



September 2020

VA HEALTH CARE

Additional Steps Could Help Improve Community Care Budget Estimates

Accessible Version

Why GAO Did This Study

In fiscal year 2019, VA obligations for veterans' community care accounted for over 17 percent of all obligations for VA health care. In implementing the VA MISSION Act of 2018, VA continues to focus on community care as a way to improve veterans' access to health care. When informing Congress of the resources needed for community care, VA must ensure its budget estimates, which are based mostly on actuarial projections, are reliable. The process to develop these estimates is inherently complex, as it requires making assumptions based on imperfect information.

GAO was asked to review VA's efforts to develop projections for community care. This report (1) describes VA's actual community care obligations for fiscal years 2018 and 2019 and estimated obligations for fiscal years 2020 through 2022 and (2) examines VA's processes related to its use of actuarial modeling for developing budget estimates for community care, among other objectives. GAO reviewed VA data and documents used to develop estimates for the budget requests for fiscal years 2020 through 2022, the most recent years for which data and documents were available. GAO also interviewed officials from VA and its actuarial consultant responsible for developing estimates.

What GAO Recommends

GAO recommends that VA (1) communicate information on data quality to its actuarial consultant and (2) assess and communicate overall uncertainty associated with actuarial projections to stakeholders. VA concurred with GAO's recommendations.

View [GAO-20-669](#). For more information, contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov or Frank Todisco at (202) 512-2700 or todiscof@gao.gov.

VA HEALTH CARE

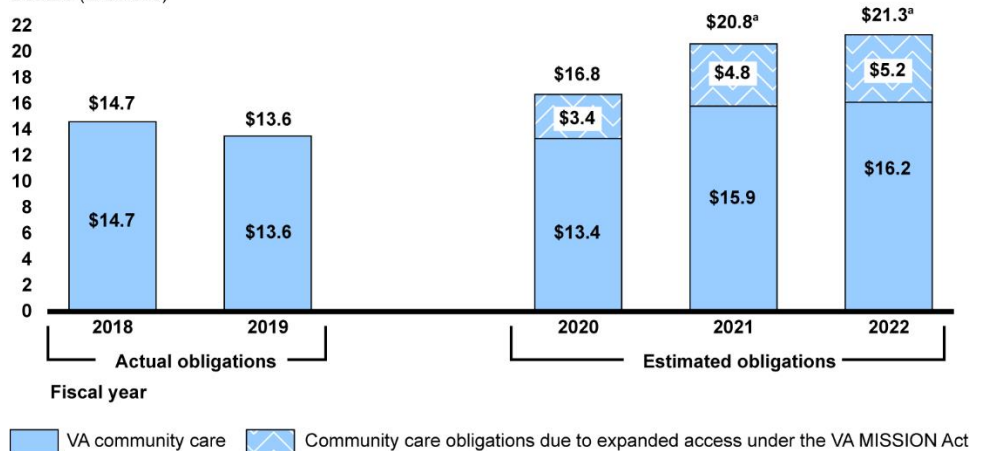
Additional Steps Could Help Improve Community Care Budget Estimates

What GAO Found

To help ensure veterans' access to timely health care services, the Department of Veterans Affairs (VA) purchases care from non-VA providers, known as community care. VA estimates that by fiscal year 2022, its obligations for veterans' community care will total \$21.3 billion, an increase of \$6.6 billion (45 percent) from fiscal year 2018. This estimated increase reflects implementation of the VA MISSION Act of 2018, which, among other things, expanded veterans' access to community care starting in June 2019.

VA Actual and Estimated Community Care Obligations, Fiscal Years 2018 through 2022

Dollars (in billions)



Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-20-669

^aTotals may not sum due to rounding.

Each year, VA develops an estimate of the budgetary resources needed to provide VA health care services, including community care, by following established processes. However, when providing data to its consultant responsible for the actuarial modeling, VA does not communicate all relevant information on the quality of its community care utilization and cost data, including any limitations affecting these data. VA officials responsible for providing the data told GAO that they rely on the offices that compile and validate the data for use throughout the department, without collecting information on the data quality from those offices. Such information could improve the actuarial modeling. In addition, VA does not fully assess and communicate to stakeholders the degree of uncertainty inherent in actuarial projections for community care that directly inform the community care budget estimates. VA officials told GAO that stakeholders have an awareness that actual community care experience may differ from projections. By fully assessing and communicating the degree of overall uncertainty associated with its projections, however, VA stakeholders would have more comprehensive information for responding to uncertainty affecting model projections when making decisions regarding VA's community care budget estimates.

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Abbreviations

ASOP	actuarial standard of practice
CCN	community care network
COVID-19	Coronavirus Disease 2019
EHCPM	Enrollee Health Care Projection Model
OMB	Office of Management and Budget
RVU	relative value unit
VA	Department of Veterans Affairs
VAMC	VA medical center
VCCP	Veterans Community Care Program
VHA	Veterans Health Administration

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September 30, 2020

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 Representatives

In fiscal year 2019, the Department of Veterans Affairs (VA) provided care to over 7 million patients—mostly veterans—and obligated nearly \$80 billion for that care.¹ The majority of veterans who utilize VA health care services receive care in VA-operated medical facilities, including 170 VA medical centers (VAMC) and over 1,000 outpatient facilities. However, eligible veterans may also obtain services from non-VA providers—known as community care—when they face long wait times at or lengthy travel distances to VA medical facilities, or when they meet other established eligibility criteria.²

¹In fiscal year 2019, veterans accounted for around 6.3 million of the over 7.0 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. An 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).

²For the purposes of this report, unless otherwise indicated, the term VA community care refers to the services the department purchases outside of VA medical facilities for veterans only. VA also purchases care for other eligible non-veteran beneficiaries, including veterans' spouses and dependent children, from community providers under certain VA health care programs, such as the Civilian Health and Medical Program of the Department of Veterans Affairs. See appendix I for information on the obligations related to community care purchased for other eligible beneficiaries.

Congress has taken steps to expand veteran access to VA community care in the last several years. The Veterans Access, Choice, and Accountability Act of 2014 created the temporary Veterans Choice Program, which, as we previously reported, contributed to an increase in overall community care obligations of \$6.7 billion from fiscal year 2014 to fiscal year 2018.³ The number of veterans authorized to use community care also increased by more than 500,000 during this time period.

More recently, beginning in June 2019, VA implemented a permanent program, called the Veterans Community Care Program (VCCP), as required by the VA MISSION Act of 2018.⁴ The VCCP consolidated or replaced many of VA's prior community care programs, including the Veterans Choice Program. The VA MISSION Act requires VA to provide veterans with the option to receive care in the community under certain circumstances, such as when VA does not operate a full-service facility in the state in which the veteran resides, and to establish designated access standards for eligibility. The VA MISSION Act, also established for veterans, expanded access to urgent care and immunizations from community care providers.

³The Act also provided \$10 billion in funding for the Veterans Choice Program, which was implemented in early fiscal year 2015 and authorized until such funds were exhausted or through August 7, 2017. Pub. L. No. 113-146, §§ 101, 802, 128 Stat. 1754, 1755-1765, 1802-1803 (2014). Additional funding for the Veterans Choice Program was provided on three separate occasions to allow the program to continue operating. 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); and 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, 1429, 1480 (2018). In fiscal years 2014 and 2018, VA obligated \$8.2 billion and \$14.9 billion for community care, respectively. These amounts reflect all funding sources for community care and include community care provided to veterans as well as programs for eligible non-veteran beneficiaries. For more information on growth in community care authorizations and obligations, see GAO, *VA Health Care: Estimating Resources Needed to Provide Community Care*, [GAO-19-478](#) (Washington, DC: June 12, 2019).

⁴Pub. L. No. 115-182, tit. I, § 101, 132 Stat. 1393, 1395-1404 (2018).

In light of the increased significance of community care in VA's overall health care budget, the department has made changes to its processes for developing budget estimates related to this care. Beginning with the President's fiscal year 2018 budget request, VA updated its Enrollee Health Care Projection Model (EHCPM), the actuarial model it uses to estimate approximately 90 percent of its health care budget, to separately estimate the resources needed to purchase care veterans receive in the community. These estimates inform the annual President's budget request for VA health care services—a request for appropriations for the following 2 fiscal years.⁵

The process to develop these estimates is inherently complex, as it requires making assumptions based on imperfect information to predict obligations for VA health care 3 and 4 years into the future. For this reason, VA's budget estimate is prepared in the context of uncertainties about the future—including changes in veterans' needs, future economic conditions, and shifting leadership priorities. For instance, the updated assumptions for the modeling that informed the most recent budget request for fiscal years 2021 and 2022 were developed beginning in the summer of 2018 through the spring of 2019 based on utilization, enrollment, and other data for fiscal year 2018. Given this timeframe, data used for modeling did not reflect actual experience under the VCCP or other community care-related provisions of the VA MISSION Act, such as access to urgent care in the community, so VA needed to make assumptions about their effects on enrollment, utilization, and unit costs with limited information.

In addition, the unprecedented effects of the Coronavirus Disease 2019 (COVID-19) pandemic on health care systems, including VA, is a recent example of conditions that could not have been reasonably anticipated when VA developed its health care budget estimates for fiscal years 2020 through 2022. Predicting the effects of implementing a new program, such as the expanded access to services in the community under the VA MISSION Act, adds to this uncertainty, as there is limited experience operating the program on which to base assumptions used to project veterans' utilization and the associated effects on the VA health care budget.

⁵In its annual appropriations for VA health care, Congress includes advance appropriations that become available one fiscal year after the fiscal year for which the appropriations act was enacted.

In light of these challenges, and the continued expansion of VA community care under the VA MISSION Act, you asked us to examine VA's practices for accurately projecting veterans' utilization of and costs for community care. This report

1. describes VA's actual and estimated obligations for community care, including obligations associated with the VA MISSION Act;
2. describes how VA developed budget estimates for community care that reflected implementation of the VA MISSION Act; and
3. examines VA's processes related to its use of actuarial modeling for developing budget estimates for community care.

To describe VA's actual and estimated obligations for community care, including obligations associated with the VA MISSION Act, we reviewed data from VA's budget justifications and other data provided by VA on actual obligations for fiscal years 2018 and 2019, the most recently completed fiscal years for which data were available.⁶ We also reviewed the budget justification and other data provided by VA on estimated obligations for fiscal years 2020 through 2022.⁷ The community care data we reviewed included obligations related to both payments to community care providers and the administration of those services.⁸ For comparison purposes, we reviewed data on VA's total obligations for health care services, including the proportion of VA facility care—that is, care provided in VA facilities—and community care, and the growth in obligations in each of those categories. Finally, we examined the proportion of community care obligations that are associated with

⁶In addition to reporting on prior fiscal year obligations, the budget justification provides Congress with estimates and other information to support the policies and spending decisions in the President's budget request. In particular, 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.

⁷The budget justification for the fiscal year 2020 President's budget request reported actual obligations for fiscal year 2018 and estimated obligations for fiscal years 2019 through 2021. The budget justification for the fiscal year 2021 President's budget request reported actual 2019 obligations as well as estimated obligations for fiscal years 2020 through 2022. Estimated obligations for fiscal year 2022 informed the advance appropriation request for that fiscal year. We note that the budget projections we reviewed were initially developed in 2019, before effects of the COVID-19 pandemic on VA health care services and VA's budget could have been reasonably anticipated.

⁸As noted above, we focus on community care obligations related to provision of health care services to veterans in this report, and we did not include analysis of obligations related to community care programs for other eligible beneficiaries.

administration of the VA MISSION Act and how these have contributed to the growth in community care obligations. We assessed the reliability of the VA data on obligations for health care services by checking for missing values and outliers and interviewing officials knowledgeable of the data. As a result of these steps, we determined that the data were sufficiently reliable for the purpose of reporting on actual obligations and VA's estimates of future obligations.

To describe how VA developed budget estimates for community care that reflected implementation of the VA MISSION Act, we reviewed VA's budget justifications for fiscal years 2020, the first to include estimates for the effects of the VA MISSION Act, and 2021—the most recently published. We analyzed documents from VA and its actuarial consultant related to the actuarial models used to estimate the effects of the VA MISSION Act on community care enrollment, utilization, and unit costs, including related assumptions and budget estimates produced by those models.⁹ We also analyzed documents related to other methods used to estimate obligations for the administration of community care services through the VA MISSION Act, such as the community care network (CCN) contracts.¹⁰

To examine VA's processes related to its use of actuarial modeling for developing budget estimates for community care, we reviewed documentation from VA and its actuarial consultant on the processes to update the data used in the EHCPM and to update the model itself, the analyses performed to quantify the effect of different variables on projections, and the way officials communicate the effects of model updates and policy decisions to stakeholders inside and outside of VA. We examined VA's actuarial consultant's role in the actuarial modeling processes in the context of actuarial standards of practice.¹¹ The results of this assessment are included in appendix II. Our actuarial work on this

⁹VA's actuarial consultant, Milliman Inc., developed the EHCPM with VA in 1998. Since its development, Milliman has continued to provide actuarial analyses and support in updating the EHCPM annually.

¹⁰CCN contractors develop and administer networks of community providers, and they facilitate payment of community provider claims when veterans access VA community care.

¹¹Actuarial standards of practice are promulgated by the Actuarial Standards Board. These standards describe the procedures an actuary should follow when performing actuarial services and identify what the actuary should disclose when communicating the results of those services.

engagement was conducted by a GAO Senior Actuary (identified in the Staff Acknowledgements section of this report) and GAO's Chief Actuary, who collectively meet the qualification standards of the American Academy of Actuaries to conduct the actuarial aspects of our work for this report. While we conducted actuarial reviews of models and processes, we did not evaluate the accuracy or reasonableness of VA's projections or their underlying assumptions, as that type of analysis was outside the scope of this report. Additionally, we assessed VA's processes related to its use of actuarial modeling for developing budget estimates for community care in the context of federal internal control standards for risk assessment and information and communication.¹²

For all objectives, we interviewed 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 VA's Office of Management.

We conducted this performance audit from July 2019 to September 2020 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 the evidence obtained provides a reasonable basis for our findings and conclusions on our audit objectives.

Background

VA Community Care and the VA MISSION Act

In June 2019, VA implemented its current community care program, the VCCP, as required under the VA MISSION Act. Previously, the Veterans

¹²Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. In this review, we relied specifically on internal control Principle 7, which states, "Management should identify, analyze, and respond to risks related to achieving the defined objectives"; and Principle 15, which states, "Management should externally communicate the necessary quality information to achieve the entity's objectives." GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 2014).

Access, Choice, and Accountability Act of 2014 created the temporary Veterans Choice Program for 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.¹³ The Veterans Access, Choice, and Accountability Act of 2014 also provided an initial \$10 billion to be deposited in the Veterans' Choice Fund. Subsequent legislation provided additional funding and extended the timeline of the Veterans' Choice Program until June 2019, when it would be replaced by the VCCP. Among other things, such as introducing a new urgent nonemergency care benefit, the VA MISSION Act established the VCCP, which consolidated or replaced VA's previous community care programs, including the Veterans Choice Program and Patient-Centered Community Care Program.¹⁴

The VA MISSION Act also established criteria under which a veteran may be eligible for the VCCP. For example, veterans are eligible to receive care under the VCCP when services are not available at a VAMC, VA cannot furnish care within its designated access standards, or a VA provider deems it is in the veteran's best medical interest.¹⁵ Additionally, the new urgent care benefit increases veterans' ability to choose health care in the community, including the VCCP. The VA MISSION Act allows eligible veterans to obtain health care services from community providers

¹³Veterans became eligible to participate in the Veterans Choice Program in six ways: (1) the next available medical appointment with a VHA clinician was more than 30 days from the veteran's preferred date or the date their physician determined the veteran should be seen; (2) the veteran lived more than 40 miles driving distance from the nearest VHA facility with a full-time primary care physician; (3) the veteran needed to travel by air, boat, or ferry to the VHA facility that was closest to his or her home; (4) the veteran faced an unusual or excessive burden in traveling to a VHA facility based on geographic challenges, environmental factors, or a medical condition; (5) the veteran's specific health care needs, including the nature and frequency of care needed, warranted participation in the program; or (6) the veteran lived in a state or territory without a full-service VHA medical facility.

¹⁴VA describes the Patient-Centered Community Care program as a nationwide network of community providers that provides eligible veterans' access to care that is not readily available through VA health care facilities. VA has several other community care programs that serve veterans but were not consolidated into the VCCP. These include agreements with federal partners and academic affiliates, emergency care, and the State Home Per Diem Programs.

¹⁵In general, except for certain emergency and pharmacy, and limited, non-emergent (urgent) 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. Each authorization may result in multiple appointments, and a single veteran may have multiple authorizations under different community care programs.

under the VCCP when they (1) are enrolled in VA's health care system, or are not enrolled but otherwise entitled to hospital care; and (2) receive VA's approval for community care because of one of the following:

- need a service that is not available at their VAMC,
- live in a U.S. state without a full-service VAMC, or
- qualify under the grandfathered provision related to distance eligibility for the Veterans Choice Program and resides in certain states.¹⁶

The VA MISSION Act also required the Secretary of VA to develop three additional eligibility criteria for care in the community: (1) if they do not have adequate access to a VA provider in accordance with designated access standards; (2) if community care is in the veteran's best medical interest; or (3) the care available at their VAMC does not comply with standards for quality.¹⁷ The designated access standards developed by the Secretary of VA include the following eligibility criteria:

- veterans' average drive time to a VA provider is more than 30 minutes for primary care or more than 60 minutes for specialty care; and
- the next available appointment with a VA provider is not available within 20 days for primary care or 28 days for specialty care of the date of request for care.¹⁸

¹⁶See Pub. L. No. 115-182, tit. I, § 101, 132 Stat. 1393, 1395-1404 (2018), codified at 38 U.S.C. § 1703(d), (e), and implementing regulations at 38 C.F.R. §§ 17.4000 - 17.4040. U.S. states and territories without a full-service VAMC include Alaska; Hawaii; New Hampshire; and the U.S. territories of Guam, American Samoa, the Northern Mariana Islands, and the U.S. Virgin Islands.

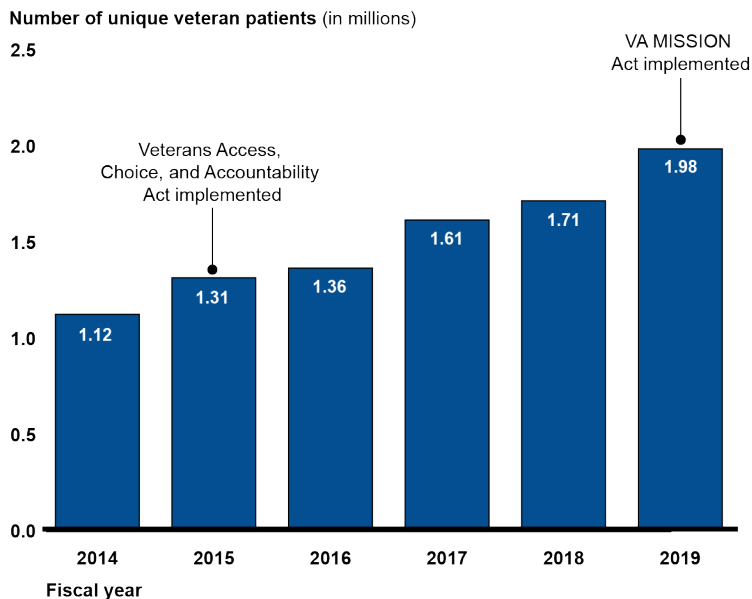
¹⁷The best medical interest criteria is used for the purpose of achieving improved clinical outcomes for the veteran based on one or more of the following factors, as applicable: the distance between the veteran and the VA medical facility providing the care, the nature of the needed care, the frequency of the needed care, the timeliness of available appointments for the needed care, the potential for improved continuity of care, the quality of the care provided, or whether the veteran faces an unusual or excessive burden in accessing a VA medical facility.

¹⁸A veteran can agree to an appointment with a longer wait time than this eligibility standard in consultation with his or her VA provider.

Veterans' Use of Community Care

Veterans' use of community care has steadily increased over the past 5 years. VA reported that the number of veteran patients receiving care in the community reached almost 2 million in fiscal year 2019—an increase of 51 percent since VA implemented the Veterans Choice Program early in fiscal year 2015.¹⁹ (See figure 1.) This number represented about 32 percent of all veterans who VA reported have accessed VA health care services that year (approximately 6.3 million veterans).

Figure 1: Veteran Patients Receiving Community Care, Fiscal Years 2014 through 2019



Source: GAO analysis of VA data. | GAO-20-669

Notes: Veteran community care patients refers to individual veterans whose treatment is provided at a non-VA facility but is paid for by VA. The Veterans Access, Choice, and Accountability Act of 2014 created the temporary Veterans Choice Program. Pub. L. No. 113-146, §§ 101, 128 Stat. 1754, 1755-1765 (2014). The VA MISSION Act of 2018 required VA to implement a permanent community care program, called the Veterans Community Care Program, beginning in June 2019. Pub. L. No. 115-182, tit. I, § 101, 132 Stat. 1393, 1395-1404 (2018).

¹⁹Veteran patients are individual veterans treated at a VA medical facility or whose treatment is paid for by VA.

Community Care Networks

Prior to enactment of the VA MISSION Act, in December 2016, VA issued a request for proposals for third party contractors to develop and administer regional CCNs of licensed health care community providers. Under the VCCP, these contractors are responsible for recruiting and building community provider networks and paying community provider claims. Contracts for Regions 1 through 4 were awarded to Optum Public Sector Solutions Inc. or TriWest Healthcare Alliance.²⁰ As of September 2020, the contracts for Region 5 and Region 6 have not been awarded.²¹

Budget Estimate Development Using EHCPM

VA uses the EHCPM to develop approximately 90 percent of its health care budget estimate and uses other methods for the remainder of the estimate. VA and its actuarial consultant, Milliman Inc., use the EHCPM to make projections 3 and 4 years into the future for budget purposes based on data from the most recent fiscal years. For example, in 2019, VA used data from fiscal year 2018 to develop the President's budget request for the fiscal year 2021 and advance appropriation request for fiscal year 2022.

Beginning with the President's fiscal year 2018 budget request, VA updated its EHCPM to directly estimate most of the resources needed to purchase community care for veterans.²² Specifically, VA updated the

²⁰Region 1 corresponds roughly with the Northeast and Mid-Atlantic geographic regions. Region 2 corresponds roughly with the Great Lakes and Midwest. Region 3 corresponds roughly with the Southeast. Region 4 includes all remaining continental U.S. states and Hawaii, and it corresponds roughly with the Rocky Mountains, Southwest, and Pacific coastal states. VA implemented the CCN contracts by region in a phased approach by VAMC, beginning with Region 1. For VAMCs in Regions 1, 2 and 3, VA allowed VAMCs to continue using TriWest Healthcare's existing Patient-Centered community care network for a designated time frame, while the new contractor continued to grow the CCN to meet each VAMC's provider network needs.

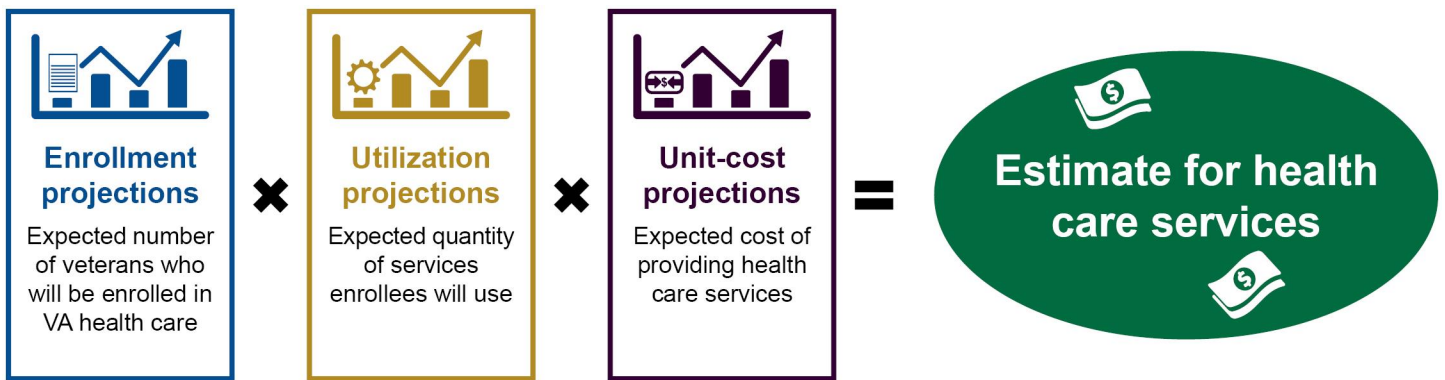
²¹Region 5 is comprised of Alaska. Region 6 includes the Pacific Island territories.

²²VA first developed a separate estimate of the resources it would need for community care in order to inform the President's fiscal year 2017 budget request. 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 facilities, because all these services were to be funded through the same appropriation account. See [GAO-19-478](#), 19.

EHCPM to estimate the amount of resources needed to purchase a set of more than 40 community care services. These health care services were grouped into seven service types and include outpatient care, inpatient care, and long-term care. 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 for non-veterans—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.²³

The EHCPM’s estimates are based on three basic components (see figure 2).²⁴ 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.

Figure 2: Basic Components of the Department of Veterans Affairs’ (VA) Enrollee Health Care Projection Model (EHCPM)



Source: GAO Analysis of VA Information. | GAO-20-669

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

²³VA provides payment on a per diem basis for eligible veterans who participate in the state home per diem program. Under this program, eligible veterans may receive nursing home, domiciliary, or adult day care services through state veterans homes. Non-veteran community care programs are programs that allow certain non-veteran eligible beneficiaries, including veterans’ spouses and dependent children, to obtain care in the community. Other methods include those used for developing estimates of the resources needed for the state home per diem program and non-veteran community care programs. For further description of these other methods, see [GAO-19-478](#), 39.

²⁴Unit 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.

care programs or insurers. Additionally, the EHCPM includes adjustments to incorporate the age, gender, priority level, and geographic location of enrolled veterans.

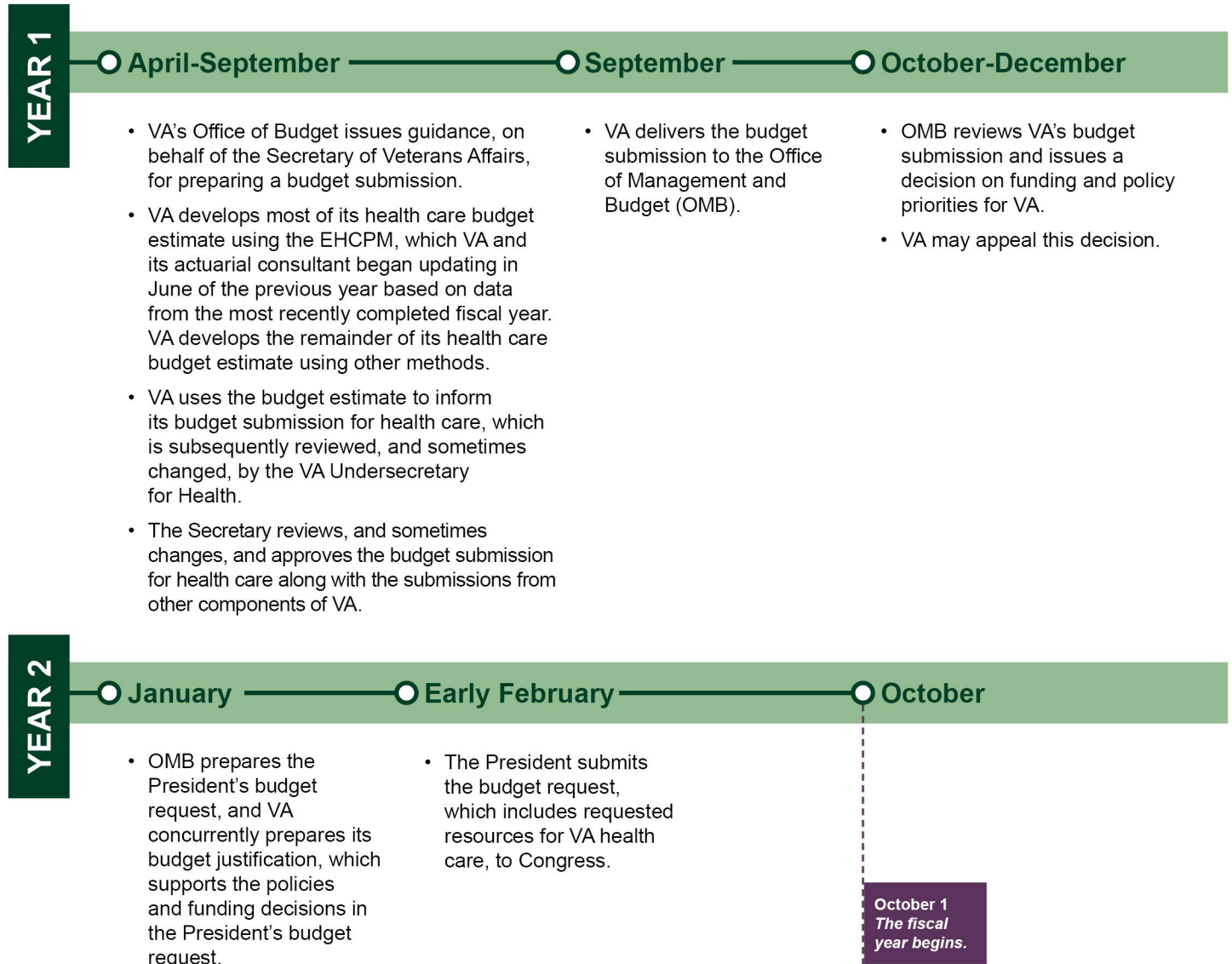
Budgetary needs estimated through the EHCPM and other methods reflect both direct patient costs—that is, the cost of providing health care services either through VA facilities or community providers—and costs for the administration of these services. Administrative costs include coordination of enrollment and referrals; claims processing; overhead related to managing VA programs, such as salaries for the Office of Community Care; and fees paid to third party contractors, such as in the CCN contracts. While some administrative costs are modeled through the EHCPM, others, such as those related to the CCN contracts, are estimated through other processes. Costs estimated through other methods are added to costs modeled in the EHCPM through an adjustment process, which may also involve adjustments made for updated data and new policies.

In June of each year, VA and its actuarial consultant begin their annual work that will culminate in updated assumptions for the EHCPM in the next year. Using enrollment, utilization, and cost data compiled and provided by VA's Office of Enrollment and Forecasting, according to agency officials, VA's actuarial consultant performs various analyses—such as comparing actual utilization to projections from prior EHCPMs—that will inform the assumptions used in the new EHCPM for projecting VA's budgetary needs. According to officials from VA and its actuarial consultant, assumptions are generally updated to reflect judgements regarding the most recent enrollment, utilization, and cost trends as well as the potential effects of new program policies, requirements, and initiatives.

VA's budget estimate for health care services is successively reviewed at higher levels within VHA, by the Secretary of VA, and finally within the Office of Management and Budget (OMB) to inform the President's budget request. VA generally starts to develop a health care budget estimate in April of each year, approximately 10 months before the President submits the budget to Congress, which should occur no later than the first Monday in February. The budget estimate changes during the 10-month budget development process, in part, due to successively higher levels of review in VA and OMB before the President's budget request is submitted to Congress. The Secretary of VA 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. The congressional budget justification contains actual obligations for the most recently completed fiscal year at the time of the release, and estimated obligations for the current fiscal year, as well as the 2 years for which VA is requesting appropriations. For example, the congressional budget justification related to the fiscal year 2021 President’s budget request, which was released in February of 2020, contains actual obligations for fiscal year 2019 and estimated obligations for fiscal years 2020 through 2022. (See figure 3.)

Figure 3: Timeline for Developing Budget Estimates Using the Department of Veterans Affairs' (VA) Enrollee Health Care Projection Model (EHCPM)



Source: GAO analysis of VA and OMB process. | GAO-20-669

VA Estimated Obligations for Community Care to Increase through Fiscal Year 2022, Largely

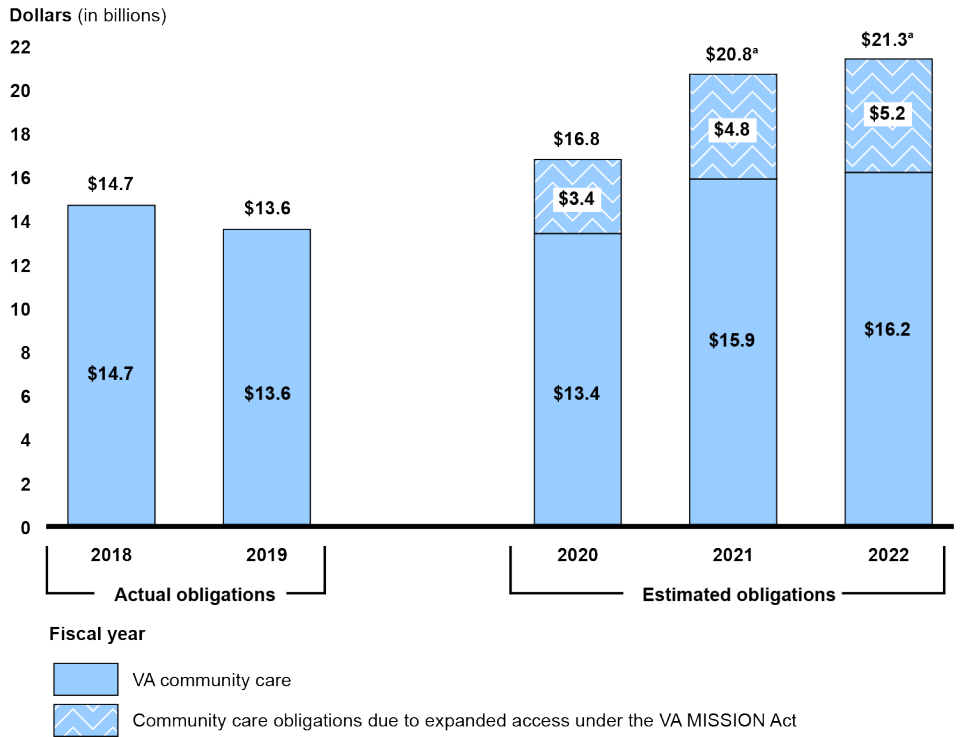
Due to Increased Utilization Resulting from Implementing the VA MISSION Act

According to our analysis of VA's obligation data, the department estimated annual obligations for community care to increase by 6.6 billion, or almost 45 percent, from fiscal years 2018 through 2022 (\$14.7 billion to \$21.3 billion). This growth is primarily due to the effects of the VA MISSION Act.²⁵ VA's estimates for fiscal years 2020 through 2022 showed that implementation of the VA MISSION Act would require billions of dollars in additional obligations for community care each year. Specifically, the department estimated it would need to obligate an additional \$3.4 billion in fiscal year 2020, \$4.8 billion in fiscal year 2021, and \$5.2 billion in fiscal year 2022 as a result of the increased utilization of community care under the VA MISSION Act. (See figure 4.)²⁶

²⁵As previously noted, these amounts do not reflect any potential effect of or VA's response to the COVID-19 pandemic. At the time we conducted this performance audit, VA had not yet determined the effects of the pandemic on obligations for veterans' health care services. This report excludes obligations for VA health care services provided to non-veterans. For a description of obligations for non-veteran community care programs, see appendix I.

²⁶Based on assumptions developed by VA for the fiscal year 2021 President's budget, the VA MISSION Act will be fully implemented by fiscal year 2021. The amount of community care obligations attributed to new VA MISSION Act requirements continues to grow in fiscal year 2022 due to general increases in both VA community and facility care.

Figure 4: Department of Veterans Affairs' (VA) Obligations for Community Care, Including the Effect of the VA MISSION Act, Fiscal Years 2018 through 2022



Source: GAO analysis of VA data. | GAO-20-669

Notes: Fiscal year 2019 obligations decreased due to a change in VA policy regarding the timing of certain community care obligations. This figure does not reflect obligations that were estimated for VA facility care to meet the requirements of the VA MISSION Act. This figure also excludes obligations for health care services provided to non-veterans. Community care obligations include funds from the following VA health care appropriations accounts that support the provision of community care services: Medical Community Care, Veterans Choice Fund, Medical Services, Medical Support and Compliance, and Medical Facilities. The VA MISSION Act of 2018 required VA to implement a permanent community program, called the Veterans Community Care Program, beginning in June 2019. Pub. L. No. 115-182, tit. I, § 101, 132 Stat. 1393, 1395-1404 (2018).

^aTotals may not sum due to rounding.

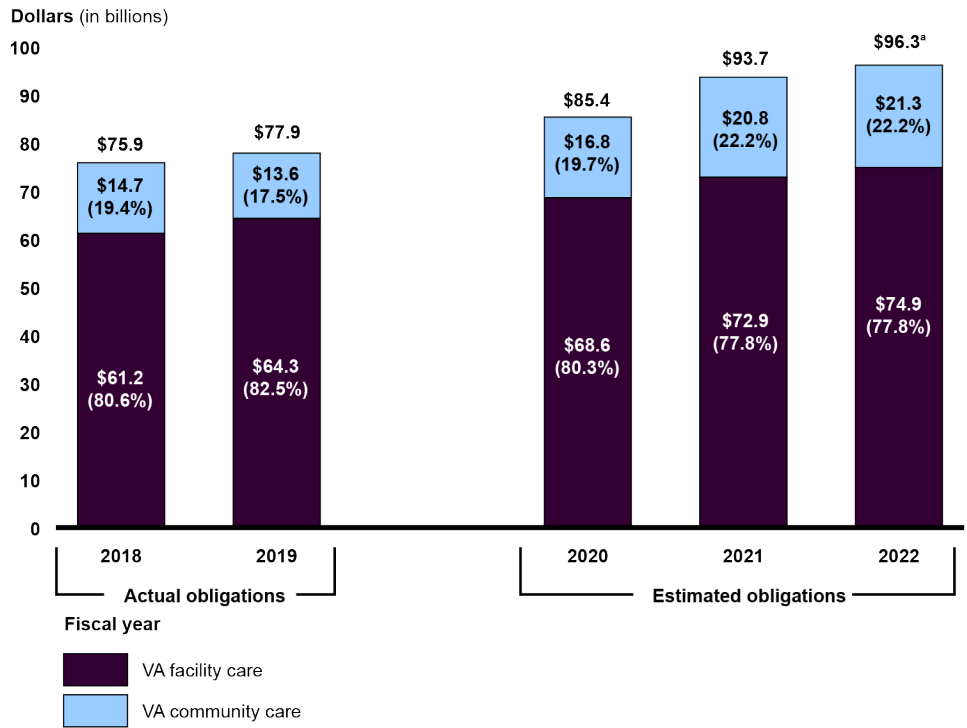
These estimated amounts reflect the implementation of new access standards for community care eligibility, such as drive time from the veteran's home to a VA facility and wait times for care within VA; access to urgent care and transplant services in the community; and the resources needed to administer the CCN contracts. The department estimated that in fiscal year 2022, implementation of the drive time and wait time access standards, which allow more veterans access to community care, would account for about \$4 billion of the \$5.2 billion in estimated obligations associated with the VA MISSION Act that year. The remaining \$1.2 billion is associated with implementation of VA MISSION

Act standards such as for urgent care, transplant services and CCN contract administration. Overall, our analysis found that total obligations for community care provided to veterans—including services provided under the VA MISSION Act—will total \$87.2 billion from fiscal years 2018 through 2022.²⁷

During the same period, our analysis found that obligations for care provided at a VA facility (VA facility care) would increase by \$13.8 billion, or almost 23 percent (\$61.2 billion to \$74.9 billion). Our analysis found that the share of VA's total obligations for health care services that is for community care is expected to increase from 19 percent in fiscal year 2018 to 22 percent in fiscal year 2022. (See figure 5.)

²⁷This report excludes obligations for VA community health care services provided to non-veterans. For a description of obligations for non-veteran community care, see appendix I.

Figure 5: Department of Veterans Affairs' (VA) Obligations for Community Care as a Share of Total Obligations for VA Health Care Services, Fiscal Years 2018 through 2022



Source: GAO analysis of VA data. | GAO-20-669

Notes: Fiscal year 2019 obligations for community care decreased due to a change in VA policy regarding the timing of certain community care obligations. The policy change did not affect obligations for VA facility care that is, care provided in VA facilities. This figure excludes community care obligations for services provided to non-veterans. We have not removed any obligations for non-veterans included with facility care data in order to align with VA's health care budget estimates for services provided in VA facilities. Community care obligations include funds from the following VA health care appropriations accounts that support the provision of community care services: Medical Community Care, Veterans Choice Fund, Medical Services, Medical Support and Compliance, and Medical Facilities.

^aTotals may not sum due to rounding.

Administrative obligations for community care. Obligations for community care include both obligations for providing care—that is, reimbursing community care providers for the care they deliver—and obligations for administering community care programs. According to agency officials, administration of community care accounts for a variety of functions, including

- care coordination activities performed by VA staff, such as referrals, eligibility verification, enrollment, and scheduling;

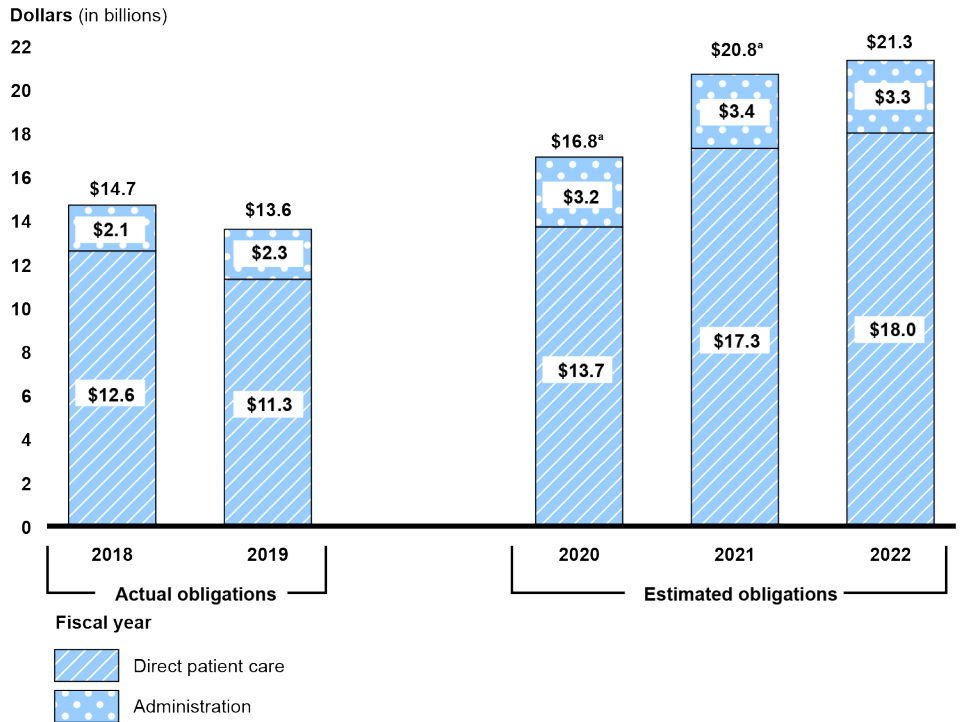
- delivery and operations activities related to billing and claims processing by VA;
- national overhead activities and costs within the VHA Central Office, such as Central Office salaries; and
- community care contracts activities related to the CCN and prior community care contracts (e.g., those for the Veterans Choice Program), including the fees paid to the contractors for developing and maintaining provider networks and other administration functions.

According to our analysis of VA's obligation data, the department estimated that obligations for the administration of community care will grow from about \$2.1 billion in fiscal year 2018 to over \$3 billion in fiscal years 2020 through 2022, an increase of more than 50 percent.²⁸ During this period, the share of obligations for administration as part of VA's total obligations for community care is expected to increase from 14 percent in fiscal year 2018 to 19 percent in fiscal year 2020 and then fall to 16 percent in fiscal year 2022.²⁹ (See figure 6.)

²⁸Our analysis of what constitutes administrative obligations is based on VA's description of the data.

²⁹VA obligations for the administration of VA facility care are not directly comparable to obligations for the administration of community care. According to VA officials, obligations for the administration of VA facility care include a variety of additional services and activities that are not included in obligations for the administration of community care, such as police and fire services and medical and prosthetic research, among others. Additionally, VA payments to community providers are intended to encompass those providers' administrative costs.

Figure 6: Department of Veterans Affairs' (VA) Obligations for Community Care and Administration of Such Care, Fiscal Years 2018 through 2022



Source: GAO analysis of VA data. | GAO-20-669

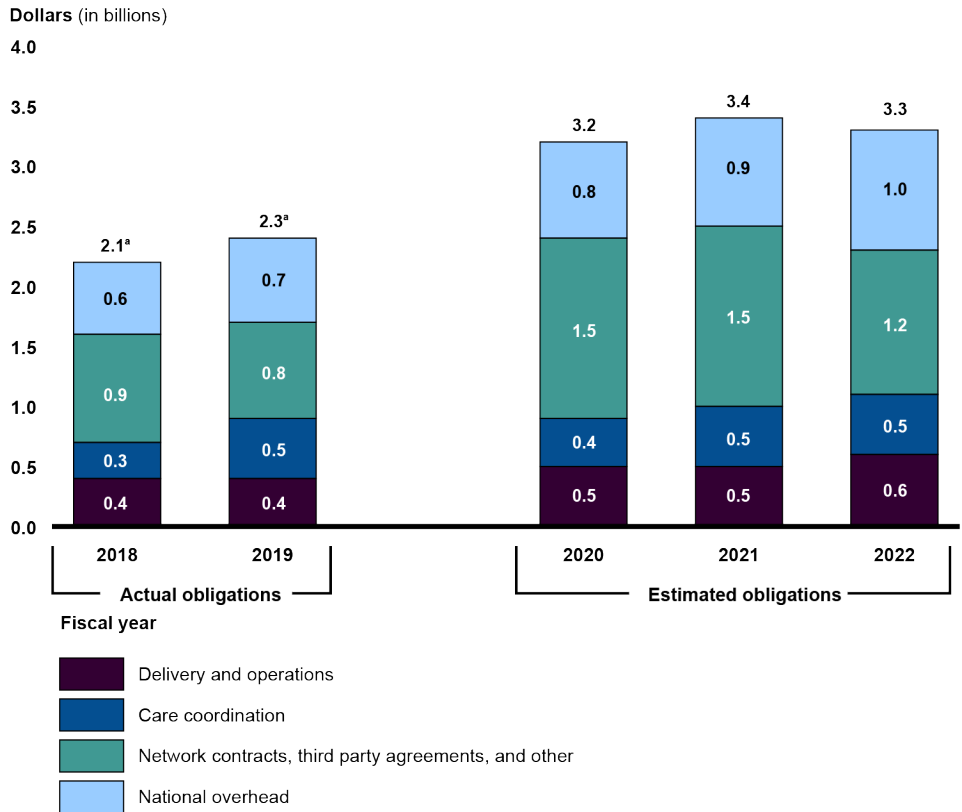
Notes: Fiscal year 2019 obligations for community care decreased due to a change in VA policy regarding the timing of certain community care obligations. Community care obligations include funds from the following VA health care appropriations accounts that support the provision of community care services: Medical Community Care, Veterans Choice Fund, Medical Services, Medical Support and Compliance, and Medical Facilities. Our analysis of what constitutes obligations for administration of community care is based on VA's description of the data.

^aTotals may not sum due to rounding.

According to our analysis of VA's data, increases in estimated obligations for administering community care are being driven, in part, by the implementation of the VA MISSION Act. Specifically, our analysis found that VA MISSION Act implementation-related obligations will account for more than 20 percent of all administrative obligations for community care by fiscal year 2022. Our analysis attributes the overall growth in obligations for the administration of community care primarily to increases in obligations for community care contracts related to expanded veteran access to community care. These obligations include those for national overhead (e.g., the salaries of officials from the VHA Central Office) allocated to community care as the number of veterans using community

care grows. For more information on the amount of administrative obligations for each type of administrative function, see figure 7.

Figure 7: Department of Veterans Affairs' (VA) Obligations for the Administration of Community Care, by Function, Fiscal Years 2018 through 2022



Source: GAO analysis of VA data. | GAO-20-669

Notes: Community care obligations include funds from the following VA health care appropriations accounts that support the provision of community care services: Medical Community Care, Veterans Choice Fund, Medical Services, Medical Support and Compliance, and Medical Facilities. Care coordination includes activities performed by VA staff, such as referrals, eligibility verification, enrollment, and scheduling. Delivery and operations includes activities related billing and claims processing by VA. National overhead includes activities within the VHA Central Office. Network contracts, third party agreements, and other includes fees paid to contractors for developing and maintaining provider networks and other functions. Our analysis of what constitutes obligations for administration of community care is based on VA's description of the data.

^aTotals may not sum due to rounding.

Community care obligations by appropriation account. VA obligates resources for community care from the department's four health care appropriations accounts and the Veterans Choice Fund. We found that VA's obligations from the Medical Community Care and Veterans Choice

Fund account for the largest share of community care obligations and include VA's reimbursements to community care providers as well as most of the fees associated with the CCN contracts.³⁰ The obligations from the Medical Support and Compliance account include delivery and operations activities related to billing and claims processing by VA. According to VA officials, VA's obligations in the Medical Services account include care coordination activities performed at VA medical facilities related to veterans' use of community care. The Medical Support and Compliance, Medical Services, and Medical Facilities accounts each include national overhead, which includes obligations such as salaries for the VHA Central Office and Office of Community Care and overhead at VA facilities. See table 1 for a breakdown of VA community care actual and estimated obligations by appropriations account, including the Veterans Choice Fund for fiscal years 2018 through 2022.³¹

Table 1: Department of Veterans Affairs' (VA) Community Care Obligations, by Appropriation Account and the Veteran Choice Fund, Fiscal Years 2018 through 2022

na	Actual obligation (dollars in billions)		Estimated obligation (dollars in billions)			na
Category	2018	2019	2020	2021	2022	Total
Medical CommunityCare	8.9	9.2	14.2	17.5	19.1	68.9
Veterans Choice Fund	4.5	2.9	0.8	1.1	0.0	9.3
Medical Support and Compliance	0.7	0.8	1.1	1.3	1.3	5.3
Medical Services	0.5	0.7	0.7	0.8	0.9	3.5
Medical Facilities	<0.1	<0.1	<0.1	<0.1	<0.1	0.2
Total	14.7	13.6	16.8	20.8	21.3	87.3

Source: GAO analysis of VA data. | GAO-20-669

Notes: Amounts may not sum due to rounding. Fiscal year 2019 obligations for community care decreased due to a change in VA policy regarding the timing of certain community care obligations. VA has four main appropriation accounts for VA health care: Medical Services (generally covers clinical staff salaries and clinical supplies and services), Medical Community Care (generally covers non-VA provided medical claims and grants for state home nursing, domiciliary, and adult day care services); Medical Support and Compliance (generally covers community care claim processing and medical facility administrative staff), and Medical Facilities (generally covers maintenance, leases, utilities, and other costs).

³⁰We found that Medical CommunityCare covers most CCN contract fees, which include administrative services such as maintaining a provider network, operating a call center, and paying claims to providers.

³¹After receiving its appropriation, VA allocates the funds in each account to its 18 regional networks and the 172 VAMCs. For an overview of the allocation process, see GAO, *Veterans Health Care: VA Needs to Improve Its Allocation and Monitoring of Funding*, GAO-19-670 (Washington, D.C.: Sept. 23, 2019). We did not audit the proper use of VA's appropriations accounts for community care obligations.

VA Used Actuarial Models and Other Methods to Develop Budget Estimates for Community Care that Reflect the Implementation of the VA MISSION Act

VA used actuarial models and other methods to develop its community care budget estimates that reflected the implementation of the VA MISSION Act. Specifically, for the fiscal years 2020 and 2021 President's budget requests, VA used actuarial models, including the EHCPM, to project the effects of VA MISSION Act implementation on veterans' demand for community care.³² However, the data available for use in this modeling did not reflect actual experience under the VA MISSION Act, so VA needed to make assumptions about the effects on enrollment, utilization, and unit cost with limited information. VA officials used other methods to estimate effects of VA MISSION Act implementation on certain administration functions—primarily those related to the administration of CCN contracts.³³

Use of actuarial models to develop budget estimates that reflect the effects of VA MISSION Act provisions. VA used its EHCPM when developing the community care budget estimates that informed the President's budget requests for fiscal years 2020 and 2021, including the advance appropriation for fiscal year 2022. In addition, VA relied on other actuarial models separate from the EHCPM to develop estimates of the additional resources needed as a result of implementing the VA MISSION Act for the fiscal year 2020 President's budget request. VA incorporated

³²The President's budget request for fiscal year 2020 was released March 11, 2019. It reported actual obligations for fiscal year 2018 and estimated obligations for fiscal years 2019 through 2021. The fiscal year 2021 President's budget request was released February 10, 2020, and reported actual 2019 obligations as well as estimated obligations for fiscal years 2020 through 2022. The fiscal year 2021 President's budget request includes advance appropriations requested for fiscal year 2022.

³³As with prior President's budget requests, VA's community care budget estimates were adjusted based on funding and policy decisions made during reviews within VA and at OMB. The decisions made for the fiscal year 2020 and 2021 President's budget requests did not reflect the effects of COVID-19 on veterans' health care utilization or the supplemental funding that VA received to cover COVID-19 related costs, which VA officials explained the department was still working to assess at the time of our review. For example, the Coronavirus Aid, Relief, and Economic Security Act included a supplemental appropriation of approximately \$17 billion for the VHA to prevent, prepare for, and respond to coronavirus. This funding is available through fiscal year 2021. Pub. L. No. 116-136, Div. B, tit. X, 134 Stat, 281, 583 (2020).

most of the effects of the VA MISSION Act implementation into the EHCPM for the estimates that informed the President's fiscal year 2021 budget request.

VA officials explained that for the President's fiscal year 2020 budget request, the first that included estimates for the effects of the VA MISSION Act, VA and its actuarial consultant initially developed actuarial models outside of the EHCPM. This facilitated timely updating and testing of new assumptions when informing both the budget process as well as the regulations that established the access standards for eligibility under the Act. Documentation obtained from the agency indicates that these actuarial models produced national-level projections based on assumptions of the effects of expanded community care access based on geographic-related standards, wait times for the next available appointment with a VA provider, and quality deficiencies, as well as increased access to urgent care services in the community.³⁴

According to these officials, VA developed actuarial models outside of the EHCPM because updating the EHCPM can require a significant amount of effort and time; the officials explained that to do so requires defining assumptions for specific geographic areas and sub-populations of veterans. The officials noted that developing separate models for VA MISSION Act provisions allowed VA to test the utilization and budgetary effects of changing assumptions and to provide more timely communication on the effects of changing these assumptions to VA and OMB leadership. Based on documentation obtained from the agency, VA and its actuarial consultant developed over 20 model projections reflecting different combinations of assumptions related to VA MISSION Act provisions to allow them to test the effects of different assumptions. According to officials from VA and its actuarial consultant, examples of these assumptions included different drive times or distances from a VA facility, how quickly the VA system would implement changes under the VA MISSION Act, and how long it would take for veterans to change their behaviors around accessing VA services based on increased access to community care services, all of which could affect veterans' utilization of community care.

³⁴In this context, geographic-related standards apply both to veterans who live 40 miles or more from a VA facility—grandfathered Veterans Choice Act veterans—and veterans who live beyond a specific driving time from a VA facility—either 30 minutes for primary care, 60 minutes for specialty care, or those who meet both these drive time standards.

When developing projections that informed the most recent President's budget request for fiscal year 2021, VA established the proposed access standards for eligibility, thus reducing the need to test a number of different factors such as veterans' drive times to VA facilities. This allowed VA to update its EHCPM incorporating most of the expected effects of the VA MISSION Act.³⁵ By updating its EHCPM, VA was able to produce more specific projections that reflected VA MISSION Act effects in specific geographic areas, instead of the national-level projections from the models outside of the EHCPM that informed the President's fiscal year 2020 budget request.

The assumptions for VA MISSION Act implementation that informed the actuarial models remained largely the same in the fiscal years 2020 and 2021 President's budget requests; the VA MISSION Act had not yet been fully implemented at the time the models were developed in fiscal years 2018 and 2019. In fact, data reflecting full implementation of the VA MISSION Act were not expected to be available for use in the EHCPM for another 2 to 3 years.³⁶ Officials based assumptions in part on data from the Veterans Choice Program as a recent example of experience with increasing access to community care.³⁷ The actuarial models

³⁵VA retained separate models where data limitations prevented full EHCPM integration, such as for the VA MISSION Act's wait time and quality related access standards for eligibility. See appendix III for more details on VA's assumptions about each of the VA MISSION Act provisions.

³⁶The modeling was based on an assumption that fiscal year 2021 would be the first year with 12 months of data reflecting full VA MISSION Act implementation, based on assumptions of how long it will take for veterans to change their behavior in response to expanded community care access. Fiscal year 2021 data will be the basis for modeling to inform the fiscal year 2024 President's budget, meaning that budget request would be the first to fully reflect actual VA MISSION Act implementation based on the timeline for EHCPM updates and developing the President's budget request. Officials also noted that the timeline to experience the effects of full VA MISSION Act implementation could change based on the yet-unknown effects of COVID-19 on VA's operation of health care services.

³⁷Specifically, VA assumed similarities between Veterans Choice Program eligible enrollees, who lived 40 miles or more from the nearest VA facility and remained eligible under the VA MISSION Act, and the veterans eligible under the VA MISSION Act's drive time access standards of 30 minutes to primary care and 60 minutes to specialty care. In addition, the populations are of similar size—veterans living 40 miles or more from the nearest facility account for about 7 percent of enrollees in VA health care, and veterans meeting one or both of the drive time standards account for 8 percent of enrollees in VA health care.

incorporated assumptions of how VA's implementation of the VA MISSION Act would affect enrollment, utilization, and unit cost.

- **Enrollment.** In its modeling, VA did not assume there would be additional enrollment in the VA health care system attributable to the VA MISSION Act's community care provisions because it assumed any potential change would be minimal based on experience with the Veterans Choice Program.³⁸ Officials from VA and its actuarial consultant noted that enrollment in VA health care is generally stable, meaning that once enrolled in the VA system, veterans tend to stay enrolled. Enrollment is affected by broader trends such as mortality—which decreases enrollment—and the number of individuals separating from military service—which increases enrollment.³⁹
- **Utilization.** In its modeling, VA assumed certain veterans eligible to access community care due to the VA MISSION Act would become more reliant on VA for health care and would increase their utilization of VA health care services.⁴⁰ In fiscal year 2017, overall veteran reliance on VA was estimated to be 36 percent. VA's actuarial modeling of the VA MISSION Act reflected the assumption that veterans eligible for community care due to their drive time to the nearest VA facility would increase their reliance to 50 percent by fiscal year 2021, and that reliance on VA for health care needs would remain at 50 percent for fiscal year 2022. For example, a veteran who previously received physical therapy outside the VA health care system paid for by private insurance may choose to instead receive the same services through VA

³⁸Following the implementation of the Veterans Choice Program, VA modeled the potential effect of the program on enrollment above and beyond other expected influences. The projections suggested enrollment increases in the VA health care system in fiscal year 2015 in certain geographic areas where 10 percent or more of veterans were eligible for community care under the Veterans Choice Program. This growth did not persist in the following years, and decreased in some years, so the cumulative growth was minimal. Officials from VA's actuarial consultant explained that the total growth of about 2,000 individuals in a total enrolled population of 9 million veterans was considered immaterial to the overall model.

³⁹VA also observed an increase in annual new enrollments during the economic crisis from 2008 to 2010, which coincided with VA expanding enrollment in priority 8 eligibility groups.

⁴⁰Reliance is the measure of the portion of an enrollee's total health care need that they are expected to receive through either VA facility care or VA community care, rather than through other health care sources such as Medicare or private insurance.

community care, thus increasing that veteran's reliance on VA for care. Officials from VA and its actuarial consultant used the department's experience under the Veterans Choice Program to develop the assumptions of increased reliance due to expanded community care access. They also based these assumptions on historical reliance levels for veterans with broad access to VA health services and lower copayment requirements due to certain service-connected conditions.⁴¹

Furthermore, VA's modeling reflected that overall utilization of VA health care would grow as a result of changing demographics and health care trends, with VA community care utilization anticipated to grow at a faster rate than VA facility care utilization due primarily to the VA MISSION Act.⁴² For the health care services that are provided to veterans through both VA facilities and the community, such as outpatient mental health care and dialysis, VA projects that the proportion of utilization met through community care will grow from 27 percent in fiscal year 2018 to 34 percent in fiscal year 2022.⁴³ (See figure 8.)

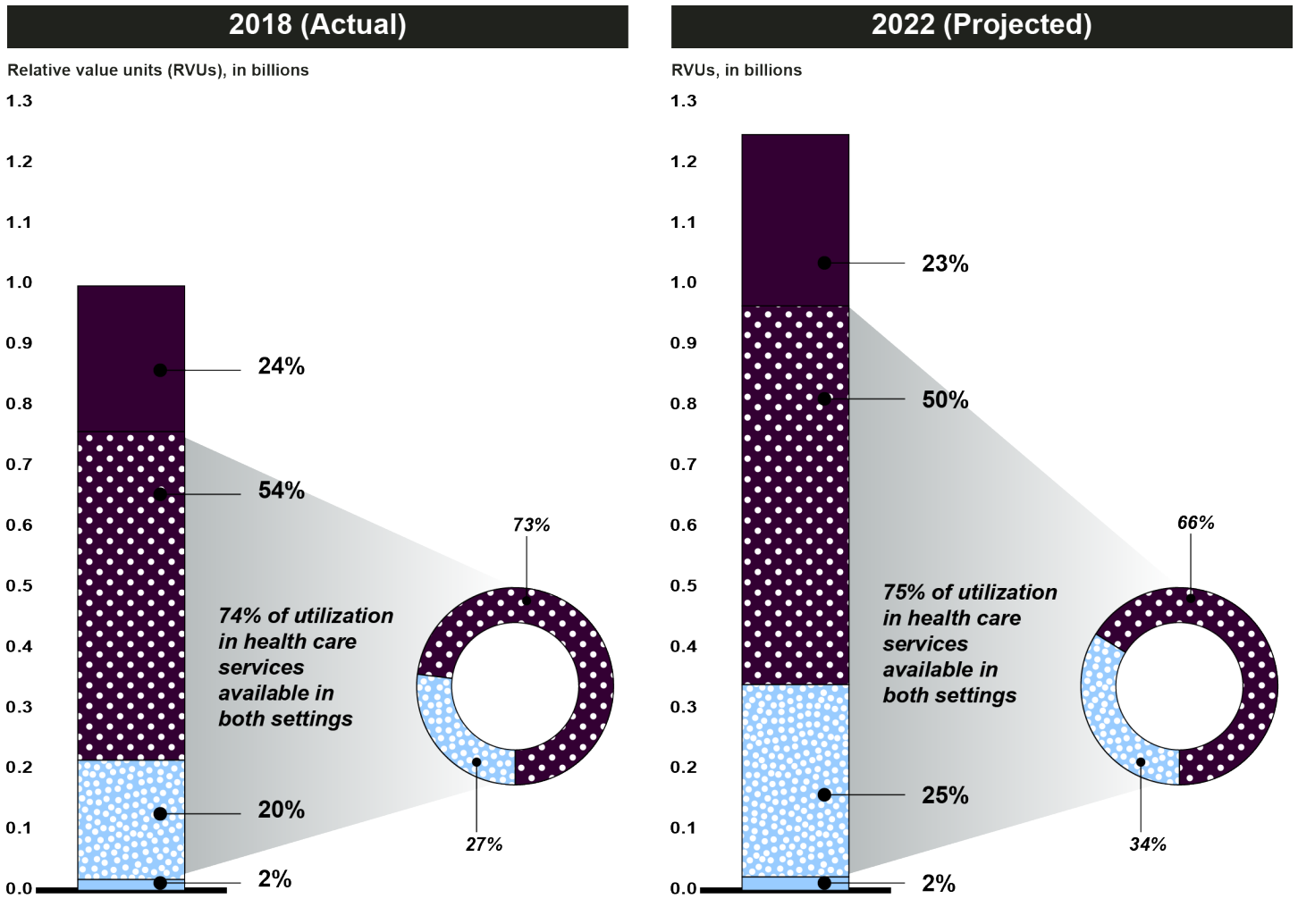
⁴¹From fiscal year 2015 to 2018, VA observed increased utilization of care in the community among veterans eligible for such care under the Veterans Choice Program, and observed no decrease in VA facility care for this population during this time period. This observation suggests that these veterans were shifting care from other health coverage to the VA health care system, thereby increasing reliance on VA. Veterans who fall into the Priority 1a enrollee group are a subset of enrollees who have a significant interaction with VA due to their service-connected conditions and minimal copays, which are payments required by the veteran to receive certain services. VA assumes reliance for this group is a reasonable benchmark for other groups of enrollees after they receive enhanced access to benefits and increase their reliance on VA, though this assumption is not specific to community care reliance.

⁴²An example of a demographic trend affecting utilization is increased morbidity in the veteran population, particularly for long term services and supports. Although the increase in veterans' reliance on VA health care due to the VA MISSION Act is primarily anticipated to increase workload for community care, it is also anticipated to have an effect on prescription drug utilization, which would increase workload for VA facility care.

⁴³In fiscal year 2018, 74 percent of all care provided to veterans was for services available both in VA facilities and available through VA community care. However, some specialty services that are generally available through VA facilities, such as oncology services, may not be available at all VA facilities. Some services, such as certain mental health programs, blind rehabilitation, and spinal cord injury programs are provided only through VA facility care. Other programs, such as home hospice care and ambulatory maternity care, are only provided in the community.

Figure 8: Actual and Projected Share of Utilization of Department of Veterans Affairs (VA) Health Care Services Provided through Facility Care and Community Care, Fiscal Years 2018 and 2022

VA projects community care utilization to grow as a proportion of utilization of services available in both VA facilities and in the community from 27 percent in fiscal year 2018 to 34 percent in fiscal year 2022.



- Services available only through VA facilities
- Services available in either VA facilities or community care, provided in VA facilities
- Services available in either VA facilities or community care, provided in the community
- Services available only through community care

Source: GAO analysis of VA data. | GAO-20-669

Notes: RVUs are a way to measure utilization based on the estimated resources needed to provide a given health care service. In fiscal year 2018, 74 percent of all care provided to veterans was for services available both in VA facilities and available through VA community care, such as outpatient

mental health and dialysis. However, some specialty services that are generally available through VA facilities, such as oncology services, may not be available at all VA facilities. Some services, such as certain mental health programs, blind rehabilitation, and spinal cord injury programs are provided only through VA facility care. Other programs, such as home hospice care and ambulatory maternity care are provided only in the community.

- **Unit cost.** In its modeling of community care unit costs for the fiscal year 2020 President's budget request, VA incorporated an expected decrease in provider payment rates for outpatient services resulting from the implementation of the CCN contracts. Based on requirements in the VA MISSION Act, the CCN contracts generally must reimburse providers based on Medicare rates, which were typically lower than the rates paid historically under VA community care programs.⁴⁴ However, updated data available for the fiscal year 2021 President's budget request, which included budget estimates for fiscal years 2020 through 2022, indicated that rates paid to community care providers were already at or near Medicare rates. The VA analysis did not identify additional areas where rates might continue to decrease, thus VA assumed no further payment rate reduction in that year's projections.⁴⁵

See appendix III for specific assumptions used in the actuarial models pertaining to specific VA MISSION Act provisions.

Other methods for developing budget estimates related to the administration of CCN contracts. Office of Community Care officials developed budget estimates for the administration of the CCN contracts, including those related to the VA MISSION Act, through methods outside of the actuarial models.⁴⁶ According to VA officials, for the fiscal years 2020 and 2021 President's budget requests, including the advance

⁴⁴The VA MISSION Act stipulated that, with some exceptions, the rate paid for care or services through the VCCP may not exceed rates paid to providers under the Medicare program. VA may negotiate rates higher than Medicare in highly rural areas, for example, to ensure a suitable number of providers are available to serve veterans living in those areas.

⁴⁵Specifically, national-level data for fiscal year 2018 showed payment for VA community care in outpatient settings at 106 percent of Medicare rates, and rates for inpatient care were essentially equal to Medicare.

⁴⁶Program officials also produced budget estimates outside of the actuarial models related to increased access to transplants through community care due to the VA MISSION Act, which expanded VA's ability to authorize community care for veterans requiring transplants. See appendix III for additional detail on these estimates and the assumptions used in the other methods outside the actuarial models.

appropriation for fiscal year 2022, VA relied largely on a cost estimate produced for the CCN contract solicitation from 2015 through 2017. That estimate was based on industry rates for certain administrative functions, such as developing and maintaining provider networks, operating call centers, complying with audit requirements, and paying providers' claims for services. Officials explained that they adjusted the initial estimates in the fiscal year 2021 President's budget to account for items such as additional contract requirements related to the VA MISSION Act, contract modifications that have been negotiated since the CCN contracts were awarded, and assumed obligations related to optional contract tasks, such as scheduling. These adjustments were characterized as ballpark estimates by VA officials; the officials explained that without actual experience operating under the CCN contracts, VA had limited data on which to base more refined estimates.⁴⁷

VA Processes for Actuarial Modeling Lack Steps for Communicating All Relevant Information on Data Quality and Overall Uncertainty Associated with Community Care Budget Estimates

VA Does Not Communicate All Relevant Information on Data Quality to Its Actuarial Consultant

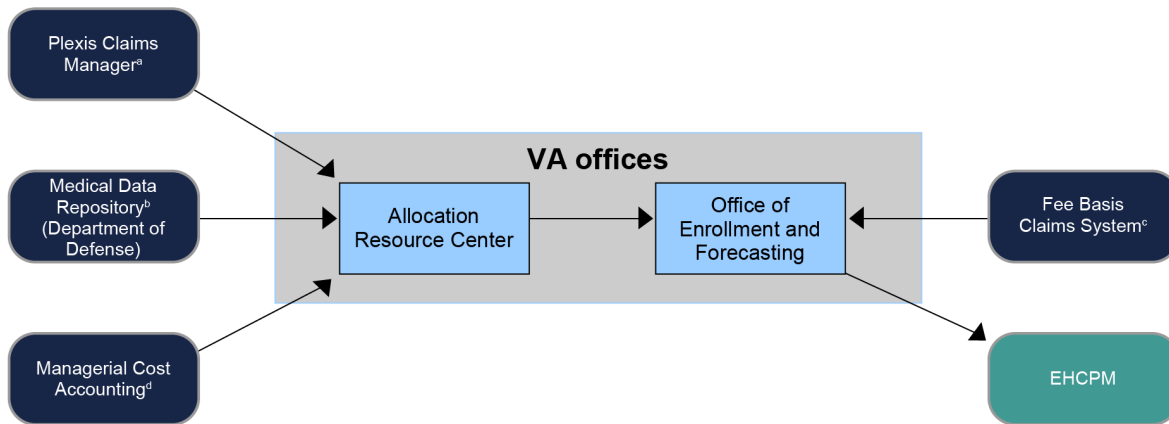
Although VA's actuarial consultant relies on the department to ensure the quality of its data used in actuarial models, VA does not communicate to the consultant information on data quality, including any limitations affecting these data.⁴⁸ As described by VA officials, VA has a process for providing its actuarial consultant with utilization and cost data for use in the actuarial modeling that informs VA's community care budget estimate.

⁴⁷VA officials explained that when they developed estimates for the fiscal year 2021 President's budget request in the summer of 2019, contracts in two of five regions operating under CCN contracts had yet to be signed, and roll out had just begun at a small number of VAMCs in Region 1. According to officials, the fiscal year 2021 President's budget request assumed that contracts in all five regions would be operational by 2021, meaning that the fiscal year 2024 President's budget request will be the first to reflect a full year of actual CCN operational experience.

⁴⁸As stated previously in this report, VA's actuarial consultant provides actuarial analyses and support in updating the EHCPM annually.

Specifically, according to VA officials, the Office of Enrollment and Forecasting—which has the lead responsibility for developing the projections from the EHCPM and annually updating the assumptions that affect those projections—obtains and provides to the consultant community care utilization and cost data from four different systems. (See figure 9.) Two of the four systems process community care claims for reimbursement of health care services to veterans. The claims data from these systems provide utilization and cost data reflecting veteran care delivered by community providers. The Office of Enrollment and Forecasting also obtains data on dual eligible veterans from the Department of Defense’s Medical Data Repository and cost data for the administration of community care (e.g., costs associated with care coordination or claims processing) from VA’s Managerial Cost Accounting system.

Figure 9: Data Sources for the Department of Veterans Affairs' (VA) 2018 and 2019 Enrollee Health Care Projection Model (EHCPM)



Source: GAO analysis of interviews with VA officials. | GAO-20-669

^aPlexis Claims Manager processes claims for the Veterans Choice Program and the Patient Centered Community Care program. VA's Allocation Resource Center is responsible for collecting data from Plexis Claims Manager.

^bThe Department of Defense's Medical Data Repository provides data for dual eligible veterans, or those veterans that are also eligible medical benefits from the Department of Defense. The Allocation Resource Center is responsible for collecting data from the Medical Data Repository.

^cThe Fee Basis Claims System processes claims for VA community care programs nationwide at individual VA medical facilities and consolidated payment processing centers. According to VA officials, the Office of Enrollment and Forecasting collects data from the Fee Basis Claims System available in VA's Corporate Data Warehouse, a national repository comprising of data from several VA clinical and administrative systems.

^dVA's Managerial Cost Accounting system provides cost data for the administration of community care programs, including those costs associated with care coordination or claims processing. VA's Allocation Resource Center is responsible for collecting data from VA's Managerial Cost Accounting system.

Upon receipt, VA's actuarial consultant reviews the reasonableness of data by, for example, verifying that all data fields are populated with the appropriate type of data and that data are consistent with expectations, according to VA officials. However, in its communications on the EHCPM to VA, VA's actuarial consultant states how it relies on VA to ensure the quality of data the department provides.⁴⁹ The consultant further notes that although it reviews the data for reasonableness and compares it to past data submissions and other information when possible, it does not audit VA data for accuracy. The consultant states that if data are

⁴⁹VA's actuarial consultant annually produces a report describing the methodology used in the EHCPM, including any updates to the methodology. This report includes disclosures on the extent to which the consultant relies on VA to ensure data accuracy.

inaccurate or incomplete, the modeled projections based on those data may also be inaccurate or incomplete.⁵⁰

Despite the consultant's explicit reliance on VA, according to VA officials, the Office of Enrollment and Forecasting does not routinely collect and communicate to the actuarial consultant all relevant information on the quality of VA's community care utilization and cost data, including any limitations affecting these data.⁵¹ For example, such limitations could include the extent to which community care claims data may be incomplete as a result of delays in claims processing that VA has recently reported.⁵² Not communicating information on data quality, especially any limitations on the data, is contrary to federal internal control standards, which call on agencies to externally communicate the necessary quality information to achieve their objectives, such as developing community care budget estimates.

When we asked officials from the Office of Enrollment and Forecasting why they do not communicate information on any limitations of data quality to the consultant, officials explained that they rely on data "owners"—that is, the VA offices that compile and validate the data for use throughout the department—to ensure the quality of the data and identify any limitations.⁵³ Officials told us that they do not routinely collect or receive information on the quality of the data from the data owners, which in turn could be communicated to the actuarial consultant.

⁵⁰We determined that VA's actuarial consultant's disclosures regarding the data are consistent with Actuarial Standard of Practice No. 23, *Data Quality*, which states that the accuracy and completeness of data supplied by others are the responsibility of those who supply the data. The standard also states that the actuary should disclose its reliance on data supplied by others in an appropriate actuarial communication, as well as any limitations on the use of the actuarial work product due to uncertainty about the quality of the data. See appendix II for additional information on actuarial standards of practice relevant to VA health care projections.

⁵¹According to VA officials, the Office of Enrollment and Forecasting communicates or facilitates the communication of changes in data quality to the actuarial consultant. However, they do not routinely communicate all potentially relevant information on the quality of data such as previously identified data quality issues, which may affect the consultant's use of the data.

⁵²On June 3, 2020, during a hearing before the Senate Committee on Veterans' Affairs, VA officials acknowledged a backlog of unpaid community care claims. Beginning in fiscal year 2019, VA's obligations for community care are recorded when provider claims are paid. Thus, any extended delays in paying provider claims would result in VA data not completely reflecting the level of community care utilization and costs.

⁵³Officials noted that these VA offices compile and validate the databases that contain utilization and cost data for VA administrative, research, and other purposes.

Communicating all relevant information on the quality of the data used in the EHCPM, such as the extent to which data may be incomplete, inaccurate, or affected by other limitations, to the actuarial consultant, would help the consultant address any such limitations as part of the actuarial modeling, thus improving the actuarial modeling that informs VA's community care budget estimates.

VA Updates Assumptions Used in Actuarial Models, But Does Not Fully Assess and Communicate Overall Uncertainty Associated with Community Care Budget Estimates

The Office of Enrollment and Forecasting and its actuarial consultant have a process for annually updating the actuarial modeling, including the projections that informs VA's community care budget estimates. Specifically, officials from this office, with the assistance of VA's actuarial consultant, validate key assumptions to reflect the most current data while also considering changes in key factors affecting the community care budget estimates, such as the new community care eligibility access standards associated with the VA MISSION Act.

In updating the actuarial modeling, the Office of Enrollment and Forecasting and VA's actuarial consultant perform two key analyses. The first analysis examines the sensitivity of modeled projections to isolated changes in key assumptions used in the modeling. This examination includes determining the effect that key assumptions have on projections of utilization or unit cost for individual health care services. For example, different projections may be run to determine how changes to individual assumptions related to veteran reliance on community care may affect the number of office visits to community providers.⁵⁴ Secondly, VA and its actuarial consultant analyze how changing the effect of key drivers, such as increased veteran reliance on community care under the VA MISSION Act, affect projections. These two analyses provide information on the sensitivity of projections to changes to actuarial assumptions and key drivers. According to officials from the Office of Enrollment and Forecasting, briefings that summarize this information are provided to stakeholders within VA (e.g., the Under Secretary for Health and the

⁵⁴Other key assumptions include those related to enrollment and morbidity.

Chief Financial Officer) and at OMB to inform their decision-making regarding VA's community care budget estimates.

While we found that the Office of Enrollment and Forecasting's process includes analyzing and communicating how community care projections might differ based on certain changes to actuarial modeling, the process lacks steps for comprehensively assessing and communicating the uncertainty inherent in VA's projections of community care that directly inform the community care budget estimates.⁵⁵ These steps could include (1) estimating an overall degree of uncertainty associated with projections for community care and (2) communicating such estimates to internal VA stakeholders and OMB.⁵⁶ Not identifying, assessing, and responding to the overall uncertainty associated with VA's projections and the budget estimates they inform are contrary to federal internal control standards for risk assessment, which state that agencies should identify, analyze, and respond to risk related to achieving their objectives, such as developing community care budget estimates. Risk tolerance is defined as an acceptable level of variation in performance relative to the achievement of the defined objective. Uncertainty in the data, assumptions, or actuarial projections could significantly increase the risk of not meeting VA's objective of developing reliable community care budget estimates if not identified, analyzed, and responded to.⁵⁷

According to VA officials, stakeholders have an awareness that actual community care obligations will likely differ from projections. Officials

⁵⁵While the scope of this engagement was the VA's community care budget, VA's process for updating its actuarial modeling, in general, does not include steps for comprehensively assessing and communicating the uncertainty inherent in the overall projections for VA health care that directly inform VA's overall health care budget estimate. During the budget process, the actuarial projections for community care and VA facility care are subject to adjustments based on the availability of new or other factors such as policy decisions made during reviews within VA and at OMB.

⁵⁶Various techniques can be used to develop and communicate overall uncertainty, and some techniques might be more practical and useful than others depending upon facts and circumstances. Techniques from the actuarial literature include scenario analysis under plausible alternative scenarios, stochastic analysis, and stress testing.

⁵⁷In identifying the risk related to uncertainty of community care obligation projections, VA would consider the types of uncertainty that may affect its community care programs, significant interactions within VA and with external parties such as community providers; changes within the internal and external environment; and other internal and external factors. In analyzing uncertainty, VA would estimate its significance by considering the magnitude of the effect, likelihood of occurrence, and nature of the uncertainty. In responding to uncertainty, VA would take actions based on the significance of the uncertainty and defined tolerance.

noted that, in particular, stakeholders are aware that actual experience may differ from key assumptions used in the modeling, and this may affect actual obligations. However, by estimating overall uncertainty associated with its projections and then communicating the results of this analysis along with the projections, VA internal and external stakeholders would have comprehensive information that is relevant and reliable on the potential magnitude of uncertainty affecting model projections. Such information would allow stakeholders to respond to this uncertainty in making decisions regarding VA's community care budget estimates.

Conclusions

As the number of veterans eligible to receive care from a community provider and the associated obligations for that care increase as a result of the VA MISSION Act, VA needs to ensure its budget estimates are reliable. VA takes steps for providing its actuarial consultant with utilization and cost data for use in the actuarial modeling that informs VA's community care budget estimate. VA also takes steps for updating the assumptions used in this actuarial modeling. However, VA could improve its actuarial modeling by taking steps to communicate to its actuarial consultant all relevant information on the quality of the community care utilization and cost data used in the modeling, including any limitations, such as the extent to which community care claims data may be incomplete as a result of delays in claims processing. This would include information on the extent to which the data may be incomplete, inaccurate, or affected by other limitations, which could help VA's actuarial consultant improve the modeling that informs VA's community care budget estimates. In addition, by establishing further steps for assessing and communicating the degree of overall uncertainty associated with projections for community care, VA's internal and external stakeholders would have more complete information on the magnitude of the overall uncertainty affecting model projections when developing the overall budget estimate for community care.

Recommendations for Executive Action

To help improve VA's budget estimates for community care, we are making the following two recommendations to VA:

- The Under Secretary for Health should establish steps for communicating to VA's actuarial consultant information on data

quality, including any limitations, used in the actuarial modeling that informs VA's community care budget estimates.
(Recommendation 1)

- The Under Secretary for Health should establish further steps for assessing and communicating to stakeholders the degree of overall uncertainty associated with actuarial projections for community care that inform the community care budget estimates.
(Recommendation 2)

Agency Comments

We provided a draft of this report to VA for review and comment. In its written comments, reproduced in appendix IV, VA concurred with both of our recommendations. VA also identified actions it is taking to address our recommendations, which include (1) developing processes and standards for clearly defining and communicating the quality of community care data for VA's actuarial consultant and other users, and (2) developing a comprehensive risk communication for stakeholders regarding the degree of uncertainty associated with actuarial projections that inform community care budget estimates. VA plans to complete these actions by March 2021. VA also provided technical comments that we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Veterans Affairs, and other interested parties. In addition, the report is available at no charge on GAO's website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov or Frank Todisco at (202) 512-2700 or todiscof@gao.gov. Contact points for our Office of Congressional Relations and Office of Public Affairs can be found on the last page of this report. Other major contributors to this report are listed in appendix V.



Letter

Sharon M. Silas
Director, Health Care

A handwritten signature in black ink that reads "Frank Todisco". The signature is written in a cursive style with a large, prominent initial "F".

Frank Todisco
Chief Actuary, Applied Research and Methods
Member of American Academy of Actuaries

Appendix I: Department of Veterans Affairs (VA) Obligations for Non-Veteran Community Care Programs

In addition to providing community care to veterans, VA has community care programs for non-veterans, including family members and dependents of veterans or other eligible beneficiaries. Non-veteran programs include the Camp Lejeune Family Member Program, Children of Women Vietnam Veterans Health Care Benefits Program, Civilian Health and Medical Program of the Department of Veterans Affairs, and Spina Bifida Health Care Benefits Program.¹ These programs are projected to account for more than \$10 billion in obligations from fiscal years 2018 through 2022. (See table 2.)

Table 2: Obligations for Non-Veteran Community Care Programs, Fiscal Years 2018 through 2022

na	Actual obligations (dollars in billions)		Estimated obligations (dollars in billions)			na
Category	2018	2019	2020	2021	2022	Total
Non-veteran community care programs	1.9	1.9	2.1	2.3	2.4	10.6

Source: GAO analysis of Department of Veterans Affairs' data. | GAO-20-669

Note: Non-veteran community care programs are programs that allow certain non-veteran eligible beneficiaries, including veterans' spouses and dependent children, to obtain care in the community.

¹The Camp Lejeune Family Member Program provides health care to veterans who served on active duty at U.S. Marine Corps Base Camp Lejeune, North Carolina, and to reimburse eligible family members for health care costs related to one or more of 15 specified illnesses or medical conditions related to exposure to contaminated drinking water. The Children of Women Vietnam Veterans Health Care Benefits Program provides some health care benefits to female Vietnam veterans' birth children who the Veterans Benefits Administration has determined to have a covered birth defect. The Civilian Health and Medical Program of the Department of Veterans Affairs provides comprehensive health care coverage to spouses, children, and certain primary caregivers of veterans who are permanently and totally disabled from a service connected disability. The Spina Bifida Health Care Benefits Program provides health care benefits to certain Korean, Thailand, and Vietnam veterans' birth children who have been diagnosed with spina bifida.

Appendix II: Actuarial Standards of Practice Relevant to Actuarial Modelling Used by Department of Veterans Affairs (VA)

We identified eight actuarial standards of practice relevant to the actuarial modeling VA uses to inform the department's budget estimates for VA health care, including community care. In reviewing the work performed by VA's actuarial consultant, nothing came to our attention to suggest that the consultant did not follow relevant actuarial standards of practice. Table 3 lists relevant actuarial standards of practice we identified, along with examples from the consultant's work we determined to be consistent with those actuarial standards of practice.

**Appendix II: Actuarial Standards of Practice
Relevant to Actuarial Modelling Used by
Department of Veterans Affairs (VA)**

Table 3: Actuarial Standards of Practice Relevant to the Department of Veterans Affairs' (VA) Use of Actuarial Modelling for Developing Budget Estimates for VA Health Care and Examples from VA's Consultant's Work

Actuarial standards of practice relevant to VA health care projections	Examples from VA's actuarial consultant's work
<p><i>Incurring Health and Disability Claims</i> (Actuarial Standard of Practice (ASOP) No. 5) – Provides guidance for estimating health care claims. This standard states an actuary should make a reasonable effort to understand changes in plan provisions or business practices and consider how such changes are likely to affect projections of claims costs. This standard also states that an actuary should consider including economic influences, among other things, in projecting claims.</p>	<p>VA's Enrollee Health Care Projection Model (EHCPM) includes adjustments to utilization projections that reflect the effects of changing economic conditions over time. Specifically, reliance—that is, the extent to which enrolled veterans rely on VA health care for their health care needs—is adjusted to reflect regional economic conditions as measured by the unemployment rate. VA experience has shown that as unemployment increases, veterans' access to non-VA health care, such as private insurance, decreases making it more likely that enrolled veterans would use VA health care. VA experience has shown that the reverse is also true.</p>
<p><i>Data Quality</i> (ASOP No. 23) – Provides guidance for (1) selecting the data that underlie the actuarial work product; (2) relying on data supplied by others; (3) reviewing data; (4) using data; (5) preparing data to be used by other actuaries in an actuarial work product; and (6) making appropriate disclosures with regard to data quality.</p>	<p>VA's actuarial consultant reviews VA data for reasonableness (e.g., consistency with past data). Documentation on VA's EHCPM and other deliverables prepared by the actuarial consultant explicitly state the extent of the consultant's reliance on data provided by VA and the potential effect if data are inaccurate or incomplete.</p>
<p><i>Risk Classification</i> (ASOP No. 12) – Provides guidance for designing, reviewing, and changing risk classifications. This standard defines risk classification as a system used to assign the individuals covered by, for example, VA health care to groups based upon the expected cost or benefit of the coverage or services provided. This standard states that when selecting which risk characteristics to use in a risk classification system, the actuary should consider the relationship of risk characteristics and the expected outcomes.</p>	<p>VA's EHCPM projects enrollment, utilization, and unit costs for VA health care services based on veteran enrollee characteristics, including priority group, age, gender, and geographic location.⁸ For example, birth year cohort adjustments are used to account for health care utilization behavior patterns unique to certain enrollee birth year ranges. Vietnam-era enrollees are an example of an observed birth year cohort. VA analysis has shown that this population exhibits higher utilization patterns than non-Vietnam era enrollees for some health care services. According to VA documentation, the birth year cohort adjustment allows the EHCPM to account for their higher utilization pattern as they age over the 21-year projection period without allowing their unique pattern to influence the utilization projected for other enrollees.</p> <p>Because of differences in morbidity and reliance on VA health care, whether a veteran enrolled prior to the Veterans' Health Care Eligibility Reform Act of 1996 or enrolled after this Act and whether a veteran participated in post-9/11 conflicts are also considered in the EHCPM.</p>
<p><i>The Use of Health Status Based Risk Adjustment Methodologies</i> (ASOP No. 45) – Provides guidance for applying health status-based risk adjustment methodologies to quantify differences in relative health care resource use due to differences in health status.</p>	<p>VA's EHCPM uses non-VA utilization benchmarks developed for commercial and Medicare markets when projecting utilization for many of VA health care services. The EHCPM makes adjustments to these benchmarks to account for differences in the morbidity, or health status, of the veteran enrollee population compared to the populations used in developing the national benchmarks. Specifically, using VA patient diagnosis data and the VA/Medicare data match for the over age 65 population, the EHCPM made risk adjustments by comparing the relative health status of Veteran enrollees to the benchmark populations in the national utilization rates.</p>

**Appendix II: Actuarial Standards of Practice
Relevant to Actuarial Modelling Used by
Department of Veterans Affairs (VA)**

**Actuarial standards of practice
relevant to VA health care projections**

Examples from VA's actuarial consultant's work

Credibility Procedures (ASOP No. 25) – Provides guidance for selecting or developing credibility procedures and the application of those procedures to sets of data.

VA's actuarial consultant considers the credibility of data—that is, the extent to which data can be relied on to predict trends and explain veterans' behavior—when developing adjustments for enrollment rates, morbidity, reliance, unit costs, and other factors used in the actuarial modeling. When credibility is low, which generally means the number of veterans reflected in a subset of data is too low to rely on these data alone, the consultant applies credibility procedures to identify additional data, often a larger data set based on a wider geographic location. For example, adjustments for veteran enrollment rates are developed based on priority rating, a 5-year age band (e.g., 30 to 34 years of age), and a geographic area, such as a sector—the smallest geographic location considered by the EHCPM, which consists of one or more contiguous counties. Because too few veterans may be within a particular priority group or 5-year age band living in a particular sector, VA's actuarial consultant develops enrollment rates using a blend of rates from the sector level, which has low credibility, and from larger geographic locations, including the area covered by a regional Veterans Integrated Service Network, to improve the credibility of the enrollment rate.

Analysis of Life, Health, or Property/Casualty Insurer Cash Flows (ASOP No. 7) – Provides guidance for analysis of liability (e.g., claims) cash flows for health care services. The actuary should consider and appropriately address the sensitivity of the model to the effect of variations in key assumptions.

VA's actuarial consultant reviews and updates VA's EHCPM each year. The actuarial consultant performs high-level sensitivity testing of projections, which includes measuring the effects of key assumptions, or changes to these assumption or factors impacting budgetary needs on obligation or utilization projections. Most key model assumptions are subjected to periodic sensitivity testing, particularly when methodology enhancements are implemented or when new data become available.

Actuarial Communications (ASOP No. 41) – Provides guidance for preparing actuarial communications, including those that may be required by other actuarial standards of practice. The performance of a specific actuarial engagement or assignment typically requires significant and ongoing communications between the actuary and the intended users regarding the following: the scope of the requested work; the methods, procedures, assumptions, data, and other information required to complete the work; and the development of the communication of the actuarial findings.

VA's actuarial consultant communicates the effects of model enhancements resulting from the annual update of the EHCPM. Briefings are provided for internal and external budget stakeholders, which include communicating the assumptions in the current budget scenario and enhancements to the newly updated EHCPM. These briefings include information on how updates and enhancements to the model and material changes to the assumptions between the current budget scenario and the previous budget scenario affected projected obligations. In addition, the annual EHCPM report also documents model updates, including enhancements and changes to assumptions.

Expert Testimony by Actuaries (ASOP No. 17) – Provides guidance for giving expert testimonies (e.g., congressional testimony). In offering expert testimony, the actuary should comply with all rules of evidence and procedure and any other rules applicable in the forum. In addition, the actuary should review and comply with any applicable actuarial standards of practice, the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States, and the Code of Professional Conduct.

VA's consultant provides support to VA for congressional hearings, as needed. A recent example was an April 2019 testimony before the Senate Committee on Veterans' Affairs on implementing the Veterans Community Care Program. During the testimony, VA's actuarial consultant provided the description of EHCPM, disclosed some of the assumptions used in the model, and discussed how the VA MISSION Act might affect veterans' reliance on VA health care and projected obligations.

Source: GAO analysis of information from VA and the Actuarial Standards Board. | GAO-20-669

Note: In total, as of July 2020, there are 56 actuarial standards of practice for actuarial services, some of which are specific to particular areas of actuarial practice (e.g., related to property and casualty

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insurance, life insurance, health insurance, and pensions), and some of which are general and apply across practice areas.

^aVA assigns veterans to one of eight priority groups for purposes of enrollment in VA health care. 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.

Appendix III: Department of Veterans Affairs (VA) MISSION Act Assumptions and Estimation Methods, Fiscal Years 2020 and 2021 President's Budget Requests

The VA MISSION Act made several changes to VA community care, including expanding veterans' access to this care, expanding the availability of urgent care and transplant services in the community, and consolidating existing community care programs into a single program—the Veterans Community Care Program (VCCP). Table 4 outlines the assumptions that VA and its actuarial consultant developed related to VA MISSION Act provisions and the administration of the VCCP that inform the fiscal years 2020 and 2021 President's budget requests.¹

¹Although the VA MISSION Act did not amend existing statutory provisions for emergency care for nonservice-connected conditions to certain veterans (38 U.S.C. §1725) or the authority to provide reimbursement for emergency care for service-connected veterans, VA assumed increased obligations for these services based on expected rates under the CCN contracts. Specifically, VA assumed that reimbursement for emergency room services under these contracts would increase from historical rates of approximately 70 percent of Medicare to 100 percent of Medicare by fiscal year 2020.

**Appendix III: Department of Veterans Affairs
(VA) MISSION Act Assumptions and
Estimation Methods, Fiscal Years 2020 and
2021 President's Budget Requests**

Table 4: Methods and Key Assumptions for Department of Veterans Affairs (VA) MISSION Act Related Projections and Estimates in Fiscal Years 2020 and 2021 President's Budget Requests

na	Methods and key assumptions	
VA MISSION Act provisions and related administration	Fiscal year 2020 President's budget request	Fiscal year 2021 President's budget request
Veterans Choice Act enrollees who continue to be eligible for access to community care under the VA MISSION Act. ^a	National-level actuarial projection produced outside the Enrollee Health Care Projection Model (EHCPM). ^b Assumptions: <ul style="list-style-type: none"> • These veterans would continue to be covered after the 2 year eligibility period under "best medical interest" standards. • These veterans' reliance on VA health care grows by 3 percentage points in fiscal year 2019, 2 percentage points in fiscal year 2020, and 1 percentage point in fiscal year 2021, reaching approximately 50 percent in fiscal year 2021.^c 	Provision incorporated into the EHCPM. Assumptions remained the same as for the fiscal year 2020 President's budget request.

**Appendix III: Department of Veterans Affairs
(VA) MISSION Act Assumptions and
Estimation Methods, Fiscal Years 2020 and
2021 President's Budget Requests**

na	Methods and key assumptions	
VA MISSION Act provisions and related administration	Fiscal year 2020 President's budget request	Fiscal year 2021 President's budget request
Access to community care based on drive time to a VA facility. ^d	<p>National-level actuarial projection produced outside the EHCPM.</p> <p>Assumptions:</p> <ul style="list-style-type: none"> • Reflected drive time standards of 30 minutes for primary care and 60 minutes for specialty care. • Reliance increases to approximately 50 percent by fiscal year 2021. • Workload growth phases in through fiscal years 2019, 2020, and 2021 to reflect an expected lag in enrollee behavior to access newly available community care services. • Workload for ambulatory care was anticipated to increase 50 percent. • Workload growth for inpatient care was anticipated to be half that of ambulatory care because half of inpatient stays are admitted through the emergency room. Officials from VA and its actuarial consultant explained that they did not anticipate veteran behavior would change due to increased community care access in emergency situations. • Workload growth for prescription drugs was anticipated to be lower than for either outpatient or inpatient care due to the already high reliance among veteran enrollees on VA prescription drug coverage. 	<p>Projection incorporated into the EHCPM. Assumptions remained the same as in the fiscal year 2020 President's budget request.</p>

**Appendix III: Department of Veterans Affairs
(VA) MISSION Act Assumptions and
Estimation Methods, Fiscal Years 2020 and
2021 President's Budget Requests**

na	Methods and key assumptions	
VA MISSION Act provisions and related administration	Fiscal year 2020 President's budget request	Fiscal year 2021 President's budget request
Access to community care based on wait times for an appointment with a VA provider. ^e	<p>National-level actuarial projection produced outside the EHCPM.</p> <p>Assumptions:</p> <ul style="list-style-type: none"> • Wait time standard of 20 days for primary care and mental health. • Wait time standard of 28 days for specialty care. Specialty care wait time of 28 days was assumed to be sufficiently similar to VA practice under the Veterans Choice Act, and thus did not result in a budget effect. • Modeling translated estimates of the VA facility staff needed to achieve these wait time standards to equivalent community care workload. • Although the wait time standards are intended to increase access to care in the community, the fiscal year 2020 President's budget requested the estimated resources necessary to address wait time access in the appropriation for care provided in VA facilities. 	<p>National-level estimate produced outside the EHCPM. Estimates continued to be produced at the national level due to the difficulties with projecting wait times in future years related to factors such as loss of providers, renovation of space, or increases in productivity at the facility level.</p> <p>Assumptions:</p> <ul style="list-style-type: none"> • Wait time standards remained the same as for the fiscal year 2020 President's budget request, and VA continued to request the estimated resources necessary to address wait time standards in the appropriation for care provided in VA facilities. • VA officials explained that investments in care provided in VA facilities would reduce the wait times and reduce the need for these services to be provided in the community.

**Appendix III: Department of Veterans Affairs
(VA) MISSION Act Assumptions and
Estimation Methods, Fiscal Years 2020 and
2021 President's Budget Requests**

na	Methods and key assumptions	
VA MISSION Act provisions and related administration	Fiscal year 2020 President's budget request	Fiscal year 2021 President's budget request
Access to community care based on deficiency in quality or timeliness of care compared to other VA facilities. ^f	<p>National-level actuarial projection produced outside the EHCPM.</p> <p>Assumptions:</p> <ul style="list-style-type: none"> Primary care services in 12 facilities would be affected each year, though in reality a mix of service lines is expected to be affected. Assumptions were made prior to establishment of the quality standards. 	<p>National-level projection produced outside the EHCPM.</p> <p>Assumptions:</p> <ul style="list-style-type: none"> Assumption that primary care services in 12 facilities would be affected each year remained the same. These projections were also made prior to establishment of the quality standards and were expected to change once quality standards were finalized.⁹ The fiscal year 2021 President's budget requested the estimated resources necessary to address deficiencies in quality or timeliness in the appropriation for care provided in VA facilities. VA officials explained that investments in care provided in VA facilities would improve the quality of care and reduce the need for these services to be provided in the community.
Access to urgent care in the community for eligible veterans needing immediate, non-emergent medical attention. ^h	<p>National-level actuarial projection produced outside the EHCPM.</p> <p>Assumptions:</p> <ul style="list-style-type: none"> Urgent care services previously provided in VA facilities or community care remain in place in addition to this new benefit. Urgent care would be reimbursed at historical community care rates or rates in line with Medicare reimbursement. Reliance on VA for urgent care would increase, but reliance would remain below 100 percent due to other health care sources available to veterans. Reliance depends in part on the copayment owed by the veteran, with higher reliance among veterans with no or smaller copayments. 	<p>Provision incorporated into the EHCPM.</p> <ul style="list-style-type: none"> Assumptions about provision of urgent care in VA facilities and reliance remain generally the same as in the fiscal year 2020 President's budget request.

**Appendix III: Department of Veterans Affairs
(VA) MISSION Act Assumptions and
Estimation Methods, Fiscal Years 2020 and
2021 President's Budget Requests**

na	Methods and key assumptions	
VA MISSION Act provisions and related administration	Fiscal year 2020 President's budget request	Fiscal year 2021 President's budget request
Access to transplants in the community. ⁱ	<p>Estimate produced by the Veterans Health Administration's (VHA) Office of Community Care.</p> <p>Assumptions:</p> <ul style="list-style-type: none"> Estimate is based on the range of potential additional transplants due to the VA MISSION Act. The budget request reflected the mid-range estimate of 84 additional transplants. 	<p>Estimate produced by the VHA Office of Community Care.</p> <p>Assumptions remained generally the same as in the fiscal year 2020 President's budget, with a mid-range estimate of 100 additional transplants.</p>
<p>VA administration of community care related to expanded access under the VA MISSION Act, which includes:</p> <ul style="list-style-type: none"> Care coordination activities performed by VA staff, such as referrals, eligibility verification, and enrollment. Delivery and operations activities related to billing and claims processing by VA. National overhead functions performed in the VHA's Central Office. 	<p>National-level actuarial projection produced outside the EHCPM. The actuarial models developed for the VA MISSION Act provisions outside of the EHCPM projected obligations based on unit costs that included administration of community care services by VA staff and at medical centers.</p> <p>Assumptions:</p> <ul style="list-style-type: none"> Incorporated specific targets for administration related to community care based on anticipated claims volumes and efficiency of new systems. 	<p>Incorporated into the EHCPM. The EHCPM projected obligations based on unit costs that included administration of community care services by VA staff and at medical centers.</p> <p>Assumptions:</p> <ul style="list-style-type: none"> Estimates for VA administration related to community care were based on the proportion of obligations for community care in fiscal year 2018 related to these activities. Additional adjustments were made outside of the model through the budget process to reflect changes since fiscal year 2018, such as additional support for expediting claims processing.

**Appendix III: Department of Veterans Affairs
(VA) MISSION Act Assumptions and
Estimation Methods, Fiscal Years 2020 and
2021 President's Budget Requests**

na	Methods and key assumptions	
VA MISSION Act provisions and related administration	Fiscal year 2020 President's budget request	Fiscal year 2021 President's budget request
Community care contract administration.	<p>Estimates produced by VHA Office of Community Care staff and through actuarial models.</p> <p>Assumptions:</p> <ul style="list-style-type: none"> Community care network (CCN) contract obligations were estimated based on an assessment of industry standards for the type of overhead and administrative tasks relevant to VA that the CCNs are expected to perform (e.g., maintaining a provider network, operating a call center, paying claims to providers, etc.).^j VA continued to use actuarial models to project amounts for other community care related contracts, including those related to the Veterans Choice Program through fiscal year 2019, and for the Patient Centered Community Care program through fiscal year 2020, at which point the EHCPM assumed the CCN contracts would be in place.^k 	<p>Estimate produced by the VHA Office of Community Care.</p> <p>Assumptions:</p> <ul style="list-style-type: none"> CCN contract obligations were estimated based on an assessment of industry standards for the type of overhead and administrative tasks the CCNs are expected to perform (e.g., maintaining a provider network, operating a call center, paying claims to providers, etc.). Amounts for transition from Patient Centered Community Care program to CCN in remaining regions were added as an adjustment to modeled amounts in the budget development process.

Source: GAO analysis of information provided by VA. | GAO-20-669

^aUnder Section 101 of the VA MISSION Act, VA is required to provide community care to certain veterans who were eligible for community care under the Veterans Choice Program due to the 40-mile distance criteria and in one of five states, or sought care within 2 years after enactment of the VA MISSION Act.

^bVA uses its 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.

^cReliance is the measure of the portion of an enrollee's total health care need that they are expected to receive through either VA facility care or VA community care, rather than through other health care sources such as Medicare or private insurance.

^dThe VA MISSION Act requires the Secretary to develop criteria for access standards to determine eligibility for the Veterans Community Care Program (VCCP). VA established standards based on driving time to a VA facility at 38 C.F.R. § 17.4040.

^eThe VA MISSION Act requires the Secretary to develop criteria for access standards to determine eligibility for the VCCP. VA established standards based on wait times for an appointment at a VA facility at 38 C.F.R. § 17.4040.

^fSection 104 of the VA MISSION Act requires the Secretary to develop quality standards for furnishing hospital care, medical services, or extended care services to eligible veterans under the VCCP. See 38 C.F.R. § 17.4015.

^gQuality standards were published in the Federal Register in October 2019, which was after the model for the fiscal year 2021 President's budget request was developed. See 84 Fed. Reg. 52932 (Oct. 3, 2019).

**Appendix III: Department of Veterans Affairs
(VA) MISSION Act Assumptions and
Estimation Methods, Fiscal Years 2020 and
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^hSection 105 of the VA MISSION Act requires the Secretary to develop procedures to allow certain veterans to access walk-in care through community providers. The final rule implementing the urgent care provisions for the VA MISSION Act is at 38 C.F.R. § 17.4600, and defines urgent care to include immunizations.

ⁱSection 153 of the VA MISSION Act authorizes the Secretary to provide organ or bone marrow transplants to eligible veterans at non-VA facilities. 38 C.F.R. § 17.4020(d).

^jCCN contractors develop and administer networks of community providers, and facilitate payment of community provider claims when veterans access VA community care. VA conducted a process to develop an independent estimate of the costs related to the functions it expected the CCN contractor to cover as part of the solicitation process.

^kVA implemented the Patient-Centered Community Care program in 2014, after awarding contracts to two entities 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 facility.

Appendix IV: Comments from the Department of Veterans Affairs

Appendix IV: Comments from the Department
of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON

September 11, 2020

Ms. Sharon M. Silas
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Silas:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: ***VA HEALTH CARE: Additional Steps Could Help Improve the Community Care Budget Estimates*** (GAO-20-669).

The enclosure contains general and technical comments, and the actions to be taken to address the draft report recommendations. VA appreciates the opportunity to comment on your draft report.

Sincerely,

A handwritten signature in blue ink that reads "Brooks D. Tucker".

Brooks D. Tucker
Acting Chief of Staff

Enclosure

**Appendix IV: Comments from the Department
of Veterans Affairs**

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
**VA HEALTH CARE: Additional Steps Could Help Improve the
Community Care Budget Estimates**
(GAO-20-669)

Recommendation 1: The Under Secretary for Health should establish steps for communicating to VA's actuarial consultant information on data quality, including any limitations, used in the actuarial modeling that informs VA's community budget estimates.

VA Response: Concur. The Veterans Health Administration (VHA) agrees that it is necessary to clearly define data quality, integrity, limitations and caveats for all users of community care data. VHA will, in coordination with the VA Office of Information and Technology and the VA Office of Enterprise Integration, develop relevant processes and standards to inform the work performed by VA's actuarial consultant to demonstrate completion of this recommendation.

Target Completion Date: March 2021.

Recommendation 2: The Under Secretary for Health should establish further steps for assessing and communicating to stakeholders the degree of overall uncertainty associated with actuarial projections for community care that inform the community care budget estimates.

VA Response: Concur. VHA's Office of Finance will work with VHA's Office of Enrollment & Forecasting to develop comprehensive risk communication to stakeholders regarding the degree of overall uncertainty associated with the actuarial projections used to support the President's Budget, including the Community Care request.

VHA currently provides briefings, tools, exhibits and memoranda to VA leadership and the Office of Management and Budget related to the actuarial projections from the VA Enrollee Health Care Projection Model that support the development of VA's budget. Those communications have included discussions about risks and uncertainties in the projections, but not always in a consolidated way. Going forward, VHA will consolidate and explicitly document the various sources of uncertainty in the projections, including the allocation of the total health care projections between VA facility care and community care. This documentation will clearly identify sources of risk and quantify the degree of uncertainty that they add to the actuarial projections and will incorporate the risk and variability analyses currently being provided and new analysis not currently performed. VHA will continue to incorporate evolving industry best practices and future changes in actuarial standards of practice when updating this analysis. In addition to using this consolidated risk assessment to inform decisionmakers during the Administration budget formulation process, VA will communicate this consolidated risk assessment in the published Congressional Justifications to accompany the President's Budget.

**Appendix IV: Comments from the Department
of Veterans Affairs**

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
***VA HEALTH CARE: Additional Steps Could Help Improve the
Community Care Budget Estimates***
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This communication of risk is intended to inform stakeholders of sources of uncertainty, describe how they may affect the key drivers of the actuarial projections, and discuss their potential magnitude. The risk assessment will include sensitivity testing for selected key drivers, such as health care trends, enrollee reliance, access to community care, enrollment and other drivers that demonstrate the potential variability of the projections over the short term and long term. In addition, high risk "what if" scenarios will be defined on both a narrative and quantitative basis, to illustrate the potential impacts of selected major events and changes that pose a significant financial risk to VA.

VA will incorporate this risk assessment into its 2022 President's Budget process, with publication in the Congressional Justifications with release of the Budget, estimated to be February 2, 2021.

Target Completion Date: February 2021.

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**Appendix IV: Comments from the Department
of Veterans Affairs**

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
**VA HEALTH CARE: Additional Steps Could Help Improve the
Community Care Budget Estimates**
(GAO-20-669)

General Comments:

Figure 9, Page 28, Plexis Claims Manager and footnote “a”:

Plexis Claims Manager Processes claims for the Veterans Choice Program and the Patient Centered Community Care program (PC3), including some expedited claims payments that are processed in bulk. VA’s Allocation Resource Center collects data from the Plexis Claims Manager available in VA’s Corporate Data Warehouse, a national repository comprising of data from several VA clinical and administrative systems. According to VA officials, prior to the implementation of Plexis Claims Manager in February 2017, VA processed some Veterans Choice Program claims, in response to backlogs of unpaid provider claims, in an expedited manner i.e. aggregated and processed in bulk) outside of VA’s historical claims processing system, Fee Basis Claims System. The Allocation Resource Center was responsible for compiling claims data related to these claims.

VA Comment: The Fee Basis Claims System (FBCS) is the system used to authorize community care and process claims resulting from that care. The payments processed through FBCS are made available as a SAS file. This dataset contains the patient level clinical and payment information which has been a reliable source for payments for more than two decades. Whereas the FBCS system was also used to process payments during the early stages of Choice program, VA has now switched over to Plexis for payment processing. As a result, the payment data is now splintered across multiple datasets, complicating access to get the clinical, patient and payment data and increasing the likelihood that claims will lack critical information like diagnosis codes, CPTs, and the patients’ home medical centers. Payment data from eCAMS and CCRS are also made available in the same CDW datasets as Plexis and accessing eCAMS and CCRS payment present the same challenges as Plexis.

The risk memorandum deliverable from Enrollment & Forecasting for the 2022 President’s Budget cycle is anticipated to discuss the following:

- The nature and magnitude of each source of uncertainty, including historical data where relevant.
- The important interactions between risks.
- Analysis of sensitivity of projections to selected sources of uncertainty.
- Narrative and quantitative description of high-risk scenarios, including a discussion of how each scenario is likely to influence the key drivers of the projections.
- Metrics and approaches to monitoring emerging experience that can identify the emergence of key risks.

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**Appendix IV: Comments from the Department
of Veterans Affairs**

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
***VA HEALTH CARE: Additional Steps Could Help Improve the
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(GAO-20-669)

- Technical appendix discussing how the risk memorandum contributes to VHA's compliance with GAO's "Standards for Internal Control in the Federal Government".
- In July 2020, the Chief Health Informatics Officer established a Data Governance Group to create and maintain policy, processes, and standards to ensure that Office of Community Care (OCC) data are managed in an integrated, efficient, and effective manner. This group will ensure that future datasets, as well as updates to existing datasets, meet pre-determined requirements as to the structure, function, and documentation of underlying data.

Consolidated community care datasets are being established that will join multiple source systems into a single source for each reporting category, build in logic to standardize reporting, and develop documentation as to the lineage, limitations, and definitions of the data. Further, they will be the approved source for community care reporting data from across VHA to ensure a common operating picture.

- OCC has significantly reduced claims awaiting processing in VA's systems. These processed claims increase overall data quality in that the processed claims data that EHCPM models rely upon accounts for more than 1.7 million additional claims.
- GAO Data caveats the following:
 - The community care costs in this report are fully loaded, meaning they include overhead costs that are not part of the Medical Community Care appropriation.
 - This report excludes the family member program costs, which is a community care cost magnitude of \$1.742 billion (excluding VA provided pharmacy, treatment and administrative costs).

VA uses actuarial models and other methods to develop budget estimates for Community Care that reflect the implementation of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act. The annual briefing accompanying the 2021 President's Budget Enrollee Health Care Projection Model (EHCPM) already states the following:

- MISSION Act related assumptions and their associated costs compared to the previous year's budget cycle.
- A note that "projected resource requirements for VA facility and community care represent a division of the total enrollee demand projected by the EHCPM" and therefore, both care locations need to be funded at the projected levels to meet the total projected enrollee demand for VA health care.

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**Appendix IV: Comments from the Department
of Veterans Affairs**

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
***VA HEALTH CARE: Additional Steps Could Help Improve the
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- What is and is not included in the community care unit cost and the results of an in-depth analysis of VA's claim costs for care purchased in the community in fiscal year (FY) 2017 and FY 2018.
- A detailed cost comparison from the previous year's model by key drivers and changes in policy assumptions.

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Appendix V: GAO Contacts and Staff Acknowledgments

GAO Contacts

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

Frank Todisco, (202) 512-2700 or todiscof@gao.gov

Staff Acknowledgments

In addition to the contacts named above, Rashmi Agarwal (Assistant Director), Michael Zose (Assistant Director), Aaron Holling (Analyst-in-Charge), Lijia Guo (Senior Actuary, Member of American Academy of Actuaries), Benjamin Legow, and Heather Tompkins made key contributions to this report. Also contributing were Jacquelyn Hamilton, Michael LaForge, Vikki Porter, Caitlin Scoville, and Ravi Sharma.

Appendix VI: Accessible Data

Data Tables

Accessible Data for VA Actual and Estimated Community Care Obligations, Fiscal Years 2018 through 2022

na	Actual obligations (dollars in billions)		Estimated obligations (dollars in billions)		
	2018	2019	2020	2021	2022
Category					
VA communitycare	14.7	13.6	13.4	15.9	16.2
Communitycare obligations due to expanded access under the VA MISSION Act	na	na	3.4	4.8	5.2
Total	14.7	13.6	16.8	20.8	21.3

Appendix VI: Accessible Data

Accessible Data for Figure 1: Veteran Patients Receiving Community Care, Fiscal Years 2014 through 2019

Category	2014	2015	2016	2017	2018	2019
Unique Veteran Patients (in millions)	1.12	1.31 (Veterans Access, Choice, and Accountability Act implemented)	1.36	1.61	1.71	1.98 (VA MISSION Act implemented)

Appendix VI: Accessible Data

Accessible Data for Figure 4: Department of Veterans Affairs' (VA) Obligations for Community Care, Including the Effect of the VA MISSION Act, Fiscal Years 2018 through 2022

na Category	Actual obligations (dollars in billions)		Estimated obligations (dollars in billions)		
	2018	2019	2020	2021	2022
VA communitycare	14.7	13.6	13.4	15.9	16.2
Communitycare obligations due to expanded access under the VA MISSION Act			3.4	4.8	5.2
Total	14.7	13.6	16.8	20.8	21.3

Accessible Data for Figure 5: Department of Veterans Affairs' (VA) Obligations for Community Care as a Share of Total Obligations for VA Health Care Services, Fiscal Years 2018 through 2022

na Category	Actual obligations (in billions)			Estimated obligations (in billions)	
	2018	2019	2020	2021	2022
VA facility care	61.2	64.3	68.6	72.9	74.9
VA community care	14.7	13.6	16.8	20.8	21.3
VA facility care	80.6%	82.5%	80.3%	77.8%	77.8%
VA community care	19.4%	17.5%	19.7%	22.2%	22.2%
Total	75.9	77.9	85.4	93.7	96.3

Appendix VI: Accessible Data

Accessible Data for Figure 6: Department of Veterans Affairs' (VA) Obligations for Community Care and Administration of Such Care, Fiscal Years 2018 through 2022

na	Actual Obligations (in billions)		Estimated Obligations (in billions)		
	2018	2019	2020	2021	2022
Category					
Direct Patient Care	12.6	11.3	13.7	17.3	18.0
Administration	2.1	2.3	3.2	3.4	3.3
Direct Patient Care	85.6%	83.0%	81.2%	83.4%	84.4%
Administration	14.4%	17.0%	18.8%	16.6%	15.6%
Total	14.7	13.6	16.8	20.8	21.3

Accessible Data for Figure 7: Department of Veterans Affairs' (VA) Obligations for the Administration of Community Care, by Function, Fiscal Years 2018 through 2022

na	Actual obligations (dollars in billions)		Estimated obligations (dollars in billions)		
Category	2018	2019	2020	2021	2022
Delivery and Operations	0.4	0.4	0.5	0.5	0.6
Care Coordination	0.3	0.5	0.4	0.5	0.5
Network Contracts, Third Party Agreements, and Other	0.9	0.8	1.5	1.5	1.2
National Overhead	0.6	0.7	0.8	0.9	1.0
Total	2.1	2.3	3.2	3.4	3.3

Appendix VI: Accessible Data

Accessible Data for Figure 8: Actual and Projected Share of Utilization of Department of Veterans Affairs (VA) Health Care Services Provided through Facility Care and Community Care, Fiscal Years 2018 and 2022

Category	FY 2018 (actual share of utilization)	FY 2022 (projected share of utilization)
Services Available Only through Community Care	2%	2%
Services Available in Either VA Facilities or Community Care, Provided in the Community	20%	25%
Services Available in Either VA Facilities or Community Care, Provided in VA Facilities	54%	50%
Services Available Only through VA Facilities	24%	23%

Appendix VI: Accessible Data

Category	FY 2018 (actual share of utilization)	FY 2022 (projected share of utilization)
Services Available in Either VA Facilities or Community Care, Provided in the Community	27%	34%
Services Available in Either VA Facilities or Community Care, Provided in VA Facilities	73%	66%

Agency Comment Letter

Accessible Text for Appendix IV Comments from the Department of Veterans Affairs

Page 1

September 11, 2020

Ms. Sharon M. Silas

Director

Health Care

U.S. Government Accountability Office

441 G Street, NW

Washington, DC 20548

Dear Ms. Silas:

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The enclosure contains general and technical comments, and the actions to be taken to address the draft report recommendations. VA appreciates the opportunity to comment on your draft report.

Sincerely,

Brooks D. Tucker

Acting Chief of Staff

Enclosure

Page 2

Recommendation 1: The Under Secretary for Health should establish steps for communicating to VA's actuarial consultant information on data quality, including any limitations, used in the actuarial modeling that informs VA's community budget estimates.

VA Response: Concur. The Veterans Health Administration (VHA) agrees that it is necessary to clearly define data quality, integrity, limitations and caveats for all users of community care data. VHA will, in coordination with the VA Office of Information and Technology and the VA Office of Enterprise Integration, develop relevant processes and standards to inform the work performed by VA's actuarial consultant to demonstrate completion of this recommendation.

Target Completion Date: March 2021.

Recommendation 2: The Under Secretary for Health should establish further steps for assessing and communicating to stakeholders the degree of overall uncertainty associated with actuarial projections for community care that inform the community care budget estimates.

VA Response: Concur. VHA's Office of Finance will work with VHA's Office of Enrollment & Forecasting to develop comprehensive risk communication to stakeholders regarding the degree of overall uncertainty associated with the actuarial projections used to support the President's Budget, including the Community Care request.

VHA currently provides briefings, tools, exhibits and memoranda to VA leadership and the Office of Management and Budget related to the actuarial projections from the VA Enrollee Health Care Projection Model that support the development of VA's budget. Those communications have included discussions about risks and uncertainties in the projections, but not always in a consolidated way. Going forward, VHA will consolidate and explicitly document the various sources of uncertainty in the projections, including the allocation of the total health care projections between VA facility care and community care. This

documentation will clearly identify sources of risk and quantify the degree of uncertainty that they add to the actuarial projections and will incorporate the risk and variability analyses currently being provided and new analysis not currently performed. VHA will continue to incorporate evolving industry best practices and future changes in actuarial standards of practice when updating this analysis. In addition to using this consolidated risk assessment to inform decisionmakers during the Administration budget formulation process, VA will communicate this consolidated risk assessment in the published Congressional Justifications to accompany the President's Budget.

Page 3

This communication of risk is intended to inform stakeholders of sources of uncertainty, describe how they may affect the key drivers of the actuarial projections, and discuss their potential magnitude. The risk assessment will include sensitivity testing for selected key drivers, such as health care trends, enrollee reliance, access to community care, enrollment and other drivers that demonstrate the potential variability of the projections over the short term and long term. In addition, high risk "what if" scenarios will be defined on both a narrative and quantitative basis, to illustrate the potential impacts of selected major events and changes that pose a significant financial risk to VA.

VA will incorporate this risk assessment into its 2022 President's Budget process, with publication in the Congressional Justifications with release of the Budget, estimated to be February 2, 2021.

Target Completion Date: February 2021.

Page 4

General Comments:

Figure 9, Page 28, Plexis Claims Manager and footnote "a":

Plexis Claims Manager Processes claims for the Veterans Choice Program and the Patient Centered Community Care program (PC3), including some expedited claims payments that are processed in bulk. VA's Allocation Resource Center collects data from the Plexis Claims Manager available in VA's Corporate Data Warehouse, a national repository comprising of data from several VA clinical and administrative systems. According to VA officials, prior to the implementation of Plexis

Claims Manager in February 2017, VA processed some Veterans Choice Program claims, in response to backlogs of unpaid provider claims, in an expedited manner i.e. aggregated and processed in bulk) outside of VA's historical claims processing system, Fee Basis Claims System. The Allocation Resource Center was responsible for compiling claims data related to these claims.

VA Comment: The Fee Basis Claims System (FBCS) is the system used to authorize community care and process claims resulting from that care. The payments processed through FBCS are made available as a SAS file. This dataset contains the patient level clinical and payment information which has been a reliable source for payments for more than two decades. Whereas the FBCS system was also used to process payments during the early stages of Choice program, VA has now switched over to Plexis for payment processing. As a result, the payment data is now splintered across multiple datasets, complicating access to get the clinical, patient and payment data and increasing the likelihood that claims will lack critical information like diagnosis codes, CPTs, and the patients' home medical centers. Payment data from eCAMS and CCRS are also made available in the same CDW datasets as Plexis and accessing eCAMS and CCRS payment present the same challenges as Plexis.

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- The important interactions between risks.
- Analysis of sensitivity of projections to selected sources of uncertainty.
- Narrative and quantitative description of high-risk scenarios, including a discussion of how each scenario is likely to influence the key drivers of the projections.
- Metrics and approaches to monitoring emerging experience that can identify the emergence of key risks.

Page 5

- Technical appendix discussing how the risk memorandum contributes to VHA's compliance with GAO's "Standards for Internal Control in the Federal Government".
- In July 2020, the Chief Health Informatics Officer established a Data Governance Group to create and maintain policy, processes, and standards to ensure that Office of Community Care (OCC) data are managed in an integrated, efficient, and effective manner. This group will ensure that future datasets, as well as updates to existing datasets, meet pre-determined requirements as to the structure, function, and documentation of underlying data.

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VA uses actuarial models and other methods to develop budget estimates for Community Care that reflect the implementation of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act. The annual briefing accompanying the 2021 President's

Budget Enrollee Health Care Projection Model (EHCPM) already states the following:

- MISSION Act related assumptions and their associated costs compared to the previous year's budget cycle.
- A note that "projected resource requirements for VA facility and community care represent a division of the total enrollee demand projected by the EHCPM" and therefore, both care locations need to be funded at the projected levels to meet the total projected enrollee demand for VA health care.

Page 6

- What is and is not included in the community care unit cost and the results of an in- depth analysis of VA's claim costs for care purchased in the community in fiscal year (FY) 2017 and FY 2018.
- A detailed cost comparison from the previous year's model by key drivers and changes in policy assumptions.

Related GAO Products

VA Health Care: Estimating Resources Needed to Provide Community Care. [GAO-19-478](#). Washington, D.C.: June 12, 2019.

Veterans Health Care: VA Needs to Address Challenges as It Implements the Veterans Community Care Program. [GAO-19-507T](#). Washington, D.C.: April 10, 2019.

Veterans Choice Program: Further Improvements Needed to Help Ensure Timely Payments to Community Providers. [GAO-18-671](#). Washington, D.C.: September 28, 2018.

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.

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.

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

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

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

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

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

Related GAO Products

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

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

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

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

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.

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