

Lorelei St. James, Director, Physical Infrastructure Issues, United States Government
Accountability

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Testimony

Before the Committee on Veterans' Affairs, United States Senate

DEPARTMENT OF VETERANS AFFAIRS

Issues Related to Real Property Realignment and Future Health Care Costs

Statement of Lorelei St. James, Director

Physical Infrastructure Issues

Madam Chairman Murray, Ranking Member Burr, and Members of the Committee:

I am pleased to be here today as you examine the lifetime costs of supporting the newest generation of veterans. The Department of Veterans Affairs (VA) operates one of the largest health care delivery systems in the nation, providing care to a diverse population of veterans. VA operates about 150 hospitals, 130 nursing homes, and 820 outpatient clinics through 21 regional health care networks called Veterans Integrated Service Networks. VA is responsible for providing health care services to various populations—including an aging veteran population and a growing number of younger veterans returning from the military operations in Afghanistan and Iraq. Budgeting for this vital health care mission is inherently complex. It is based on current assumptions and imperfect information, not only about program needs, but also on future economic and policy actions that may affect demand and the cost of providing these services. Adding to this complexity, VA has recognized over the years the need to plan and budget for facility modernization, and realign its real property portfolio to provide accessible, high-quality, and cost-effective access to its services.

My statement today addresses VA's real property realignment efforts and VA's approach to developing budget estimates for health care. It is based on our prior real property realignment work, where we examined the extent to which VA's capital planning efforts resulted in changes to its real property portfolio, helped VA identify facility planning priorities, and reflected leading federal practices for real property management. It is also based on our prior budget estimate work, where we examined how VA develops its health care budget estimate, addressed what VA identified as the key changes that were made to its budget estimate to develop the President's budget request for fiscal years 2012 and 2013, and explained how various sources of funding for VA health care and other factors informed the President's budget requests. To perform the work related to real property realignment efforts, we reviewed leading capital planning practices and data on VA's real property portfolio and future priorities. We also interviewed VA officials and veterans service organizations, and visited sites in 5 of VA's 21 Veterans Integrated Service Networks. To perform the work related to budget estimates for health care, we reviewed VA documents on the methods, data, and assumptions used to develop VA's health care budget estimate that informed the President's two most recent budget requests for fiscal year 2011, 2012 and 2013. Our review of those most recent budget requests focused on the three appropriations accounts for VA health care services: Medical Services, Medical Support and Compliance, and Medical Facilities. We also interviewed VA officials responsible for developing this estimate and

staff from the Office of Management and Budget (OMB). Our work was performed in accordance with generally accepted government auditing standards. More detailed information on our objectives, scope and methodology for this work can be found in the issued reports.

Summary

Through its capital planning efforts, VA has taken steps to realign its real property portfolio from hospital based, inpatient care to outpatient care, but a substantial number of costly projects and other long-standing challenges remain. For example, VA reported in its 5-year capital plan for fiscal years 2010-2015 that it had a backlog of \$9.4 billion of facility repairs. The 5-year plan further identified an additional \$4.4 billion in funding to complete 24 of the 69 ongoing major construction projects. We also found that VA, like other agencies, has faced underlying obstacles that have exacerbated its real property management challenges and can also impact its ability to fully realign its real property portfolio. We have previously reported that such challenges include competing stakeholder interests, legal and budgetary limitations, and capital planning processes that did not always adequately address such issues as excess and underutilized property. Furthermore, we found that VA's capital planning efforts generally reflected leading practices, but lacked transparency about the cost of future priorities that could better inform decision making. VA concurred with our recommendation to improve the transparency of its budget submissions. We have not yet assessed the extent to which VA has implemented our recommendation in relation to the President's 2012 budget.

VA uses what is known as the Enrollee Health Care Projection Model (EHCPM) to develop most of its health care budget estimate and uses other methods for the remainder. The EHCPM's estimates for these services are based on three basic components: projected enrollment in VA health care, projected use of VA's health care services, and projected costs of providing these services. The EHCPM makes a number of complex adjustments to the data to account for characteristics of VA health care and the veterans who access VA's health care services. For example, these adjustments take into account veterans' age, gender, geographic location, and reliance on VA health care services compared with other sources, such as health care services paid for by Medicare or private health insurers. VA officials identified changes made to its estimate of the resources needed to provide health care services to reflect policy decisions, savings from operational improvements, resource needs for initiatives, and other items. The President's request for appropriations for VA health care for fiscal years 2012 and 2013 relied on anticipated funding from various sources, including new appropriations, collections, unobligated balances of multiyear appropriations, and reimbursements VA receives for services provided to other government entities.

Real Property Realignment Efforts Progressing, but Greater Transparency Needed About Future Priorities

In January 2011, we reported that through its capital planning efforts, VA had taken steps to realign its real property portfolio from hospital based, inpatient care to outpatient care, but a substantial number of costly projects and other long-standing challenges also remain. Several of VA's most recent capital projects—such as community based outpatient clinics, rehabilitation centers for blind veterans, and a spinal cord injury center—were based on its Capital Asset Realignment for Enhanced Services (CARES) efforts and subsequent capital planning. VA

officials and veterans service organizations we contacted agreed that these facilities have had a positive effect on veterans' access to services. However, VA had identified several high-cost priorities such as facility repairs and projects that have not yet been funded. For example, VA reported in its 5-year capital plan for fiscal years 2010-2015 that it had a backlog of \$9.4 billion of facility repairs. The 5-year plan further identified an additional \$4.4 billion in funding to complete 24 of the 69 ongoing major construction projects. Besides substantial funding priorities, we also found that VA, like other agencies, has faced underlying obstacles that have exacerbated its real property management challenges and can also impact its ability to fully realign its real property portfolio. We have previously reported that such challenges include competing stakeholder interests, legal and budgetary limitations, and capital planning processes that did not always adequately address such issues as excess and underutilized property.

Furthermore, we found that VA's capital planning efforts generally reflected leading practices, but lacked transparency about the cost of future priorities that could better inform decision making. For example, VA's 2010-2015 capital plan linked its investments with its strategic goals, assessed the agency's capital priorities, and evaluated various alternatives. Also, VA's new Strategic Capital Investment Planning (SCIP) process strengthened VA's capital planning efforts by extending the horizon of its 5-year plan to 10 years, and providing VA with a longer range picture of the agency's future real property priorities. VA officials told us that the SCIP process builds on its existing capital planning processes, addresses leading practices, and further strengthens VA's efforts in some areas. We have not fully assessed SCIP and it remains to be seen what impact SCIP will have on the results of VA's capital planning efforts. While these changes were positive steps, we found that VA's planning efforts lacked transparency regarding the magnitude of costs of the agency's future real property priorities, which may limit the ability of VA and Congress to make informed funding decisions among competing priorities. For instance, for potential future projects, VA's 2010-2015 capital plan only listed project name and contained no information on what these projects were estimated to cost or the priority VA had assigned to them beyond what was then the current budget year. Transparency about future requirements would benefit congressional decision makers by putting individual project decisions in a long-term, strategic context, and placing VA's fiscal situation within the context of the overall fiscal condition of the U.S. government. It is important to note that providing future cost estimates to Congress for urgent, major capital programs is not without precedent in the federal government. Other federal agencies, such as the Department of Defense, have provided more transparent estimates to Congress regarding the magnitude of its future capital priorities beyond immediate budget priorities.

We concluded in our report that billions of dollars have already been appropriated to VA to realign and modernize its portfolio. Furthermore, VA had identified ongoing and future projects that could potentially require several additional billion dollars over the next few years to complete. Given the fiscal environment, VA and Congress would benefit from a more transparent view of potential projects and their estimated costs. Such a view would enable VA and Congress to better evaluate the full range of real property priorities over the next few years and, should fiscal constraints so dictate, identify which might take precedence over the others. In short, more transparency would allow for more informed decision making among competing priorities, and the potential for improved service to veterans over the long term would likely be enhanced. To enhance transparency and allow for more informed decision making related to VA's real property

priorities, we recommended that the Secretary of Veterans Affairs provide the full results of VA's SCIP process and any subsequent capital planning efforts, including details on the estimated cost of all future projects, to Congress on a yearly basis. VA concurred with the recommendation. We have not yet assessed the extent to which VA has implemented our recommendation in relation to the President's 2012 budget.

VA Uses a Projection Model to Develop Most of Its Health Care Budget Estimate and Changes Were Made to the Estimate for Fiscal Years 2012 and 2013

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

In June 2011, we reported on the President's budget request for fiscal years 2012 and 2013. We reported that VA officials had identified changes made to its estimate of the resources needed to provide health care services to reflect policy decisions, savings from operational improvements, resource needs for initiatives, and other items to help develop the President's budget request for fiscal years 2012 and 2013. One of the changes that VA identified was in its estimates for non-recurring maintenance to repair health care facilities. Non-recurring maintenance funds are used for expansion, renovation, and infrastructure improvements that cost more than \$25,000. VA's estimate for non-recurring maintenance was reduced by \$904 million for fiscal year 2012 and \$1.27 billion for fiscal year 2013, due to a policy decision to fund other initiatives and hold down the overall budget request for VA health care. VA's estimates were further reduced by \$1.2 billion for fiscal year 2012 and \$1.3 billion for fiscal year 2013 due to expected savings from operational improvements, such as proposed changes to purchasing and contracting. Other changes had a mixed impact on VA's budget estimate, according to VA officials; some of these changes increased the overall budget estimate, while other changes decreased the overall estimate.

The President's request for appropriations for VA health care for fiscal years 2012 and 2013 relied on anticipated funding from various sources. Specifically, of the \$54.9 billion in total resources requested for fiscal year 2012, \$50.9 billion was requested in new appropriations. This

request assumes the availability of \$4.0 billion from collections from veterans and private health insurers, unobligated balances of multiyear appropriations, and reimbursements VA receives for services provided to other government entities. Of the \$56.7 billion in total resources requested for fiscal year 2013, \$52.5 billion was requested in new appropriations, and \$4.1 billion was anticipated from other funding sources. The President's request for fiscal year 2012 also included a request for about \$953 million in contingency funding to provide additional resources should a recent economic downturn result in increased use of VA health care. Contingency funding was not included in the advance appropriations request for fiscal year 2013. As mentioned earlier, budgeting for VA health care is inherently complex because it is based on assumptions and imperfect information used to project the likely demand and cost of the health care services VA expects to provide. The iterative and multilevel review of the budget estimates can address some of these uncertainties as new information becomes available about program needs, presidential policies, congressional actions, and future economic conditions. As a result, VA's estimates may change to better inform the President's budget request. The President's request for VA health care services for fiscal years 2012 and 2013 was based, in part, on reductions to VA's estimates of the resources required for certain activities and operational improvements. However, in 2006, we reported on a prior round of VA's planned management efficiency savings and found that VA lacked a methodology for its assumptions about savings estimates. If the estimated savings for fiscal years 2012 and 2013 do not materialize and VA receives appropriations in the amount requested by the President, VA may have to make difficult trade-offs to manage within the resources provided.

Madam Chairman Murray, Ranking Member Burr, and Members of the Committee, this concludes my prepared remarks. I would be happy to answer any questions that you may have.