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Report to Congressional Requesters

January 2011

VETERANS' HEALTH CARE

VA Uses a Projection Model to Develop Most of Its Health Care Budget Estimate to Inform the President's Budget Request

GAO-11-205

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Highlights

Highlights of GAO-11-205, a report to congressional requesters

Why GAO Did This Study

Funding for the Department of Veterans Affairs' (VA) health care is determined by Congress in the annual appropriations process. Prior to this process, VA develops a budget estimate of the resources needed to provide health care services to eligible veterans. The Veterans Health Care Budget Reform and Transparency Act of 2009 requires GAO to assess whether the funding requested for VA health care in the President's budget requests submitted to Congress in 2011, 2012, and 2013 is consistent with VA's estimates of the resources needed to provide health care services.

In anticipation of these future studies, GAO was asked to obtain information on how VA prepares its health care budget estimate. In this report, GAO describes (1) how VA develops its health care budget estimate, and (2) how VA's health care budget estimate is used in the President's budget request to Congress. To conduct this work, GAO reviewed VA documents on the methods, data, and assumptions used to develop VA's health care budget estimate that informed the President's budget request for fiscal year 2011 and request for advance appropriations for fiscal year 2012. GAO also interviewed VA officials responsible for developing this estimate and staff from the Office of Management and Budget (OMB), which is responsible for overseeing the development and implementation of the federal budget.

View GAO-11-205 or key components. For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov or Denise M. Fantone at (202) 512-6806 or fantoned@gao.gov.

What GAO Found

VA uses what is known as the Enrollee Health Care Projection Model (EHCPM) to develop most of its health care budget estimate and uses other methods for the remainder. Specifically, VA used the EHCPM to estimate the resources needed to meet expected demand for 61 health care services that accounted for 83 percent of VA's health care budget estimate for fiscal year 2011 and similarly for fiscal year 2012. The EHCPM's estimates for these services are based on three basic components: projected enrollment in VA health care, projected use of VA's health care services, and projected costs of providing these services. To make these projections, the EHCPM uses data on the use and cost of these services that reflect data from VA, Medicare, and private health insurers. The EHCPM makes a number of complex adjustments to the data to account for characteristics of VA health care and the veterans who access VA's health care services. For example, these adjustments take into account veterans' age, gender, geographic location, and reliance on VA health care services compared with other sources, such as health care services paid for by Medicare or private health insurers. VA uses other methods to develop nearly all of the remaining portion of its budget estimate for long-term care and other services, as well as initiatives proposed by the Secretary of VA or the President. Long-term care and other services accounted for 16 percent and initiatives accounted for 1 percent of VA's health care budget estimate for fiscal year 2011 and similarly for fiscal year 2012.

VA's health care budget estimate is reviewed at successively higher levels. Within the agency, the Secretary of VA reviews the health care budget estimate in the context of departmentwide priorities, including trade-offs between health care and other services. The budget estimate is presented in different ways, including the appropriations accounts structure used by Congress for decision making. OMB considers VA's budget submission in light of presidential priorities and needs governmentwide. VA can appeal decisions before OMB finalizes the President's budget request to Congress.

VA and OMB provided technical comments, which GAO incorporated as appropriate.

Contents

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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United States Government Accountability Office
Washington, DC 20548

January 31, 2011

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

The Honorable Daniel K. Akaka
United States Senate

The Honorable Jeff Miller
Chairman
The Honorable Bob Filner
Ranking Member
Committee on Veterans' Affairs
House of Representatives

The Department of Veterans Affairs (VA) operates one of the largest health care delivery systems in the nation, serving 5.7 million patients and spending $43.3 billion in fiscal year 2009. The amount VA spends on its health care services is driven by several factors, including the number of eligible veterans who choose to seek care and the types and the cost of the services they receive. VA provides a range of services for eligible veterans.[1] Many of these services—including primary care, inpatient and outpatient surgery, prosthetics, mental health services, and prescription drugs—are part of a uniform medical benefits package VA provides to all veterans enrolled in VA health care. Other services, such as nursing home care, are not part of the medical benefits package and are required to be made available for a more limited veteran population specified in law, although VA also makes these services available to other veterans on a discretionary basis.

The amount of funding VA receives for health care is determined by Congress in the annual appropriations process, during which funds are also provided for a wide range of other national programs, such as those

[1]Eligibility is determined on the basis of service-connected disability, income, and other special statuses, such as former prisoners of war, and is used to determine priority for VA services. VA is required to provide a specified set of health care services to eligible veterans. 38 U.S.C. §§ 1710(a)(1), (2), 1701(6). VA is authorized to provide these health care services to other veterans not identified in these groups. 38 U.S.C. § 1710(a)(3).

serving defense, education, and transportation. Prior to this process, VA must annually develop a budget estimate of the resources needed for its health care services, including costs for the administration and operation of VA facilities. Developing a budget estimate is the first step in a complex, multistep budget formulation process, which culminates in the President's annual budget request to Congress.

As we have previously reported, VA's formulation of its health care budget estimate is by its very nature challenging, as it is based on assumptions and imperfect information used to project the likely quantity and cost of the health care services VA expects to provide.[2] VA, similar to other agencies, generally begins work on the budget for a fiscal year that begins 18 months later, meaning that the budget is prepared with uncertainty not only about program needs, but also about future economic conditions, presidential policies, and congressional actions. In addition, our prior work has highlighted some of the challenges VA has faced formulating its budget estimate, including obtaining sufficient data, making accurate calculations, and making realistic assumptions. For example, in 2006, we reported that VA underestimated the cost of serving veterans returning from military operations in Afghanistan and Iraq due in part to insufficient data about these veterans, which led to requests for additional funding for fiscal years 2005 and 2006.[3] In 2009, we reported that VA's long-term care estimate for fiscal year 2009 was based on assumptions and projections that appeared unrealistic.[4]

Congress passed the Veterans Health Care Budget Reform and Transparency Act of 2009,[5] which provided that VA's annual appropriations for health care include advance appropriations that become available 1 fiscal year after the fiscal year for which the appropriations act was enacted. The 2009 law also requires that we assess whether the amount of VA health care funding in the President's budget

[2]See GAO, *VA Health Care: Challenges in Budget Formulation and Execution*, GAO-09-459T (Washington, D.C.: Mar. 12, 2009).

[3]See GAO, *VA Health Care: Budget Formulation and Reporting on Budget Execution Need Improvement*, GAO-06-958 (Washington, D.C.: Sept. 20, 2006).

[4]See GAO, *VA Health Care: Long-Term Care Strategic Planning and Budgeting Need Improvement*, GAO-09-145 (Washington, D.C.: Jan. 23, 2009).

[5]Pub. L. No. 111-81, § 3, 123 Stat. 2137, 2137–38 (2009), *codified at* 38 U.S.C. § 117. The act provided for advance appropriations for the Medical Services, Medical Support and Compliance, and Medical Facilities appropriations accounts.

request to Congress is consistent with VA's estimate of the resources needed to provide health care services. The law requires that we report on our analysis within 120 days after the President's budget requests are submitted in 2011, 2012, and 2013.[6]

In anticipation of the reports we are required to provide, you expressed interest in obtaining information on how VA's health care budget estimate is prepared. In this report, we describe (1) how VA develops its health care budget estimate, and (2) how VA's health care budget estimate is used in the President's budget request to Congress.

To describe how VA develops its health care budget estimate, we reviewed VA documents that describe the methods, types of data, and assumptions used. Specifically, we reviewed VA documents for the fiscal year 2011 estimate and the fiscal year 2012 estimate. We also interviewed VA officials to discuss how the methods, types of data, and assumptions are used to develop VA's health care budget estimate. Specifically, we spoke with VA's Office of Budget and VA's Veterans Health Administration's (VHA) Office of Finance as well as the Office of Enrollment and Forecasting, which is within the Office of the Assistant Deputy Under Secretary for Health for Policy and Planning. We also interviewed officials from VA's Office of Mental Health Services and the Pharmacy Benefits Management Services office to understand the subject-matter expertise these program offices provide in developing VA's health care budget estimate. These program offices were selected because the requested funding levels for these services comprised a substantial proportion of the President's budget request for VA health care for fiscal years 2007 through 2010. We used the information obtained from VA's documents and through interviews with VA officials to describe how VA develops its health care budget estimate and to determine the proportion of this estimate that is developed using each of VA's methods. To assess the reliability of the data on the proportion of VA's budget estimate that is determined using each method, we obtained and checked the consistency of VA documents that detail the various estimates and verified the information contained in the documents with VA officials. We also verified that VA correctly calculated budget estimates that represented more than 90 percent of VA's total health care budget estimate for fiscal year 2011 and for fiscal year 2012.

[6]The President's budget request is submitted to Congress in February for the fiscal year that starts the following October. Thus, for example, the President's budget submission in February 2011 would be for fiscal year 2012—which starts October 1, 2011—and would also include a request for advance appropriations for VA health care for fiscal year 2013.

We verified VA's calculations using components VA said it used to compute the estimates. We also relied on our prior work to compare data and to check for internal consistency. We found the data reliable for our purposes of describing each component of VA's health care budget estimate and the methodology used.

To describe how VA's health care budget estimate is used in the President's budget request to Congress, we reviewed the President's budget request for fiscal year 2011, which includes the request for VA appropriations for fiscal year 2011 and the advance appropriations request for fiscal year 2012.[7] We also interviewed VA officials involved in VA's budget preparation process to discuss internal guidance, the communication of policy priorities, and the focus of their review. We also interviewed staff from the Office of Management and Budget (OMB), which is responsible for overseeing the development and implementation of the federal budget.

We conducted this performance audit from July 2010 through January 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VA operates one of the largest health care delivery systems in the nation, providing care to a diverse population of veterans. VA operates about 150 hospitals, 130 nursing homes, 950 outpatient clinics, and 230 readjustment counseling centers—Vet Centers—through 21 regional health care networks called Veterans Integrated Service Networks. VA is responsible for providing health care services to various populations—including an aging veteran population and a growing number of younger veterans returning from the military operations in Afghanistan and Iraq.

[7]The fiscal year 2011 President's budget request was submitted to Congress on February 1, 2010.

VA is required by law to provide health care services to certain veterans and may provide care to other veterans.[8] In general, veterans must enroll in VA health care to receive VA's medical benefits package—a set of services that includes a full range of hospital and outpatient services, prescription drugs, and noninstitutional long-term care services provided in veterans' own homes and in other locations in the community.[9] VA also provides some services that are not part of its medical benefits package, such as nursing home care. The population of veterans to whom VA is required to provide nursing home care is more limited than the population to whom VA is required to provide other health care services. VA is required by law to provide nursing home care to certain veterans needing such care who also have service-connected disabilities, and VA also makes nursing home care available to other veterans on a discretionary basis as resources permit.[10]

VA's enrollment system includes eight categories for enrollment established by law[11] to manage access to services in relation to available resources. The order of priority for the categories is generally based on service-connected disability, income, or other special status such as having been a prisoner of war.[12] If sufficient resources are not available to

[8]38 U.S.C. §§ 1710(a)(1)-(3), 1701(6). Requirements for VA health care services are effective in any fiscal year only to the extent and in the amount provided in advance in appropriations acts for such purposes. 38 U.S.C. § 1710(a)(4).

[9]Under 38 U.S.C. § 1710B, VA is required to provide adult day care and respite care. VA provides these and other noninstitutional long-term care services as part of VA's medical benefits package and makes them available to veterans enrolled in VA health care.

[10]VA is required by law to provide nursing home care to veterans needing such care and who have a service-connected disability rating of 70 percent or greater. In addition to these veterans, VA is also required to provide nursing home care that the Secretary of VA determines is needed for veterans in need of such care for a service-connected disability. 38 U.S.C. § 1710A(a). These requirements will terminate on December 31, 2013. 38 U.S.C. § 1710A(d). The statute states that these requirements may not be construed as authorizing or requiring that a veteran who was receiving nursing home care in a department nursing home on November 30, 1999, be displaced, transferred, or discharged from the facility. 38 U.S.C. § 1710A(b)(2). VA, however, provides most of its nursing home care to veterans who receive it on a discretionary basis. See 38 U.S.C. § 1710(a)(2), (3).

[11]See 38 U.S.C. § 1705(a); 38 C.F.R. § 17.36 (2010).

[12]For example, Priority 1—the highest-priority category—consists of veterans with a service-connected disability rated at 50 percent or more, based on the severity of the disability. Priority 8—the lowest-priority category—consists of veterans with no compensable service-connected disability and who have incomes exceeding certain thresholds.

provide care that is timely and acceptable in quality, VA must restrict enrollment consistent with its priority categories.[13] VA also provides enhanced priority status for veterans with combat experience—including those who participated in Operation Enduring Freedom in Afghanistan, Operation Iraqi Freedom, and Operation New Dawn in Iraq[14]—for up to 5 years from their date of discharge or release from active-duty service.[15]

Veterans who enroll in VA health care may choose not to access VA's health care services in any given year. This is in part because many veterans have other options, such as Medicare,[16] Medicaid,[17] or private health insurance,[18] to access and pay for health care services. Enrollees choose whether to access services through VA or other providers based on factors such as their proximity to VA providers. Additionally, downturns in economic conditions may reduce veterans' access to sources of private insurance, such as employer-sponsored insurance, and influence enrollees' choice to access VA health care.

Estimating the resources required to provide health care services to veterans and developing VA's budget request is a collaborative process involving several offices within VA, mainly at VA headquarters. Within VA, VHA's Office of Finance is responsible for policy and operational issues relating to budget formulation for all VHA services. It works with the

[13]See 38 U.S.C. § 1705(a); 38 C.F.R. § 17.36(c) (2010).

[14]In September 2010, Operation Iraqi Freedom changed to Operation New Dawn. VA provides the same enhanced priority status for veterans of Operation New Dawn.

[15]In general, any veteran who served in a combat theater after November 11, 1998, including Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn, and who was discharged or released from active service on or after January 28, 2003, has up to 5 years from the date of the veteran's most recent discharge or release from active-duty service to enroll in VA health care and receive VA's health care services without charge for any condition that may be associated with the veteran's combat service. 38 U.S.C. § 1710(e)(1)(D), (e)(3). Veterans who were discharged or released before January 28, 2003, and who did not enroll in VA health care, are eligible for VA's health care services for 3 years after January 28, 2008.

[16]Medicare is the federally financed health insurance program for persons aged 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease.

[17]Medicaid is a joint federal and state program that finances health care coverage for certain low-income populations.

[18]Private health insurance is generally provided by health insurers, such as preferred provider organizations and health maintenance organizations. The majority of Americans under age 65 access health care services paid for by private health insurers.

Office of the Assistant Deputy Under Secretary for Health for Policy and Planning, which has responsibilities for managing knowledge and data related to VHA's policies and strategic planning. Program offices, which are responsible for setting policies for providing specific health care services, provide information to support the budget formulation process. VA's Office of Budget is responsible for overseeing the budget formulation process for the department as a whole on behalf of the Secretary and submitting VA's budget request for OMB's review and consideration in developing the President's Budget.

OMB plays a key role in the budget formulation process by providing the framework for agencies to follow. OMB annually issues Circular No. A-11, which contains detailed instructions and schedules for the submission of agencies' budget estimates. It also includes other material to ensure that agency budget requests adhere to standardized conventions and formats. OMB also provides general guidance to federal agencies via bulletins and memoranda that include, among other things, the President's priorities to consider as agencies prepare their budget submissions. Additional communications between OMB and an agency can occur anytime during the year.

VA, like other agencies, begins formulating a budget request approximately 10 months before the President submits the budget to Congress in early February. This is approximately 18 months before the start of the fiscal year to which the request relates and about 30 months prior to the start of the fiscal year to which the advance appropriations request relates. The formulation of VA's budget request is a process that follows the general schedule in table 1.

Table 1: General Schedule for Formulating the President's Budget Request

Time frame	Offices involved and actions taken
Year 1:	
April	VA Office of Budget issues guidance, on behalf of the Secretary, for preparing a budget submission.
	VHA collaborates with VA's Office of Budget to develop the health care budget estimate, which is subsequently approved by the Under Secretary for Health, to use for VA's budget submission.
April-June	VHA Office of Finance works with VHA Office of Assistant Deputy Under Secretary for Health for Policy and Planning to compile a budget.
July	The Secretary of VA reviews the budget submission for health care along with the submissions from other components of VA.
	The Secretary approves VA's health care budget estimate.
August	VA Office of Budget compiles the department's budget submission to OMB.
	The Secretary approves VA's budget submission.
September	VA delivers the budget submission to OMB.
October-December	OMB reviews VA's budget submission.
	OMB issues a decision on funding and policy priorities for VA and VA may appeal this decision.
Year 2:	
January	OMB prepares the President's budget request, and VA concurrently prepares its congressional 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 VA and OMB information.

VA Develops Most of Its Health Care Budget Estimate Using a Projection Model and Uses Other Methods for the Remaining Portion

VA uses a projection model to develop estimates of the resources needed to deliver most of the health care services VA provides. These services accounted for most of VA's health care budget estimate for fiscal year 2011. VA uses other methods to develop nearly all of the remaining portions of its health care budget estimate for long-term care and other services as well as proposed initiatives.

VA Uses a Projection Model to Develop Most of Its Health Care Budget Estimate to Meet Expected Demand

VA uses what is known as the Enrollee Health Care Projection Model (EHCPM)—a model developed in partnership with VA's actuarial consultant[19]—to estimate the amount of resources VA will need to meet the expected demand for most of the health care services VA provides. These services accounted for 83 percent of VA's health care budget estimate for fiscal 2011.[20] VA used the EHCPM to estimate the resources needed for fiscal year 2011 for 61 health care services, which VA grouped into seven service types (see app. I for a list of the 61 health care services that were grouped into the seven service types). Outpatient services accounted for almost half of the resources VA estimated using the EHCPM for fiscal year 2011. (See fig. 1.)

[19]The EHCPM was developed in 1998 by VA and Milliman, Inc. It supports the development of VA's budget estimate for health care and informs strategic and capital planning.

[20]Similarly, health care services included in the EHCPM accounted for 83 percent of VA's health care budget estimate for the advance appropriations request for fiscal year 2012.

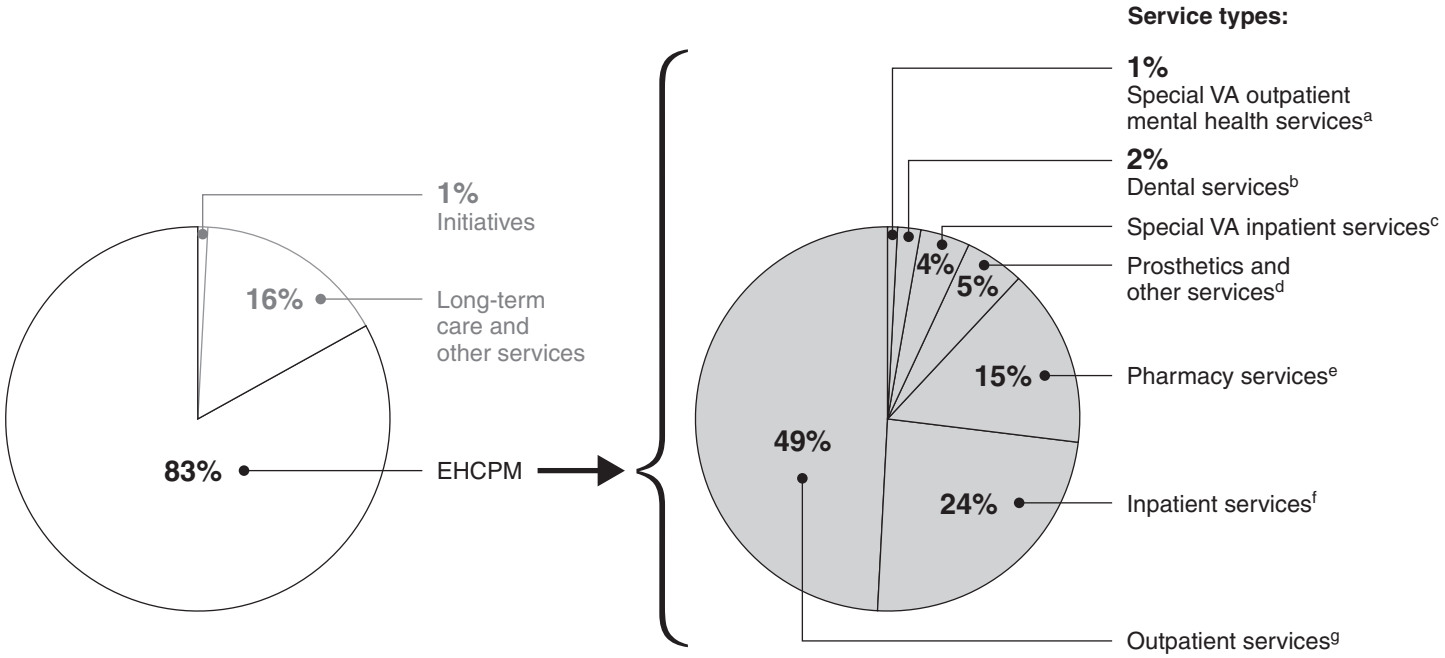
Figure 1: Proportion of VA's Health Care Budget Estimate Developed for 61 Services Using VA's Enrollee Health Care Projection Model, by Service Type, Fiscal Year 2011

VA's health care budget estimate, fiscal year 2011

VA used the Enrollee Health Care Projection Model (EHCPM) to estimate needed resources for 61 health care services

VA's EHCPM, by service type

VA grouped the 61 health care services included in the EHCPM into seven service types



Source: GAO analysis of VA information.

[a]Special VA outpatient mental health services include services such as mental health intensive case management, services for the homeless, and work therapy.

[b]Dental services include preventative and basic dental services as well as major and minor restorative dental services.

[c]Special VA inpatient services include services such as residential rehabilitation and treatment of spinal cord injuries.

[d]Prosthetics and other services include services such as artificial limbs, surgical implants, durable medical equipment, glasses, contacts, and hearing aids.

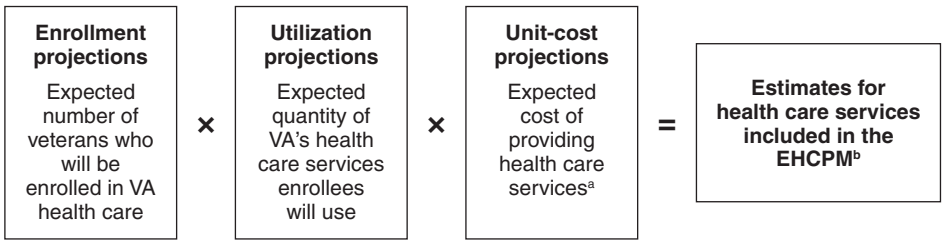
[e]Pharmacy services include prescription and over-the-counter medications and pharmacy-related supplies.

[f]Inpatient services include services such as medical, surgical, and psychiatric services.

[g]Outpatient services include services such as radiology, office/home visits, and pathology services.

The EHCPM is used to estimate needed resources based on the total cost of providing each health care service. VA officials said this total cost reflects direct patient costs as well as costs associated with management, administration, and maintenance of facilities. The EHCPM's estimates are based on three basic components: the projected number of veterans who will be enrolled in VA health care, the projected utilization of VA's health care services—that is, the quantity of health care services enrollees are expected to use—and the projected unit cost of providing these services.[21] (See fig. 2.) 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. The EHCPM makes these projections 3 or 4 years into the future for budget purposes based on data from the most recent fiscal year. For example, in 2009, VA used data from fiscal year 2008 to develop its health care budget estimate for the fiscal year 2011 request, including the advance appropriations request for fiscal year 2012.

Figure 2: Basic Components of VA's Enrollee Health Care Projection Model (EHCPM)



Source: GAO analysis of VA information.

[a]VA calculates the cost of providing a unit of service in different ways for various types of health care services. 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 represent the cost of a day of care at an inpatient facility.

[b]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 VA's copayment structure and enrollees' use of other sources of health care. Additionally, the EHCPM includes adjustments to incorporate the age, gender, priority level, and geographic location of enrolled veterans. For fiscal year 2011, the EHCPM included enrollment, utilization, and unit-cost projections for 61 health care services.

[21]Unit costs are the costs to VA of providing a unit of service, such as a 30-day supply of a prescription or a day of care at an inpatient facility.

To project the expected number of veterans who will be enrolled in VA health care, the EHCPM relies on a combination of VA and other federal data to identify current enrollees and to estimate how many eligible, nonenrolled veterans will choose to enroll. The EHCPM uses VA data to identify the number of current enrollees in VA health care and to calculate historical enrollment rates by various characteristics, including age, gender, priority level, and geographic location.[22] In addition, the EHCPM uses data developed by VA that combine federal census data on veterans and Department of Defense data on service members separated from active duty since the last decennial census to identify the number of eligible veterans not currently enrolled in VA health care.[23] The data developed by VA also incorporate Department of Defense estimates of how many service members will separate from active duty each year into the future. The EHCPM uses these data to estimate how many eligible veterans will choose to enroll in VA health care by applying VA's historical enrollment rates to this population.[24]

To project the utilization or the quantity of VA's health care services veterans will use and the unit costs of VA's health care services, VA groups these services into two major categories in the EHCPM: (1) those services that VA provides in a manner comparable to other providers, whose services are paid for by Medicare and private health insurers; and (2) those services that are unique to or are provided in a different manner by VA. For example, VA provides services, such as emergency room visits and physician office visits, in a manner comparable to other providers. In contrast, VA provides rehabilitation services to homeless veterans and certain types of prosthetic services that VA officials said are not generally offered by other providers.

For health care services that VA provides in a manner comparable to other providers, the EHCPM uses utilization and unit-cost data developed by VA's actuarial consultant that reflect data from Medicare and private

[22]VA data also include information on those veterans who have disenrolled or died.

[23]The EHCPM separately estimates the number of veterans from Operation Enduring Freedom and Operation Iraqi Freedom, which changed to Operation New Dawn in September 2010. These estimates are based in part on assumptions developed by the Congressional Budget Office about troop levels for these conflicts.

[24]The EHCPM also ensures that enrollment projections do not exceed the actual number of eligible veterans in a geographic area. Enrollment projections are also adjusted to account for changes in enrollment rates of eligible, non-enrolled veterans over time.

health insurers in addition to data from VA's own experience. VA used these data for 33 of the 61 health care services whose estimates were developed by the EHCPM for fiscal year 2011. (See app. I for the data sources used to generate utilization and unit-cost projections for each of the 61 health care services for fiscal year 2011.) Data from Medicare and private health insurers allow the EHCPM to better account for the impact of a number of factors—such as age, gender, geographic location,[25] and benefit structure—that may affect utilization and unit-cost projections because these data represent more than 60 million individuals, compared with the 8.5 million veterans expected to be enrolled in VA health care in fiscal year 2011. Additionally, VA officials said that using data from Medicare and private health insurers allows the EHCPM to account for enrollees' utilization of health care services outside of VA health care.

For health care services that are unique to or are provided in a different manner by VA, the EHCPM uses utilization and unit-cost data from VA's own experience. VA used these data for 28 of the 61 health care services whose estimates were developed by the EHCPM for fiscal year 2011. While VA data can be used to reasonably estimate the likely demand for these specific services, VA officials said these data do not allow the EHCPM to account for as many factors that may affect utilization and unit-cost projections. For example, VA uses national unit costs in most projections of services that are unique to VA health care because it lacks sufficient data to use in the EHCPM to account for geographic variations in the unit cost of these services.

To project utilization and unit costs using the EHCPM, VA makes a number of complex adjustments to the utilization and unit-cost data to account for the characteristics of VA health care and enrolled veterans.[26] For example, these adjustments take into account enrollees' age,[27] gender,

[25]For example, data from Medicare and private health insurers allow VA to account for characteristics of individuals in geographic areas where few VA enrollees live.

[26]VA has compiled over 800 pages of documentation detailing the numerous adjustments in the EHCPM.

[27]The EHCPM accounts for enrollees' age in two ways. The EHCPM includes an adjustment to account for variation in the utilization and unit costs of health care services by enrollees of different ages. The EHCPM also includes an adjustment to account for additional variation in the utilization of health care services by enrollees in certain age groups who served during conflicts such as World War II and the Vietnam War. Enrollees that served during the Vietnam War, for example, are expected to have higher utilization of some health care services than other groups of enrollees.

priority level, and geographic location. VA also makes additional adjustments to account for changes expected to occur over time. For example, adjustments are made to utilization projections to account for changes in health care practice patterns, such as greater use of magnetic resonance imaging to diagnose a condition. Additionally, unit-cost projections are adjusted to account for the effect of inflation on the costs of labor and supplies.

For services that VA provides in a manner comparable to other providers, VA also adjusts data from Medicare and private health insurers in the EHCPM to account for the extent to which enrolled veterans will choose to access health care services through VA—referred to as reliance on VA health care—or obtain these services through non-VA sources.[28] VA uses Medicare data for enrolled veterans to estimate the proportion of each health care service that veterans age 65 and over access through Medicare instead of VA. However, VA does not have a comprehensive data source to estimate the proportion of each health care service that enrolled veterans under age 65 access through non-VA sources, such as private insurers. To estimate the proportion of each health care service that enrollees under 65 access through VA and non-VA sources, VA relies on an extrapolation from its analysis of Medicare data and from data collected through periodic telephone surveys of enrollees about their use of VA and non-VA health care services. Additionally, VA adjusts data from Medicare and private health insurers in the EHCPM to incorporate characteristics unique or more common to VA health care and its enrollee population. For example, VA does not require copayments for physician office visits for veterans that meet certain eligibility criteria and VA's enrollee population is predominantly male.

Within VHA's Office of the Assistant Deputy Under Secretary for Health for Policy and Planning, the Office of Enrollment and Forecasting has the lead responsibility for developing the estimates from the EHCPM and annually updates the assumptions that may affect utilization or unit-cost projections. VHA's Office of Enrollment and Forecasting works closely with VHA's Office of Finance, which is responsible for coordinating the process for developing VA's health care budget estimate. The Office of Enrollment and Forecasting also consults with VA's health care program

[28]More than half of all enrollees in VA health care are covered by Medicare and approximately 80 percent of enrollees reported having some type of health insurance in 2008, according to VA's most recent telephone survey of enrollees on reliance.

offices, which provide input ranging from identifying VA's policy goals for the health care services they administer to providing subject-matter expertise on trends expected to affect the delivery of these services. Input from the program offices is incorporated into the underlying assumptions used in the EHCPM. For example, VA officials told us that the Office of Enrollment and Forecasting collaborated with VA's pharmacy program office to obtain information about what brand-name drugs are coming off patent, for which lower-cost, generic alternatives may be available. The Office of Enrollment and Forecasting incorporated this information into assumptions used in the EHCPM to project utilization and unit costs for VA's pharmacy services. Also, VA officials told us that the Office of Mental Health Services provided information to the Office of Enrollment and Forecasting on VA's increasing provision of mental health services in less restrictive treatment facilities and outpatient settings, and this information supported assumptions used in the EHCPM to project utilization of VA's mental health services.

VHA's Office of Enrollment and Forecasting annually briefs VA leadership, including the VA Secretary and VHA Under Secretary, and OMB on updates to the EHCPM and assumptions used in the EHCPM to generate the estimates. According to VHA officials, the briefings are intended to provide VA and OMB a better understanding of the EHCPM and its assumptions and facilitate their review of VA's health care budget estimate. VA Office of Budget officials said they review the assumptions used in the EHCPM by comparing them to data on past trends. For example, VA officials said that the VA Office of Budget along with the program office for pharmacy services were involved in reviewing assumptions regarding unit-cost projections for pharmacy services taking into account VA's heavy reliance on low-cost, generic drugs.

VA Uses Other Methods to Develop Portions of Its Health Care Budget Estimate Related to Long-term Care and Other Services

VA uses methods other than the EHCPM to develop estimates of the amount of resources needed for long-term care and other services. VHA's Office of Finance coordinates the development of the estimates for these services, which accounted for 16 percent of VA's health care budget estimate for fiscal year 2011. Long-term care was 13 percent of the overall budget estimate, and other services accounted for 3 percent.[29]

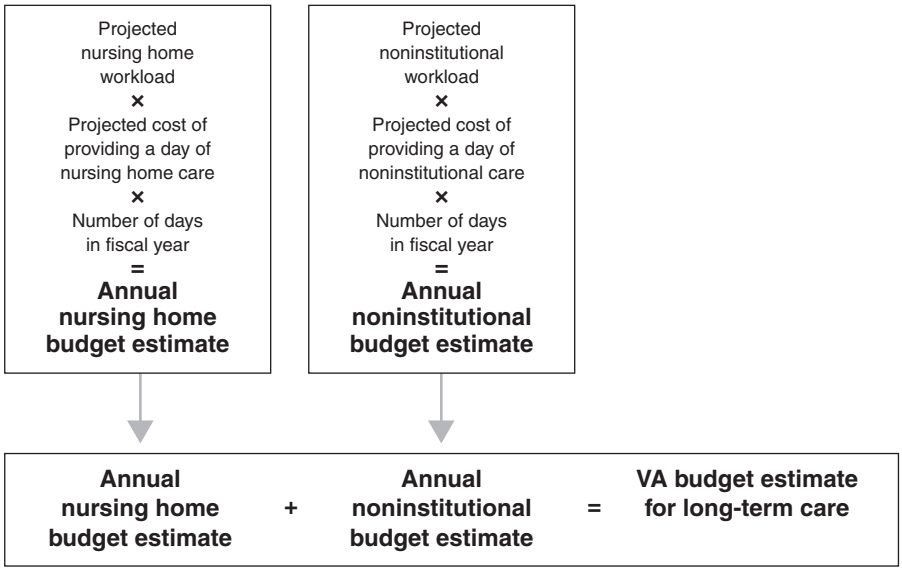
VA develops its estimates for long-term care by developing separate estimates for nursing home and noninstitutional care services. Noninstitutional care services include such services as home-based primary care and care coordination/home telehealth programs.[30] VA's estimates for nursing home and noninstitutional care are based on projections of the amount of care provided—which is known as workload[31]—and the unit cost of providing a day of this care. VA multiplies the workload estimates, unit-cost estimates, and the number of days in the fiscal year to develop estimates of the amount of resources for both nursing home care and noninstitutional care. (See fig. 3.) VHA's Office of Finance also incorporates input from VHA's Geriatrics and Extended Care program office about workload and unit-cost estimates for long-term care services.

[29]Estimates for long-term care and other services also accounted for 16 percent of VA's health care budget estimate for the advance appropriations request for fiscal year 2012. Long-term care was 13 percent of the fiscal year 2012 budget estimate and other services—such as health care coverage for spouses and children of certain veterans and individuals who died while on active duty—accounted for 3 percent.

[30]Care coordination/home telehealth involves using telecommunications technology to remotely monitor patients with chronic conditions each day in their places of residence.

[31]Nursing home care workload is measured in terms of the number of nursing home residents per day, on average, during the fiscal year. Workload for most noninstitutional 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. The exception is spinal cord injury home care, which measures workload based on average monthly enrollment.

Figure 3: VA Budget Estimate for Long-term Care



Source: GAO analysis of VA information.

Notes: Nursing home workload is measured as the number of nursing home residents per day, on average, during the fiscal year. Nursing home care accounted for 93 percent of VA's institutional long-term care workload in fiscal year 2009—the most recent year for which workload data were available. The remaining 7 percent was for other institutional long-term care services which are not reflected in this figure, but are in VA's estimate for long-term care.

Workload for most noninstitutional 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. The exception is spinal cord injury home care, which measures workload based on average monthly enrollment.

For nursing home care, VA develops workload projections by estimating the amount of nursing home care in demand by two groups of veterans—high-priority veterans for whom VA is required by law to provide nursing home care and other veterans for whom such care is provided on a discretionary basis.[32] VA officials said that when making workload projections, they consider the resources necessary to serve high-priority veterans whom VA must serve. In addition, VA's overall policy goal for nursing home workload is to keep nursing home workload consistent with recent experience, as VA focuses on expanding noninstitutional care services in order to provide long-term care in the least restrictive and most

[32]VA provides most of its nursing home care on a discretionary basis.

clinically appropriate settings.[33] The nursing home workload for veterans whom VA serves on a discretionary basis is contingent on the amount of care needed to serve those veterans whom VA must serve by law.

VA generally projects unit cost for nursing home care by calculating unit-cost increases observed from recent experience and then using this information to project future unit costs. For example, VA used the unit-cost increases from fiscal year 2008 to fiscal year 2009 and applied this percentage increase to project nursing home unit-cost estimates for fiscal year 2011, except for services delivered through community nursing homes.[34] VA officials said they began using recent experience as a basis to estimate unit cost for nursing home care in response to a recommendation that we made in a 2009 report.[35]

For noninstitutional care, VA's projected workload for these services is based on VA's policy goal of meeting, by fiscal year 2011, the noninstitutional care needs of veterans who seek such care from VA. VA projects the demand for noninstitutional care services using information about the size and demographic characteristics of the enrolled veteran population. To meet its policy goal, VA has expanded the amount of noninstitutional care services it has provided. Specifically, VA increased workload for noninstitutional services by 34 percent from fiscal year 2008 to fiscal year 2009 and projects a 19 percent increase from fiscal year 2010 to fiscal year 2011. VA projected a smaller increase—4 percent—for its noninstitutional workload between fiscal year 2011 and fiscal year 2012.

[33]VA officials noted that new construction of state veterans' nursing homes is also taken into account as an additional source of nursing home capacity. State veterans' nursing homes are joint federal-state partnerships in which VA pays a portion of the cost of providing care for eligible veterans and also provides grants to cover part of the cost of construction, acquisition, and renovation of these nursing homes. Projected increases in state nursing home workload are relatively small, however. For example, the average daily census—a workload measure—in state veterans' nursing homes was projected to increase from 19,308 in fiscal year 2010 to 19,588 in fiscal year 2011.

[34]Community nursing homes are non-VA nursing homes that contract with VA to provide care. VA officials said they used the 4.43 percent inflation rate used in the EHCPM to project unit costs for community nursing homes for fiscal year 2011. This inflation rate was higher than the 3.90 percent increase in unit costs from fiscal year 2008 to 2009 for community nursing homes.

[35]GAO recommended that VA use cost assumptions for estimating nursing home spending that are consistent with VA's recent experience or report the rationale for using cost assumptions that are not consistent with recent experience. See GAO, *VA Health Care: Long-Term Care Strategic Planning and Budgeting Need Improvement*, GAO-09-145 (Washington, D.C.: Jan. 23, 2009).

VA projects unit cost for noninstitutional care services using the same general method as for nursing home care—by calculating unit-cost increases observed from recent experience and then using this information to project future unit costs. For some services, however, VA experienced decreases in unit cost from fiscal year 2008 to fiscal year 2009. To develop fiscal year 2011 budget estimates for those services, VA did not rely on its recent experience and instead chose to assume a unit-cost increase between 4.52 percent and 4.60 percent, depending on the service.

The remaining services for which VA developed estimates using methods other than the EHCPM made up 3 percent of VA's health care budget estimate for fiscal year 2011. The largest of these services was the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), which provides health care coverage for spouses and children of veterans who are permanently and totally disabled from a service-connected disability.[36] CHAMPVA functions similarly to traditional health insurance—most care within CHAMPVA is delivered using private-sector health care 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 CHAMPVA are developed using a formula that computes the predicted number of users and costs per-member per-year.[37] Since 2004, VA' s Health Administration Center, which oversees administration of CHAMPVA, has worked with VA's 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. More recently, the Health Administration Center and VA's actuarial consultant added projections of cost per-member per-year. These costs are 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.

[36]CHAMPVA 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.

[37]VA considers members to be those who access CHAMPVA services.

VA Also Incorporates Estimates of Resources for Initiatives Proposed by the Secretary or the President

VA also incorporates into its budget estimate the amount of resources needed for health-care-related initiatives proposed by the Secretary or the President. For fiscal year 2011, health-care-related initiatives made up 1 percent of VA's health care budget estimate.[38] Some initiatives can be implemented within VA's existing authority, while other initiatives would require a change in law. These initiatives can vary from year to year depending on policy priorities. VA officials said the EHCPM can be used to estimate the resources needed for these initiatives if VA has the data necessary for the model's estimates to be useful. If not, VA uses other estimation methods and sometimes VA receives estimates from OMB.

Estimates for two VA health care initiatives and two presidential health care initiatives were in the President's fiscal year 2011 budget request for VA. For example, one VA initiative focused on expanding telehealth services for noninstitutional long-term care. The Secretary directed that VA include $40 million for this initiative in VA's estimate. Additionally, one presidential initiative was a governmentwide emphasis on reducing operating costs associated with maintaining surplus property. For this initiative, OMB provided VA with estimates of the savings associated with reducing these operating costs.

VA also developed estimates for the President's fiscal year 2011 budget request for 11 proposed health-care-related initiatives that require a change in law. Some proposed initiatives would increase spending while others would decrease spending. For example, VA estimated that one proposed initiative to pay travel expenses for caregivers to support veterans receiving certain VA health care services would cost $16 million in fiscal year 2011. For a different proposed initiative, VA estimated savings of $325,000 in fiscal year 2011 if VA were permitted to stop reimbursing physicians and dentists for certain continuing education expenses.[39]

[38]Health-care-related initiatives also accounted for 1 percent of VA's health care budget estimate for the advance appropriations request for fiscal year 2012.

[39]VA is required to reimburse full-time board-certified physicians and dentists for continuing professional education expenses up to $1,000 per year. 38 U.S.C. § 7411.

VA's Health Care Budget Estimate Informs the Decision-making Process for the President's Budget Request

VA's health care budget estimate prepared by VHA is reviewed at successively higher levels. Within the agency, the Secretary of VA reviews the health care budget estimate in the context of departmentwide priorities, including trade-offs between health care and other services. OMB considers VA's budget submission in light of presidential priorities and needs governmentwide. VA and OMB communicate these priorities by providing guidance.

One source of guidance for developing the budget request is the Secretary of VA. VA officials told us that each April they issue departmental guidance that may include funding targets and policy priorities. The guidance communicates the Secretary's priorities and may identify the specific VA services to be emphasized in that year's budget request. In addition to preparing the estimate for existing health care services, VHA may have to estimate the resources required to carry out a new initiative identified in guidance from the Secretary. VA officials said that in some years they may direct VHA to estimate the resources needed under different levels of demand for services to reflect a changing internal or external environment, such as legislative changes or economic conditions.

Another source of guidance for developing the budget request is OMB, which issues OMB Circular No. A-11. It includes guidance to agencies for preparing budget submissions. According to OMB staff, additional guidance from OMB gives more specific information on priorities or target funding levels. OMB staff also stated that they maintain ongoing contact with VA officials as the budget submission is formulated to provide guidance and to keep apprised of VA budgetary concerns.

The budget estimate for health care services is presented in different ways for review and decision making. VA must present the budget estimate in the appropriations accounts' structure used by Congress, but the budget estimate is also shown by broad service categories, such as acute, mental health, and institutional long-term care, and the Secretary's and President's initiatives. For the purpose of presentation in the President's Budget, agencies start from the most recently enacted appropriations, even if the President proposes changes to the structure and purposes of the appropriations accounts. Congress funds VA health care services in three appropriations accounts. The three appropriations accounts for VA health care services are:

- **Medical Services**, which includes funds for health care services provided to eligible veterans and beneficiaries in VA's medical centers, outpatient clinic facilities, contract hospitals, state homes, and outpatient programs on a fee basis;

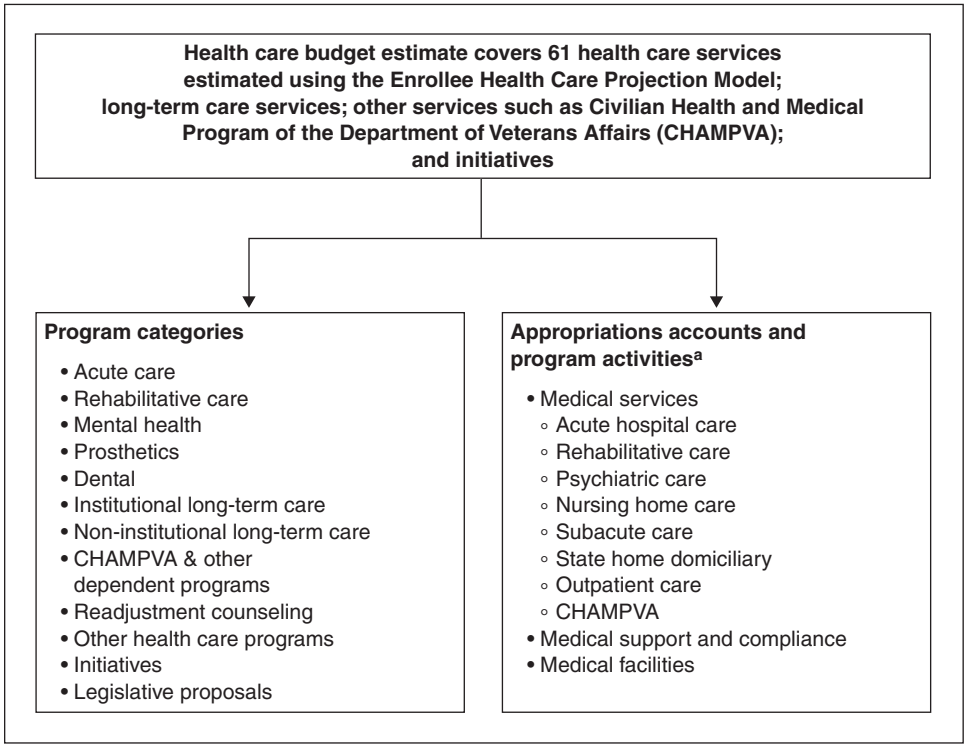
- **Medical Support and Compliance**, which includes funds for management and administration of the VA health care system, including financial management; and

- **Medical Facilities**, which includes funds for the operation and maintenance of the VA health care system's capital infrastructure, such as costs associated with utilities, facility repair, laundry services, and groundskeeping.[40]

Figure 4 shows the different structures in which the fiscal year 2011 budget estimate was presented for review and decision making.

[40]This account does not include construction funding because separate appropriations provide funding for "Major" and "Minor" construction.

Figure 4: Structures Used for Fiscal Year 2011 Budget Review and Decision Making



Source: GAO analysis of VA information on its budget estimate and VA's fiscal year 2011 Congressional Budget Justification.

[a]For fiscal year 2011, all eight program activities are in each of the three appropriations accounts; however, no funding is requested for the state home domiciliary program in the Medical Support and Compliance and the Medical Facilities accounts.

Because support and compliance (administrative) costs and facility costs are not estimated separately by the EHCPM or other methods used by VA to develop its resource estimates, VHA officials said they generally distribute the total health care budget request among the three appropriations accounts based on historical spending trends. Specifically, VA uses the proportions of funding for health care services, administration, and facility costs that were obligated in the last budget year as a baseline and makes adjustments as appropriate. For example, if VA is requesting a relative increase in maintenance efforts, VA would increase the share of the budget requested for the Medical Facilities account. Funding was requested for fiscal year 2011 for the three accounts in the following proportions: Medical Services at 77 percent, Medical Support and Compliance at 11 percent, and Medical Facilities at 12 percent.

Officials from VA's Office of Budget said that they focus on changes from the previous year and review whether the changes are consistent with past trends, whether projected trends are consistent with their expectations, and whether the changes are justified. Given that VA's Office of Budget has already reviewed the underlying assumptions in the early stages of developing the health care budget estimate, VA budget officials said that, at this point, they ensure that the budget estimate is internally consistent, the justifications are clear, and the amounts requested are reasonable. For example, the Office of Budget verifies that the resources requested are sufficient to cover the salaries for the number of employees included in the request. The Office of Budget also verifies whether the estimates for collections and new initiatives are sufficient.[41]

The Secretary of VA considers the health care budget estimate when assessing resource requirements among competing interests within VA, particularly in times of fiscal constraints. The departmentwide budget submission includes resources for the administration of veterans' compensation and benefit programs as well as proposed investments for improving the delivery of those benefits using information technology and for construction projects at hospitals and other facilities. VA officials said the Secretary most often makes trade-offs in areas such as new initiatives and new construction. As an example, VA officials said that the Secretary may want to dedicate more resources for mental health services to reduce homelessness among veterans than the budget estimate initially provided. As a result of these trade-offs, VA's budget request for health care could be different from the resource estimates developed using the EHCPM and other methods.

VA's Office of Budget includes supporting materials accompanying VA's budget request that are submitted to OMB. These supporting materials include narrative statements of selected health care services, such as mental health and homeless programs. VA also submits additional data to justify VA's request for resources. For example, VA submits detailed estimates from the EHCPM separately to OMB. According to VA officials, these estimates are used to communicate to decision makers how the estimated spending for services supports VA's mission to provide health

[41]VA has statutory authority to collect certain costs of providing health care services from third parties, such as private health insurers, and veterans' copayments. VA credits these sums to a collections fund and may transfer them to its Medical Services account.

care services to veterans instead of listing all the details of health care services in the budget submission.

In September of each year, VA transmits its departmentwide budget submission, including its budget estimate for health care, to OMB. OMB staff stated that they initially review VA's assumptions, such as economic assumptions pertaining to inflation, and review cost and utilization trends used to develop the health care budget estimate. OMB staff also review the policy priorities in VA's submission, which includes the funding request for VA health care, to verify that the President's priorities are reflected. OMB staff stated that they also talk with VHA officials to ensure that the resources requested support the initiatives as described.

Traditionally, OMB issues decisions, known as passback, to VA and other agencies in late November on the funding and policy proposals to be included in the President's budget request. OMB staff said that they consider broader resource constraints and competing priorities of other agencies when making decisions about the level of funding for VA's services. VA may appeal the decision before OMB finalizes the President's budget request.[42] The OMB decision and appeals process can result in a presidential budget request that is different from VA's budget submission to OMB. The budget formulation process culminates with OMB preparing the accompanying documents submitted to Congress in February. Concurrently, VA prepares a congressional budget justification that provides details supporting the policy and funding decisions for the President's budget request to Congress.

Agency Comments

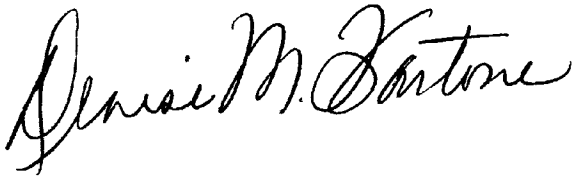
We provided a draft of this report to VA and OMB for comment. VA and OMB provided technical comments, which we incorporated as appropriate.

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

[42]According to OMB staff, the OMB decision and appeals process involves the Director of OMB and in some cases, the President.

If you or your staff have any questions about this report, please contact Randall B. Williamson at (202) 512-7114 or at williamsonr@gao.gov, or Denise M. Fantone at (202) 512-6806 or at fantoned@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 II.

Randall B. Williamson
Director, Health Care



Denise M. Fantone
Director, Strategic Issues

Appendix I: Data Sources for Utilization and Unit-Cost in VA's Enrollee Health Care Projection Model, Fiscal Year 2011

Service type	Health care service	Data source used to generate utilization and unit-cost projections: VA, Medicare, and private health insurer data	Data source used to generate utilization and unit-cost projections: VA data only
Outpatient services			
	Allergy immunotherapy	✓	
	Allergy testing	✓	
	Anesthesia	✓	
	Cardiovascular	✓	
	Chiropractic	✓	
	Consults	✓	
	Emergency room visits	✓	
	Hearing/speech exams	✓	
	Immunizations	✓	
	Maternity deliveries	✓	
	Maternity nondeliveries	✓	
	Miscellaneous medical	✓	
	Office/home visits	✓	
	Outpatient psychiatric	✓	
	Outpatient substance abuse	✓	
	Pathology	✓	
	Physical exams	✓	
	Physical medicine	✓	
	Radiology	✓	
	Surgery	✓	
	Sterilizations	✓	
	Therapeutic injections	✓	
	Urgent care visits	✓	
	Vision exams	✓	
	Compensation & pension exams		✓
Inpatient services			
	Medical	✓	
	Surgical	✓	
	Psychiatric	✓	
	Substance abuse	✓	
	Maternity deliveries	✓	
	Maternity nondeliveries	✓	

Service type	Health care service	Data source used to generate utilization and unit-cost projections: VA, Medicare, and private health insurer data	Data source used to generate utilization and unit-cost projections: VA data only
	Skilled nursing facility (non-acute)	✓	
Pharmacy services			
	Prescription drugs (brand & generic)	✓	
	Over-the-counter medication		✓
	Pharmacy-related supplies		✓
Prosthetics and other services			
	Glasses/contacts		✓
	Hearing aids		✓
	Ambulance	✓	
	Durable medical equipment: oxygen		✓
	Durable medical equipment: wheelchairs		✓
	Durable medical equipment: medical equipment and supplies		✓
	Prosthetics—artificial limbs		✓
	Orthotics		✓
	Surgical implants		✓
	VA specialized products		✓
	Recreational therapy		✓
Special VA inpatient services			
	Blind rehabilitation		✓
	Spinal cord injury		✓
	Sustained treatment and rehabilitation		✓
	Residential rehabilitation		✓
	Compensated work therapy/transitional residence		✓
Dental services			
	Preventative and basic dental services		✓
	Minor restorative dental services		✓
	Major restorative dental services		✓
Special VA outpatient mental health services			
	Domiciliary aftercare/screening/outreach		✓
	Day treatment center/Psychosocial Rehabilitation and Recovery Center		✓
	Homeless		✓

Service type	Health care service	Data source used to generate utilization and unit-cost projections	
		VA, Medicare, and private health insurer data	VA data only
	Opioid substitution program		✓
	Mental health intensive case management		✓
	Work therapy		✓
	Community residential care		✓

Source: GAO analysis of VA documentation of the Enrollee Health Care Projection Model.

Appendix II: GAO Contacts and Staff Acknowledgments

Contacts

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In addition to the contacts named above, James C. Musselwhite and Melissa Wolf, Assistant Directors; Rashmi Agarwal; Deirdre Brown; Amber G. Edwards; Krister Friday; Lauren Grossman; Tom Moscovitch; Lisa Motley; Leah Probst; Steve Robblee; and Jessica Smith made key contributions to this report.

Related GAO Products

VA Health Care: Spending for and Provision of Prosthetic Items. GAO-10-935. Washington, D.C.: September 30, 2010.

VA Health Care: Reporting of Spending and Workload for Mental Health Services Could Be Improved. GAO-10-570. Washington, D.C.: May 28, 2010.

Continuing Resolutions: Uncertainty Limited Management Options and Increased Workload in Selected Agencies. GAO-09-879. Washington, D.C.: September 24, 2009.

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

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

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

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

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

VA Long-Term Care: Trends and Planning Challenges in Providing Nursing Home Care to Veterans. GAO-06-333T. Washington, D.C.: January 9, 2006.

VA Long-Term Care: More Accurate Measure of Home-Based Primary Care Workload Is Needed. GAO-04-913. Washington, D.C.: September 8, 2004.

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