CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

May 14, 2018

H.R. 5674
VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018

As reported by the House Committee on Veterans' Affairs
on May 11, 2018

SUMMARY

H.R. 5674 would change how the Department of Veterans Affairs (VA) purchases medical care and services for veterans from health care providers in the private sector. The bill also would expand the caregivers program and make other changes to VA's health care programs and compensation of employees. In total, CBO estimates that implementing the bill would cost $46.5 billion over the 2019-2023 period, assuming appropriation of the necessary amounts.

In addition, H.R. 5674 would directly appropriate $5.2 billion for the Veterans Choice Program (VCP), increase the fees charged to veterans who obtain loans guaranteed by VA, and extend the current limit on pensions that can be paid to certain veterans who receive benefits from Medicaid. In total, CBO estimates that enacting the bill would increase direct spending by $4.5 billion over the 2018-2028 period.

Pay-as-you-go procedures apply because enacting H.R. 5674 would affect direct spending. Enacting the bill would not affect revenues.

CBO estimates that enacting H.R. 5674 would not increase net direct spending or on budget deficits by more than $2.5 billion in any of the four consecutive 10-year periods beginning in 2029.

H.R. 5674 would impose intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA) by requiring states to grant VA personnel access to state programs that monitor prescription drugs and by preempting state laws that prohibit VA personnel from practicing telemedicine in another state. CBO estimates the costs of the mandates would not exceed the threshold established in UMRA ($80 million in 2018, adjusted annually for inflation).

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

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary effects of H.R. 5674 are shown in Table 1. The costs of this legislation fall within budget function 700 (veterans benefits and services).

TABLE 1. ESTIMATED BUDGETARY EFFECTS OF H.R. 5674, THE VA MAINTAINING INTERNAL SYSTEMS AND STRENGTHENING INTEGRATED OUTSIDE NETWORKS ACT OF 2018

	By Fiscal Year, in Millions of Dollars						
	2018	2019	2020	2021	2022	2023	2018-2023
INCREASES IN SPENDING SUBJECT TO APPROPRIATION							
Estimated Authorization Level	0	1,138	9,903	11,416	12,832	13,773	49,062
Estimated Outlays	0	964	8,662	10,966	12,464	13,439	46,495
INCREASES IN DIRECT SPENDING							
Budget Authority	5,200	0	0	0	0	0	5,200
Estimated Outlays	800	4,400	0	0	0	0	5,200

In addition to the amounts shown above, enacting H.R. 5674 would decrease direct spending by $729 million in 2028, for a total of $4.5 billion over the 2018-2028 period.

BASIS OF ESTIMATE

For this estimate, CBO assumes that the bill will be enacted by the end of May 2018 and that the estimated amounts will be appropriated each year of the 2019-2023 period. Estimated outlays are based on historical spending patterns for the affected programs. Because CBO does not expect additional appropriations to be provided for VA in 2018 beyond the amounts that would be directly provided by this bill, we estimate no additional spending in 2018 subject to such appropriations.

Spending Subject to Appropriation

CBO estimates that implementing H.R. 5674 would cost $46.5 billion over the 2018-2023 period, subject to appropriation of the necessary amounts (see Table 2). Most of the bill's estimated costs stem from provisions that would expand community health care for veterans and increase eligibility and benefits for caregivers.

Veterans Community Care Program. Section 101 would establish the Veterans Community Care Program (VCCP) under which VA would be required to enter into contracts to 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 this program, VA would be required to provide care through those networks, at the veteran's discretion, in the following situations:

- VA does not offer the care needed,
- VA is not able to provide the care needed in a manner that complies with its designated access standards (that would be developed by the department under section 104),
- The veteran resides in Alaska, Hawaii, or New Hampshire, or
- The veteran, as of the day before enactment, lives 40 miles away from a VA medical facility in a state with a low population density and actively uses the VA health care system.

In addition, VA would be authorized to offer community care if it determines that a VA medical center is not meeting the standards for quality that would be developed by the department for different types of care (under section 104). Section 101 would require VA to promulgate regulations to implement the program within one year.

The VCCP would replace an existing program that authorizes VA to provide community care to certain veterans when VA does not offer the needed care, or when that care is geographically inaccessible to the veteran. Eligible veterans are those who have service-connected disabilities (SCDs), are housebound, or receive veterans pensions. Under current law, VA also provides community care to women veterans who need hospital care. Under its existing program, VA currently spends roughly $9 billion a year for community care (excluding emergency care). CBO expects the VCCP could increase costs because:

- VA would be required, subject to appropriations, to provide community care;
- The number of veterans with priority to receive community care would be larger than under the current program, and
- The criteria for offering community care would be broader.

However, CBO expects the following factors would limit the rate and ultimate extent of cost:

- A greater number of enrolled veterans receiving community care could shorten wait times for care provided in VA facilities. That would reduce the number of veterans that need to be referred to community care because VA care is not available in a timely fashion.

- Many of the regulations that need to be written to implement the program could curtail use. For instance, VA would probably require all veterans to be seen by a VA provider before being referred for community care.

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

- VA might roll out (or implement) the program slower than expected, as happened with the VCP.

Under the new program VA would be required to develop designated access standards that may expand or restrict eligibility for community care. Absent further information from the department on those access standards, CBO expects that the average referral rate under the VCCP would be comparable to that of the existing community care program.

To estimate the cost of this program over the next five years, CBO focused primarily on the extent to which the use of community care under VCCP would be higher than under the existing community care program. Under current law, in 2017, over 20 percent of patients who have the highest priority for receiving community care (veterans with the most severe SCDs) receive health care at non-VA facilities. CBO expects that percentage will return to pre-VCP levels of about 35 percent when VCP ends in 2019. In contrast, less than 10 percent of patients in the lowest priority groups received community care in 2017. On the basis of that information, CBO expects that this proposal would increase the use of community care for all enrollees to levels comparable to those of veterans who have the highest priority for community care under current law.

After accounting for the factors that might restrict use, CBO estimates that in the early years of the program, roughly 640,000 additional veteran patients would be referred out to community care each year at an average cost of $8,600 per patient. In addition, while VA faced a number of problems implementing the VCP, CBO expects that the experience gained in starting up that program will allow VA to more expediently implement the VCCP. On that basis, CBO estimates that implementing section 101 would cost $21.4 billion over the 2019-2023 period.

TABLE 2. ESTIMATE OF THE EFFECTS ON SPENDING SUBJECT TO APPROPRIATION OF H.R. 5674, THE VA MAINTAINING INTERNAL SYSTEMS AND STRENGTHENING INTEGRATED OTSIDE NETWORKS ACT OF 2018

	By Fiscal Year, in Millions of Dollars						
	2018	2019	2020	2021	2022	2023	2019-2023
INCREASES IN SPENDING SUBJECT TO APPROPRIATION							
Veterans Community Care Program							
Estimated Authorization Level	0	600	4,700	5,300	5,800	6,100	22,500
Estimated Outlays	0	500	4,100	5,100	5,700	6,000	21,400
Veterans Care Agreements							
Estimated Authorization Level	0	*	3,800	3,900	4,000	4,100	15,800
Estimated Outlays	0	*	3,300	3,800	3,900	4,000	15,000
Expansion of Family Caregivers Program							
Estimated Authorization Level	0	253	779	1,380	2,110	2,597	7,119
Estimated Outlays	0	221	705	1,282	1,983	2,486	6,677
Walk-In Clinics							
Estimated Authorization Level	0	82	170	332	437	453	1,474
Estimated Outlays	0	72	156	307	415	441	1,391
Agreements for State Veterans Homes							
Estimated Authorization Level	0	*	110	130	160	180	580
Estimated Outlays	0	*	90	120	150	180	540
Prompt Payment to Providers							
Estimated Authorization Level	0	26	75	87	94	98	380
Estimated Outlays	0	23	68	83	91	96	361
Center for Innovation for Care and Payment							
Estimated Authorization Level	0	2	53	50	50	50	205
Estimated Outlays	0	2	47	49	49	49	196
Limitation on Bonuses							
Estimated Authorization Level	0	65	65	65	0	0	195
Estimated Outlays	0	62	65	65	3	0	195
Transplant Donors							
Estimated Authorization Level	0	17	35	47	49	54	202
Estimated Outlays	0	15	32	45	48	52	192
Debt Reduction for Medical Education							
Estimated Authorization Level	0	31	33	35	36	38	173
Estimated Outlays	0	27	32	34	35	37	165

(Continued)

TABLE 2. CONTINUED

	By Fiscal Year, in Millions of Dollars						
	2018	2019	2020	2021	2022	2023	2019-2023
INCREASES IN SPENDING SUBJECT TO APPROPRIATION							
Pilot Program for Graduate Medical Education							
Estimated Authorization Level	0	7	15	23	32	42	119
Estimated Outlays	0	6	14	22	30	40	112
Podiatrists							
Estimated Authorization Level	0	10	11	12	14	14	61
Estimated Outlays	0	9	11	12	14	14	60
Debt Reduction for Vet Center Employees							
Estimated Authorization Level	0	7	8	8	8	9	40
Estimated Outlays	0	6	8	8	8	9	39
Modify Threshold for Major Medical Facilities							
Estimated Authorization Level	0	16	16	16	16	16	80
Estimated Outlays	0	1	3	8	11	13	36
Peer Specialist Program							
Estimated Authorization Level	0	3	6	6	6	6	27
Estimated Outlays	0	3	6	6	6	6	27
Mobile Deployment Teams							
Estimated Authorization Level	0	5	8	9	3	0	25
Estimated Outlays	0	4	7	9	4	0	24
Health Professional Scholarship Program							
Estimated Authorization Level	0	0	4	6	6	7	23
Estimated Outlays	0	0	4	6	6	7	23
Loan Repayment for Medical Specialists							
Estimated Authorization Level	0	3	3	3	3	3	15
Estimated Outlays	0	3	3	3	3	3	15
Procedures for Recommendations							
Estimated Authorization Level	0	1	3	3	3	1	11
Estimated Outlays	0	1	3	3	3	1	11
Scholarship Program							
Estimated Authorization Level	0	2	2	2	2	0	8
Estimated Outlays	0	2	2	2	2	0	8

(Continued)

TABLE 2. CONTINUED

	By Fiscal Year, in Millions of Dollars						
	2018	2019	2020	2021	2022	2023	2019-2023
INCREASES IN SPENDING SUBJECT TO APPROPRIATION							
Pilot Program for Medical Scribes							
Estimated Authorization Level	0	2	3	0	0	0	5
Estimated Outlays	0	2	3	*	0	0	5
Studies, Reports, and Training							
Estimated Authorization Level	0	6	4	2	3	5	20
Estimated Outlays	0	5	3	2	3	5	18
Total Changes in Spending Subject to Appropriation							
Estimated Authorization Level	0	1,138	9,903	11,416	12,832	13,773	49,062
Estimated Outlays	0	964	8,662	10,966	12,464	13,439	46,495

* = less than $500,000.

Veterans Care Agreements. Section 102 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. Such agreements would:

- Exempt VA from using the competitive bidding procedures as required under the Federal Acquisition Regulation (FAR),
- Require VA to verify that those community providers meet the conditions for certification, and
- Require VA to periodically review the necessity of the agreements.

Under current law, VA must comply with the FAR for agreements and contracts with community health care and extended-care providers. The FAR is an extensive and complex set of rules governing the federal government's purchasing processes.

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. This bill 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 $10 billion for community health care at VA (excluding the VCP). Using information from VA, CBO estimates that implementing section 102 would give VA the legal authority to continue to provide about 40 percent (or $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 $15 billion over the 2019-2023 period.

Expansion of Family Caregivers Program. Section 161 would expand access to the Family Caregivers Program, which provides stipends, health insurance, respite care, training, and other forms of support to caregivers of eligible veterans enrolled in the program. Veterans are eligible for the program if they require assistance in activities of daily living, such as bathing, eating, or grooming, as a result of injuries incurred during military service on or after September 11, 2001. Section 161 would open that program in two stages to eligible veterans of any era and would expand its benefits to include legal and financial-planning services. In total, CBO estimates that implementing section 161 would cost $6.7 billion over the 2019-2023 period. Because the expansion under section 161 is designed to be implemented in stages, that estimate is not representative of the long-term cost of implementing the program.

Under stage one, eligible veterans who were injured during service on or before May 7, 1975, could enter the Family Caregivers Program. That stage would begin in early fiscal year 2019, once VA certifies that its ongoing work to develop a new information technology (IT) system to track benefits (required under section 162) has been completed. Stage two would begin two years after stage one and would open the program to the remaining eligible veterans—those injured during service after May 7, 1975, and before September 11, 2001. For the purposes of this estimate, CBO assumes that the bill will be enacted by the end of May 2018, that stage one of the proposal will begin early in 2019, and that stage two will begin early in 2021.

In 2017, costs for the Family Caregivers Program totaled $478 million, about $18,300 per participating veteran. Most of that cost resulted from monthly stipends paid to caregivers. Stipends are based on the hours of daily care the veteran requires and the prevailing wage for home health aides. In 2017, the annual stipends paid under the program ranged from $7,800 to $30,000 and averaged roughly $15,600. Caregivers also are eligible to participate in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), a program run by VA that provides health insurance for dependents and survivors of certain disabled veterans. In addition, the Family Caregivers Program provides up to 30 days of respite care each year as well as training and other

support services. In 2017, costs under the Family Caregivers Program for CHAMPVA and the remaining services averaged about $2,700 per veteran.

CBO's estimate of the cost of expanding the caregivers program is based on the patterns of use and the average costs of the existing program and the number of veterans with significant, service-connected disabilities in the cohorts that would be newly eligible. Furthermore, to account for the advanced age of the newly eligible veterans, the estimate reflects the following findings from a 2014 RAND study:[1]

- Disabled veterans rely more heavily on assistance for daily activities as they age,
- Older veterans tend to rely on older caregivers, and
- Health care costs for caregivers increase with age.

For stage one, CBO estimates that about 16,900 additional veterans would participate in the program starting in 2019, increasing to roughly 35,500 by 2023. CBO expects that the youngest would be in their late 60s. After factoring in a heavier reliance on caregiver assistance for activities of daily living and higher health care costs for an older group of caregivers, CBO estimates that the average cost per participant in 2019 would be about $28,900. However, VA already provides respite care to assist some caregivers through its General Caregiver Program, which provides limited support services to caregivers of eligible veterans from all eras. Accounting for those current benefits in the estimate reduces the average added cost per participant to $28,500. After accounting for gradual implementation and incorporating annual inflation, CBO estimates that stage one of the proposal would cost $4.2 billion over the 2019-2023 period.

For stage two, CBO estimates that about 24,700 additional veterans would use the Family Caregivers Program in 2021. Because those veterans would be younger than the group under the initial expansion, they would have less need for caregiver assistance (with a correspondingly lower stipend amount) and the caregivers would be younger (and have lower CHAMPVA costs). After accounting for existing benefits under the General Caregiver Program, the average incremental cost per participant in 2021 would be $24,000, about 20 percent lower than the cost for participants under stage one in that year. After factoring in a gradual implementation for the second stage of expansion and incorporating annual inflation, CBO estimates that the additional costs for stage two of the Family Caregivers Program would be $2.5 billion over the 2020-2023 period. Those costs would rise to billions of dollars a year by the end of the 10-year window, CBO estimates.

1. Rajeev Ramchand and others, Hidden Heroes: America's Military Caregivers (RAND Corporation, 2014), www.rand.org/pubs/research_reports/RR499.html.

In addition, CBO estimates that roughly 22,000 caregivers in the current Family Caregivers Program (for veterans injured during service on or after September 11, 2001) would receive legal and financial support services. On the basis of the resources necessary to provide counseling under the existing program, CBO estimates an average annual cost of $130 per beneficiary for legal and financial services. CBO estimates a cost of $16 million over the 2019-2023 period to provide those benefits to individuals eligible for the Family Caregivers Program under current law. The costs of providing that additional benefit for newly eligible enrollees in the Family Caregivers Program under this provision are included in the estimates above for adding those people to the program.

Furthermore, in anticipation of the surge of new applications upon expansion of the Family Caregivers Program, VA would need to hire and train additional staff to manage the program (to staff a caregiver support line, provide outreach, and monitor the program). On the basis of program data from 2015 and adjusting for inflation, CBO estimates overhead costs of about $400 per participant to process 26,000 new applications starting in 2020. As a result, CBO estimates the additional overhead costs would be $20 million over the 2019-2023 period.

Walk-In Clinics. Within a year of enactment, section 105 would require VA to provide access to walk-in clinics operated by non-VA entities for veterans actively using the VA health care system. For their first two visits to a private clinic in any year, veterans' copayments would be limited to the amount, if any, required at VA facilities, as determined by the department. For subsequent visits, the veterans would be required to make copayments in an amount set by the department.

Using information from VA, CBO estimates that the department would reimburse about 2.7 million claims for visits to walk-in clinics each year, at an average of $200 per visit. After adjusting for time to prepare the regulations and a gradual implementation, CBO estimates that implementing section 105 would cost $1.4 billion over the 2019-2023 period.

Agreements for State Veterans Homes. Section 103 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. VA pays SVHs the full cost of care for veterans with an SCD rating of 70 percent or more, under a contract or agreement. For all other veterans, VA pays SVHs a grant based on a fixed daily allowance.

According to VA, in 2017 the department used such agreements to reimburse state-run nursing homes at a daily rate of $397.40 for each veteran with an SCD of 70 percent or more—at an annual cost of roughly $570 million (or 46 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 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 $170 per patient. By allowing VA to enter into agreements outside of the FAR framework, CBO estimates, this proposal would nearly triple VA's reimbursements to SVHs for veterans with SCDs of 70 percent or more.

As a result, after factoring in a gradual phase out of existing non-FAR agreements, CBO estimates that enacting this provision would cost $540 million over the 2020-2023 period. The additional costs from waiving the FAR requirements would begin in 2019. Because appropriations have already been provided for such agreements in 2019, we estimate no additional funding would be necessary in that year.

Prompt Payment to Providers. Section 111 would establish standards for prompt payment of claims for reimbursement for health care provided to veterans in the community, and it would require VA to enter into a contract or agreement with a nondepartment entity to process those claims. In total, CBO estimates, implementing this section would cost $361 million over the 2019-2023 period.

Expedited Processing of Claims. Currently, department standards require VA to process 90 percent of claims for reimbursement of non-VA health care within 30 days. However, VA has been unable to meet such standards. Under section 111, VA would be required to reimburse non-VA providers within 30 to 45 days of receiving a completed claim form. On the basis of a report by the Government Accountability Office and information from VA, CBO estimates that the department would need 340 additional claims processors at an average annual compensation of $51,000 to meet the expedited time frame for reimbursing existing non-VA health care. After factoring in how long it took for VA to prepare similar regulations in 2016, CBO estimates that expediting the processing of claims for such health care would cost $68 million over the 2019-2023 period.

Contracted Claims Processors. Section 111 also would require VA to outsource the processing of claims for non-VA health care. Currently, VA employs about 2,000 claims processors for that purpose at an average compensation of $51,000. CBO expects that the costs for using contractors rather than VA employees would be the same; therefore, no additional costs are estimated for replacing existing VA claims processors with contractors. Upon entering into contracts for claims processors, CBO expects that VA would offer current existing claims processors the following options:

- Accept placement in another vacant local position at VA,
- Relocate to a position that already exists in another VA location, or
- Voluntarily separate from VA employment.

CBO estimates that placing one-third (or about 600) of the claims processors in other local positions would present minimal costs for administrative duties to select and train the staff. CBO expects that the other two-thirds (about 1,100 claims processors) would relocate or voluntarily end their employment at VA. Using information from VA, CBO estimates that the average cost for relocation or incentive payments for voluntary separation would be $20,000 per employee. As a result, CBO estimates that relocating or ending employment for VA claims processors would cost $24 million over the 2019-2020 period.

Processing New Claims. In order to handle the additional claims of the VCCP established under section 101 of the legislation, CBO estimates that VA would gradually expand the contract discussed above to account for the more than doubling of non-VA health care. By 2022, an additional 1,300 processors would be needed at an average annual compensation of $51,000. After factoring in a gradual implementation of the program, adding those claims processors would cost about $270 million over the 2018-2023 period.

Center for Innovation for Care and Payment. Section 152 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 2019-2020 period.

For the pilot programs that would test the models, VA may not spend more than $50 million each year, unless receiving Congressional approval. CBO assumes that VA would stay within those limits. After factoring in a gradual implementation period similar to that of CMMI, CBO estimates that the costs for the center would be $190 million over the 2020-2023 period. In total, CBO estimates that implementing section 152 would cost about $196 million over the 2019-2023 period.

Limitation on Bonuses. Section 305 would increase the amounts VA may spend on bonuses. Currently, such spending is capped at $230 million in 2018 and $225 million a year over the 2019-2021 period. Under this provision, those caps would be increased to

$250 million and $290 million, respectively. Because we do not expect additional appropriations to be provided for 2018, CBO ascribes no additional cost to the cap increase in 2018. However, CBO estimates that the agency would spend the full amount authorized for bonuses in each year, over the 2019-2021 period for a total cost of $195 million over the 2018-2023 period.

Transplant Donors. Section 153 would allow VA to cover costs related to organ transplant procedures for veterans and their living donors 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). For procedures that take place at nondepartment facilities, VA reimburses donors only for transportation and lodging. In 2017, VA provided 560 organ transplants, most of which occurred at VATCs. Of those operations, about 200 were for kidney transplants and about 20 were with living donors.

Section 153 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 this section roughly 60 additional veterans would undergo transplants at nondepartment facilities. CBO estimates an average cost of $750,000 per patient based on billed charges for transplant procedures in the private sector, as cited by the 2014 Milliman Research report.[2] While we consider it likely that VA could negotiate lower rates, we have no information on which to base an estimate of those negotiated discounts.

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 costs for transportation reimbursements of about $4 million each year. Based on the expectation

2. Bentley, Scott T., 2014 U.S. Organ and Tissue Transplant Cost Estimates and Discussion (Milliman, 2014), http://www.milliman.com/uploadedFiles/insight/Research/health-rr/1938HDP_20141230.pdf.

that VA would implement the bill gradually, CBO estimates that implementing section 153 would have a net cost of $192 million over the 2019-2023 period.

Debt Reduction for Medical Education. Section 302 would increase the maximum amount of medical school debt that VA could pay for medical providers at the department who are eligible for the Education Debt Reduction Program (EDRP). Under current law, VA may pay up to $120,000 in total medical school debt in annual increments of up to $24,000. Section 302 would increase that amount to $200,000 (and $40,000 annually). In 2017, under EDRP VA spent a total of $35 million for debt reduction for medical education—at an average cumulative award amount of $75,000 per recipient.
For this estimate, CBO adjusted the total cost for EDRP, under current law, upward by 67 percent to reflect the proposed increase in the maximum award (from $120,000 to $200,000). After adjusting for inflation, CBO estimates that implementing this section would cost $165 million over the 2019-2023 period.

Pilot Program for Graduate Medical Education. Section 403 would require VA to establish a pilot program to expand the number of medical residencies in health care facilities operated by VA, the Department of Defense, Indian Health Services, and other entities. The program would terminate on August 7, 2024. Under the proposed pilot program, VA would be authorized to pay stipends and benefits to eligible medical residents at certain health care facilities. For certain locations, the VA would be required to reimburse those facilities for curriculum development, staff support, and costs related to accreditation of the residency program.

On the basis of information from VA, CBO estimates that about 110 additional medical residents would join the program each year, that each resident would take an average of three years to complete the program, and that the average annual cost for stipends and benefits would be $70,000 per participant. In addition, CBO estimates minimal costs for VA to cover the costs of curriculum development, staff support and accreditation costs. In total, CBO estimates implementing this section would cost $112 million over the 2019-2023 period.

Podiatrists. Section 502 would add podiatrists to the same pay schedule as physicians and dentists and thereby increase their pay. Currently, VA employs about 400 podiatrists nationwide at an average annual salary of about $130,000. On the basis of information from VA about the average increase necessary for podiatrists to move to a pay schedule comparable to that of physicians and dentists, CBO estimates that the base salary for podiatrists would increase by about 15 percent to $150,000 in 2018. In addition, using data on hiring from VA, CBO estimates that VA would be able to hire an additional 30 podiatrists because the increased pay would make working at VA more attractive. After accounting for projected pay raises, CBO estimates that implementing the provision would cost $60 million over the 2019-2023 period.

Debt Reduction for Vet Center Employees. Section 306 would expand eligibility for Education Debt Reduction Program to include clinical staff at Vet Centers. On the basis of information from VA, CBO estimates that 50 additional employees (of the total 2,120 readjustment counselors at Vet Centers) would participate in EDRP at an average cost of about $150,000 per participant. After adjusting for inflation, CBO estimates implementing this section would cost $39 million over the 2019-2023 period.

Modify Threshold for Major Medical Facilities. Section 503 would expand the authority of VA to construct medical facilities. Specifically, this section would allow VA to construct medical facilities with total costs of up to $20 million without legislative authorization. Under current law, VA must receive legislative authorization to construct medical facilities with total expenses above $10 million.

Using information on planned construction projects in VA's 2019 budget submission, CBO estimates that implementing this section would authorize one additional construction project each year with an average cost of $16 million. On that basis, CBO estimates costs of $36 million over the 2019-2023 period for construction of new facilities.

Peer Specialist Program. Section 506 would require that VA establish a program to include at least two peer specialists in Patient Aligned Care Teams (PACTs) to promote services for mental health, substance use disorders, and behavioral health in primary care. A PACT is a team-based model of care to address all of the patient's healthcare needs at VA medical centers. The program would require a rapid rollout, being implemented in at least 15 medical centers by May 31, 2019, and in at least 30 medical centers by May 31, 2020. CBO expects the department would implement the program in two PACTs per medical center. Using information from VA, CBO estimates that the 120 additional peer specialists by 2020 would receive an average salary of $46,500. After adjusting for wage growth, CBO estimates that implementing this section would cost $27 million over the 2019-2022 period.

Mobile Deployment Teams. Section 402 would require VA to establish a program to provide mobile deployment teams of medical personnel to provide health care at underserved VA facilities. CBO estimates that each team would include three health care providers, and that the cost to employ the staff of each medical team would be about $500,000. In addition, CBO estimates costs for transportation and room and board of $64,000 per team. CBO expects that VA would implement this program gradually, starting with ten mobile deployment teams in 2019 and growing to 15 in 2020. As a result, CBO estimates that implementing this section would cost $24 million over the 2019-2023 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 $23 million over the 2020-2023 period.

Loan Repayment for Medical Specialists. Section 303 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 $24,000. After factoring in a gradual implementation period and growth in tuition, CBO estimates that implementing section 303 would cost $15 million over the 2019-2023 period.

Procedures for Recommendations. By February 1, 2021, section 203 would require VA, in consultation with Veterans Service Organizations, to publish the criteria for assessing and making recommendations for modernizing, realigning, and closing VA medical facilities. In making recommendations VA must hold public field hearings with local stakeholders. The final criteria must be published by May 1, 2021, after receiving comments from the public. In addition, VA would be required to conduct capacity and commercial market assessments. On the basis of costs for nationwide assessments, CBO estimates that an equivalent of 20 full time employees (with average annual compensation of $150,000) would be necessary. Thus, CBO estimates implementing this provision would cost $11 million over the 2019-2023 period.

Scholarship Program. Section 304 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 2019-2023 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 2019-2023 period. In addition, CBO estimates that the costs of residency fees, off-site rotations, and reports would cost $1 million over 2020-2023 period.

In total, CBO estimates that implementing section 304 would cost $8 million over the 2019-2023 period.

Pilot Program for Medical Scribes. Section 507 would require VA to establish a two-year pilot program to increase the number of medical scribes (or personal assistants to physicians) employed at the department. The bill also would require VA to report to the Congress every six months and would require the Government Accountability Office (GAO) to report, within 90 days of the program's termination, the results of the pilot program compared to similar programs in the private sector.

Under the bill, CBO estimates that VA would need to hire 40 medical scribes (20 term employees and 20 contractors) in 10 medical centers. CBO expects that the pilot would run from the end of fiscal year 2018 through the end of fiscal year 2020 and that the GAO report would be completed in 2020. On the basis of information from VA on the average salary for medical support assistants, CBO estimates that pay and benefits for a medical scribe would be roughly $48,000 in 2018. After incorporating the effects of inflation, CBO estimates that implementing the two-year pilot program and preparing the required reports would cost $5 million over the 2019-2023 period.

Studies, Reports, and Training. H.R. 5674 would require VA to conduct studies, issue reports, and provide training for staff. Based on the costs of similar activities, CBO estimates that meeting those requirements would cost $18 million over the 2019-2023 period.

- By June 1, 2018, section 162 would require VA to develop and implement an IT system to track and assess data from the Family Caregiver Program. VA reports that it is currently working to enhance its existing IT system for tracking caregivers to allow for an easier application process and for tracking stipend

awards and other benefits. As a result, CBO estimates that this requirement would mostly codify existing practice and would have no budgetary effect. However, the provision also includes assessment and reporting requirements that CBO estimates would cost $2 million over the 2019-2023 period.

- Section 104 would require that VA establish benchmark guidelines for access to health care at VA medical facilities. Such guidelines would assist medical providers on whether to refer veterans into the community for health care. The section also would establish quality standards for health care at the department. CBO estimates that this section would cost $2 million over the 2019-2023 period.

- Starting in 2019 and every two years thereafter, section 106 would require that VA conduct market area assessments on the health care services provided by the department. Every four years, this section also would require VA to develop a strategic plan to meet the demand for health care provided by the department. CBO estimates that implementing this section would cost $2 million over the 2019-2023 period.

- Other provisions, including sections 108, 109, 121, 122, 123, 131, 133, 134, 151, 163, and 211 would require periodic reports on education and training programs, personnel, telemedicine, and performance awards and bonuses for employees at VA. In total, CBO estimates that those reports and criteria would cost $12 million over the 2019-2021 period.

Direct Spending

H.R. 5674 would directly appropriate funds for the Veterans Choice Program (VCP). In addition, the bill would increase the fees charged to veterans who obtain loans guaranteed by VA and would extend the current limitation on pension amounts that can be paid to certain veterans who receive benefits from Medicaid. CBO estimates enacting those provisions would increase net direct spending by $4.5 billion over the 2018-2028 period (see Table 3).

Direct Appropriations for VCP. Section 301 would appropriate $5.2 billion for VCP. VCP pays for certain veterans to receive health care from participating providers in the private sector. In fiscal year 2018, VCP had about $3.9 billion in available funds. According to VA, those funds will be exhausted before the end of 2018. Under current law, the program will terminate once that funding is exhausted. CBO expects that enacting this provision would extend the life of VCP through the first half of 2019 and estimates that would increase direct spending by $5.2 billion over the 2018-2028 period.

TABLE 3. ESTIMATE OF THE EFFECTS ON DIRECT SPENDING OF H.R. 5674, THE VA MAINTAINING INTERNAL SYSTEMS AND STRENGTHENING INTEGRATED OUTSIDE NETWORKS ACT OF 2018

	By Fiscal Year, in Millions of Dollars												
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2018-2023	2018-2028
INCREASES IN DIRECT SPENDING													
Direct Appropriations for VCP													
Budget Authority	5,200	0	0	0	0	0	0	0	0	0	0	5,200	5,200
Estimated Outlays	800	4,400	0	0	0	0	0	0	0	0	0	5,200	5,200
Loan Guarantee Fees													
Estimated Budget Authority	0	0	0	0	0	0	0	0	0	0	-436	0	-436
Estimated Outlays	0	0	0	0	0	0	0	0	0	0	-436	0	-436
Pensions for Veterans in Medicaid-Approved Nursing Homes													
Estimated Budget Authority	0	0	0	0	0	0	0	0	0	0	-293	0	-293
Estimated Outlays	0	0	0	0	0	0	0	0	0	0	-293	0	-293
Total Changes in Direct Spending													
Estimated Budget Authority	5,200	0	0	0	0	0	0	0	0	0	-729	5,200	4,471
Estimated Outlays	800	4,400	0	0	0	0	0	0	0	0	-729	5,200	4,471

VCP = Veterans Choice Program

Loan Guarantee Fees. Under its Home Loan program, VA guarantees mortgages made to veterans. Those guarantees enable veterans to get better loan terms, such as lower interest rates or smaller down payments. The loan guarantee provides lenders a payment of up to 25 percent of the outstanding balances (subject to some limitations on the original loan amounts) in the event that a veteran defaults on a guaranteed loan. Section 508 would increase some of the fees that VA charges certain veterans for providing those guarantees. Those fees lower the subsidy cost of the guarantees by partially offsetting the costs of subsequent defaults.[3] The subsidy cost of VA loan

2. Under the Federal Credit Reform Act of 1990, the subsidy cost of a loan guarantee is the net present value of estimated payments by the government to cover defaults and delinquencies, interest subsidies, or other expenses, offset by any payments to the government, including origination fees, other fees, penalties, and recoveries on defaulted loans. Such subsidy costs are calculated by discounting those expected cash flows using the rate on Treasury securities of comparable maturity. The resulting estimated subsidy costs are recorded in the budget when the loans are disbursed.

guarantees are paid from mandatory appropriations. Hence, by decreasing the subsidy cost, increasing those fees would decrease direct spending.

Under current law, the up-front fee varies on the basis of the size of the down payment and whether the veteran has previously used the loan-guarantee benefit. Borrowers who are members of the reserve component pay an additional fee of 0.25 percent of the loan amount. Veterans who receive compensation for service-connected disabilities are exempt from paying the fee. The fees that would be affected by section 508 are currently set as follows:

- 2.15 percent of the loan amount for loans with no down payment on the first use of the guarantee benefit,
- 3.30 percent of the loan amount for loans with no down payment on subsequent uses of the guarantee benefit,
- 1.50 percent of the loan amount for loans with a 5 percent down payment, and
- 0.75 percent of the loan amount for loans with a 10 percent down payment.

Those fees are scheduled to decline on October 1, 2027, to 1.40 percent, 1.25 percent, 0.75 percent, and 0.50 percent, respectively.

Under section 508, that scheduled fee reduction would occur one year later, on September 30, 2028. Increasing the fees from their current level would increase collections by VA, thereby decreasing the subsidy cost of the loan guarantees. Based on data from VA regarding the number and initial principal value of the loans it guarantees each year, CBO estimates that enacting section 508 would decrease direct spending by $436 million over in 2028.

Pensions for Veterans in Medicaid-Approved Nursing Homes. Section 509 would extend for one year (through September 30, 2028), a provision of current law that sets a $90 per month limit on pensions paid to any veteran who does not have a spouse or child and who is receiving Medicaid benefits in a Medicaid-approved nursing home. That provision also applies to any survivors of a veteran who are receiving such coverage. Under current law, when a veteran or survivor receiving a pension benefit and Medicaid goes into a Medicaid nursing home, VA decreases the individual's pension payments to $90 per month. This creates savings for VA, but also increases costs for Medicaid, as the Centers for Medicare and Medicaid Services need to make payments to nursing homes for amounts that would otherwise be paid by the veterans and surviving spouses. Those higher Medicaid payments would offset some of the savings from the reduced pensions.

Based on historical information on the number of veterans and survivors receiving a pension benefit and also receiving care in a Medicaid-approved nursing home, CBO estimates about 11,000 veterans and 26,000 survivors will have their pensions reduced in 2028. The reduction would save VA about $737 million in 2028, but would increase costs to Medicaid by $444 million. Thus, net savings from the pension reduction would be $293 million in 2028. The change would decrease direct spending by $293 million in 2028 and by the same amount over the 2018-2028 period.

PAY-AS-YOU-GO CONSIDERATIONS

The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in Table 4.

TABLE 4. CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS OF H.R. 5674, THE VA MAINTAINING INTERNAL SYSTEMS AND STRENGTHENING INTEGRATED OUTSIDE NETWORKS ACT OF 2018, AS REPORTED BY THE HOUSE COMMITTEE ON VETERANS' AFFAIRS ON MAY 11, 2018

	By Fiscal Year, in Millions of Dollars												
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2018-2023	2018-2028
NET INCREASE OR DECREASE (-) IN THE ON-BUDGET DEFICIT													
Statutory Pay-As-You-Go Impact	800	4,400	0	0	0	0	0	0	0	0	-729	5,200	4,471

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO estimates that enacting the draft bill would not increase net direct spending or on budget deficits by more than $2.5 billion in any of the four consecutive 10-year periods beginning in 2029.

MANDATES

H.R. 5674 would impose intergovernmental mandates as defined in UMRA by requiring states to grant VA personnel access to prescription drug monitoring programs (PDMPs) operated by states and by preempting state laws that prohibit VA personnel from

practicing telemedicine in another state. CBO estimates that both incremental cost to states of servicing additional PDMP users and the revenue lost from individuals foregoing reciprocal medical licenses would be small. Therefore, the costs of the mandates would not exceed the threshold established in UMRA ($80 million in 2018, adjusted annually for inflations).

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

PREVIOUS CBO ESTIMATE

On February 15, 2018, CBO transmitted a cost estimate for H.R. 4242, the VA Care in the Community Act, as ordered reported by the House Committee on Veterans' Affairs on December 19, 2017. Sections 301, 303, and 304 of H.R. 5674 are similar to sections 301, 302, and 303 of H.R. 4242, respectively. The costs are higher, however, because an additional projection year is included and economic factors have been updated.

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, 105, 111, 153, 402, and 502 of H.R. 5674 are similar to sections 102, 103, 105, 111, 252, 233, and 202 of S. 2193, respectively. The costs of those sections are higher because an additional projection year is included and economic factors have been updated. Section 161 is similar to section 301. The cost of section 161 has been updated for new information on historical spending for the Family Caregivers Program and adjusted for an earlier start date.

On November 13, 2017, CBO transmitted a cost estimate for H.R, 4243, the VA Asset and Infrastructure Review Act of 2017, as ordered report by House Committee on Veterans' Affairs on November 8, 2017. Section 203 is similar to section 103. The cost for that proposal is higher because an additional projection year is included and economic factors have been updated.

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