CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

February 15, 2018

H.R. 4242
VA Care in the Community Act

As ordered reported by the House Committee on Veterans' Affairs on December 19, 2017

SUMMARY

H.R. 4242 would increase the use of community health care and long-term care by the Department of Veterans Affairs (VA) by broadening eligibility for such care and allowing VA to enter into agreements with health care providers in the private sector without complying with the Federal Acquisition Regulation (FAR). The bill also would change VA's coverage of ambulance services and transplant operations at nondepartment facilities. In addition, H.R. 4242 would allow VA to repay loans for and provide scholarships to its medical staff. In total, CBO estimates that implementing the bill would cost $38.8 billion over the 2018-2022 period, assuming appropriation of the necessary amounts.

Enacting the bill would not affect direct spending or revenues; therefore, pay-as-you-go procedures do not apply.

CBO estimates that enacting H.R. 4242 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2028.

H.R. 4242 would impose an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) by preempting state laws that prohibit VA physicians from practicing telemedicine to treat veterans across state lines. Although it would limit the application of state regulations, that mandate would impose no duty on state governments that would result in additional spending or any significant loss of revenues.

The bill contains no private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary effects of H.R. 4242 are shown in the following table. The costs of this legislation fall within budget function 700 (veterans benefits and services).

	By Fiscal Year, in Millions of Dollars					
	2018	2019	2020	2021	2022	2018-2022
INCREASES IN SPENDING SUBJECT TO APPROPRIATION						
VA Care in the Community Program						
Estimated Authorization Level	200	2,000	4,200	6,700	8,800	21,900
Estimated Outlays	200	1,700	3,900	6,200	8,300	20,300
Veterans Care Agreements						
Estimated Authorization Level	*	4,400	4,500	4,700	4,800	18,400
Estimated Outlays	*	3,800	4,300	4,500	4,700	17,300
Agreements for State Veterans Homes						
Estimated Authorization Level	0	80	110	130	160	480
Estimated Outlays	0	70	100	130	150	450
Center for Innovation for Care and Payment						
Estimated Authorization Level	2	3	86	131	128	350
Estimated Outlays	2	3	75	122	124	326
Ambulance Services						
Estimated Authorization Level	0	57	78	80	83	298
Estimated Outlays	0	50	73	77	81	281
Transplant Donors						
Estimated Authorization Level	2	17	35	47	49	150
Estimated Outlays	2	15	32	44	47	140
Health Professional Scholarship Program						
Estimated Authorization Level	0	0	4	6	6	16
Estimated Outlays	0	0	3	6	6	15
Loan Repayment for Medical Specialists						
Estimated Authorization Level	1	3	3	3	3	13
Estimated Outlays	1	3	3	3	3	13
Health Care Productivity						
Estimated Authorization Level	1	2	2	2	2	9
Estimated Outlays	1	2	2	2	2	9
Scholarship Program						
Estimated Authorization Level	0	2	2	2	2	8
Estimated Outlays	0	2	2	2	2	8
Total Changes in Spending Subject to Appropriation						
Estimated Authorization Level	206	6,564	9,020	11,801	14,033	41,624
Estimated Outlays	206	5,645	8,490	11,086	13,415	38,842

* = between zero and $500,000; VA = Department of Veterans Affairs.

BASIS OF ESTIMATE

For this estimate, CBO assumes that the bill will be enacted early in calendar year 2018 and that the estimated amounts will be appropriated each year. Estimated outlays are based on historical spending patterns for the affected programs.

VA Care in the Community Program. Section 102 would establish the VA Care in the Community Program. Through that program, the department would establish networks of health care providers outside of VA to furnish hospital care, medical services, and extended-care services to veterans enrolled in the VA health care system. Under the program, subject to appropriations, VA would be required to pay for care through those networks if VA cannot assign the veteran to a suitable primary care physician or a Patient Aligned Care Team (PACT) at a VA medical facility. Assignment may be unsuitable in the following situations:

- The veteran would face excessive challenges in receiving care at a VA medical facility because of geographic, environmental, or medical factors;
- The veteran believes that the assignment to a particular primary care physician or PACT at a VA medical facility would result in unsatisfactory health care;
- The veteran would face long wait times for care at a VA medical facility; or
- The veteran resides in a state without a full-service medical facility (such as Alaska, Hawaii, or New Hampshire).

Veterans may later choose to receive care at a VA medical facility if VA notifies them that a primary care provider or a PACT has become available.

The bill would require VA to promulgate regulations to implement the program within one year.

The VA Care in the Community Program is similar to the Veterans Choice Program (VCP), which CBO expects will end in 2018. The VCP provides community care to veterans who face excessive wait times or live 40 miles or more from a VA medical facility. CBO estimated the costs for the VA Care in the Community Program based on information about the VCP.

CBO expects that the VA Care in the Community Program would cost more than the VCP for the following reasons:

- Veterans would make more visits for community health care because once they are referred for community care they could see network providers for primary care for at least one year without additional authorization from VA.

- Veterans would be eligible for community care under the new program in more circumstances.

However, there are several factors that CBO expects would constrain that cost growth:

- Diverting more veterans to community care could shorten wait times at VA facilities and thus reduce the number of veterans who would need to be referred to community care because VA care was not available in a timely fashion.

- Regulations that need to be written to implement the program could curtail use.

- Veterans would need approval from VA to receive certain specialty services.

- The size and scope of community care networks could be limited, particularly in rural areas, reducing the accessibility of such care.

- VA might implement the program slowly, as it did the VCP.

CBO expects that the new program would be implemented gradually and by 2022, usage of the new program would be 30 percent greater than for the VCP. CBO estimates that eventually usage of the new program would be about 75 percent greater than that of the VCP.

In 2017, VA processed 8.7 million claims at a total cost of $5 billion for community health care under the VCP. After accounting for the increase in usage, inflation, and underlying growth in enrollment in the VA health system, CBO estimates that the new program would cost $8.3 billion by 2022. In total, implementing section 102 would cost $20.3 billion over the 2018-2022 period, CBO estimates.

Veterans Care Agreements. Section 103 would allow VA to enter into Veterans Care Agreements with health care providers in the community to provide hospital care, medical services, or extended care to eligible veterans. The authorization for such agreements would exempt VA from using the competitive bidding procedures as required under the FAR. The FAR is an extensive and complex set of rules governing the federal government’s purchasing processes.

Under current law, VA must comply with the FAR for agreements and contracts with community health care and extended-care providers.

According to VA, the FAR's requirements are appropriate for large and long-term agreements for contracted health care services but may not be practical for case-by-case arrangements in all regions of the United States. H.R. 4242 would allow VA to use other agreements for certain health care services and extended care provided outside the VA system.

For 2018, the Congress has provided roughly $10 billion for community health care at VA (excluding the VCP). Using information from VA, CBO estimates that implementing section 103 would give VA the legal authority to continue to provide about 40 percent (or roughly $4 billion annually) of that community health care. After adjusting for inflation and accounting for existing appropriations, CBO estimates that implementing this section would cost $17.3 billion over the 2018-2022 period.

Agreements for State Veterans Homes. Section 104 would waive the requirements of the FAR for contracts and agreements that VA enters into with state-run nursing homes for veterans. Under current law, the state veterans' homes (SVHs) must fill 75 percent of their beds with veterans. Under a contract or agreement, VA pays SVHs the full cost of care for veterans with a service-connected disability (SCD) rating of 70 percent or more. For all other veterans, VA pays SVHs a fixed daily allowance.

According to VA, in 2015 the department used such agreements to reimburse state-run nursing homes at a daily rate of $380 for each veteran with an SCD of 70 percent or more—at an annual cost of roughly $350 million (or 37 percent of the total reimbursed to SVHs). However, those agreements do not comply with the FAR, and VA does not expect to be able to enter into new FAR-compliant agreements with any of the SVHs. In the absence of this legislation, CBO expects that VA would gradually phase out the use of such agreements as veterans who are currently under that payment structure die or leave the SVHs. Those veterans would probably be replaced by veterans under the lower daily allowance rate of roughly $100 per patient. By allowing VA to enter into agreements outside of the FAR framework, CBO estimates, this proposal would more than triple VA's reimbursements to SVHs for veterans with SCDs of 70 percent or more.

As a result, after factoring in a gradual phaseout of existing non-FAR agreements, CBO estimates that enacting this provision would cost $450 million over the 2018-2022 period. The additional costs from waiving the FAR requirements would begin in 2019. Because appropriations already have been provided for such agreements in 2018, no additional funding would be necessary in that year.

Center for Innovation for Care and Payment. Section 210 would require VA to establish the Center for Innovation for Care and Payment, which would evaluate ways to reduce costs and increase efficiency at VA medical facilities. CBO expects that the center would pursue programs similar to those that were tested by the Center for Medicare and Medicaid Innovation (CMMI) operated by the Centers for Medicare & Medicaid Services. CBO estimates that costs for the center would be similar to those for CMMI. CBO expects any savings that resulted from the center's efforts would not occur in the next five years.

In 2010, CMMI received $5 million to develop models for reducing health care costs and increasing efficiency for Medicare. CBO expects that VA would need similar resources to establish its program. On the basis of information from the department regarding the availability of necessary staff, CBO expects that it would take VA two years to establish the center at an estimated cost of $5 million over the 2018-2019 period.

CMMI received $10 billion over the 2011-2019 period to test its models. CBO expects that VA's costs would be proportional. VA Health Administration costs are approximately one-tenth those of Medicare. After factoring in a gradual implementation period similar to that of CMMI, CBO estimates that the costs for the center would be $321 million over the 2020-2022 period.

In total, CBO estimates that implementing section 210 would cost $326 million over the 2018-2022 period.

Ambulance Services. Section 201 would require VA to reimburse veterans for ambulance services under certain conditions. Currently, VA can choose to reimburse veterans for ambulance services when they receive emergency care at nondepartment medical facilities. H.R. 4242 would require VA to cover the cost of ambulance services if a delay in providing immediate medical attention could result in death or harm to the veteran.

Using data from the National Institutes of Health and VA, CBO estimates that VA would reimburse veterans for about 165,000 ambulance trips each year, at an average cost of $480 per trip. The bill would require VA to pay for ambulance trips after January 1, 2019. Thus, CBO estimates that implementing section 201 would cost $281 million over the 2018-2022 period.

Transplant Donors. Section 109 would allow VA to cover costs related to organ transplant procedures incurred by veterans and their living donors for procedures at nondepartment facilities. Currently, VA covers the medical and service expenses (such as transportation and lodging) for veterans and their living donors only for procedures performed at the Department of Veterans Affairs Transplant Centers (VATCs).

Otherwise, VA reimburses donors only for transportation and lodging. In 2017, VA provided 560 organ transplants, most at VATCs. Of those operations, about 200 were kidney transplants and about 20 involved living donors.

Section 109 would authorize VA to pay for transplant procedures at various locations nationwide with minimal out-of-pocket expenses for veterans and their living donors. As a result, CBO expects more veterans would use VA for such procedures and more people would be willing to donate organs. In determining the additional number of transplant procedures, CBO considered the other sources of health care coverage carried by enrolled veterans and the likelihood, under this proposal, that those veterans would instead use VA for their transplant procedures.

Using information from the Census Bureau, VA, and the Department of Health and Human Services, CBO estimates that under section 109, roughly 60 additional veterans would undergo transplants at nondepartment facilities each year, at an average cost of $750,000 per patient. CBO estimates that VA would cover the medical expenses of an additional 50 living donors (some for procedures that will occur under current law but for which VA would not pay medical expenses) each year, at an average cost of $80,000 per donor. In addition, CBO believes that implementing this section would allow veterans to undergo transplants closer to home. As a result, CBO estimates a reduction in transportation reimbursements of about $4 million each year. Based on the expectation that VA would implement the bill gradually, CBO estimates that implementing section 109 would have a net cost of $140 million over the 2018-2022 period.

Health Professional Scholarship Program. Section 301 would extend the Health Professional Scholarship Program, currently set to expire on December 31, 2019, through December 31, 2033. At an annual cost of $5 million, the program subsidizes tuition and educational fees and provides monthly stipends to medical students who pursue careers at VA. After accounting for rising tuition costs, CBO estimates that implementing section 301 would cost $15 million over the 2019-2022 period.

Loan Repayment for Medical Specialists. Section 302 would authorize VA to repay the education loans of practitioners in medical specialties for which the department has difficulty recruiting. In exchange, those specialists would commit to work for VA for two to four years. The payments could not exceed $40,000 for each year worked or a total of $160,000 over four years. Those limits could be waived for medical positions for which a shortage exists because of the location or requirements of the position.

Under a similar loan repayment program, VA can reimburse up to $120,000 for tuition and educational fees for medical personnel at the department. In 2016, roughly 2,000 employees (or less than 1 percent of total employees) received an average award of about $15,000. On the basis of participation rates and costs of that program, CBO estimates that

roughly 120 medical practitioners in specialty areas would participate in the new program each year and would receive an average annual award of $23,000. After factoring in a gradual implementation period and growth in tuition, CBO estimates that implementing section 302 would cost $13 million over the 2018-2022 period.

Health Care Productivity. Section 205 would require that VA develop standards for using relative-value units (RVUs) to evaluate medical services. It also would require VA to train its health care providers to use and adhere to those standards. RVUs are tools used by physicians participating in Medicare to rank on a common scale the resources (such as medical supplies) used to provide health care.

On the basis of information from VA regarding its ability to train personnel to use RVUs in all department facilities, CBO estimates that VA would need to hire the equivalent of 10 full-time clinicians at an average annual compensation of $150,000 to develop standards and provide ongoing training and support. CBO expects that VA would develop an internal website to train its medical providers to use RVUs. CBO estimates that development of the website would cost less than $500,000.

As a result, CBO estimates that implementing section 205 would cost $9 million over the 2018-2022 period.

Scholarship Program. Section 303 would require VA to fully cover the costs of medical school for 18 eligible veterans. Under this scholarship program, VA would pay for tuition, books, fees, technical equipment, rotations, and reasonable living expenses for newly separated veterans who enter medical school in 2019. Veterans who are entitled to other education benefits provided by VA would not be eligible. Participating veterans would be required to agree to work full time at a VA medical facility for four years after completing medical school.

On the basis of the average costs to attend a private medical school, which includes tuition, books, fees, and technical equipment, CBO estimates that annual costs would average $69,000 per awardee. After adjusting for growth in the costs of medical school, CBO estimates that such education expenses would cost $5 million over the 2019-2022 period.

The Department of Defense pays monthly stipends for living expenses to recipients of similar scholarships that currently average $2,229 a month. On that basis, CBO estimates that individual stipends would total roughly $25,000 over a 10.5-month school year. After adjusting for inflation, CBO estimates that such stipends would cost a total of $2 million over the 2019-2022 period. In addition, CBO estimates that the costs of residency fees, off-site rotations, and reports would cost $1 million over 2020-2022 period.

In total, CBO estimates that implementing section 303 would cost $8 million over the 2019-2022 period.

PAY-AS-YOU-GO CONSIDERATIONS: None.

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO estimates that enacting H.R. 4242 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2028.

MANDATES

H.R. 4242 would impose an intergovernmental mandate as defined in UMRA by preempting state laws that prohibit VA physicians from practicing telemedicine to treat veterans across state lines. Although it would limit the application of state regulations, that mandate would impose no duty on state governments that would result in additional spending or any significant loss of revenues.

The bill contains no private-sector mandates as defined in UMRA.

PREVIOUS CBO ESTIMATES

On January 17, 2018, CBO transmitted a cost estimate for S. 2193, the Caring for Our Veterans Act of 2017, as ordered reported by the Senate Committee on Veterans' Affairs on December 5, 2017. Sections 102, 103, and 242 in S. 2193 are similar to sections 103, 104, and 109 of H.R. 4242 and the estimated costs for those sections are the same for each bill.

ESTIMATE PREPARED BY

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