidate

Dialysis contracts. When dialysis services—a life-saving medical procedure for patients with permanent kidney failure—are not feasibly available at VA medical facilities, veterans may be referred to one of VA's contracted dialysis providers, and veterans may receive dialysis at local clinics on an outpatient basis, or at home (if the contractors offer home-based dialysis services).

Individually authorized care. When a veteran cannot access a particular specialty care service from a VA medical facility—either because the service is not offered, the veteran would have to wait too long for an appointment, or the veteran would have to travel a long distance to a VA medical facility—VA medical facility staff may request an individual authorization for the veteran to obtain the service from a community provider who is willing to accept VA payment.

Patient-Centered Community Care. VA contracted with two third-party administrators to develop regional networks of community providers of specialty care, mental health care, limited emergency care, and maternity

¹Unless otherwise indicated, the terms “community care” and “community providers” refer, respectively, to the services the department purchases outside VA medical facilities. Additionally, “community care programs” includes programs and activities that provide community care whether under statutory or contractual authority.

²John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018. Pub. L.No. 115-182, tit. I, 132 Stat. 1392 (2018) (VA MISSION Act).

and limited newborn care when such care is not feasibly available from a VA medical facility. To be eligible to obtain care from Patient-Centered Community Care providers, veterans must meet the same criteria that are required for individually authorized care.

Veterans Choice Program. VA modified its Patient-Centered Community Care contracts with the two third-party administrators to implement the Veterans Choice Program. This program allows eligible veterans to obtain health care services from community providers if the veteran meets certain criteria, including when a veteran cannot receive care within 30 days from the veteran's or physician's preferred date, or face an unusual or excessive burden in traveling to a VA medical center.³

Other Community Care Programs for Veterans

Agreements with federal partners and academic affiliates. When services are not available at VA medical facilities, VA may obtain specialty, inpatient, and outpatient health care services for veterans through different types of sharing agreements—those with other federal facilities (such as those operated by the Department of Defense and the Indian Health Service), those with Tribal Health Programs, and those with university-affiliated hospitals, medical schools, and practice groups (known as academic affiliates).

Emergency care. When emergency community care is not preauthorized, VA may reimburse community providers for emergency care for eligible veterans for a condition related to a service-connected

³Other criteria for the Veterans Choice Program include if the veteran lives more than 40 miles driving distance from the nearest VA medical center with a full-time primary care physician; or would have to travel by air, boat, or ferry to the VA medical center closest to their home; or have specific health care needs that warrant participation (including the nature and frequency of care); or live in a state or territory without a full-service VA medical center.

disability, and for eligible veterans for a condition not related to a service-connected disability.⁴

Foreign Medical Program. The Foreign Medical Program is VA's health care benefits program for eligible veterans who are residing or traveling abroad and have a service-connected disability.

State Home Per Diem Program. Under the State Home Per Diem Program, states provide care for eligible veterans in three different types of programs: nursing home, domiciliary, and adult day health care.

Community Care Programs for Other Beneficiaries

Camp Lejeune Family Member Program. The Camp Lejeune Family Member Program is for family members of veterans that lived or served at U.S. Marine Corps Base Camp Lejeune, North Carolina, for no fewer than 30 days between January 1, 1957, and December 31, 1987, and were potentially exposed to drinking water contaminated with industrial solvents, benzene, and other chemicals. The program provides health care to veterans who served on active duty at Camp Lejeune and to reimburse eligible Camp Lejeune family members for health care costs related to one or more of 15 specified illnesses or medical conditions specified in law.⁵

Children of Women Vietnam Veterans Health Care Benefits Program. This program provides health care benefits to female Vietnam veterans' birth children who the Veterans Benefits Administration has determined to have a covered birth defect. This program is not a comprehensive health care plan and only covers those services necessary for the treatment of a covered birth defect and associated medical conditions.

⁴A veteran may access emergency care for a condition related to a service-connected disability when a prudent layperson (1) would classify the condition as an emergency, and (2) would have deemed it unreasonable for the veteran to access the care at a VA or other federal facility. In addition to meeting the previously stated criteria, a veteran may access emergency care for a condition not related to a service-connected disability if services were rendered before they were stable for transfer to a VA or other federal facility; if the veteran was enrolled in and accessed care from a VA clinician in the 24 months preceding the emergency care; if the veteran is financially liable to the community provider; if the veteran has no entitlement under another health plan contract (such as Medicare); and if the veteran has no recourse against a third party that would wholly extinguish liability to the community provider.

⁵Examples of conditions listed in the law include bladder cancer, breast cancer, leukemia, and lung cancer. See Pub. L. No. 112-154, § 102, 126 Stat. 1165 (2012).

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). CHAMPVA is a comprehensive health care program that provides health care coverage for spouses, children and primary caregivers of veterans who are permanently and totally disabled from a service-connected disability.⁶ CHAMPVA functions similarly to traditional health insurance, with most care in the program delivered using non-VA community providers.

Spina Bifida Health Care Benefits Program. This program provides health care benefits to certain Korea and Vietnam veterans' birth children who have been diagnosed with spina bifida.⁷

⁶CHAMPVA also provides coverage for spouses and children of those who died in the line of duty or from a service-connected disability. Eligibility for spouses also includes widowed spouses. See 38 U.S.C. § 1781.

⁷Spina bifida is a type of birth defect that results from the neural tube (the embryonic structure that eventually develops into the brain and spinal cord) failing to develop or close properly in utero, which can cause a range of physical and neurological defects.

Appendix II: Budget Formulation Process for the State Home Per Diem Program and Non-Veteran Community Care Programs

The Department of Veterans Affairs (VA) and its actuarial consultant use the Enrollee Health Care Projection Model to develop most of the department's estimate of the resources needed to meet the expected demand for VA's health care services. VA uses other methods to estimate the remaining resources needed. This remaining portion includes community care programs for veterans and other eligible beneficiaries, including the State Home Per Diem Program and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).¹

State Home Per Diem Program. This program pays per diem for state-provided care for eligible veterans in three different types of programs: domiciliary, nursing home, and adult day health care. For state home domiciliary and nursing care, categorized as institutional care, VA creates budget projections based on historical funding data. For state home adult day health care, categorized as non-institutional care, VA's budget estimates are based on projections of the amount of care provided—which is known as workload—and the unit cost of providing a day of this care.² VA projects the demand for non-institutional care services using information about the size and demographic characteristics of the enrolled veteran population. VA projects unit cost for non-institutional care services by calculating unit-cost increases observed from recent experience and then using this information to project future unit costs. VA multiplies the workload estimates, unit-cost estimates, and the number of days in the fiscal year to develop an estimate of the amount of resources needed for non-institutional care.

CHAMPVA. CHAMPVA provides health care coverage for spouses and children of veterans who are permanently and totally disabled from a service-connected disability.³ CHAMPVA functions similarly to traditional health insurance—most care within CHAMPVA is delivered using non-VA community providers. Therefore, developing estimates of the resources needed for CHAMPVA requires factoring in utilization patterns and cost inflation that are generally outside of VA's control. Budget estimates for

¹Other eligible beneficiaries may include a veteran's spouse or dependent child.

²Workload for most non-institutional services is measured as the average number of people enrolled per day for the number of days in the fiscal year that the service is available.

³CHAMPVA also provides coverage for spouses and children of those who died in the line of duty or from a service-connected disability. Eligibility for spouses also includes widowed spouses. See 38 U.S.C. § 1781.

**Appendix II: Budget Formulation Process for
the State Home Per Diem Program and Non-
Veteran Community Care Programs**

CHAMPVA are developed using a formula that computes the predicted number of users and costs per-member per-year.⁴ VA works with its actuarial consultant to generate projections of CHAMPVA users that incorporate changes related to the population of disabled veterans and projections of expected increases and decreases in the CHAMPVA-eligible population. In addition, the actuarial consultant projects the costs per-member per-year, which is calculated by dividing the most current fiscal year data on total CHAMPVA expenditures by the number of actual users. Trends are then incorporated to predict the future costs per-member per-year, which is multiplied by projections of the number of CHAMPVA users to develop CHAMPVA budget estimates.

⁴VA considers members to be those who access CHAMPVA services.

Appendix III: Health Care Services included in the Enrollee Health Care Projection Model for Fiscal Year 2019

Using its Enrollee Health Care Projection Model (EHCPM), the Department of Veterans Affairs (VA) developed estimates for 79 health care services—available in VA medical facilities or through community care—for the fiscal year 2019 President’s budget request. As shown in table 7, VA developed separate estimates for the 43 services that were available through community care. Some of these 43 services were only available through community care. These services were primarily long-term care, including nursing home care provided at community nursing homes, home hospice care, home respite care, homemaker or home health aid programs, and purchased skilled nursing care.

Table 7: Health Care Services Included in the Department of Veterans Affairs’ Enrollee Health Care Projection Model, Fiscal Year 2019

Service type	Health care service	Estimates developed for VA facility care	Estimates developed for community care
Dental care			
	Major restorative dental services	✓	✓
	Minor restorative dental services	✓	✓
	Preventative and basic dental services	✓	✓
Inpatient care			
	Maternity deliveries	✓	✓
	Maternity non-deliveries	✓	✓
	Medical	✓	✓
	Surgical	✓	✓
Long-term care			
	Community adult day health care		✓
	Community nursing home (long stay)		✓
	Community nursing home (short stay)		✓
	Community residential care	✓	
	Home-based primary care	✓	
	Home hospice care		✓
	Home respite care		✓
	Homemaker/home health aide programs		✓
	Home telehealth	✓	
	Purchased skilled home care		✓
	Spinal cord injury and disorders home care	✓	
	VA adult day health care	✓	
	VA community living center (long stay)	✓	
	VA community living center (short stay)	✓	

**Appendix III: Health Care Services included in
the Enrollee Health Care Projection Model for
Fiscal Year 2019**

Service type	Health care service	Estimates developed for VA facility care	Estimates developed for community care
Mental health care			
	Acute substance abuse	✓	✓
	Compensated work therapy/transitional residence	✓	
	Homeless	✓	
	Inpatient mental health	✓	✓
	Intensive community mental health recovery services	✓	
	Mental health residential rehabilitation	✓	
	Mental health office visits	✓	
	Mental health residential rehabilitation treatment program outpatient encounters	✓	
	Mental health residential rehabilitation treatment program residential encounters	✓	
	Outpatient mental health	✓	✓
	Outpatient substance abuse	✓	✓
	Psychosocial rehabilitation and recovery centers	✓	
	Psychotherapy (individual or group)	✓	✓
	Sustained treatment and rehabilitation	✓	✓
	Work therapy	✓	
Outpatient care			
	Allergy immunotherapy	✓	✓
	Allergy testing	✓	✓
	Ambulance		✓
	Cardiovascular	✓	✓
	Chiropractic	✓	✓
	Compensation and pension exams	✓	
	Dialysis and related services	✓	✓
	Emergency room visits	✓	✓
	Hearing aid services	✓	✓
	Hearing and speech exams	✓	✓
	Immunizations	✓	✓
	Maternity	✓	✓
	Miscellaneous medical	✓	✓
	Nutritional counseling	✓	✓
	Office administered drugs	✓	✓
	Office visits, urgent care, physical exams–non-mental health	✓	✓
	Outpatient medication therapy management	✓	✓

**Appendix III: Health Care Services included in
the Enrollee Health Care Projection Model for
Fiscal Year 2019**

Service type	Health care service	Estimates developed for VA facility care	Estimates developed for community care
	Over-the-counter medication	✓	
	Pathology	✓	✓
	Physical medicine	✓	✓
	Prescription drugs (brand and generic)	✓	
	Prescription related supplies	✓	
	Prosthetic and orthotic services	✓	✓
	Radiology—computerized tomography, magnetic resonance imaging, and positron emission tomography	✓	✓
	Radiology—general	✓	✓
	Recreational therapy	✓	
	Surgery	✓	✓
	Vision exams	✓	✓
Prosthetics			
	Blind aids	✓	
	Cardiothoracic surgical implants	✓	
	Glasses/contacts	✓	
	Hearing aids	✓	
	Home telehealth devices	✓	
	Medical equipment and supplies	✓	
	Orthotics	✓	
	Oxygen	✓	
	Prosthetics-artificial limbs	✓	
	Respiratory equipment	✓	
	Surgical implants	✓	
	VA specialized products and services	✓	
	Wheeled mobility devices	✓	
Rehabilitation care			
	Blind rehabilitation	✓	
	Spinal cord injury and disorders	✓	

Source: GAO analysis of Department of Veterans Affairs (VA) data and documentation of the Enrollee Health Care Projection Model. | GAO-19-478

Appendix IV: Community Care Data Sources in the Department of Veterans Affairs' Enrollee Health Care Projection Model

The Department of Veterans Affairs (VA) and its actuarial consultant use the Enrollee Health Care Projection Model (EHCPM) to develop most of the department's budget estimate to meet the expected demand for VA's health care services.¹ This estimate includes the services that VA purchases from non-VA community providers through its various community care programs, including the Veterans Choice Program (Choice Program).

Based on our interviews with various VA officials, VA's Office of Enrollment and Forecasting provided utilization and cost data from fiscal year 2016 community care claims from four different sources for use in the 2017 EHCPM, which was used to project the fiscal year 2019 budget estimate.² (See fig. 7.) Specifically, the Office of Enrollment and Forecasting—which is responsible for compiling the claims data used in the EHCPM—obtained community care claims data, including Choice Program claims, from VA's Fee Basis Claims System. In addition, the Office of Enrollment and Forecasting worked with VA's Allocation Resource Center to gather additional utilization and cost data from Choice Program claims processed outside the Fee Basis Claims System, and other data needed for the 2017 EHCPM.³ Specifically, the Allocation

¹The EHCPM was developed in 1998 by VA and its actuarial consultant. VA uses other methods to estimate the remaining resources needed.

²According to VA officials, they conduct risk assessments and review security controls of their financial management systems, including a recent review of the Fee Basis Claims System, to support the Secretary for Veterans Affairs' annual attestation of the effectiveness of internal control over those systems. In particular, the Secretary is responsible for establishing and maintaining effective internal controls and financial management systems that meet the objectives of 31 U.S.C. § 3512(c), (d), commonly known as the Federal Managers' Financial Integrity Act of 1982 and the Office of Management and Budget (OMB) Circular No. A 123, *Management's Responsibility for Enterprise Risk Management and Internal Control*. These objectives are to ensure (1) effective and efficient operations, (2) compliance with applicable laws and regulations, and (3) reliable financial reporting. The Federal Managers' Financial Integrity Act of 1982 and OMB Circular No. A-123 require an annual statement of assurance to Congress attesting to the effectiveness of internal controls and identifying material weaknesses. This statement is included as part of the VA's Agency Financial Report, which is published annually by November 15.

Resource Center compiled claims data for those Choice Program claims paid through expedited payments.⁴ The Allocation Resource Center also pulled data on dual eligible veterans, from the Department of Defense's Medical Data Repository, and indirect costs associated community care claims (for example, costs associated with care coordination or claims processing) from VA's Managerial Cost Accounting system.⁵

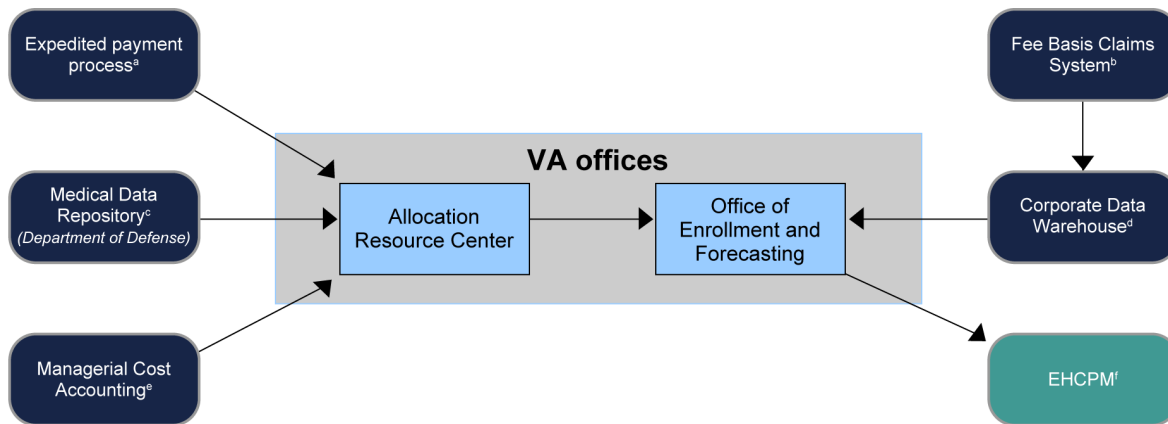
³According to VA officials, prior to the implementation of the Choice Program in November 2014, staff from the Office of Enrollment and Forecasting were responsible for pulling all relevant claims data needed by its actuarial consultant for the EHCPM. Because of the introduction of the Choice Program, and the changing ways through which Choice Program claims were processed, VA officials stated that the Office of Enrollment and Forecasting asked for assistance from the Allocation Resource Center to identify and gather Choice Program claims data. VA officials anticipate that once the Choice Program ends, staff from the Office of Enrollment and Forecasting will be responsible again for pulling the relevant claims data needed by its actuarial consultant for the EHCPM.

⁴Since implementation of the Choice Program in November 2014, VA has modified the way it has processed and paid Choice Program claims. All Choice Program claims were initially processed through the Fee Basis Claims System. Due to Choice Program claim processing backlogs, some Choice Program claims were processed in an expedited manner outside of the Fee Basis Claims System from March 2016 through July 2016. These claims were aggregated and processed in bulk. Since April 2017, VA has been processing Choice Program claims through a different claims processing system, Plexis Claims Manager. However, according to VA officials, a small number of Choice Program claims continue to be paid through an expedited payment process based on the date of service of the claim. For more information on changes to how Choice Program claims have been processed and paid, see Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System*, Report No. 15-03036-47 (Washington, D.C.: Dec. 12, 2017), and Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Program Contracts*, Report No. 17-02713-231 (Washington, D.C.: Sept. 6, 2018).

⁵Dual eligible veterans are those veterans that are also eligible for medical benefits from the Department of Defense.

Appendix IV: Community Care Data Sources in the Department of Veterans Affairs' Enrollee Health Care Projection Model

Figure 7: Data Sources for the Department of Veterans Affairs' 2017 Enrollee Health Care Projection Model



Source: GAO analysis of interviews with VA officials. | GAO-19-478

^aWhen the Veterans Choice Program was implemented in November 2014, all Veterans Choice Program claims were initially processed through the Fee Basis Claims System. In fiscal year 2016, due to Veterans Choice Program claim processing backlogs, some Veterans Choice Program claims were processed in an expedited manner outside of the Fee Basis Claims System from March 2016 through July 2016. These claims were aggregated and processed in bulk.

^bThe Fee Basis Claims System processes claims for the Department of Veterans Affairs' (VA) community care programs nationwide at individual VA medical facilities and consolidated payment processing centers.

^cThe Allocation Resource Center pulled data from the Medical Data Repository on dual eligible veterans, or those veterans that are also eligible for medical benefits from the Department of Defense.

^dVA's Corporate Data Warehouse is a national repository comprising data from several VA clinical and administrative systems.

^eThe Allocation Resource Center pulled indirect costs from VA's Managerial Cost Accounting system. Indirect costs include those costs associated with care coordination or claims processing.

^fVA's Enrollee Health Care Projection Model (EHCPM) is operated by VA's actuarial consultant.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Sharon M. Silas, (202) 512-7114 or silass@gao.gov

Staff Acknowledgments

In addition to the contact named above, Rashmi Agarwal (Assistant Director), Aaron Holling (Analyst-in-Charge), Chad Clady, and Kate Tussey made key contributions to this report. Also contributing were Krister Friday, Jacquelyn Hamilton, and Muriel Brown.

Related GAO Products

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Veterans' Health Care: Proper Plan Needed to Modernize System for Paying Community Providers. [GAO-16-353](#). Washington, D.C.: May 11, 2016.

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