



Report to the Ranking Member,
Subcommittee on Oversight and
Investigations, Committee on Veterans'
Affairs, House of Representatives

September 2019

VETERANS HEALTH CARE

VA Needs to Improve Its Allocation and Monitoring of Funding

GAO Highlights

Highlights of [GAO-19-670](#), a report to the Ranking Member, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

VHA operates one of the largest health care systems in the nation with an estimate of \$81 billion for providing care to over 6.9 million veterans in fiscal year 2019. Recently, VHA has repeatedly requested that Congress provide supplemental funding due to higher-than-expected needs for care.

GAO was asked to examine how VHA allocates funds and monitors use of these funds. This report examines (1) VHA's processes for allocating general purpose and specific purpose funds to its VISNs and medical centers and (2) the extent to which VHA monitors the use of these funds.

GAO reviewed VHA's processes for allocating funds, analyzed data on allocation levels for fiscal years 2015 through 2019, and reviewed documentation on VHA's processes for allocating funds and monitoring. GAO interviewed officials from VHA; all 18 VISNs; and a non-generalizable sample of five medical centers selected based on size, facility complexity, growth in funding, and geographic variation.

What GAO Recommends

GAO is making five recommendations including that VHA use workload data from the most recently completed fiscal year to allocate funds; take steps to review adjustments; revise existing guidance to require VISNs to provide information on adjustment amounts and the reasons for doing so; and require VISNs to provide explanations for redistributions of allocated funds between VISNs and medical centers and then review the amounts redistributed. VA concurred with four recommendations and concurred in principle with one recommendation.

View [GAO-19-670](#). For more information, contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov.

September 2019

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VA Needs to Improve Its Allocation and Monitoring of Funding

What GAO Found

The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) has developed processes for allocating health care funds to its regional Veterans Integrated Service Networks (VISN) and medical centers. Each year, VHA allocates about two-thirds of funds for general patient care—known as general purpose funds—using two, main allocation models. The first model allocates general purpose funds to each VISN and a second model then allocates these funds to the medical centers that report to each VISN. These models are based on patient workload—that is, the number and type of veterans served and the complexity of care provided. VHA allocates its remaining one-third of funds—known as specific purpose funds—to program offices that manage various, specific programs, such as community care and prosthetics. Program offices, in turn, allocate these funds directly to medical centers using different methodologies, including a workload-based model for community care. GAO found the following weaknesses in VHA's processes for allocating funds:

- VHA's allocation models do not use workload data from the most recently completed fiscal year. For example, the fiscal year 2019 allocation levels determined by the models were based on data from fiscal years 2013 through 2017 but did not include data from fiscal year 2018. The models do not use more recent data because officials believed that doing so would not significantly affect allocations. By not using the most recent data available when it makes final allocations, VHA's allocations may not accurately reflect medical centers' funding needs if they experience workload changes. For example, from fiscal years 2017 through 2018, 34 medical centers had patient workload growth of over 3 percent, and 9 experienced a decline of over 3 percent, which was not reflected in the fiscal year 2019 allocations.
- VISNs are allowed to make adjustments to allocated funding levels determined by the models and must submit written explanations for doing so according to VHA guidance. However, VHA officials did not adequately review adjustments for fiscal year 2019 to ensure adjustments were documented. Specifically, VHA officials did not provide evidence they sought an explanation for adjustments made by two VISNs that provided no written explanation for their adjustments. Furthermore, GAO also found that VHA guidance does not require VISNs to explain how they determined adjustment amounts and why they made them. Without requiring this information, VHA cannot ensure that these adjustments lead to efficient use of funds.

Once VISNs have made adjustments to allocated funding levels and funds are distributed to VISNs and medical centers, VHA uses multiple mechanisms to monitor the balance of funds. Throughout the year, VHA redistributes funds across the VA health care system to address unfunded needs and surpluses that are identified. However, GAO found that VHA does not adequately monitor the redistribution of allocated funds between VISNs and medical centers. VHA does not require VISNs to provide explanations for redistributions and does not review the amount redistributed. As a result, VHA does not know the extent to which redistributions deviate from workload-based allocations and if VISNs and medical centers are operating efficiently.

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Abbreviations

MCAS	Medical Center Allocation System
PWW	patient weighted work
VA	Department of Veterans Affairs
VCCP	Veterans Community Care Program
VERA	Veterans Equitable Resource Allocation
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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September 23, 2019

The Honorable Jack Bergman
Ranking Member
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) operates one of the nation's largest health care delivery systems. VA budget documents show an estimate of \$81 billion for providing care to over 6.9 million veterans in fiscal year 2019.¹ VHA allocates its funds by the beginning of each fiscal year. VHA allocates about two-thirds of its funds for general patient care—known as general purpose funds—using two main allocation models. VHA uses the first model to allocate general purpose funds to each of the 18 regional Veterans Integrated Service Networks (VISN). VHA uses a second model to allocate these funds to medical centers within each VISN.² VHA allocates the remaining one-third of its funds for specific patient care—referred to as specific purpose funds—outside of these models.³ Specific purpose funds are designated for certain programs, including programs for community care (care provided by non-VA providers but paid for by VHA), prosthetics, and homelessness.⁴

¹Patients include 6.2 million veterans and an additional 0.7 million non-veteran patients, including veterans' beneficiaries; active duty military; reserve personnel; and VA employees.

²There are 172 medical centers across VHA. Each of VHA's 18 VISNs is responsible for managing and overseeing the medical centers within their networks.

³According to VHA, specific purpose funds are allocated differently than general purpose funds because of special legal or programmatic requirements, national support functions, and projects where economies of scale can be achieved at a national level by having some allocations outside VHA's main allocation models. There are over 700 specific purpose funding subaccounts.

⁴VA has purchased health care services from community providers since as early as 1945. In general, veterans may be eligible for community care when they are faced with long wait times or travel long distances for appointments at VA medical facilities, or when a VA medical facility is unable to provide certain specialty care services, such as cardiology or orthopedics. In general, community care services must be authorized in advance of when veterans access the care.

In fiscal year 2019, VHA allocated about \$49 billion in general purpose funds and about \$23 billion in specific purpose funds.⁵ In recent years, community care has accounted for the largest share of special purpose funds. VHA, VISN, and medical center officials are responsible for monitoring the use of allocated funds—including both general purpose and specific purpose funds. This monitoring is largely to ensure that medical centers operate within their allocated funding levels.

In recent years, VHA has repeatedly requested and received supplemental appropriations from the Congress to address higher-than-expected costs and utilization of community care.⁶ As a result, you have had questions about whether VHA allocates its funds in a way that promotes efficiency. In light of these questions, you asked us to review VHA's processes for allocating funds and its monitoring of the use of these funds. In this report, we examine

1. VHA's processes for allocating general purpose and specific purpose funds to its VISNs and medical centers, and
2. the extent to which VHA monitors the use of these funds.

To examine VHA's processes for allocating general purpose and specific purpose funds to its VISNs and medical centers, we reviewed VHA's models and methods for allocating funds and tracked the total allocation levels for general purpose and specific purpose funds from fiscal years 2015 through 2019. Allocations made in fiscal year 2019 were the most recent allocations available at the time of our review. For general purpose funds, we examined VHA's Office of Finance guidance regarding allocation and specifically examined the allocation level for each VISN and for each medical center for fiscal years 2018 and 2019. For specific purpose funds, we examined the guidance and allocation methods used

⁵These amounts do not include funds for the Veterans Choice Program and those resulting from collections, such as co-payments and third-party payments. The Veterans Choice Program was implemented in early fiscal year 2015 and allowed 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. The program's authority sunsetted on June 6, 2019, when a new Veterans Community Care Program was implemented.

⁶As a result of the additional appropriations, the amounts VA actually obligated for health care services—that is, made a definite commitment to pay—were higher than VHA originally estimated. Specifically, as we have previously reported, in fiscal years 2017 and 2018 VA's actual obligations were \$1.2 billion and \$2.2 billion more for community care than it estimated for those years. See GAO, *VA Health Care: Estimating Resources Needed to Provide Community Care*, [GAO-19-478](#) (Washington, D.C.: June 12, 2019).

by the five VHA program offices that each managed at least \$1 billion of these funds and collectively managed about 80 percent of specific purpose funds in fiscal year 2019.⁷ We also interviewed officials from VHA's Office of Finance, the five VHA program offices, and the chief financial officers from the 18 VISNs on the processes used to allocate general purpose and specific purpose funds. We assessed VHA's allocation processes in the context of federal standards for internal control related to information and monitoring activities.⁸ We also assessed these processes in the context of VA's strategic plan, which calls for the efficient allocation of funds.⁹ Furthermore, we assessed the reliability of any data we obtained by checking for missing values and outliers, and by interviewing relevant VHA officials who are knowledgeable about the data. As a result of these steps, we determined that the data were sufficiently reliable for the purpose of our reporting objectives.

To examine the extent to which VHA monitors the use of general purpose and specific purpose funds, we assessed the monitoring efforts of VHA—including the Office of Finance and the five program offices—and each of the 18 VISNs. We reviewed VHA documents that outline VHA's requirements for monitoring the use of funds. We also interviewed officials from VHA's Office of Finance and VHA's Deputy Under Secretary for Health Operations and Management, the five VHA program offices, and the chief financial officers from the 18 VISNs on the steps they take to monitor the use of funds and examined documentation on their monitoring activities. We assessed VHA's monitoring in the context of federal standards for internal control related to monitoring and control activities.¹⁰

⁷The five program offices included the Office of Community Care, the Homeless Program Office, the Office of Patient Care Services, the Office of Academic Affiliations, and the Office of Capital Asset Management Engineering and Support.

⁸GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: September 2014). Internal 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.

⁹According to VA's strategic plan, VA will modernize systems and focus resources more efficiently to be competitive and to provide world-class capabilities to veterans and its employees. See Department of Veterans Affairs, *FY 2018–2024 Strategic Plan* (February 2018).

¹⁰[GAO-14-704G](#).

For both objectives, we also interviewed officials at a non-generalizable sample of five medical centers that we selected based on geographic diversity, differences in facility complexity, size, and growth rate of general purpose funds (including three medical centers that had experienced significant growth in their general purpose funds—which we defined as growth of more than 8 percent—in fiscal year 2019 and ones that experienced growth of 2 percent or less in that year, which we defined as minimal growth). We interviewed medical center officials about their involvement with VHA’s allocation process, the data used for allocating funds, and any challenges they experienced allocating funds. We also asked them how they monitored the use of funds allocated to them.¹¹ The five medical centers we selected were located in El Paso, Texas; Marion, Illinois; Minneapolis, Minnesota; New York, New York; and Prescott, Arizona.

We conducted this performance audit from October 2018 to September 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform our work to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VHA’s Allocation of Funds

In February of each year, the President submits the budget request for VHA health care, which includes requested funding for the upcoming fiscal year as well as an advance appropriation request to Congress.¹² VHA allocates funds by the beginning of each fiscal year—October 1—to VISNs and medical centers based on the amount VA received in the advance appropriation. Once appropriations are enacted for the

¹¹Officials we interviewed at each medical center included the medical center leadership, the chief financial officer, the community care manager, the Veterans Equitable Resource Allocation (VERA) coordinator—responsible for managing patient workload data—and the Health Information Management Specialist—responsible for data integrity and improvement efforts.

¹²VHA’s annual appropriations for health care include advance appropriations that become available 1 fiscal year after the fiscal year for which the appropriations act was enacted.

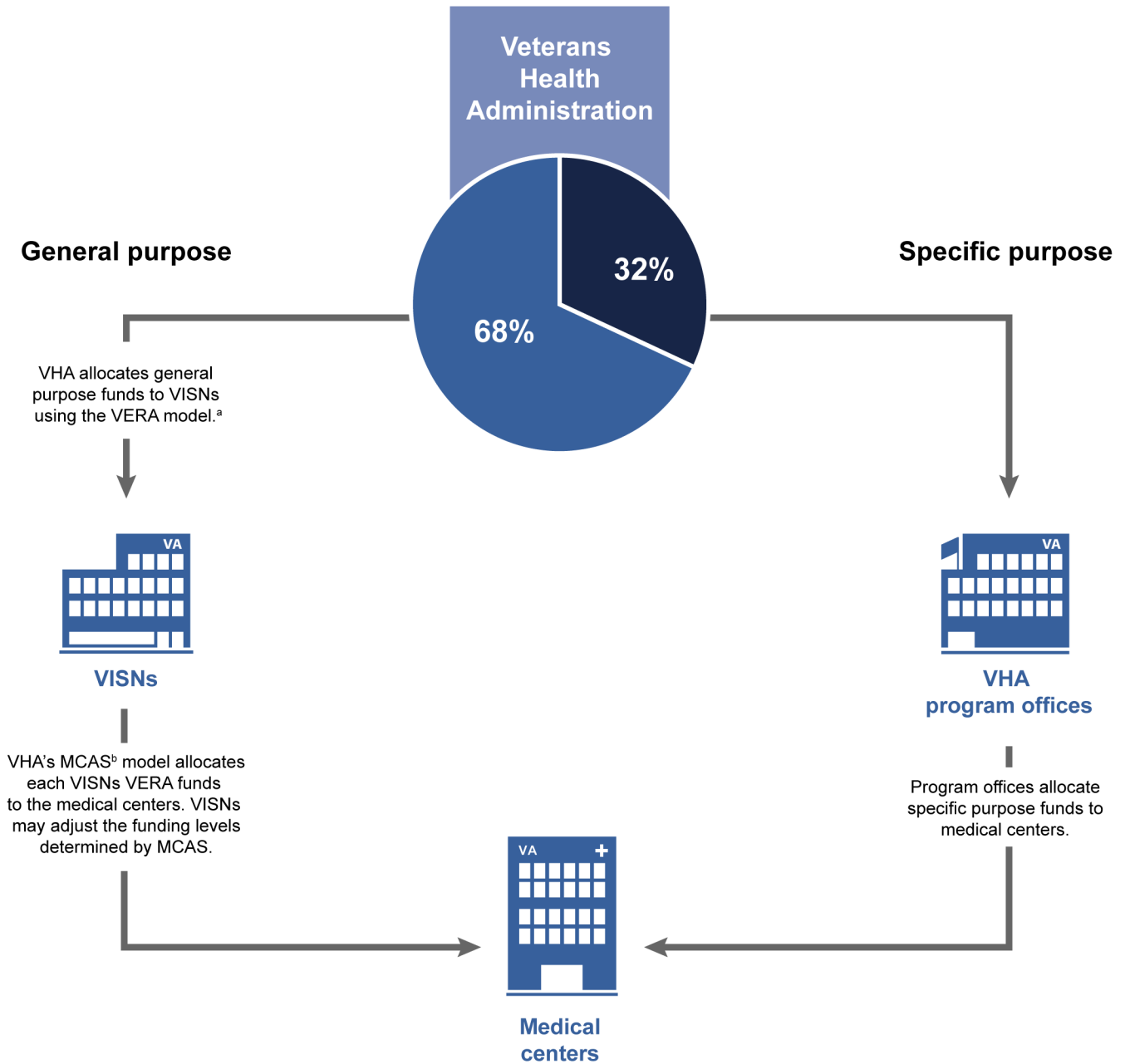
upcoming fiscal year, VHA updates the allocated funding levels for VISNs and medical centers. For example, VHA's appropriations for fiscal year 2018 included advance appropriations for fiscal year 2019. VHA allocated funds by October 1, 2018 (the beginning of fiscal year 2019), based on the advance appropriation for fiscal year 2019 and updated the funding levels once appropriations for fiscal year 2019 were enacted.

VHA allocates general purpose funds to its 18 VISNs through the Veterans Equitable Resource Allocation (VERA) model. It uses a separate model, called the Medical Center Allocation System (MCAS), to allocate each VISN's general purpose funds—as determined by the VERA model—to the medical centers within each network. VHA guidance permits VISNs to make adjustments to the general purpose funding levels determined by MCAS for each medical center.

VHA uses other methods to allocate specific purpose funds to VHA program offices that manage various health care programs, such as those for community care, prosthetics, and homelessness.¹³ The program offices, in turn, typically allocate funds for these programs directly to medical centers. (See fig. 1.)

¹³According to VHA, specific purpose funds are allocated differently than general purpose funds because of special legal or programmatic requirements, national support functions, and projects where economies of scale can be achieved at a national level by having some allocations outside the VERA and MCAS models.

Figure 1: VHA Allocation of General and Specific Purpose Funds, Fiscal Year 2019



Source: GAO analysis of Veterans Health Administration (VHA) data and documents. | GAO-19-670

Note: VHA's allocation process for medical care is divided into general purpose funds allocated for general patient care and specific purpose funds, which are designated for certain programs, including programs for community care (care provided outside of the VHA health care system but paid for by VHA), prosthetics, and homelessness.

^aEach of VHA's 18 Veterans Integrated Service Networks (VISN) is responsible for managing and overseeing the Department of Veterans Affairs (VA) medical centers within their networks. VHA allocates general purpose funds to its 18 VISNs through the Veterans Equitable Resource Allocation (VERA) model.

^bVHA's Medical Center Allocation System (MCAS) model allocates each VISN's general purpose funds—as determined by VERA—to the medical centers within each of the 18 VISNs.

Once funds are allocated and distributed to VISNs and medical centers, these funds may be redistributed in accordance with law across VA's health care system. These redistributions can help address unfunded needs or surpluses that may arise. For example, according to officials, a medical center may need additional funds to provide care for veterans when natural disasters occur.

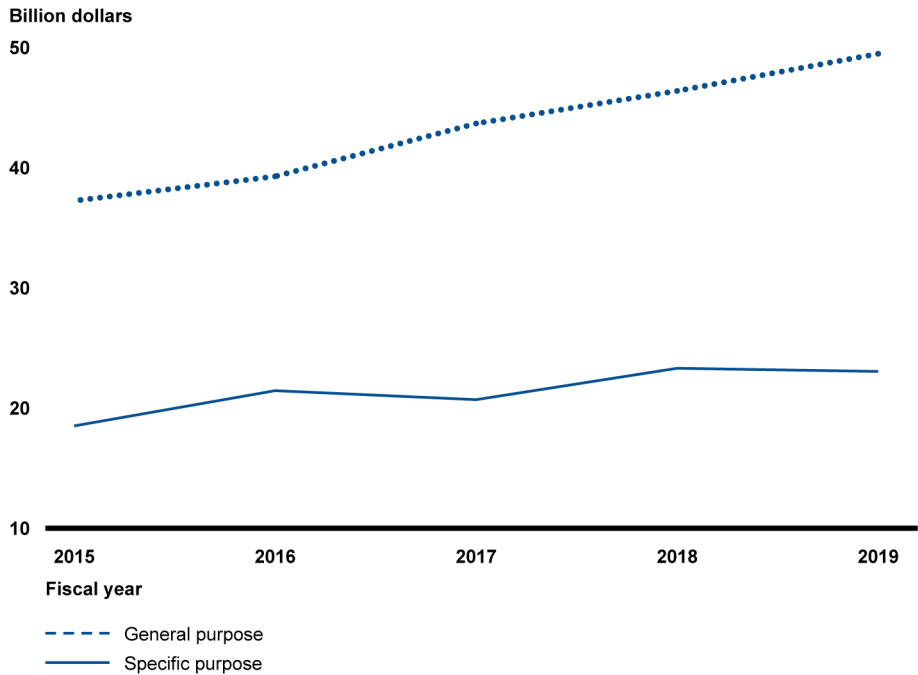
VHA's General Purpose and Specific Purpose Funding Levels

From fiscal year 2015 to fiscal year 2019, general purpose funds increased by 33 percent— from \$37 to \$49 billion—while specific purpose funds increased by 24 percent—from \$19 to \$23 billion.¹⁴ (See fig. 2.) In fiscal year 2019, community care accounted for \$10.5 billion—46 percent—of the \$23 billion allocated in specific purpose funds. Patient care services, homelessness programs, non-recurring maintenance, and medical residency programs also accounted for large portions of specific purpose funds.¹⁵

¹⁴These data do not include funds for the Veterans Choice Program and those resulting from collections, such as co-payments and third-party payments.

¹⁵The \$10.5 billion for community care does not include funding in the Veterans Choice Fund for the Veterans Choice Program. Patient care services include specific purpose funds for prosthetics and hepatitis C drugs. Collectively, funds for community care, patient care services, homelessness programs, non-recurring maintenance, and medical residency programs made up 82 percent of all specific purpose funds in fiscal year 2019.

Figure 2: Trends in VHA's General Purpose and Specific Purpose Funding Levels, Fiscal Years 2015-2019



Source: GAO analysis of Veterans Health Administration (VHA) data. | GAO-19-670

Note: These data do not include funds in the Veterans Choice Fund for the Veterans Choice Program and those resulting from collections, such as co-payments and third-party payments. The Veterans Choice Program allowed 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. The program's authority sunsetted on June 6, 2019, when the Veterans Community Care Program was implemented.

VA's Appropriation Accounts and Community Care

As of fiscal year 2017, VA primarily receives appropriated funds for all health care it provides or purchases through four appropriation accounts. The amount of funds in each appropriation account is determined by VA's annual appropriation. VHA allocates both general and specific purpose funds from these appropriation accounts. These accounts include the following:

- Medical Services: health care services provided to eligible veterans and other beneficiaries in VA facilities and non-VA facilities, among other things.

-
- Medical Community Care: health care services that VA authorizes for veterans and other beneficiaries to receive from community providers.¹⁶
 - Medical Support and Compliance: the administration of the medical, hospital, nursing home, domiciliary, supply, and research activities authorized under VA's health care system, among other things.
 - Medical Facilities: the operation and maintenance of VHA's capital infrastructure, such as the costs associated with nonrecurring maintenance, leases, utilities, facility repair, laundry services, and groundskeeping, among other things.¹⁷

Separate from VA's health care appropriation accounts, the Veterans Access, Choice, and Accountability Act of 2014 established the Veterans Choice Fund and provided \$10 billion in funds for the Veterans Choice Program (Choice Program), which was implemented in early fiscal year 2015 and authorized until funds were exhausted or through August 7, 2017, whichever occurred first.¹⁸ The Choice Program allowed veterans to elect to receive care from community providers when the services needed were not available at a VA medical center, were not available within VHA's wait-time goals, or when veterans did not reside near a VA medical facility with a full-time primary care provider. Eligible veterans could also elect to receive care in the community if they met other eligibility criteria as well.

VA received additional authority and funds to maintain the Choice Program through June 6, 2019, when it sunsetted, and the new Veterans Community Care Program (VCCP) went into effect. The VCCP was established by the VA MISSION Act and consolidated the Choice Program along with several other community care programs.¹⁹ The VCCP is primarily funded through specific purpose funds in the Medical

¹⁶The VA Budget and Choice Improvement Act required the inclusion of an appropriation account specifically for community care starting with the President's fiscal year 2017 budget request. Pub. L. No. 114-41, Tit. IV, § 4003, 129 Stat. 443, 462-463 (2015).

¹⁷Nonrecurring maintenance is designed to correct, replace, upgrade, and modernize existing infrastructure and utility systems.

¹⁸Pub. L. No. 113-146, §§ 101(p), 802, 128 Stat. 1754, 1755-1765, 1802-1803 (2014).

¹⁹Pub. L.No. 115-182, tit. I, 132 Stat. 1393 (2018). The VA MISSION Act required VA to implement a permanent community care program—the VCCP—that consolidates the Choice Program along with several other community care programs. The VCCP was implemented on June 6, 2019.

Community Care appropriation account. The VCCP is similar to the former Choice Program in allowing veterans to elect to receive care from community providers when certain eligibility criteria are met, including criteria relating to the availability and accessibility of the services at VHA.²⁰ Under the VCCP, VHA adopted designated access standards for VCCP eligibility determinations that are broader than the eligibility criteria that existed under the Choice Program.²¹

VHA Allocates Funds Based on Patient Workload but Does Not Use the Most Up-to-date Data and Certain Adjustments to Funding Levels May Lead to Inefficiencies

²⁰Under the VCCP, veterans are eligible for community care when (1) VA does not offer the care or service required by the veteran; (2) the veteran resides in a state without a full-service VA medical facility; (3) the veteran would have been eligible under the 40-mile criterion of the Choice Program before June 6, 2018; (4) VA cannot provide the veteran with care and services that comply with its designated access standards; or (5) the veteran and the veteran's referring clinician agree that it is in the best interest of the veteran to receive care in the community.

²¹VA's expanded designated access standards for eligibility determinations for the VCCP are based on average drive times and wait times: (1) For primary care, mental health, and non-institutional extended care services, VA designated a 30-minute average drive time standard and a 20-day wait-time standard from the date of request with certain exceptions; (2) for specialty care, VA developed a 60-minute average drive time standard and a 28 day wait-time standard from the date of request with certain exceptions.

VHA Allocates General Purpose and Community Care Funds Based on Patient Workload

VHA's VERA model uses a national, formula-driven approach that considers the number and type of veterans served and the complexity of care provided—collectively referred to as patient workload—as well as certain geographic factors, such as local labor costs, to determine the amount of general purpose funds each VISN should receive.²² VHA uses VERA to establish funding levels for each VISN in the following areas: patient care, equipment, education support, and research support, the largest of which is patient care.²³

After determining the amount of funds VISNs should retain for VISN-level initiatives, administrative purposes, and reserves, VHA uses its MCAS model to distribute the remainder of each VISN's general purpose funds to medical centers within the VISN.²⁴ MCAS is based on a workload measure developed by VHA, called patient-weighted work (PWW) that accounts for medical center-level factors such as patient volume, case-mix, and specialized services.²⁵ According to VHA officials, PWW

²²VHA has three general types of veterans: 1) those that use some health care services but are less reliant on the VA system; 2) those with "routine" health care needs who rely on VA health care, and 3) those with "special" or "complex," and generally chronic, health care needs that are relatively expensive.

²³VHA assesses its VERA model annually to determine any needed changes to the model. We have previously reported that VERA is a reasonably sound methodology for VHA to allocate funds to networks, although we have made recommendations to improve the methodology, some of which VHA has incorporated. See GAO, *VA Health Care: Resource Allocation Has Improved, but Better Oversight Needed*, [GAO/HEHS-97-178](#) (Washington, D.C.: Sept. 1997); *VA Health Care: More Veterans Are Being Served, but Better Oversight Is Needed*, [GAO/HEHS-98-226](#) (Washington, D.C.: Aug. 1998). *VA Health Care: Allocation Changes Would Better Align Resources with Workload*, [GAO-02-338](#) (Washington, D.C.: Feb. 2002).

²⁴VHA guidance allows VISNs to retain general purpose funds allocated through VERA for VISN-level initiatives, such as to offset start-up costs for new projects, including medical center expansions or new clinics, or for the VISNs' consolidation of services shared across medical centers such as consolidated accounting or laboratory services. For example, according to officials from one VISN, because the VERA model is largely based on workload from prior years, it does not account for new projects. VISNs have to fund these projects by retaining general purpose funds allocated to them and dedicating them to such projects. VHA guidance does not place a limit on the amount of funds that may be retained for VISN-level initiatives, but requires these initiatives to be approved by VHA. Additionally, VISNs retain funds for the administrative costs associated with operating the VISN—such as salaries for VISN employees—and may retain up to 1.5 percent of their general purpose allocation as a reserve.

²⁵According to VHA documentation, the VERA model is not intended to allocate funds below the VISN level, primarily because the patient population is not sufficiently diverse at every medical center. For this and other reasons, MCAS uses a separate workload measure—PWW—to distribute VISN-level VERA funds to medical centers within each VISN.

establishes an equitable measure of workload among medical centers that vary significantly in their geographic location, and types and costs of services provided. Furthermore, PWW lessens the impact of cost differences between medical centers, by recognizing the varying costs and levels of resource intensity associated with providing care for each patient at each medical center. For example, PWW would result in more funds being allocated to a medical center that provides more complex care, such as open heart surgery, than a workload measure based solely on a count of each individual patient, which would not account for the additional costs associated with more complex care.

Similar to MCAS, VHA's Office of Community Care uses a patient workload-based model to allocate community care funds—which are specific purpose funds—to medical centers, based on each medical center's community care patient workload in prior years. To determine the community care funding needs for each medical center, VHA calculates the PWW associated with community care.²⁶ VHA determines the total amount of funds available for community care based on the amounts appropriated to the Medical Community Care appropriation account and the amount available for community care in the Veterans Choice Fund. VHA distributes the funds to each medical center in proportion to each medical center's PWW.²⁷ VHA officials told us that VHA is considering making changes to the methodology for allocating community care funds under the new VCCP, but as of July 2019, updates to the methodology had not been developed or implemented.

The other four program offices we reviewed developed other methodologies for allocating other specific purpose funds. In general, these methodologies involve coordination between VISNs and their medical centers on needs for these funds and allocating available funds based on identified needs. For example, the Office of Patient Care Services which manages prosthetics and hepatitis C drugs allocates available funds based on identified needs by each of the medical centers. Appendix 1 provides an overview of the methodologies used by these four program offices to allocate special purpose funds.

²⁶For fiscal year 2019, VHA set aside additional funds for the Alaska medical center due to the high cost of community care in Alaska not accounted for by PWW.

²⁷For fiscal year 2019, VHA determined the portion of community care funds for each medical center that would come from the Medical Community Care appropriation account and the portion that would come from the Veterans Choice Fund.

VHA's Allocation Models for General Purpose and Community Care Funds Do Not Reflect the Most Up-To-Date Patient Workload Data Available

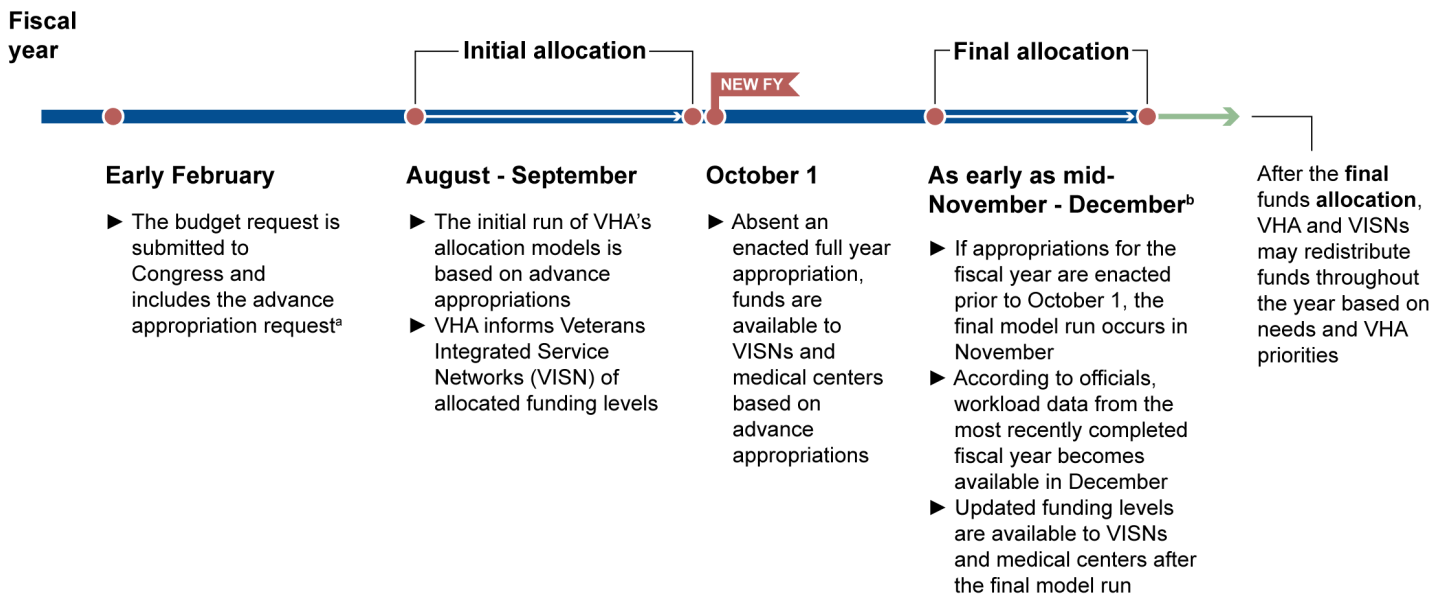
To allocate funds for an upcoming fiscal year, VHA's allocation models rely on actual patient workload data from prior fiscal years, but not the most recently completed fiscal year.

- VHA's VERA model relies on actual patient workload data from two to six years prior to the upcoming fiscal year, in addition to future workload projections.²⁸ For example, to allocate funds for fiscal year 2019, the VERA model relied on actual workload data from fiscal years 2013 and 2017, in addition to some future projected workload, but did not take into account actual workload data from fiscal year 2018.
- VHA's MCAS and community care models rely on actual patient workload data from two years prior to the upcoming fiscal year. For example, the 2019 MCAS and community care models were based on actual workload data from fiscal year 2017, but did not take into account actual workload data from fiscal year 2018.

According to VHA officials, patient workload data from the most recently completed fiscal year are not yet available when VHA runs the preliminary VERA, MCAS, and community care models for each fiscal year in August. However, these officials told us that these data would be available in December of each year and therefore could be incorporated into the final model run after VHA receives its enacted appropriation amount for the upcoming fiscal year. These officials told us that doing so would result in little to no delay in when the final model run and the final distribution of funds takes place, which occurs after the appropriation act is enacted. Specifically, according to officials from VHA's Office of Finance, if the full fiscal year appropriation is enacted prior to the start of the fiscal year on October 1, VHA will be able to perform the final model runs by mid-November. As a result, incorporating data from the most recent fiscal year would result in a one month delay in the final model run. Should the enactment of a full year appropriation be delayed, the timing of the final model would not be impacted by using data from the most recently completed fiscal year. (See fig. 3.)

²⁸VERA takes into account future workload for a subset of the veteran population as projected by a separate model called the Enrollee Health Care Projection Model. For more information on this model, see [GAO-19-478](#).

Figure 3: Timeline for Allocating VHA’s General Purpose Funds



Source: GAO analysis of Veterans Health Administration (VHA) processes. | GAO-19-670

^aVHA's annual appropriations for health care include advance appropriations that become available 1 fiscal year after the fiscal year for which the appropriations act was enacted. For example, VHA's appropriations for fiscal year 2018 included advance appropriations for fiscal year 2019. Our previous work provides a detailed overview of VHA's budget formulation process, including the projection model VHA uses to determine budgetary needs, and the appropriation process. See GAO, *VA Health Care: Estimating Resources Needed to Provide Community Care*, GAO-19-478 (Washington, D.C.: June 12, 2019).

^bAccording to officials from VHA's Office of Finance, if the full year appropriation is enacted prior to the start of the fiscal year on October 1, VHA is able to perform the final model runs by mid-November. Should the enactment of the full year appropriation be delayed, the final model runs would be delayed accordingly, and the timing of the final model would not be impacted by using data from the most recently completed fiscal year.

A VHA Office of Finance official told us that VHA had not previously considered using patient workload data from the most recently completed fiscal year because VHA did not believe that using updated data would have a significant impact on the model. However, the official told us that the implementation of the VCCP in June 2019 may result in more significant year-to-year workload changes due to veterans increasing their use of VHA health care services. As a result, the official told us that using more up to date information would be more useful in informing allocation levels. Federal standards for internal control related to information calls for management to use quality information to achieve the entity's objectives. Quality information is appropriate, current, complete, accurate, accessible, and provided on a timely basis.

Because the VERA, MCAS, and community care models do not use the most up-to-date patient workload data available, the models may not reflect the most recent workload trends affecting medical centers. This may result in funding levels determined by the models that may not be commensurate with medical centers' actual patient workload. For example, VHA data we reviewed show that some medical centers experienced workload changes in fiscal year 2018—changes that were not captured by the models for fiscal year 2019 allocations. Specifically, from fiscal years 2017 through 2018, while PWW for care provided by VA medical centers grew over 1 percent VHA-wide, 34 medical centers experienced growth of over 3 percent, and 9 experienced a decline of over 3 percent. Similarly, the PWW for care in the community grew over 6 percent VHA-wide from fiscal year 2017 to fiscal year 2018, with 97 medical centers experiencing growth of over 3 percent and 25 experiencing a decline in community care of over 3 percent over this time period.

Additionally, officials we interviewed at six VISNs told us that the models have not accounted for recent workload growth their medical centers were experiencing due to an increase in the number of veterans they serve, the addition of new services, or changes in the medical centers' reliance on community care. Two of these VISNs analyzed recent workload trends at the medical centers within their VISN and allocated additional funds to those medical centers with recent growth not accounted for by MCAS. If VHA were to incorporate the most recent available workload data into its allocation models, the need for such funding changes would likely be reduced.

VHA Does Not Adequately Monitor Adjustments Made to Medical Centers' Allocated Funding Levels, and Certain Adjustments May Lead to Inefficiencies

As part of the allocation process, VISNs may make adjustments to the amounts of general purpose funds calculated by MCAS and allocated to medical centers. VHA guidance requires VISNs to provide a written explanation to VHA for any adjustments. However, we found that VHA does not adequately monitor these adjustments and that some of these adjustments may lead to inefficiencies.

VHA Does Not Adequately
Monitor Allocation Adjustments

We found that VHA Office of Finance officials did not adequately review the fiscal year 2019 MCAS adjustments to ensure that adjustments were documented and fully explained.²⁹ Specifically, VHA did not provide evidence that they sought an explanation for MCAS adjustments made by 2 VISNs that provided no written explanation for their adjustments, even though these explanations are required by VHA guidance.³⁰ VHA Office of Finance officials said they use informal methods via email to learn about the adjustments and follow-up as needed, but could not provide documentation that follow-up and review had occurred. Additionally, VISN officials we interviewed from all 18 VISNs stated that they had not received questions or other feedback from the VHA Office of Finance on the adjustments they made, even if they had not documented and explained the adjustments.

Furthermore, even if VISNs follow the requirement and submit written explanations for the adjustments, they may not provide the type of information VHA needs to adequately monitor the adjustments. This is because VHA guidance does not require VISNs to provide information on how they determined how much and for what reasons they are making the adjustments. For example, we found that 6 VISNs provided limited explanations for their fiscal year 2019 MCAS adjustments, such as stating that they had decided to reallocate funds among medical centers to ensure “continuity of operations,” which is insufficient information to allow VHA to determine if the adjustments were appropriate.

Federal standards for internal control related to monitoring state that management should establish and operate monitoring activities to monitor the internal control system and evaluate the results. These monitoring activities could include establishing a formal process to document VHA’s review of VISN adjustments to medical center allocations. Additionally, monitoring activities could include requiring VISNs to provide information on how they determined how much and for what reasons they are making

²⁹In total, 11 VISNs made adjustments to their fiscal year 2019 MCAS allocation levels. We found that 8 VISNs provided either no explanation or only a limited explanation for adjustments they made and 3 VISNs provided a sufficient explanation for their adjustments. For fiscal year 2018, we found that 14 VISNs made adjustments to MCAS allocation levels, of which 6 VISNs provided either no explanation or only a limited explanation for adjustments they made and 8 VISNs provided a sufficient explanation for their adjustments.

³⁰Across these two VISNs, the adjustments ranged from a \$11 million reduction in allocated funds to a \$7 million addition in allocated funds for individual medical centers.

the adjustments and then reviewing such information. As VHA evaluates the adjustments, documenting the results of its monitoring and having the information needed to help determine the appropriateness of the adjustments will help VHA identify areas for improvement in the allocation process. Without adequate monitoring, VHA cannot reasonably ensure these adjustments are justified and align with VA's strategic plan, which calls for the efficient allocation of funds.

Certain Adjustments May Lead to Inefficiencies

Based on interviews with VISN officials, we found that, in fiscal year 2019, seven VISNs adjusted the allocations determined by MCAS to ensure that every medical center within their VISN received either the same level of funding or a minimum funding increase of up to 2 percent relative to the prior year. According to VISN officials, funds were often shifted from medical centers that had received relatively large increases in funds due to growing workload to medical centers that had received a decrease or relatively flat funds compared to the prior year due to either declining or relatively flat workload. According to VISN officials, declining workload may be the result of medical centers serving fewer patients or patients obtaining care from community providers rather than VA providers. When asked about these adjustments, officials at the seven VISNs stated that they were necessary to ensure that affected medical centers could continue to cover the costs for the services they offer and the staff they employ, including providing federally mandated annual salary increases for those staff. Officials from four of these VISNs stated that it is difficult for medical centers to absorb a funding cut or only a small increase in funding from one year to the next due to rising costs they face.

While VISNs are allowed to make adjustments to medical centers' allocated general purpose funds, these adjustments may lead to inefficiencies because medical centers are not required to improve efficiency—such as, adjust the level of services they offer—to account for their decreases in workload.³¹ Additionally, officials from VHA's Allocation

³¹Officials from one VISN stated that they had met with medical center officials earlier in the year to develop plans to "right-size" medical centers with declining workload by, for example, consolidating services currently offered at multiple locations, in order to improve efficiency. Officials at this VISN stated that, eventually, without efficiency improvements, the VISN will not have sufficient funding to reallocate among medical centers, in order to avoid funding decreases relative to the prior year. Officials stated that they had not communicated these plans to VHA's Office of Finance in writing. Officials at two other VISNs stated that, in the future, medical centers within the VISN would either have to improve efficiency, reduce their size, or find a way to generate greater workload in order to operate within their allocated general purpose funding levels.

Resource Center within the Office of Finance, which is responsible for developing and executing VHA's allocation models, told us that because allocations made through MCAS are based on medical center workload, VISNs should avoid reallocating funds so that all medical centers receive a minimal increase. These officials said that doing so results in medical centers failing to adjust the level of services to meet workload needs. However, we found that for medical centers with declining workload, VHA guidance on allocation of funds does not require VISNs—in conjunction with these medical centers—to develop and submit approaches to improve the efficiency of medical center operations. Such improvements in efficiency would help lower overall costs.

As we have previously stated, VHA's strategic plan calls for the efficient allocation of funds. In addition, federal internal control standards related to control activities state that management should design control activities to achieve agency objectives. Such an activity could include having guidance on the allocation and adjustment of funds that promotes the efficient use of funds for delivering health care services to veterans. Without requiring VISNs—in conjunction with medical centers—to develop and submit an approach to change how medical centers with decreasing workload should operate, VHA increases the risk that these adjustments will not align with VA's strategic plan.³²

³²VA has a future effort that may impact the allocation of funds throughout the health care system, with a goal of improving efficiency. Specifically, the VA MISSION Act established the Asset and Infrastructure Review Commission, which is required to meet in 2022 and 2023. According to VHA officials, this commission will evaluate the results of market assessments currently being conducted to create high-performing care delivery networks, maximizing access and quality for veterans. The officials stated that these market assessments are scheduled to be completed in 2020. The concerns we identified above are related to planned activities of the Asset and Infrastructure Review Commission, which is designed to ensure that funds are allocated to facilities in a manner that aligns with veterans' care needs. See Pub. L. No. 115-182, § 202, 132 Stat. 1393, 1443 (2018).

VHA Monitors the Use of Allocated Funds, but Does Not Adequately Monitor Redistribution of Funds

VHA Monitors the Use of Allocated General Purpose and Specific Purpose Funds Using Multiple Mechanisms

Once funds are allocated and distributed to VISNs and medical centers, VHA uses multiple mechanisms to monitor the balance of general purpose and specific purpose funds. VA uses these mechanisms to ensure that VISNs and medical centers operate within their allocated funding levels and are in compliance with the Anti-Deficiency Act.³³ VHA's primary monitoring mechanism is through VA's financial management system, which is used to track obligations and prevent VISNs and medical centers from obligating amounts that are greater than the funds they have available.³⁴ VHA also employs additional mechanisms to monitor the use of general and specific purpose funds. These additional mechanisms are described below.

General Purpose Funds

VHA's Office of Finance requires each VISN to prepare an annual operating plan after the initial allocation of general purpose funds for each fiscal year that reflects the total planned obligations for the medical centers they oversee. These operating plans describe the planned obligation of funds throughout the fiscal year for various budget categories, such as personnel, equipment, transportation, and supplies

³³In general, the Anti-Deficiency Act prohibits agencies from obligating or expending in excess or in advance of an available appropriation unless otherwise authorized by law. 31 U.S.C. §§ 1341, 1342, 1517.

³⁴We have previously reported that, according to VHA officials, VA's financial management system electronically prevents VISNs and medical centers from spending more than their available funding (which is the funds they were allocated, less the funds unobligated). The agency financial management system has automated controls in place that prevent networks and medical centers from spending more than their available funds. When medical centers want to spend some of their funds, they enter requests for the obligation of funds into the system. If the amount entered exceeds what is available to them, the request is rejected by the system, and cannot be processed. See GAO, *VA Health Care: Need for More Transparency in New Resource Allocation Process and for Written Policies on Monitoring Resources*, [GAO-11-426](#) (Washington, D.C.: Apr. 29, 2011).

and materials. VHA requires planned obligations reported in operating plans to align with the funding levels available to each VISN, which include allocated funds as well as anticipated collections, reimbursements, and funds carried over from previous years.³⁵ VISNs are required to revise their operating plans during the fiscal year if major changes are made to their available funding levels, due to, for example, the enactment of a final appropriation bill, which results in final allocations.

To monitor VISNs' use of general purpose funds, VHA uses the operating plans to compare each VISN's planned obligations with actual obligations on a monthly basis. VHA does not compare planned obligations with actual obligations for each medical center individually; instead, each of the 18 VISNs as well as the five medical centers we reviewed developed their own tools to monitor the use of funds. According to VHA officials, VHA requires each VISN to provide an explanation to VHA's Office of Finance on a monthly basis about any variances of 5 percent or more above or below the amount between planned obligations in their operating plans and actual obligations.

Based on VHA documents we reviewed, all 18 VISNs provided explanations for situations in which their actual obligations were equal to, higher, or lower than 5 percent from their planned obligations in fiscal years 2018 and 2019 and in some cases, also explained the actions they were planning to take to address the variance. VISNs reported several reasons for the variances. For example, some VISNs reported that their actual obligations exceeded planned obligations in some months because contracts or equipment purchases were executed earlier than anticipated in the year. Conversely, some VISNs reported that contracting delays led to actual obligations lagging behind planned obligations reported in their operating plans. An official from the VHA Office of Finance told us that they may contact VISN leadership—including the Director and Chief Financial Officer—if the variations are significant and additional actions needed to be taken. VHA Office of Finance officials also told us that they may review other reports if they become aware of an issue of significant

³⁵In fiscal year 2019, allocated general and specific purpose funds comprised over 95 percent of VISNs' available funding, while estimated collections comprised less than 5 percent and estimated reimbursements and funds carried over from prior years comprised less than 1 percent. Collections include funds collected from copayments and third-party insurance companies, and reimbursements include funds reimbursed to VHA by other agencies, such as the Department of Defense, for services provided to military service members.

interest to VHA leadership regarding a VISN's or medical center's obligations.

Specific Purpose Funds

Based on our review of VHA documents and interviews with program office officials, VHA program offices use various monitoring processes developed by each program office to monitor the use of specific purpose funds. Specifically, officials from the Office of Community Care told us that they monitor the use of community care funds by comparing actual obligations to planned obligations based on authorized community care.³⁶ According to VHA officials, as of February 2019, VHA was in the process of developing an updated process to monitor the use of community care funds, which—starting in fiscal year 2019—were obligated at the time of claim payment rather than when care in the community was authorized.³⁷ The other four VHA program offices we reviewed monitor the use of the funds they manage by generating a monthly or quarterly budget status report that compares each medical center's actual obligations against their planned obligations. For example, officials from the Office of Patient Care Services told us that to monitor the use of funds for prosthetics, they conduct monthly reviews of obligations and ask the VISNs and medical centers to explain deviations between the actual and planned expenditures and provide an action plan.

VHA Does Not Adequately Monitor the Redistribution of Funds Throughout the VA Health Care System, Which May Promote Inefficiencies

After funds are allocated and distributed to VISNs and medical centers, VHA can redistribute funds across the VA health care system in accordance with law. VHA officials told us these redistributions are done to address unfunded needs and surpluses as they are identified and occur throughout the year. However, we found that VHA does not adequately monitor redistributions. We identified the following instances in which allocated funds are redistributed:

- VHA officials told us that VHA's Office of Finance redistributes any surplus general purpose and specific purpose funds to medical

³⁶Except for certain emergency, urgent, and pharmacy care, all community care services for veterans must be authorized in advance of when veterans access the care in order for claims to be paid. Effective June 6, 2019, eligible veterans may access certain, limited, urgent care in the community without prior approval. 84 Fed. Reg. 25,998, 26,018 (June 5, 2019) (codified at 38 C.F.R. § 17.4600).

³⁷We are evaluating whether VHA's change in obligation policy complies with 31 U.S.C §1501(a), commonly known as the Recording Statute, and will issue a separate legal opinion on this matter, if warranted.

centers based on VHA priorities and to address needs identified by VISNs.³⁸ These officials said that these redistributions typically occur after the middle of the fiscal year. As of June 2019, according to VHA officials, one VISN had identified unfunded needs to VHA, but the VISN was working on addressing the funding needs using its own internal resources. Officials from another VISN told us that the VISN anticipated unfunded needs, but had not made a request to VHA for additional funds as of the end of May 2019.

- VISNs may also exchange funds with other VISNs. For example, if a VISN has excess medical facilities funds but a shortage of medical services funds, the VISN may exchange these funds with another VISN that has excess medical services funds but a shortage of medical facilities funds.³⁹ According to VHA officials, VISNs must inform VHA about these exchanges of funds, but are not required to provide an explanation and do not require VHA approval for the exchanges.⁴⁰
- VHA officials told us that VISNs also have the flexibility to redistribute funds throughout the year from medical centers within their VISN that are experiencing a funding surplus to ones with unfunded needs. However, VISNs are not required to inform VHA about these redistributions and are not required to provide an explanation or get approval from VHA. For example, officials at one medical center told us that in recent years, its VISN redistributed an average of \$15 million per year above allocated funding levels to this medical center to address unfunded needs.

While the redistribution of funds throughout the year gives VHA flexibility to move funds where they are needed, VHA's Office of Finance does not adequately monitor these redistributions. Specifically, VHA's Office of Finance does not require VISNs to identify the reasons why they redistribute funds between VISNs and medical centers, and a VHA Office

³⁸VHA maintains a national reserve amount that is intended to address emergency needs. According to officials from the Deputy Undersecretary for Operations and Management, requests for emergency funding, such as funds to address natural disasters including floods or hurricanes, are rare and require formal VHA approval. If no such needs arise, VHA distributes these funds to VISNs based on workload.

³⁹Officials from 15 of the 18 VISNs told us that the amount of funding available to them in each appropriation account is not always in line with the needs of their medical centers, which makes it necessary to exchange funds with other VISNs.

⁴⁰We did not audit whether the transferred amounts were used for authorized purposes of the respective appropriation accounts.

of Finance official told us VHA does not examine the amount of funds that are redistributed. For example, VHA's Office of Finance could not provide us the total amount of redistributions that occurred throughout fiscal year 2018. As a result, VHA's Office of Finance does not know why VISNs redistributed funds and the extent to which redistributions resulted in a deviation from VHA's workload-based allocation levels. Monitoring the redistributions would provide VHA with information on the effectiveness of the allocation models and how they might be improved.

VHA's actions are inconsistent with federal internal control standards related to monitoring, which state that management should establish and operate monitoring activities to monitor the internal control system and evaluate the results. Without requiring VISNs to provide this information and without requiring VHA to document the results of its review of the redistributions, VHA cannot ensure that these redistributions align with VHA's workload-based allocation of funds. As a result, VISNs and medical centers may not be efficiently operating within available funding levels, which include allocated funds, collections, reimbursements, and carry over from previous years.

Conclusions

VA's strategic plan calls for the efficient use of funds for delivering health care services to veterans. Accordingly, it is critical that VHA closely monitor and account for how its funds are allocated to VA medical centers and redistributed throughout the year to help ensure the most efficient use of funds. Especially as the number of veterans eligible to receive care from a community provider potentially expands, it will be important for VHA to ensure allocated funding levels accurately reflect individual medical center funding needs.

However, VHA has opportunities to strengthen its processes for allocating and monitoring funds distributed across its health care system. VHA could improve how it allocates funds to its VISNs and medical centers if it were to use the most up-to-date workload data available as part of its allocation models. This would allow VHA to account for significant changes in workload from year-to-year. VHA could also improve how it monitors VISN adjustments to medical center allocation levels as well as redistributions that may occur after medical centers receive their allocations. While these adjustments and redistributions afford flexibility and may be appropriate in certain circumstances, VHA does not have the information it needs to monitor these changes to ensure that they are appropriate and consistent with department goals. Specifically, VHA does not require VISNs and medical centers to provide information on how they

determined the amount and reasons for adjustments, nor does VHA require VISNs—in conjunction with medical centers—to develop and submit an approach to improve efficiency at medical centers with declining workload, such as adjusting the level of services offered. Additionally, VHA does not require VISNs to identify the reasons why they redistribute funds between VISNs and medical centers after allocations have been made, and VHA does not document its review of these redistributions. As a result, VHA lacks reasonable assurance that adjustments and redistributions align with its strategic goals for efficient use of funds to best serve the needs of veterans across its healthcare system.

Recommendations for Executive Action

We are making the following five recommendations to VHA:

- The VA Under Secretary of Health should use workload data from the most recently completed fiscal year as part of the models that inform VISNs' and medical centers' general purpose funding needs, when doing so would not significantly delay the allocation of funds. (Recommendation 1)
- The VA Under Secretary of Health should establish a formal process to document VHA's review of VISNs' adjustments to medical center allocation levels. (Recommendation 2)
- The VA Under Secretary of Health should revise VHA's existing guidance to require VISNs to provide information on how they determined how much and for what reasons they made adjustments to medical center allocation levels. (Recommendation 3)
- The VA Under Secretary of Health should revise its existing guidance to require VISNs—in conjunction with medical centers—to develop and submit approaches to improve efficiency at medical centers with declining workload that received adjusted funding levels. These approaches could include adjusting the level of services offered. (Recommendation 4)
- The VA Under Secretary of Health should require VISNs to provide explanations on the amount of funds redistributed between VISNs and medical centers and VHA to document its review of these redistributions. (Recommendation 5)

Agency Comments

We provided a draft of this report to VA for review and comment. In its written comments, reprinted in appendix II, VA concurred with four recommendations and concurred in principle with one recommendation.

VA also described steps that it plans to take to implement the recommendations. In addition, VA provided a technical comment, which we incorporated as appropriate.

Specifically, VA concurred with the first recommendation, stating that it will re-run the VERA model to allocate funds based on prior year workload data if an enacted budget is passed after the start of the second quarter of the current fiscal year. VA also concurred with the second and third recommendations, stating that it will update guidance to establish a formal process to document the review of VISN adjustments to medical center allocation levels and will require VISNs to provide information on how they determined adjustments prior to processing the adjustments. VA concurred in principle with the fourth recommendation, stating that VHA is conducting market assessments over a multi-year period to increase access and quality of care to veterans. VA said that after completing the market assessments and reviewing information from other VHA efforts, it may consider adjusting the level of services along with other alternatives. VA also concurred with the fifth recommendation, stating it will require review of redistributions between VISNs to ensure adequate explanations are included. According to VA, the department will also run a monthly report identifying redistributions between medical centers in a VISN that exceed 1.5 percent of the VISN's funding allocation.

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

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

Sincerely yours,



Sharon M. Silas
Director, Health Care

Appendix I: Methodologies Used by Four Selected Program Offices to Allocate Specific Purpose Funds

In addition to the Office of Community Care, which managed \$10.5 billion, or 46 percent, of specific purpose funds in fiscal year 2019, we contacted four other Veterans Health Administration (VHA) program offices that managed the largest amounts of specific purpose funds in fiscal year 2019—these included funds for patient care services, homelessness programs, non-recurring maintenance, and medical residency programs. These four program offices managed at least \$1 billion of funds and collectively managed about 36 percent of all specific purpose funds in fiscal year 2019. The four program offices developed methodologies for allocating specific purpose funds that involve coordinating with VISNs and their medical centers on the purposes for which the funds would be used and allocating available funds based on these needs. See table 1.

Table 1: Methodologies Four VHA Program Offices Use to Allocate Specific Purpose Funds, Fiscal Year 2019

Program office	Funds managed in fiscal year 2019 (in billions)	Allocation methodology ^a
Office of Patient Care Services	\$4.9	The Office of Patient Care Services manages funds for prosthetics and hepatitis C drugs. To allocate funds for prosthetics, according to officials, in advance of the fiscal year that starts on October 1, the program office provides Veterans Integrated Service Networks (VISN) a templated spreadsheet to identify funding needs for their medical centers. Program office officials review those funding needs and allocate available funds based on identified needs. To allocate funds for hepatitis C drugs, according to officials, the program office determines the number of patients at each medical center requiring treatment for hepatitis C and allocates available funds accordingly.
Homeless Program Office	\$1.3	The Homeless Program Office manages funds to provide services to homeless veterans. According to officials, in advance of the fiscal year, the Homeless Program Office sends a templated spreadsheet to VISNs and medical centers and asks them to identify their funding needs for various categories of homeless program funds including staffing, contracts, training, and transportation. These officials stated that funding requests that are more than 5 percent higher than funds provided in the previous year require an explanation. Program office officials review the funding requests and allocate available funds accordingly.

Appendix I: Methodologies Used by Four Selected Program Offices to Allocate Specific Purpose Funds

Program office	Funds managed in fiscal year 2019 (in billions)	Allocation methodology^a
Office of Capital Asset Management Engineering and Support	\$1.2	<p>The Office of Capital Asset Management Engineering and Support manages funds to address facility condition assessments (FCA) and funds for medical center infrastructure sustainment.^b According to officials, to determine each medical center's needs for FCA funds, program office officials first identify maintenance projects medical centers need to undertake based on the FCA process and ask medical centers to develop a cost estimate for each project. Program office officials review the list of projects and associated cost estimates.</p> <p>According to officials, because available funds are typically not sufficient to address all identified projects, projects are prioritized. The program office determines each medical center's needs for sustainment funds based on the Department of Defense's sustainment model, which estimates the annual funds needed to sustain a building with no existing FCA deficiencies and prevents building systems from becoming deficient. The program office allocates both the FCA and sustainment funds to each VISN as a single lump sum. According to program office officials, the VISNs have flexibility to use the funds for both FCA and sustainment projects at their medical centers as they deem appropriate.</p>
Office of Academic Affiliations	\$1.1	<p>The Office of Academic Affiliations manages funds for VHA's graduate medical education residency and clinical trainee programs. According to officials, in advance of the fiscal year, the Office of Academic Affiliations asks medical centers to identify their funding needs for medical residents and other clinical trainees based on the number of approved positions. Medical centers are instructed to multiply the number of positions by the salary and benefit cost for each position. Program office officials review the funding requests and allocate available funds accordingly.</p>

Source: GAO analysis of Veterans Health Administration (VHA) information. | GAO-19-670

^aThe majority of funds managed by each of these program offices is allocated to medical centers based on the methodologies described in this table. The remaining funds support program office operations or other activities.

^bContractors perform FCAs at each medical center once every 3 years on a rotating basis. Infrastructure systems in each building receive A thru F grades based on their condition. Systems in poor or critical condition are graded D or F and are considered deficiencies that should have been addressed in previous years. In addition, the Office of Capital Asset Management Engineering and Support uses a Department of Defense sustainment model to calculate the funding necessary to maintain medical center in good working order.

Appendix II: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

SEP 10 2019

Ms. Sharon M. Silas
Acting 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: **VETERANS HEALTH CARE: VA Needs to Improve Its Allocation and Monitoring of Funding** (GAO-19-670).

The enclosure sets forth the actions to be taken to address the draft report recommendations and provides general and technical comments.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

A handwritten signature in blue ink, appearing to read "Pamela Powers".

Pamela Powers
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
**VETERANS HEALTH CARE: VA Needs to Improve Its
Allocation and Monitoring of Funding**
(GAO-19-670)

Recommendation 1: The VA Under Secretary of Health should use workload data from the most recently completed fiscal year as part of the models that inform VISNs' and medical centers' general purpose funding needs, when doing so would not significantly delay the allocation of funds.

VA Comment: Concur. If an enacted budget is passed after the start of quarter two of the current fiscal year, the Veterans Equitable Resource Allocation model will be re-run to reallocate funds based on prior year workload data. Note that this may cause internal fund recessions at the Veterans Integrated Service Network (VISN), medical center, and program office levels for re-allocation of funds. Target Completion Date: After enactment of the budget.

Recommendation 2: The VA Under Secretary of Health should establish a formal process to document VHA's review of VISNs' adjustments to medical center allocation levels.

VA Comment: Concur. The Veterans Health Administration (VHA) Chief Financial Officer (CFO) will update guidance to establish a formal process to document the review of VISN adjustments to medical center allocations. Target Completion Date: October 2019.

Recommendation 3: The VA Under Secretary of Health should revise VHA's existing guidance to require VISNs to provide information on how they determined how much and for what reasons they made adjustments to medical center allocation levels.

VA Comment: Concur. VHA's CFO will revise guidance to require VISNs to provide information on how they determined adjustments to medical center allocation levels. VHA's CFO will require this justification prior to processing. Target Completion Date: October 2019.

Recommendation 4: The VA Under Secretary of Health should revise its existing guidance to require VISNs - in conjunction with medical centers - to develop and submit approaches to improve efficiency at medical centers with declining workload that received adjusted funding levels. These approaches could include adjusting the level of services offered.

VA Comment: Concur in Principle. Oversight of medical center budgets is an important element of facility and VISN management. The ongoing work to align resources with workload can be shared in the context of the Network Director Quarterly Reviews. VHA is currently conducting market assessments, also referred to as the

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
**VETERANS HEALTH CARE: VA Needs to Improve Its
Allocation and Monitoring of Funding**
(GAO-19-670)

Market Area Health Systems Optimization Initiative (MAHSO) project, to create a high performing network of services for Veterans as mandated by the VA MISSION Act of 2018. VHA leadership will use the market assessments to increase access and quality of care to Veterans. The MAHSO is a multi-year study. The information developed from the market assessments will be presented to the Secretary of Veterans Affairs. Adjusting the level of service may be considered along with a variety of alternatives after completion of the market assessment work, completion of associated enterprise-wide strategy review, and assessment of impact on national policy and guidance. Target Completion Date: December 2020.

Recommendation 5: The VA Under Secretary of Health should require VISNs to provide explanations on the amount of funds redistributed between VISNs and medical centers and VHA to document its review of these redistributions.

VA Comment: Concur. All transfers of funds between VISNs will require review by the Associate Chief Financial Officer for Resource Management prior to processing to ensure adequate explanations are included. In addition, a monthly report will be provided to VHA's CFO identifying all transfers between medical centers within a VISN that exceed 1.5 percent of the VISNs overall funding allocation. Target Completion Date: November 2019.

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***VETERANS HEALTH CARE: VA Needs to Improve Its
Allocation and Monitoring of Funding***
(GAO-19-670)

General Comment: VA appreciates GAO's review of VHA's budget execution. To add some context to the budgeting and allocation process, upon creating the Veterans Equitable Resource Allocation model, VA recognized that allocation at the regional level was desirable to create a system that could properly account for annual workload shifts and regional variability. In creating the Medical Center Allocation System (MCAS), VA bridged the gap between the regional allocation system and a budget that is primarily executed at the facility level. The MCAS model is laudable for its comprehensiveness and ability to account for most factors on the ground; however, no model can account for the dynamic nature of budget execution in a health care environment. The very nature of regional management, which VA firmly supports, is it requires that VISN leaders have reasonable flexibility to move funds between sites to account for short-term workload changes, emerging priorities, shifts in strategic focus, and other operational factors.

Appendix III: GAO Contact and Staff Acknowledgments

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Staff Acknowledgments

In addition to the contact named above, Rashmi Agarwal (Assistant Director), Michael Zose (Analyst-in-Charge), and Carmen Rivera-Lowitt made key contributions to this report. Also contributing were Krister Friday, Cathleen Hamann, Jacquelyn Hamilton, and Ethiene Salgado-Rodriguez.

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