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VETERANS' HEALTH CARE

Facilities' Resource Allocations Could Be More Equitable





United States
General Accounting Office
Washington, D.C. 20548

**Health, Education, and
Human Services Division**

B-259872

February 7, 1996

The Honorable John McCain
United States Senate

Dear Senator McCain:

The Department of Veterans Affairs (VA) is faced with the challenge of equitably allocating more than \$16 billion in health care appropriations across a nationwide network of hospitals, clinics, and nursing homes. The challenge is made greater by the shifting demographics of veterans. While nationally the veteran population is declining, veterans have migrated from northeastern and midwestern states to southeastern and southwestern states in the past decade, offsetting veteran deaths in these states.

VA has historically based its allocations to facilities primarily on their past funding levels—providing incremental increases to facilities' past budgets. In an effort to improve its planning, allocation, and management processes, VA made a considerable investment in implementing a new system, called the Resource Planning and Management (RPM) system, for use initially in fiscal year 1994. VA considers RPM to be a management decision process to use to formulate its budget, allocate most of its resources, and compare facility performance.¹ As the basis for resource allocation, RPM classifies each patient into a clinical care group, calculates average facility costs per patient, and forecasts future workload. VA envisioned that the system would improve VA's management of limited medical care resources, better define future resource requirements, and enable VA to explore opportunities to improve quality and efficiency in its health care system. This vision included improving the equity of its allocations by more closely linking resources with facility workloads and alleviating inconsistencies in veterans' access to care across the system.

Two recent events could have significant implications for VA's resource allocation system. First, VA is restructuring its organization to establish 22 veterans integrated service networks (VISN) that will replace four regional offices and assume the individual facilities' role as the basic budgetary and planning unit for health care delivery. The new structure will require some

¹VA in 1995 operated 172 hospitals, 375 ambulatory clinics, 133 nursing homes, and 39 domiciliaries. For resource allocation purposes, RPM combines certain health care facilities that are managerially associated. In total, the RPM system develops allocations for 167 facilities.

change in how resources are allocated.² Second, the Senate passed your proposed amendment to the VA appropriations bill that would require VA to develop a plan for the allocation of health care resources among its health care facilities to ensure that veterans have the same access to quality health care.³

Because of your interest in this issue, you asked us to review the equity of VA's resource allocation system, particularly as it related to the allocations made to the Carl T. Hayden Medical Center in Phoenix, Arizona. More specifically, you asked us to determine the following:

- To what extent does VA's allocation system provide for an equitable distribution of resources among VA facilities?
- What are the causes of any inequity in the distribution of resources, and what changes, if any, would help ensure that the system more equitably distributes resources?

In September 1995, we sent you our preliminary observations.⁴ This report presents our final results.

To accomplish our objectives, we first needed to apply a definition of the term "equity." We based our evaluation of the equity of the system's distribution on VA's vision for RPM.⁵ We considered the following two elements to be characteristics of an equitable system:

- It provides comparable resources for comparable workload.
- It provides resources so that veterans within the same priority categories have the same availability of care, to the extent practical, throughout the VA health care system.

We then reviewed VA documents and analyzed RPM system data to determine the degree to which these two elements were present. We

²VA officials indicated that as part of this change, the resource planning and management processes it used would change and the system would be renamed. At the time of our review, the system was known as RPM.

³On September 26, 1995, the Senate adopted amendment number 2787 to the VA appropriations bill, which was in conference at the time of our review. If it becomes law, the provision would require the Secretary of VA to develop a plan for the allocation of health care resources to ensure that veterans having similar economic status, eligibility priority, and/or similar medical conditions have similar access to care regardless of the region in which the veterans reside. The plan will include, among other things, procedures to identify reasons for variations in operating costs among similar facilities.

⁴See VA's Medical Resource Allocation System (GAO/HEHS-95-252R, Sept. 12, 1995).

⁵This vision was described in the Secretary's statements to the Congress on RPM and in other VA publications.

discussed potential reasons for any inequities in allocations with VA Headquarters, the Boston Development Center, the RPM Committee, and facility officials in several locations. To assess potential changes to address inequities, we discussed such changes with VA officials and reviewed VA documents on its original plans for RPM and minutes of several RPM committees and work groups. Further details of our scope and methodology are in appendix I. We performed our review between December 1994 and October 1995 in accordance with generally accepted government auditing standards.

Results in Brief

The resource allocation system gives VA the ability to identify potential inequities in resource distribution and to forecast workload changes. Data generated by the system show wide differences in operating costs among facilities that VA considers comparable, even after factors such as locality costs and patient mix differences are considered. VA's data also show some facilities' overall patient workloads increasing by as much as 15 percent between 1993 and 1995, and others' workloads declining by as much as 8 percent. However, in the two budget cycles in which RPM has been in effect, VA used it to make only minimal changes in facilities' funding levels—the maximum loss to any facility was about 1 percent of its past budget and the average gain was also about 1 percent. As such, VA's distribution of resources has remained almost exclusively related to incremental changes to the amount that each facility has received in the past.

To date, VA has chosen not to use the RPM system to help ensure resources are allocated more equitably. VA officials indicated that larger reallocations were not made during the first 2 years of RPM to allow facilities time to understand the process. VA officials also cited several other reasons that significantly larger reallocations among facilities could not be made. Although VA is taking some actions on these issues, it has not fully addressed concerns that (1) facilities cannot efficiently adjust to large budget changes, (2) VA needs a better understanding of the reasons for the variations, and (3) resources allocated to facilities outside the RPM process should also be considered in judging the equity of distributions. VA's reasons for not using RPM to even out differences in veteran access to care were less clear as there appeared to be confusion within VA about whether the resource allocation system was intended to achieve this goal.

Background

The VA health care system, established in 1930, is one of the nation's largest direct delivery systems. VA's health care facilities provide services to veterans both with and without service-connected disabilities. Individual facilities vary widely in the inpatient, outpatient, and long-term care services they provide. For example, some facilities provide only basic clinical care; whereas, others have capabilities to provide special care such as for organ transplants, spinal cord injuries, or chronic mental illness.

VA historically allocated funds to its facilities on the basis of the facilities' past expenditures, with incremental increases for such factors as inflation and new programs. Beginning in 1985, VA modified its allocation system because it recognized the need to more directly relate funding to the work performed and the cost to perform it, and to improve the efficiency and productivity with which medical care is delivered to veterans.

The Resource Allocation Methodology (RAM) was VA's first attempt to better link resources to workload.⁶ VA ended RAM in 1989 because of concerns that facilities had inappropriate incentives to perform work beyond their resources, possibly affecting quality of care and resulting in a budget crisis at some facilities. Between 1990 and 1993, VA again based allocations on making incremental changes to facilities' historical budgets. But to further its efforts to link resources and workload and to provide data that it could use to improve quality and efficiency in the system, VA implemented its current RPM system for the fiscal year 1994 allocation process.

System Goals and Design

The Secretary of VA, in endorsing the new RPM system, stated he hoped it would improve VA's management of limited medical care resources, enable VA to explore opportunities to improve quality and efficiency in its health care system, and better define future resource requirements. To those ends, VA's stated goals for RPM are to (1) improve its resource allocation methodology, (2) move from retrospective to prospective workload management, and (3) reform medical care budgeting.⁷

VA has established high expectations for how RPM would improve the equity of its allocations. VA hoped to better link resources and facility

⁶We reported in 1989 that RAM had little impact on medical center budgets. See *VA Health Care: Resource Allocation Methodology Has Had Little Impact on Medical Centers' Budgets* (GAO/HRD-89-93, Aug. 18, 1989).

⁷Our review was limited to aspects of how RPM has been used to allocate and manage resources.

workload, move to prospective workload management by forecasting workload changes, and provide for differences in facility efficiencies in the allocations. VA also hoped that by forecasting workload changes, it could better establish and justify its budget requests. VA envisioned the system overcoming inconsistencies in facilities' provision of care to veterans by allowing for a more equitable distribution of resources to meet veteran needs systemwide. Finally, by identifying facility differences, VA intended that the system would provide managers with useful information, including the matching of resources to quality of care issues.

Part of this effort to improve resource allocation involved linking the budget allocation process to VA's strategic plan. The strategic plan was to be the driving force behind RPM, providing it with a set of goals, performance standards, and workload priorities. Furthermore, the system's link to the strategic plan was intended to allow consideration of service distribution, practice patterns, geographic factors affecting costs, and access differences.

RPM was also designed to be a patient-based system. It differs from past resource allocation processes in defining workload as patients served rather than as procedures performed—this is the basis for VA's characterization of RPM as "capitation-based." For resource allocation purposes, the RPM database, managed by VA's Boston Development Center (BDC) in Braintree, Massachusetts, integrates workload data, case mix, and costs to project facility-specific resource needs. With significant input from VA managers in the field and Headquarters, BDC has developed a complex data analysis process to estimate facility unit costs. Generally, this process involves adjusting for case mix differences by classifying patients into clinical classes and groups, forecasting changes by class in the numbers of patients served, and developing average costs per patient type that are then applied to the number of expected patients in each group to achieve a preliminary budget estimate. The facility estimates are adjusted to reflect inflation, VA regional input, and facility efficiencies. A further discussion of the RPM system is in appendix II.

Because resource allocation is a sensitive and complex undertaking in VA's health care system, VA has made a considerable investment in it. Significant VA Headquarters and field managers' time and effort is spent adjusting the RPM methodology from year to year—one reason the process is continually changing. In addition to the 26 BDC staff responsible for data processing and education efforts, VA Headquarters chief financial officer, quality management, operations, and clinical staff also provide input to the

process through frequent meetings. Facility directors sit on the RPM Field Oversight Committee, a group of about 15 managers (with 10 to 20 support staff and visitors usually present) who meet regularly to discuss implementation issues. Six technical assistance groups comprising physicians and other clinicians in each clinical area generally represent the RPM clinical groups and advise on clinical issues such as the classification of patients. Other RPM committees include a Planning Group and a Financial Advisory Group, which assist in determining forecasting methodologies and advise on the correct allocation of costs. While many parties provide input to the RPM process, the Budget Policy and Review Committee, comprising VA associate chief medical directors and other senior VA managers, makes the final recommendation on the resource allocation methodology, which the Under Secretary for Health approves.

System's Potential to Improve Equity May Not Be Realized

The resource allocation system shows mixed results with regard to the two aspects of equity that we examined. The system design produces data that point to potential inequities so that VA can better link resources to facility workloads. However, VA has not yet used the system for this purpose. VA has not designed the system to address the goal of providing greater consistency in veterans' systemwide access to services.

System Design Provides Data on Potential Inequities

The resource allocation system provides VA managers with data that compare facility costs on a standardized workload unit basis and in this way, provides data that could point to potential inequities in allocations.⁸ Through an outlier process, the system identifies facility cost differences, a feature that allows VA to reallocate monies from the budgets of the highest cost facilities to those with the lowest costs. VA places facilities into one of nine facility groups that it considers comparable based on a complex consideration of factors such as affiliation with teaching facilities and size.⁹ Then, to provide a fair comparison, the system "levels the playing field" by adjusting for differences among facilities such as case mix, locality costs, salaries, training, and research. After adjustments are made, the system considers variations in workload costs to be more

⁸The current system design addresses some of the concerns raised about the RAM system that preceded it by focusing on patients rather than on programs or procedures. This redefinition of workload also changes the incentives in the system and makes it less susceptible to attempts to gain resources through inappropriate performance or recording of workload. For example, under RAM, a facility could get more workload credit for hospitalizing a patient than if the same care was provided on an outpatient basis.

⁹Specifically, the complexity index applied in developing the groups considered facility size, clinical variety, size of medical resident teaching mission, variety of medical resident programs, size of allied health training mission, managerial complexity, and research.

indicative of efficiency differences than facility characteristics. Comparative data show that even after adjustments are made, significant facility cost variations remain. Variations typically ranged 30 percent or more within each facility group. Appendix III and figure III.3 provide an example of the variations the RPM data show in adjusted costs per workload for one group of facilities that VA considered comparable.

Another important aspect of the RPM system is its ability to forecast workload changes. For each patient class, the system forecasts the number of patients that facilities are likely to see, based on historical trends. The forecasting process recognizes that facility workloads are changing at relatively different rates and that facilities' clinical workloads or "case mix" are also changing. For example, the system forecasts that patient classes for pulmonary disease patients or ear, nose, and throat patients are generally expected to decrease in fiscal years 1994 and 1995; whereas, classes for outpatients or human immunodeficiency virus (HIV) patients are expected to increase. System forecasts showed rates of change for total patients expected to be seen at facilities ranging from an 8-percent decrease to a 15-percent increase between 1993 and 1995.¹⁰

VA Has Done Little to Change Past Facility Allocations

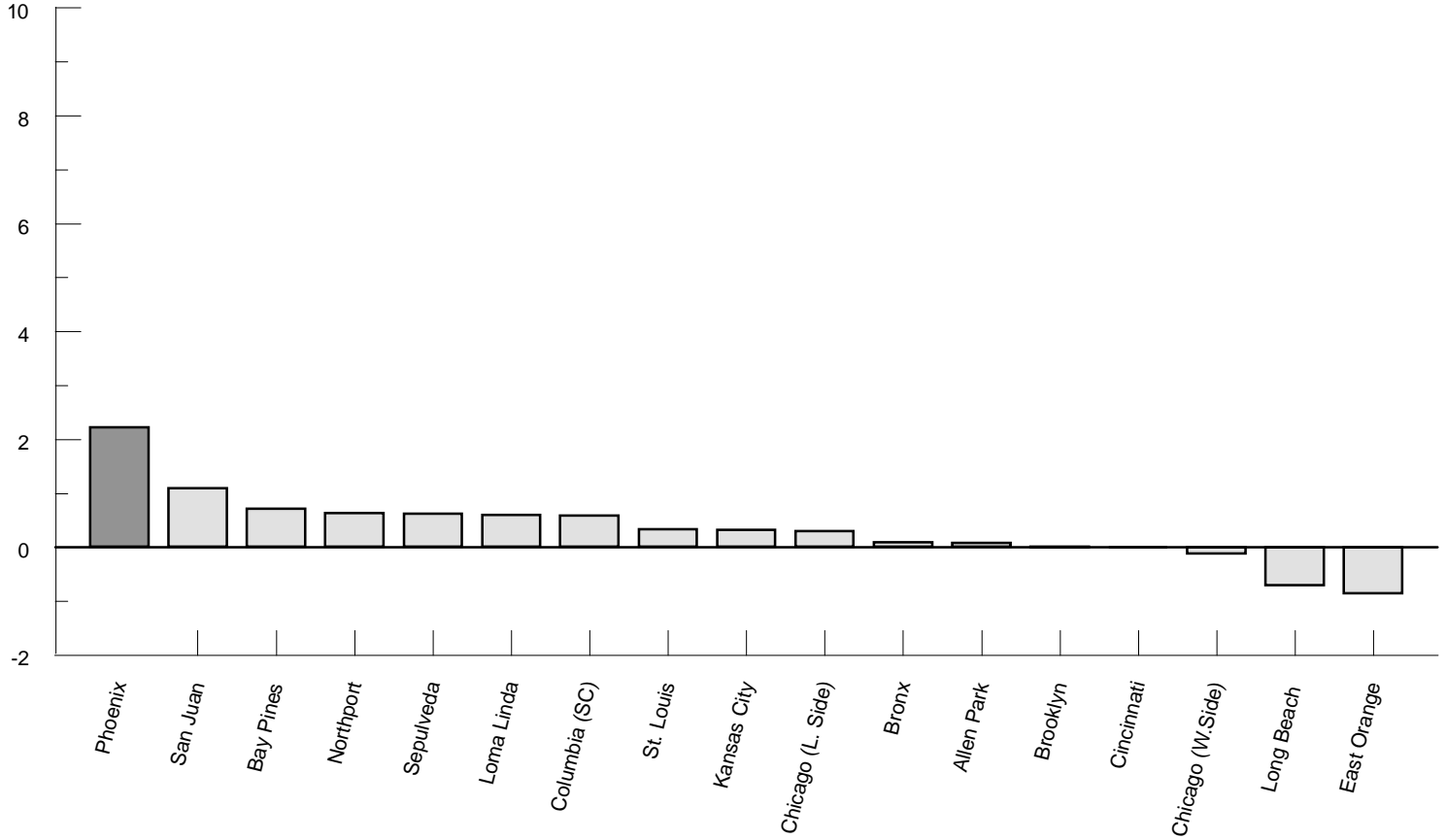
Despite cost variations and differing workload changes among facilities reflected in RPM data, VA has done little to use the data to change facility allocations. We estimate that 1 percent was the maximum real decrease in allocations that any facility had in 1995 based on RPM budget adjustments. While one facility gained as much as 3.4 percent through the process, the average uninflated gain¹¹ was also about 1 percent. Facility budget changes for RPM Facility Group 5 are shown in figure 1. Appendix IV contains data for facilities nationwide.

¹⁰We did not review the adequacy of the resource allocation system's forecasting methodologies because data to compare actual with forecasted workload and assess the accuracy of the forecasts over time were unavailable at the time of our review.

¹¹All facilities received larger budgets in fiscal year 1995 than the previous year because of inflation adjustments. The uninflated gain represents the budget change before the inflation adjustment.

Figure 1: Facility Group 5 Budget Changes Resulting From RPM Process, Fiscal Year 1995

Percentage Change in Budget



Note: L. Side = Lakeside facility; W. Side = Westside facility.

Source: GAO analysis of RPM data.

VA made two significant decisions that limited the resource allocation adjustments to facilities' budgets:

- By limiting the movement of resources between the high- and low-cost facilities, VA in effect allowed the wide variations in patient costs among

facilities to continue. VA limited the amount of dollars moved between high- and low-cost facilities to \$10 million in fiscal year 1994 and \$20 million in fiscal year 1995.

- VA did not include enough resources in its RPM allocations to fully fund all the facilities' expected needs¹² and distributed the shortfall by limiting the amount of resources given to those facilities with growing workloads.¹³ Furthermore, for those facilities with decreasing workloads, VA chose to limit their budget decreases. These decisions led to funding for the projected cost of increased workload at approximately 17 cents on the dollar. At the same time, facilities with decreasing workloads were given more money than needed to support the forecasted workload. Appendix III discusses the impact of this decision in further detail.

Both of these decisions on VA's part had a greater impact on those facilities that historically had received less funding for their workloads—and therefore were shown to have lower workload costs—than those that had relatively faster growing workloads. For example, the Carl T. Hayden Medical Center adjusted workload costs were 16.8 percent lower than those of other facilities that VA considered comparable in mission and size, and its forecasted workload growth was 4.5 percent—third highest among comparable facilities between 1993 and 1995. However, because of VA's decisions that limited the reallocation of funds, Carl T. Hayden experienced a 2.2-percent increase in uninflated funding between 1993 and 1995. By comparison, the Long Beach Medical Center—the “high outlier” in the same comparative facility group as Carl T. Hayden—had adjusted workload costs that were 13.9 percent higher than other facilities and a forecasted workload decrease of approximately 1 percent. Long Beach's funding decrease was less than 1 percent in 1995 (before the inflation adjustment). A further discussion and data related to the system's provision of funding for workload are in appendixes III and IV.

The System Does Not Address Veterans' Unequal Access to Care

Part of VA's original plan for RPM was to use it to help alleviate inconsistencies in veterans' access to outpatient care—a plan that has not materialized. Consequently, inconsistencies that we reported in the past are likely to remain, as demonstrated by differences in facilities' ability to provide outpatient care.

¹²As discussed later in this report, VA excluded over \$4 billion, or 25 percent, of its medical care appropriation from the RPM process.

¹³While the system data indicated that VA needed \$242 million to fund the forecasted increases in workload for fiscal year 1995, VA provided \$42 million.

We reported in 1993 that veterans' access to outpatient care at VA facilities varied widely—veterans within the same priority categories received outpatient care at some facilities but not at others.¹⁴ This occurred because VA facilities were given discretion to determine whether to ration, or limit, discretionary or nonmandated care when resources are insufficient to care for all veterans.¹⁵ While considerable numbers of veterans have migrated to southeastern and southwestern states, there was little shift in VA resources. As a result, facilities mainly in the eastern states were more likely to have adequate resources to treat all veterans seeking care than other facilities. VA facilities in other states have adapted by restricting veterans' access to care.

Our 1993 report found that 118 facilities indicated they rationed outpatient care for nonservice-connected conditions, while 40 facilities reported no rationing. The facilities that did ration used different methods to determine who got care. Some rationed on the basis of economic status, others on the basis of medical service or medical condition. Consequently, significant inconsistencies existed in veterans' access to care both among and within centers.

In responding to our report and in correspondence to the Congress, VA indicated that the RPM system would consider and help overcome inconsistencies among facilities in veterans' access to outpatient care, allowing for a more equitable distribution of resources to meet outpatient needs systemwide. However, this vision remains unfulfilled. The system does not distinguish between facilities' discretionary and mandatory workload in determining past and forecasting future workload.

Consequently, the access problems we reported in 1993 are likely to have continued. VA management systems, however, still lack reliable data on facilities' rationing or denial of care, which prevented us from confirming the extent to which the rationing we reported earlier still exists. But available data indicate that the ability of facilities to provide care to discretionary categories of veterans still varies. For example, fiscal year 1994 data indicate that although up to 13 percent of some facilities' patients were veterans in a discretionary category because they had

¹⁴VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO-HRD-93-106, July 16, 1993).

¹⁵As we reported in VA Health Care: Issues Affecting Eligibility Reform (GAO/T-HEHS-95-213, July 19, 1995), VA uses a complex priority system—based on such factors as the presence and extent of any service-connected disability, the incomes of veterans with nonservice-connected disabilities, and the type and purpose of care needed—to determine which eligible veterans receive care within available resources.

nonservice-connected conditions and higher incomes, other facilities treated none of these discretionary patients. Appendix V discusses these differences further.

VA Barriers to Equitable Allocations Can Be Overcome

VA officials offered a number of reasons for not reallocating larger percentages of dollars in fiscal years 1994 and 1995, thereby addressing the goal of better linking resources to workload. These reasons included the need for a transition period, the difficulty facilities would have adjusting efficiently to large annual budget changes, and the need to evaluate the reasons for the cost variations and whether to include more of VA's resources in the RPM system. With regards to the goal of reducing access differences, officials expressed uncertainty over how the system could be used for this purpose.

Although VA is planning to reallocate more funds for the fiscal year 1996 budget cycle, further changes are needed to establish equitable allocations. VA's original plans for the system remain valid and in line with current governmentwide efforts to develop strategic plans and performance measurement systems. These efforts, legislated under the Government Performance and Results Act, provide for performance measurement as the basis for improving government operations and, eventually, linking desired outcomes to resource allocation. Although we and others have recognized the inherent difficulties of linking performance measures and budgeting,¹⁶ VA has opportunities to improve the equitability of its allocations by revisiting its original plans for RPM and forging long-range plans for working toward its original visions.

VA Cited Several Barriers to Reallocating More Money

The basis for VA's facility allocations remains largely unchanged because VA officials decided to limit the changes to facilities' budgets, rather than because the RPM design or process does not allow them to do so. Officials cited several reasons for not using the RPM system data to reallocate larger amounts in fiscal years 1994 and 1995. Among those reasons were the following:

- A transition period was needed. VA officials indicated that time was needed to educate facility managers and to obtain facility buy-in to the process. Also, VA made several changes during the first years of the process to help

¹⁶Performance Budgeting: State Experiences and Implications for the Federal Government (GAO/AFMD-93-41, Feb. 17, 1993).

address facility concerns about the accuracy of data that facilities submit.¹⁷

- **Facilities cannot efficiently adjust to large budget changes.** VA officials believed that absent plans to phase in resource changes over a 3- to 5-year period, facilities could not efficiently adjust to large changes in their budgets in any single year. A facility does not know what its allocation for the fiscal year will be until shortly before the year starts—depending on how soon the VA medical care appropriation is determined. Officials believed it unreasonable to expect facility directors to adjust to significant changes given the short lead time between when they learn what their budget allocations will be and the start of the fiscal year. Furthermore, officials believed that facility directors had few management options for reducing operating budgets because 70 percent or more of facilities' budgets is spent on salaries.¹⁸
- **Reasons for variations are unclear.** Officials indicated that they lacked a good understanding of what causes the variations, which some thought could be attributed to factors, such as quality of care, that are not considered in the adjustment process. For example, high-cost facilities may provide higher quality or more timely care and may not necessarily have higher costs because of operating inefficiencies. At the same time, low-cost facilities may be efficient and may become less so if given more money for the same workload. Because VA does not have a standard for what facility unit costs should be, the current process “titrates budgets to the mean,” that is, only very slowly brings facility budgets closer to the mean.

VA officials further maintained that the RPM allocations alone could not be used to judge the equity of facility budgets because facilities get funds that are not distributed through RPM. About \$4.1 billion, or 25 percent, of the fiscal year 1995 medical budget was allocated to VA facilities by processes separate from the RPM system. About \$2.3 billion of the \$4.1 billion was allocated to facilities at the beginning of the year and included funding for items such as the community nursing home contract program, activation of newly constructed facilities, outpatient fee-basis care, prosthetics, and resident training. The remaining \$1.8 billion in non-RPM-allocated funds

¹⁷RAM, the system that preceded RPM, was ended in part because of concerns that facilities' data coding was affecting resource allocations. For RPM, VA has established facility education and data validation efforts to help facilities understand RPM reports and to give facilities the opportunity to make corrections to the data used in the process.

¹⁸Largely because of this concern, VA managers have made decisions on RPM methodology in part on the basis of whether resulting budget changes to individual facility budgets were considered “manageable.” To do this, the VA managers reviewed a number of different budget scenarios using varied implementation methodologies. A committee of senior VA managers then chose the methodology after considering the potential effects on individual facilities.

paid for leases, travel, and patient care programs such as dental programs and women veterans health programs. In part, these funds also were to pay for contingencies that arose through the year.¹⁹

An assessment of the equity of these allocations, and their impact on the relative equity of the RPM system allocations, could not be made with available data.²⁰ While VA's financial system accounts for individual transactions to facilities throughout the year, it does not summarize for each program the amount received by each facility.²¹ VA officials agreed that some non-RPM resources support patient care operations, such as those for prosthetics or facility activations, and indicated that they had conducted special evaluations of non-RPM accounts to determine whether any of the funds should be allocated through the RPM system. As a result of these evaluations, the percentage of the medical care funds allocated through RPM increased from 66 percent in fiscal year 1994 to 75 percent in fiscal year 1995. VA documents indicate that at the time of our review, VA was considering establishing a formal process to ensure that non-RPM funds are inventoried, monitored, and considered for possible inclusion in RPM.

VA Unclear About Why System Was Not Used to Address Access Differences

Why VA has not used its resource allocation system to help overcome inconsistencies in veterans' access to care was not clear because confusion existed at VA over what needs to occur to meet this goal. For example, some officials indicated that legislative reforms to current eligibility requirements were needed to ensure greater consistency in eligibility determinations when veterans seek care. However, other officials' statements to us and the Congress indicated that the resource allocation system would be used regardless of legislative reforms and that the delay was attributable largely to the absence of useful eligibility data and the difficulty of incorporating this goal in the RPM model. While we

¹⁹In 1989, we reported that regional directors helped centers cope with budget shortages beyond the initial resource allocations because directors could adjust centers' budgets throughout the year. Budget adjustments were made through reserves set aside at the start of a year, supplemental appropriations, or transfers of funds among centers. Regional directors and Headquarters managers maintain these "contingency funds"—amounting to about \$90 million in fiscal year 1995—for such purposes.

²⁰For example, VA officials indicated that the Carl T. Hayden Medical Center received \$11.3 million in non-RPM funding for patient care in 1994 and 1995. Because this information was obtained through a one-time analysis, they could not provide comparable funding-level data for all other facilities.

²¹Officials gave various reasons why non-RPM accounts were not allocated through the RPM system (for example, the associated workload had not been properly identified). RPM Field Oversight Committee meeting minutes indicated that some officials had concerns about the lack of proper accounting for non-RPM funds (for instance, that non-RPM funding not initially allocated to facilities is not well tracked to patient care).

agree that reform that simplifies VA's complex eligibility requirements might allow VA to more easily consider veterans' access differences in allocating resources, we do not believe such legislation is a prerequisite to meeting this goal because the Congress has established the priorities for the provision of veterans' care. Because this issue has not yet been resolved within VA, the management support and responsibility for ensuring the mechanisms are put in place to achieve this goal are lacking.

Changes Needed to Provide for More Equitable Facility Allocations

VA officials indicated they were taking several steps to more actively use the RPM system data and to improve the resource allocation process. First, given that the initial 2 years of the system's implementation were intended to help facilities adjust to the new process, the Deputy Under Secretary for Health told us in September 1995 that VA was planning to reallocate a significantly larger amount of money for the fiscal year 1996 facility budgets based on RPM. Furthermore, officials indicated that they were implementing a Decision Support System²² to better coordinate VA's clinical and financial data systems and allow VA to compute more accurately the costs of specific services provided to each patient. Nonetheless, we believe that several additional changes are needed to foster facility budget changes and to provide for more equitable allocations. In particular, VA should take steps to address other notable barriers that limit VA's ability to reallocate funds, as discussed below.

Linking Strategic Plans to Resource Allocation Could Help Facilities Adjust to Budget Changes

If the provision of comparable resources for comparable workload is a goal, long-term strategies to help facilities adjust to changing budgets must be put in place. VA's resource allocation could be made more equitable if it is clearly linked to VA's strategic plan goals, performance standards, and workload priorities. In particular, VA could coordinate its future plans for facility missions, services, and capacity with its facility budgets over time, establishing a plan for phasing in resource changes and giving facilities and VISN managers financial objectives with which they can plan more than 1 year in advance.

²²VA is investing a projected \$132 million to implement a medical Decision Support System (DSS). Such a system has provided hospitals in the private sector with improved data on patterns of patient care and the cost of providing health care services. However, we reported in September 1995 that VA had not developed the comprehensive business strategy necessary to achieve the system's potential benefits or taken critical steps to ensure that data upon which DSS is based are complete, accurate, and consistent. It is unknown at what point implementation concerns will be corrected and the system will be fully operational. Although it appears DSS, if implemented to achieve such a goal, has the potential to greatly improve on or replace significant parts of the RPM process, such as the process for patient costing, VA has not clarified how RPM and DSS will interact. See *VA's Decision Support System: Top Management Leadership Critical to Success of Decision Support System* (GAO/AIMD-95-182, Sept. 29, 1995).

Linking resource allocation to VA planning efforts is not a new idea in VA. Starting in 1992, VA developed what was known as the National Health Care Plan (NHCP) to coordinate RPM, VA strategic planning, and other VA planning efforts. NHCP was developed by a multidisciplinary committee charged with looking at facility missions, identifying gaps and overlaps in services, and developing a planning process. However, VA officials told us the draft plan was preempted by the Clinton administration's push for national health reform in 1994. Efforts to determine how VA would be integrated within the administration's health reform plan superseded other planning efforts within VA.

After NHCP was dropped, strategic planning reemerged in early 1995 in a plan that the Under Secretary for Health set forth to the Congress to restructure VA to make it a more efficient and patient-centered health system. As previously mentioned, the plan would further decentralize VA operations by establishing 22 VISNS throughout the country to coordinate and integrate VA's health care delivery assets. A key part of the VISN plan is that VISN directors would be held responsible for strategic planning, with greater systemwide direction in strategic planning as well. It is not clear from current VA planning documents how the VISN and VA systemwide strategic plan might interact with resource allocation and how resources will be allocated to VISNS. It is not evident what VA's plan is for moving facilities and VISNS toward more comparable funding for comparable workload and achieving the coordination between planning and resource management envisioned in NHCP. As it implements its new VISN structure, VA will need to link its planning and resource allocation processes and establish long-range plans for using resource allocation to help achieve its goals.

Better Understanding of Cost Variations Would Help Support Budget Changes

To better link resources to workload, manage limited resources, and ensure quality of care, VA could establish a review and evaluation process as part of the formal RPM system. Although VA has spent considerable time and effort determining how the system should use and develop data to produce facility budgets, few resources have been devoted to determining why the system shows such significant cost variations among facilities. Understanding these variations could help VA improve its comparisons of facilities' efficiencies by providing information on how further adjustments might increase the comparisons' fairness. These adjustments might include other locality-specific, mission-related, or data-reporting factors that may contribute to cost differences. Finally, VA could identify potential ways that quality of care or other aspects of facility performance are affected by resources. With a better understanding of the variations,

decisionmakers could make more informed decisions on the RPM system adjustments necessary to compare facilities fairly and set expectations for how facilities should adjust to changing resource levels.

Originally, the RPM system was designed to include a review and evaluation element that could help provide feedback to VA managers on how facilities performed compared with their expected workloads and costs. Structured site reviews of high- and low-cost facilities were intended to help determine possible reasons for the cost variations by identifying efficiencies and allowing a closer assessment of the potential impact of resources on quality.²³ Furthermore, VA hoped to better link cost data with quality indicators so an assessment of resources' impact on quality could be made. In its 1994 Quality Management Plan, VA set forth how it would assess progress in delivering quality health care to veterans. VA reported that it sought to produce resource profiles for each level of the organization that could be analyzed for connections between quality of care and resource availability. The RPM system was envisioned as a critical part of this effort. For example, it was expected to provide information about facilities with resource profiles that suggested resources were insufficient and to lead to reviews that could ensure more consistent care across the VA system. VA anticipated that by the end of fiscal year 1994, RPM would match resources to quality of care issues and improve information for management at all levels. None of these original plans for RPM has yet materialized, apparently because of VA's priorities, time constraints, data on quality becoming available only recently, and lack of consensus on how to implement VA's original plans.

An example of how decisionmakers can be given information on health care cost variations was illustrated in a report by the Prospective Payment Assessment Commission (PROPAC), which advises the Congress on Medicare issues.²⁴ PROPAC has analyzed state variations in per capita health care costs in order to understand the implications of the wide variations in

²³We have previously reported that VA lacks oversight procedures to effectively assess the operations of its medical centers and that VA Headquarters should be serving as an information exchange, identifying and evaluating locally developed programs and methods and disseminating best practices to other medical centers. We also reported that VA has an opportunity to improve the efficiency of its facility operations, as VA lags far behind the private sector in this regard. See VA Health Care: Challenges and Options for the Future (GAO/T-HEHS-95-147, May 9, 1995).

²⁴The option of establishing a formal oversight body such as PROPAC for RPM was suggested by a VA contractor in a review of RPM. An advantage is that it would ensure the reviews are conducted by an objective, outside group rather than by stakeholders to the process. As part of its role, the group charged with examining variations among VA facilities and their expected workloads and costs would need to advise on adding management incentives for improvements in both quality of care and cost-effective delivery. Its overall mission could be to provide oversight and analysis to the process to ensure that quality, access, timeliness, and cost-effectiveness are considered.

the delivery and financing of health care nationwide. It has identified factors that contribute to cost differences across states, such as the mix and volume of services; mix of physicians, medical specialists, and other health professionals practicing in a state; and policy-related factors such as state licensing requirements or regulations that influence the amount of labor used to provide health services. PROPAC also determined that 6 of the 10 states with the best health status were among the 10 with the lowest standardized resource costs per enrollee.²⁵

The limited effort VA has put into understanding possible reasons for variations has already achieved some change in facility management, according to the VA official overseeing the technical advisory groups of physicians and other clinicians who advise RPM on clinical issues. The Chronic Mental Illness Technical Advisory Group had assessed discharge cost, costs per day (possibly reflecting staffing levels), length of stay, and other data related to high- and low-cost facilities for chronic mental illness patients and provided facility management with information on factors potentially contributing to their facility's high or low cost.

Explore Options for Tracking Allocations by Program Area

To ensure that the RPM allocations are coordinated with those made through other allocation processes, VA needs to establish a formal process for evaluating whether non-RPM-allocated funds should be incorporated into the RPM system. In doing so, VA will need to track by facility the non-RPM allocations, by program, over the course of the year as well as those made under RPM. VA officials indicated that current financial systems would allow a manual tracking of these allocations. We believe VA needs to explore options for using existing financial management systems to capture these management data. The availability of these data would allow for better assessments of the total funding provided to facilities for patient care and the priorities that the various allocation processes use to distribute facility funding.

Explore Options for Considering Facility Differences in the Provision of Discretionary Care

To ensure that veterans within the same priority categories are afforded more equal access to care, VA needs to explore options for using the resource allocation system to achieve this goal. VA would need to assess the extent that current databases could be used to distinguish and account for the facility differences in their rationing practices and abilities to provide discretionary care. VA may also need to determine how to collect more specific data on differences in facilities' provision of care, for example, differences in the extent facilities are providing services to

²⁵PROPAC, *Medicare and the American Health Care System*, Report to Congress (Washington, D.C.: June 1995).

veterans in their area (market share) or in the extent veterans are denied health care services because of a lack of resources.

Conclusions

VA for years has struggled with implementing an equitable resource allocation method—one that would link resources to facility workloads and foster efficiency. The need for such a system has become greater in recent years as veterans' demographics shift and as health care delivery undergoes dramatic changes to adjust to increasingly limited resources. The resource allocation system can help VA achieve this goal by forecasting workload changes and providing comparative data on facilities' costs. Nonetheless, though VA has understandably focused its efforts in the first years of RPM on improving the system's data and design, VA has not taken steps to address several barriers that prevent it from acting on the data the system produces. If the system is to live up to its potential, several changes need to be made, including linking resource allocation to VA's strategic plan, conducting a formal review and evaluation of facility (or VISN) cost variations, evaluating the basis for not allocating funds through RPM, and using RPM to overcome differences in veterans' access to care.

Recommendations

We recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to

- link the resource allocation process to the strategic planning process in the VISN structure so that (1) allocations are more clearly associated with VA's long-range goals, performance standards, and workload priorities; and (2) facility and VISN managers are given short- and long-range financial objectives;
- institute a formal review and evaluation process within the resource allocation system to examine the reasons for cost variations among facilities and VISNS;
- establish a process for evaluating non-RPM patient care funds to determine whether they can be included in the RPM allocation system, including exploring options for using existing financial management systems to capture data on the provision of non-RPM allocated funds by facility and program area; and
- explore options for using existing or improved databases to (1) understand the extent to which veterans within the same priority categories have consistent access to care within the VA health care system

and (2) include such data in VA's resource allocation system to help ensure that veterans have consistent access to care throughout the system.

Agency Comments and Our Evaluation

The Deputy Under Secretary for Health, the Chief Financial Officer, and other VA officials provided comments on our draft report. They stated that the report represents an accurate and balanced analysis of VA's past efforts. The Deputy Under Secretary pointed out that VA has recently taken steps to implement changes to the resource allocation process that are consistent with the draft report's overall recommendations. He also indicated that although equity of access for veterans is a laudable goal, incorporating this goal in the allocation of resources is necessarily complex.

More specifically, VA concurred with our recommendation to link the resource allocation system with its strategic plan for its VISN structure and indicated that VISN directors have been charged with formulating long-range VISN plans. VA also concurred with our recommendation to institute a formal review and evaluation process within the RPM system to examine reasons for cost variations among facilities and VISNs, and cited some efforts already in place to begin studying these cost variations. These efforts, such as the analyses of the Chronic Mental Illness Technical Advisory Group, which we describe in the report, represent, in our view, a step in the right direction. Our recommendation for a formal review and evaluation process, however, envisioned a more structured, detailed process using the RPM database and other performance measure databases. Such a process would not only address ways to improve efficient delivery of quality care but also ways to improve the estimates and comparisons made by the resource allocation system.

VA also concurred with our recommendation to establish a process for evaluating non-RPM patient care funds to determine whether they can be included in the RPM allocation system. VA indicated that this process had already begun in that criteria for determining when resources should and should not be allocated through the RPM process had been established. VA hoped to include 90 to 95 percent of VA's health care budget in the RPM allocations system by fiscal year 1997. Because of the large proportion of resources it plans to include in the RPM process, VA stated that the second part of this recommendation—to explore options for capturing data on the non-RPM funds by facility and program area—would be unnecessary. In our view, VA's plans appear to meet the intent of our recommendation. Nevertheless, there still may be a need to track non-RPM funds by facility or

VISN if VA falls short of its stated objectives for including the maximum practical amount of health care funding in RPM. As a result, we have not changed our recommendation.

VA concurred with qualifications with our final recommendation that VA explore options for (1) using existing or improved databases to understand the extent to which veterans receive consistent access to care and (2) including such data in the resource allocation process. VA agreed with the need to explore options for improving information about veterans' access to care. However, VA also stressed that before it knows whether it could use that information to allocate resources, it would first need to define what "consistent access" really means. The agency expressed its commitment to developing that definition, even though it acknowledged that the plan for how it would do so was not fully developed. In VA's opinion, consistent access to care is complex and not easy to implement fairly so that special populations, such as the homeless and women veterans, are not adversely affected. VA stated that improving access is more fundamental than a database issue.

We acknowledge the complexity of access issues and agree that this is more than a database issue. However, we continue to believe that VA should—at a minimum—know the extent to which veterans in the different statutorily determined priority categories are being served in different medical centers and take those categories into consideration in its allocation of resources.

As arranged with your staff, unless you announce its contents earlier, we plan no further distribution of this report until 7 days after its issue date. At that time, we will send copies to the Secretary of Veterans Affairs, interested congressional committees, and other interested parties. We will also make copies available to others upon request.

If you have any questions about this report, please call me or David P. Baine, Director, at (202) 512-7101. Other major contributors to this report included Frank C. Pasquier, Assistant Director; Katherine M. Iritani, Evaluator-in-Charge; Linda Bade, Senior Evaluator; Doug Sanner, Evaluator; and Evan Stoll, Technical Analyst.

Sincerely yours,

A handwritten signature in cursive script that reads "Carlotta C. Joyner".

Carlotta C. Joyner
Associate Director
Health Care Delivery
and Quality Issues

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Abbreviations

BDC	Boston Development Center
DSS	Decision Support System
FY	fiscal year
HD	Highland Drive [facility]
HIV	human immunodeficiency virus
NHCP	National Health Care Plan
OPC	outpatient clinic
PROPAC	Prospective Payment Assessment Commission
RAM	Resource Allocation Methodology
RPM	Resource Planning and Management
UD	University Drive [facility]
VA	Department of Veterans Affairs
VISN	veterans integrated service network

Scope and Methodology

To determine the extent to which VA's RPM system provides for an equitable distribution of resources among VA facilities, we reviewed two aspects of the system as originally envisioned by VA. First, we determined the extent that it provided for comparable resources for comparable workloads. Second, we assessed the extent it provided for resources so that facilities can serve comparable categories of veterans. To make these determinations, we documented the system design and analyzed the system's impact on facility budgets.

We reviewed documents and discussed the resource allocation system with the Director and analysts of VA's Boston Development Center. Documents reviewed included the RPM Handbook, RPM Primer, BDC Draft Development Plan, and relevant BDC Newsline newsletters. We interviewed the leaders and some members of various RPM committees, including the RPM Field Oversight Committee, RPM Incentives Subgroup, the RPM Outlier Group, the Reinventing RPM Subcommittee, and the RPM Financial Advisory Committee. We also reviewed committee reports and meeting minutes.

We also analyzed various BDC RPM data files to determine the impact of VA decisions on facility budgets. The data reviewed included workload forecasts and allocation amounts related to various decisions occurring as part of the process. We relied on VA analyses of the impact of RAM and RPM on regional allocations over the past decade. We also analyzed veteran eligibility data in VA's Outpatient File and summarized by the National Center for Veteran Analysis and Statistics in its Summary of Medical Programs to assess the variations among facilities in the provision of care to discretionary categories of veterans.

Finally, we tested the sensitivity of the allocations to the accuracy of the cost and workload data feeding the RPM system to determine how coding or other errors in the cost and workload data may affect allocations under the system's current design.

To address the causes of any inequities in the distribution of resources, we interviewed various VA officials, including the Deputy Under Secretary for Health; Associate Deputy Chief Medical Director; Associate Chief Medical Director for Quality Management; Deputy Director, Quality Management Systems Office; Director, Budget Office; Chief, Medical Formulation Branch; Assistant Director for Budget Execution; Chief, Allocation and Control Branch; Chief, Health Resources Management Branch; Acting Director, Strategic Planning and Policy Office; Director and analysts of the Management Sciences Group; and Director and analysts of the National

Center for Cost Containment. To address the changes that could help ensure that the system more equitably distributes resources, we reviewed various related studies, including a contractor's study conducted in 1992²⁶ and a VA Inspector General report on physician staffing, Audit of Veterans Health Administration Resource Allocation Issues: Physician Staffing Levels.²⁷ Finally, we reviewed VA strategic plans, including VA's Blueprint for Quality, the unpublished National Health Care Plan, and the VA Secretary's plan for restructuring VA, entitled Vision for Change.

To understand the RPM system's impact on the Carl T. Hayden Medical Center in Phoenix, we visited the facility and interviewed key management officials. We also reviewed the report of a Western Region task force looking at the allocations awarded to Carl T. Hayden and met with officials of the Western Regional Office.

Our review was limited to the resource allocation process as it operated for the fiscal year 1994 and 1995 allocation process. The VA appropriation for fiscal year 1996 had not been determined at the time of our review. Our review was limited primarily to the process as it was used to allocate and manage facility budgets and did not include a review of other goals, such as how the process is used to formulate VA's budget.

Our review was conducted between December 1994 and October 1995 in accordance with generally accepted government auditing standards.

²⁶Ann M. Hendricks and Henry G. Dove, Review of the Resources Planning and Management System: Report to the Management Decision and Research Center (Boston: Management Decision and Research Center, Nov. 1992).

²⁷Report No. 5R8-A19-113 (Washington, D.C.: Sept. 29, 1995).

VA's Resource Planning and Management System

The Resource Planning and Management system is the management decision process VA uses to allocate most of its resources and to compare VA medical facilities' performance. The system provides the information VA uses as a basis for resource allocation by classifying each patient into a clinical care group, calculating the cost per patient, and forecasting future patients. The system also provides comparative data on facility cost per workload unit so that funds can be reallocated from the high- to low-cost facilities.

VA Resource Allocation History

Each year, VA receives an appropriation to operate its health care system—about \$16.2 billion in fiscal year 1995. To finance its medical care system, VA uses what is considered a “global budgeting” system. VA calls it that because of its fixed budget—resources are first approved by the Congress, then allocated to individual facilities for the ensuing fiscal year. VA facility directors are charged with managing their assigned workload targets within their allocated budgets. Before 1985, VA Headquarters developed facility budgets by incrementally adjusting the facilities' past budgets rather than building the budget based on the facilities' expected workload.

Beginning in fiscal year 1985, VA attempted to modify its incremental budgeting process of making adjustments to historical budgets. This new system, called the Resource Allocation Methodology, was intended to provide a more equitable distribution of available funds by adjusting budgets according to the work produced and its associated cost. RAM tried to match resources to facility workloads by linking allocations to the reported clinical services or procedures performed in each of three areas—acute care, ambulatory care, and long-term care. RAM was suspended in 1990, however, because of concerns about the unintended impact on clinical practice patterns and administrative management of VA medical care. Under RAM, facilities and regions competed with each other for a fixed resource pool. Facilities began acting as if VA had an open-ended reimbursement system—having incentive to perform work beyond their resources—when in reality it was a closed, fixed budget system. This open-ended expansion of workload led to a budget crisis at a number of VA facilities and caused concern about the potential impact on quality of care.

After RAM was suspended, VA began moving to a new system—RPM—that would be more prospective and capitation-based—in line with where the private sector was heading. RPM was to be prospective in that the process

forecasted workload changes and future facility resource requirements, enabling VA to use the data to formulate its budget. RPM was "capitation like" in that it was designed to consider workload on a per person basis, rather than as procedures performed.²⁸ This new definition of workload was expected to lessen the incentive to inappropriately provide care. RPM was used for the first time to allocate facility resources for fiscal year 1994.

The RPM system differed from RAM in several ways. First, VA envisioned a broad management decision process with RPM that would integrate planning, budgeting, and operational management. VA expected RPM to be used to formulate the Veterans Health Administration's budget from year to year, to be linked to and driven by VA's strategic plan, and to be used to review and evaluate facilities' unit costs.

RPM Committee Structure

VA's considerable investment in RPM is reflected in the significant involvement of VA managers, technicians, and physicians from throughout the country serving on RPM committees. In total, several major committees and subcommittees, six technical advisory groups of clinicians generally representing the RPM clinical patient groups, and key VA Headquarters managers have been involved in RPM's design and implementation. Operationally, the Boston Development Center, a group of about 26 staff with a fiscal year 1995 budget of \$3.3 million, is responsible for RPM data processing and education. The RPM development and management structure includes the RPM Subcommittee and Field Oversight Committee and the technical advisory groups, which are responsible for, among other things, incorporating clinical definitions into the RPM system. In addition, the process includes input from each of the four VA regions (replaced by VISNs in fiscal year 1996) and all facilities. While the various RPM committees, subcommittees, and advisory groups make recommendations on how the system should be implemented, the Budget Policy and Review Committee, comprising VA associate chief medical directors and other senior VA managers, makes the final recommendation on RPM methodology, which the Under Secretary for Health approves.

Summary of the Process

BDC uses a complex data compilation and analysis process to develop data that VA Headquarters and other managers use to determine facility

²⁸Generally, capitation means paying providers a flat fee in advance to take care of members' health care needs during a defined period according to an agreed-upon benefit package and copayments, as necessary. For VA to have such a system, many legislative and other barriers would have to be addressed. See Barriers to VA Managed Care (GAO/HEHS-95-84R, Apr. 20, 1995).

allocations. Key decisions made by RPM committees and approved by Headquarters managers have dictated the final outcome of the facility allocations, as described here and in appendix III. Generally, the RPM budget allocations to the facilities have been driven by the number of (case-mix-adjusted) unique patients expected to be seen and the facility-specific unit cost of providing care. "Unit costs" refer to each facility's average cost for treating a patient in each of five RPM patient groups. The key steps in the process are as follows:

- Patient classification: Using clinical information, VA classifies each veteran seen in the base year into one of 49 clinical classes ranked by resource intensity.²⁹ The patient classes are intended to reflect the kinds of medical care being provided. A patient who qualifies for two or more classes is placed in the most resource-intensive class.
- Patient (workload) counts: VA counts the unique patients in each class at each facility.
- Workload forecasts: VA predicts changes to the numbers of patients expected to be seen within each class by applying forecasting methods to historical trend data.³⁰
- Patient costing: Using facility "bed-days of care" provided and other clinical information from VA's Patient Treatment File, Outpatient File, Patient Assessment File, and other data sources, combined with facility cost data from the Cost Distribution and other cost reports, VA estimates a total cost for each patient.
- Patient groups: VA groups the patients within each class into one of five major patient groups and calculates an average facility cost per patient within each group.

Using the data developed in these steps, VA establishes the facility target budget allocation through a series of calculations. First, average facility costs per patient group are multiplied by the expected numbers of patients to be seen at the facility within each group. These initial facility numbers are then adjusted to reflect marginal costs associated with increased and decreased workload, VA budget constraints, facility efficiencies, inflation,

²⁹Unique patients are classified into one of 49 classes (such as lung transplants, end stage renal disease, stroke, substance abuse, and oncology) that are then contained within one of five patient care groups—transplants, special care, extended care, chronic mental illness care, and primary care. For the fiscal year 1996 process, VA intends to increase the number of patient classes to 51.

³⁰RPM used actual patient data through fiscal year 1993 as the basis for fiscal year 1995 allocations and future budget projections. RPM forecasts patients at the class level using one of five methodologies (population-based, Bayesian, rate-based, average of population and Bayesian, and manually set forecasts). RPM applies the projection methodology selected by VA management to best represent national and facility workload trends or national policy direction.

and VA regional input. These adjustments are described in detail in the sections that follow.

Marginal Rate Adjustment

The RPM process has applied "marginal rates" in calculating the incremental resource needs facilities have given their changing workloads. In other words, marginal rates account for the expected resources needed for seeing one additional or one less patient. VA decided to use marginal rates because of the assumptions that, given the relatively fixed nature of some operating costs such as salaries, workload increases would not have to be funded at the same rate as the base budget workload and that facilities with decreasing numbers of patients could not be expected to reduce their per patient costs at the same rate as their base budget. VA has not determined the true incremental cost per patient, however. Officials indicated they judgmentally chose a 75-percent marginal rate for workload increases and a 50-percent marginal rate for workload decreases to reflect incremental costs associated with workload changes.³¹

Adjustment to Accommodate Budget Shortfalls

Because VA has not had enough funds to fully cover all of the expected facility costs, VA officials chose to address the shortfall in both fiscal years 1994 and 1995 by applying an "implementation rate" to provide a percentage of the funding that facilities had been expected to get for workload changes. The implementation rate in both fiscal years 1994 and 1995 was 17.36 percent. The impact of the implementation rate, and how it was applied, is more fully discussed in appendix III.

Cost-Efficiency Adjustment

To measure and provide in the allocations for differences in facility efficiency, the RPM system uses a complex process for comparing like facilities' costs. Through this process, VA removes funds from the budgets of the "least efficient" facilities (called high outliers) to provide more funds to the "most efficient." The outlier process involves grouping comparable facilities, adjusting costs to make comparisons more equitable, and developing cost-efficiency and productivity data for facility comparisons and for the outlier process.

VA Facility Groupings

To compare facility costs, the process first groups facilities considered comparable. The nine medical center groups used in the fiscal year 1995

³¹The VA Budget Director indicated the 75/50 marginal rate percentages were a result of knowledgeable VA officials' judgment and consideration of several years' experience. He also indicated that the marginal rate for fiscal year 1996 is expected to be 75 percent for both workload increases and decreases.

process were created by merging the hospital groups used for planning purposes and a complexity index. The complexity index is based on a number of variables, including facility size, clinical variety, resident teaching mission, resident programs, allied health training, managerial complexity, and research.

VA Cost Adjustments for Facility Comparisons

To more fairly compare facility costs per workload, the process adjusts for case mix differences (that is, differences in the types of patients treated at each facility) by developing a standardized workload measure called facility work or facwork. Facwork is an age- and case-mix-adjusted workload measure that recognizes that different classes of patients have different resource intensities. For example, a transplant patient is more resource intensive than a primary care patient. Facwork is calculated solely on costs, recognizes that VA patients may visit more than one facility, and allows workload credit to be shared among facilities.

In fiscal year 1995, a cost adjustment process was developed to "level the playing field" by adjusting for facility-specific cost and workload factors in order to make fairer cost comparisons. The costs removed from the facility comparisons included those for resident training, research, geographic pay, and specialized programs. In addition, workload was adjusted for fee and contract programs and for high-cost programs. This process ensured that the costs for a facility that provided extensive resident training, for example, were not used in comparing that facility with others in its group.

VA Efficiency Comparisons and Allocation Adjustments

Once the cost adjustments were made to provide for fairer comparisons, VA ranked the facilities within each facility group. This ranking and the supporting data were provided to each facility for data validation before the final allocations were made. RPM also produced data showing productivity comparisons, that is, comparisons for facilities within each facility group of the staff level per workload.

VA used the resulting cost comparisons in its outlier process to adjust the initial allocations. Through this process, funds from the initial projected budgets of high-cost facilities were removed and added to the budgets of low-cost facilities. The high- and low-outlier facilities were identified based on their differences from the group average. RPM resources were withdrawn for high outliers using a sliding scale of up to 1 percent and added to low outliers at a flat rate of 1.25 percent until the amount that VA officials decided to reallocate was reached. Approximately \$10 million was

moved between the high- and low-cost outliers in fiscal year 1994, and approximately \$20 million was moved in fiscal year 1995.

Inflation

The inflation adjustment is facility-specific and is based on locality pay adjustments and specific assumptions included in the President's medical care budget. Inflation rates varied from 4.1 to 16.7 percent in fiscal year 1995 and averaged 6.3 percent.

Regional Directors' Adjustments

The four regional directors had the authority to change the initial allocations that BDC produces through its data analyses process; however, we identified few instances in which regional directors actually changed the initial allocation numbers. Regional input to the facility allocation process has been mainly through a \$5 million allocation over which each regional director had discretion and for which facilities "negotiated." The negotiations were considered part of RPM's management process, which was intended to allow for facility-specific factors not captured in the RPM data. Each regional director developed his or her own criteria for allocating resources, subject to VA Headquarters approval. The criteria and methodologies used by regional directors for their allocation funds varied. For example, one region in the fiscal year 1995 process allocated its \$5 million on the basis of facility market share, unit cost differences, and the impact of workload and outlier adjustments. Another region removed allocations for forecasted workload increases from high outliers to create a regional contingency fund.³²

In the fiscal year 1995 negotiation process, 56 percent of the facilities had their dollar base adjusted, with 84 facilities gaining and 10 facilities losing funds. The gains ranged from \$2,798 to \$1.5 million, and losses ranged from \$83,000 to \$712,277. See appendix IV for fiscal year 1994 and 1995 RPM adjustments for each facility.

RPM Data Sources and Sensitivity to Data Errors

The RPM system relies on data from many data sources within VA, including the Cost Distribution Report, Patient Treatment File, Outpatient File, Patient Assessment File, Fee File, Immunology Case Registry, and the Home Dialysis Reporting System. Each facility director is responsible for ensuring the accuracy of patient care workload and cost data, and most facilities have data validation committees responsible for the review of

³²These allocations in some cases acted as a buffer to the outlier changes because regional directors provided funding to high outliers that had lost money through the outlier process.

internal controls, data collection procedures, and adherence to reporting instructions, among other things. Once BDC obtains facility data, it merges the basic patient care data sets into its relational databases and produces RPM reports known as the facility "tables." These tables are distributed to facilities for data validation.

We have previously reported concerns about some aspects of VA's cost and workload system. Specifically, we reported in 1987 that one problem VA had in implementing RAM, RPM's predecessor, was that unreliable clinical and financial databases limited VA's ability to establish accurate target allowances for individual facilities.³³

RPM relies less on specific clinical diagnoses coding than RAM because workload is defined as the whole patient and the patient's associated costs rather than being based on specific clinical diagnoses. Furthermore, RPM includes most facility operating costs in developing patient cost averages and uses each facility's historical workload costs in developing allocations, reducing the chance that facility cost errors would significantly affect allocations. For example, costs inappropriately allocated to one cost center would result in lower than actual costs being reflected in others. Because RPM captures most patient care costs in calculating patient cost averages, these misallocations would show higher than actual costs for some patient types, but lower than actual costs for others. For these reasons, it appears that potential inaccuracies in the clinical and cost data are less likely to affect facility allocations under RPM than under RAM.

Our sensitivity analysis of the RPM facility allocations to workload and cost errors supports this conclusion. Our analysis found that even with potential errors of up to 50 percent in the reported workload levels or patient group costs, the budget allocation for the majority of the facilities would change less than 1.2 percent. The maximum change for any facility under our analysis was a 2.03-percent increase in allocation and a 2.27-percent decrease. We believe that our tests represent extreme error rates and that these changes are far greater than those VA is likely to experience.

Process Changes

The RPM process has changed significantly from year to year and continues to do so. For example, the fiscal year 1994 facility budgets were developed

³³See VA Health Care: Resource Allocation Methodology Should Improve VA's Financial Management (GAO/HRD-87-123BR, Aug. 31, 1987).

using per patient average costs for each of the 49 patient class levels; whereas, fiscal year 1995 funding was based on the average patient costs within each of the five patient groups. VA hoped that the move to group costs would reward those facilities that increased the number of low-cost patients. The move to group costs was also intended to eliminate the significant incentive to admit a patient just to obtain funding at the higher valued RPM class.

The fiscal year 1996 RPM allocation is expected to shift the funding mechanism from facility-specific patient costs more toward a systemwide capitation rate. For the first time, VA officials told us, they intend to base RPM allocations on a "blended rate" to achieve a balance among national, regional, and local cost considerations. The blended rate may include facility, medical center group, VISN/regional, and national components. The magnitude of blended rates at the facility level depends heavily on the relative weights attributed to each component; for example, the blended rate could be based on 90 percent of each facility's costs, with the remaining 10 percent based on average national and facility group costs. VA officials indicated that blended rates will eliminate the outlier adjustment process that has been in place for the last two RPM allocations. Under a blended rate, all facilities, rather than only those considered "outlier" facilities, would see their initial budgets change based on the process. The farther the facility lies above or below the mean, the more the facility would lose or gain under the process.

Resource allocation within VA could further change with the VISN implementation. A significant goal for the agency under the VISN reorganization is to move to a full capitation system in which a unit of payment is based on the enrollee—for example, a certain fee would be paid per member per month or year of enrollment for a defined package of covered health services. At issue is how soon, given the many barriers to implementing full capitation, VA will be in a position to allocate resources under full capitation.

Provisions for Comparable Resources for Comparable Workloads

For the last decade, VA has sought through its resource allocation systems to better link resources to workload and depart from its traditional process of basing allocations on historical budgets. Part of the need for this better link stems from the shifting demographics of veterans across the nation. RPM data show that facilities' per patient costs vary widely, even after adjustments are made to ensure cost comparisons fairly exclude costs that facilities cannot control. The data also show changing facility workloads. VA changes to facility budgets have generally averaged about 1 percent per year through the process. Two key VA decisions account for the limited change: the funding of workload changes was limited and the adjustments from high- to low-cost facilities were limited. This conservative implementation of RPM continues VA's history of limiting changes to facility budgets from year to year.

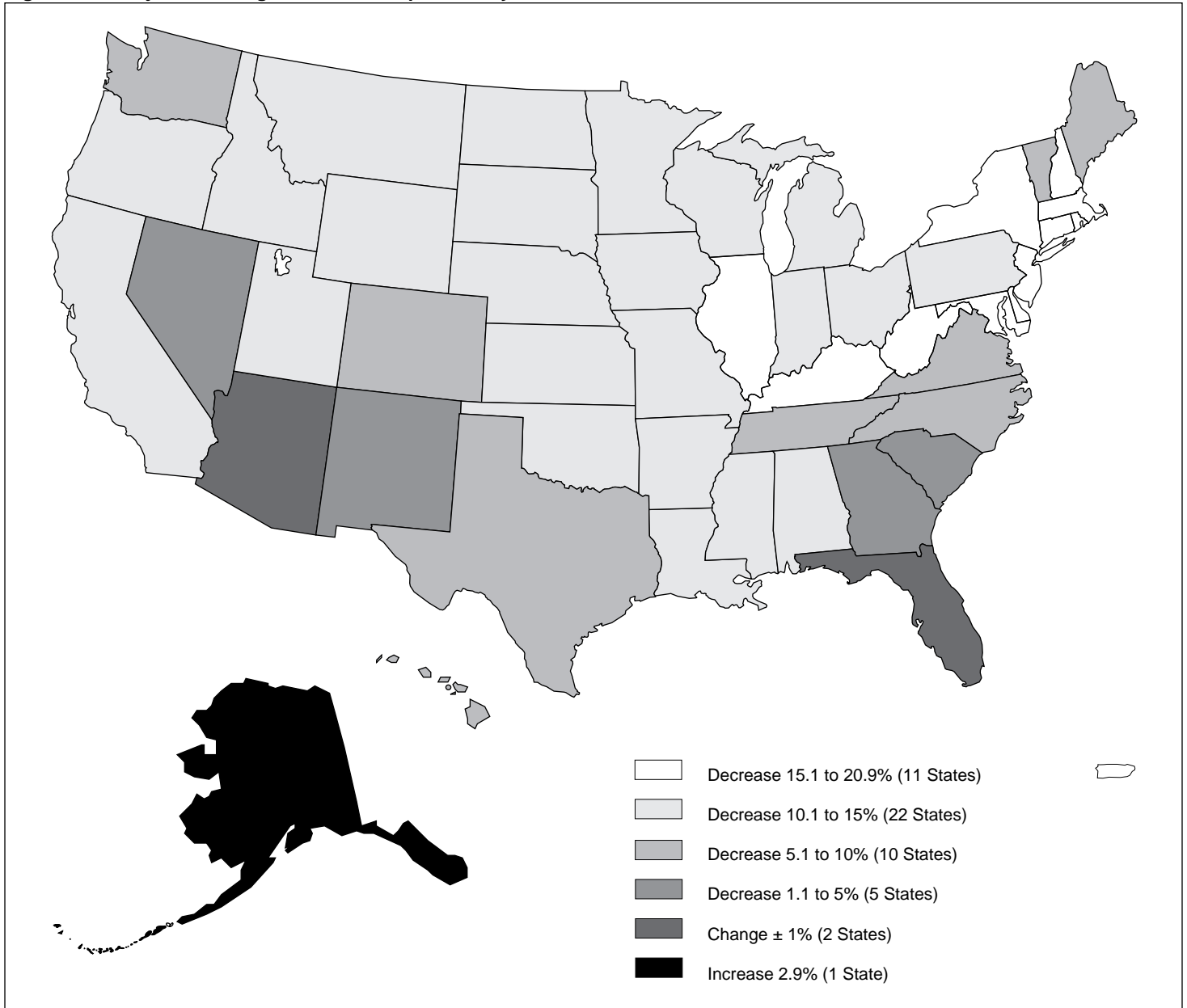
Changing Veteran Demographics

Over the last decade, although the overall veteran population has decreased, veterans have been migrating from northeastern and midwestern states to southeastern and southwestern states. Nationally and in each of the 50 states and the District of Columbia, veteran deaths are expected to outnumber separations from the armed forces. Therefore, the only states expected to have stable numbers of veterans in their populations through the year 2000 are those to which enough veterans migrate to offset deaths of veterans in the states' existing populations. For example, 60,000 veterans are expected to move to Arizona between 1989 and 2000, offsetting the deaths of veterans already living in that state.

Figure III.1 shows projected veteran population change by state, based on Census data, from 1989 to 2000.

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Figure III.1: Projected Change in Veteran Population by State, 1989 to 2000



Source: VA Statistical Service, Research Division.

Facility Variations in Resource Distribution and Workload Changes

Per patient facility costs vary significantly among facilities, ranging from less than \$800 per patient to over \$11,000 per patient. While the basis for allocations is each facility's historical average cost per patient within each of the five RPM patient groups, the system also provides comparative data to include facilities' cost efficiency, productivity, and workload changes. A discussion of some of the facility comparisons shown by the RPM system follows.

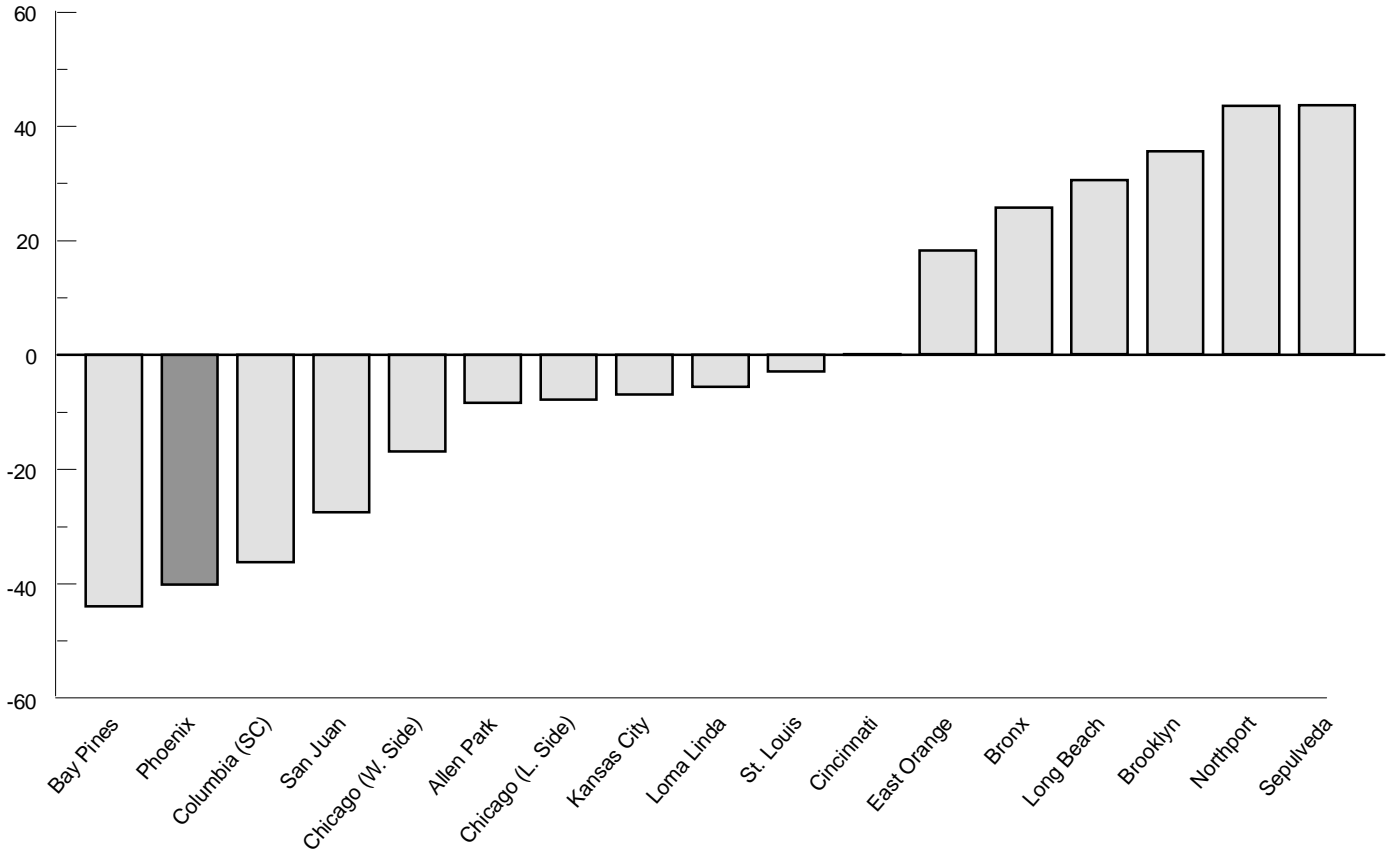
Cost-Efficiency Data

Much of the difference in facility per patient costs can be explained by differences in mission, for example, the level of specialized care facilities may be providing. An outpatient clinic, for example, is likely to spend far less per patient than a hospital that provides specialized services such as organ transplants. As discussed in appendix II, to provide for comparative data, the system places facilities into groups with other facilities VA considers comparable. This "grouping" of comparable facilities, along with the classification of patients by clinical type, lessens the range of differences in costs, as shown in figure III.2 for Facility Group 5.

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Figure III.2: Facility Unadjusted Per Patient Cost Differences, Facility Group 5

Percentage Difference From Average



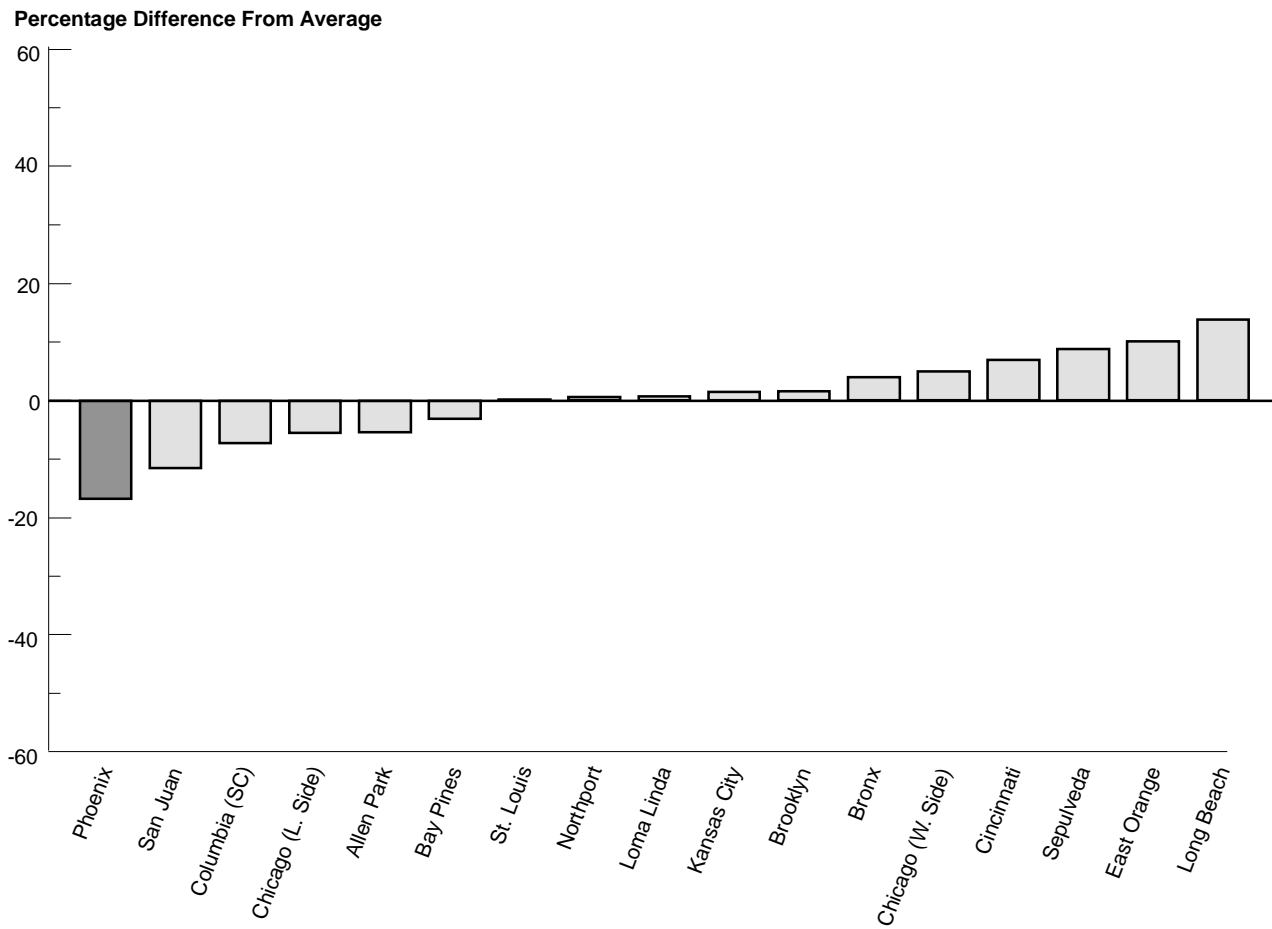
Note: L. Side = Lakeside facility; W. Side = Westside facility.

Source: GAO analysis of RPM data.

Even after adjusting for facility locality pay and other uncontrollable cost differences, variations among facilities within each of the RPM groups remain, as shown in figure III.3.

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Figure III.3: Facility Adjusted Costs Per Workload Unit, Facility Group 5



Note: L. Side = Lakeside facility; W. Side = Westside facility.

Source: VA RPM data.

Productivity Data

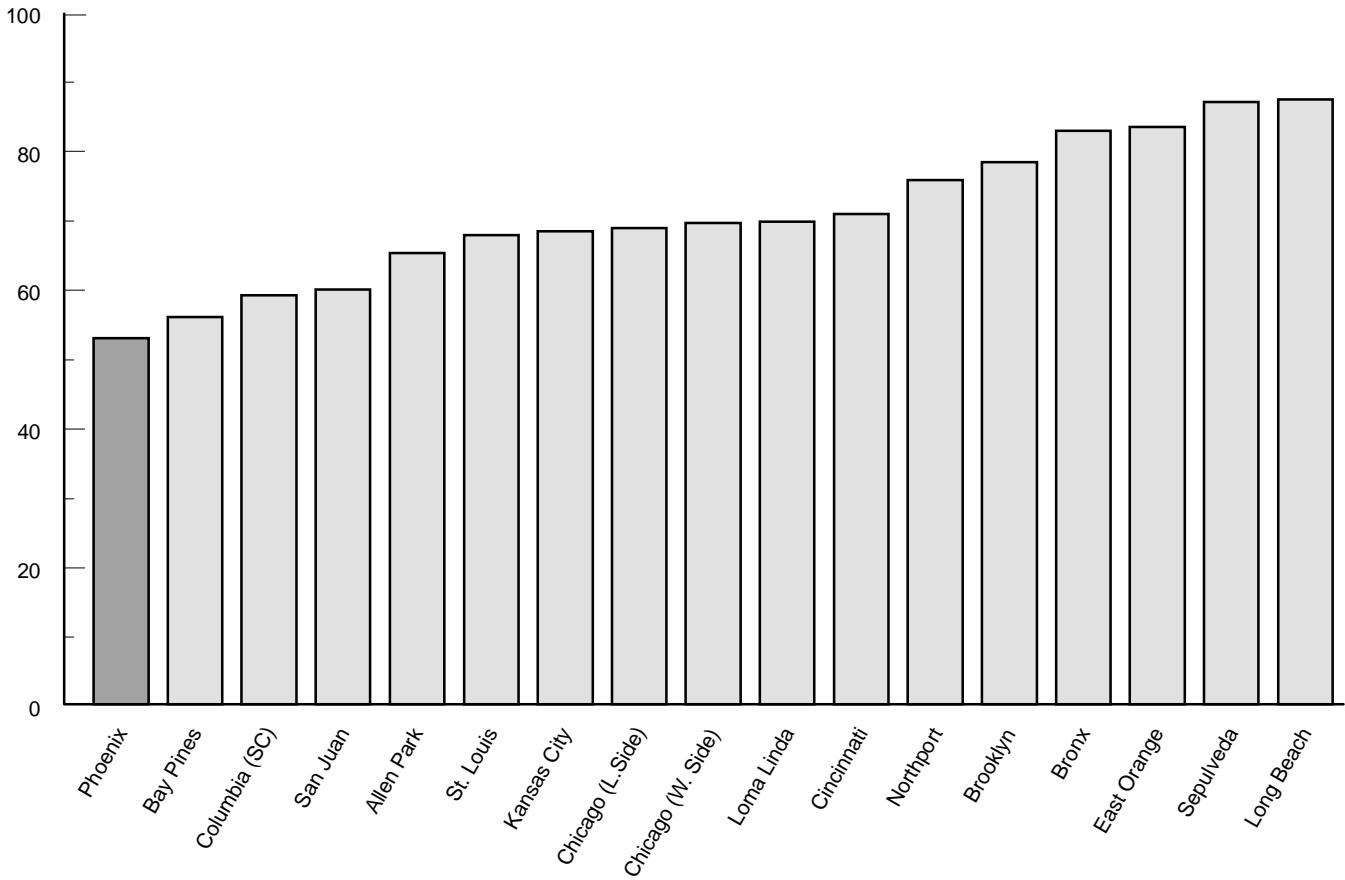
The system also produces data on productivity differences among facilities, as shown, for example, by differences in physicians per standard workload units³⁴ as well as total staffing per workload unit. Figure III.4 shows an example of these data for Facility Group 5.

³⁴These standardized workload units, called facility work or facwork, are described in appendix II.

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Figure III.4: Variations in Full-Time Employees Per 1,000 Workload Units, Facility Group 5

Full-Time Employees per 1,000 Workload Units



Note: L. Side = Lakeside facility; W. Side = Westside facility.

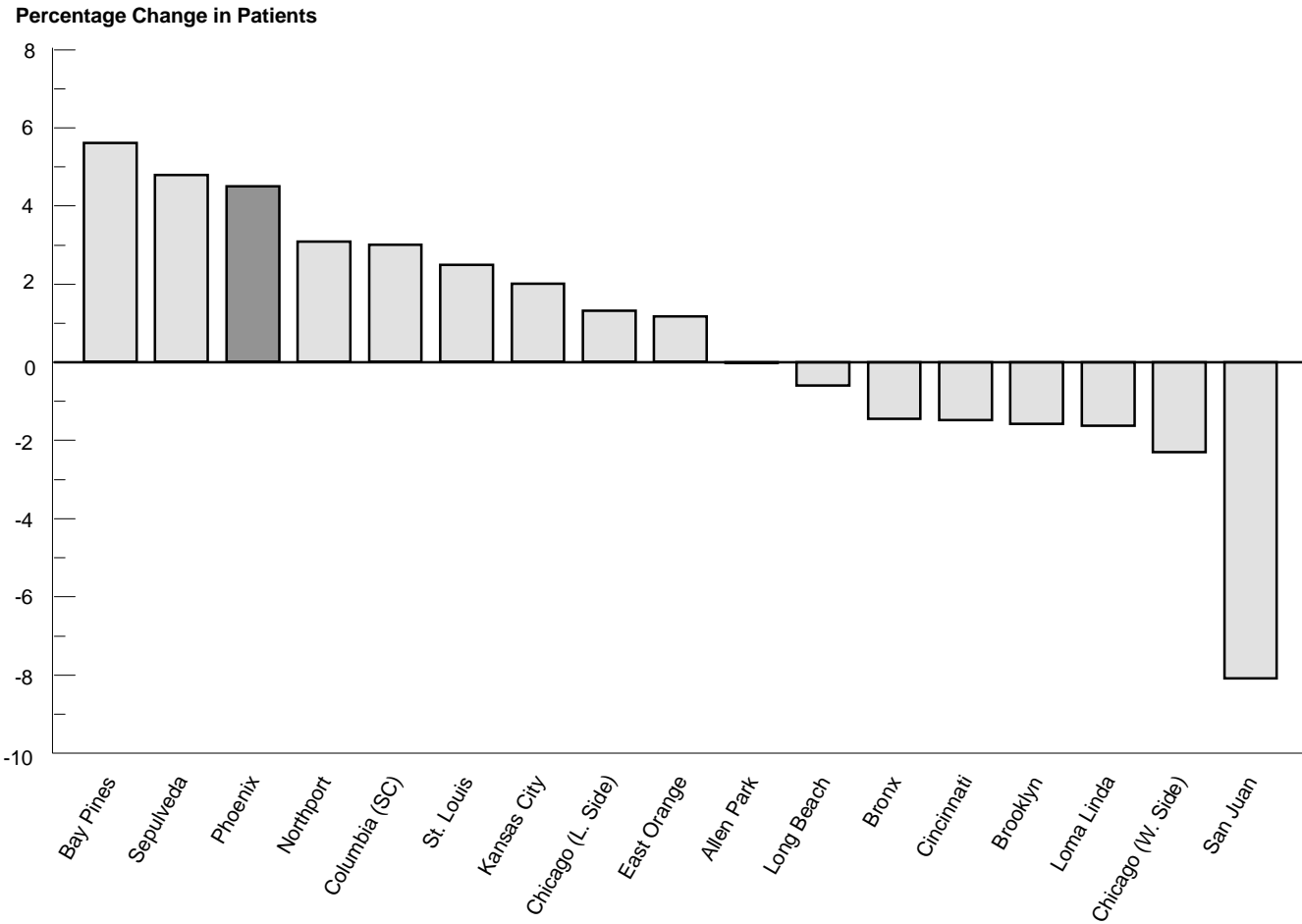
Source: VA RPM data.

Data on Workload Changes

As discussed in appendix I, the system estimates workload changes through its forecasting process. The differences in expected workload for Facility Group 5 are shown in figure III.5.

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Figure III.5: Variations in Forecasted Workload Changes, Fiscal Years 1993 to 1995, Facility Group 5



Note: L. Side = Lakeside facility; W. Side = Westside facility.

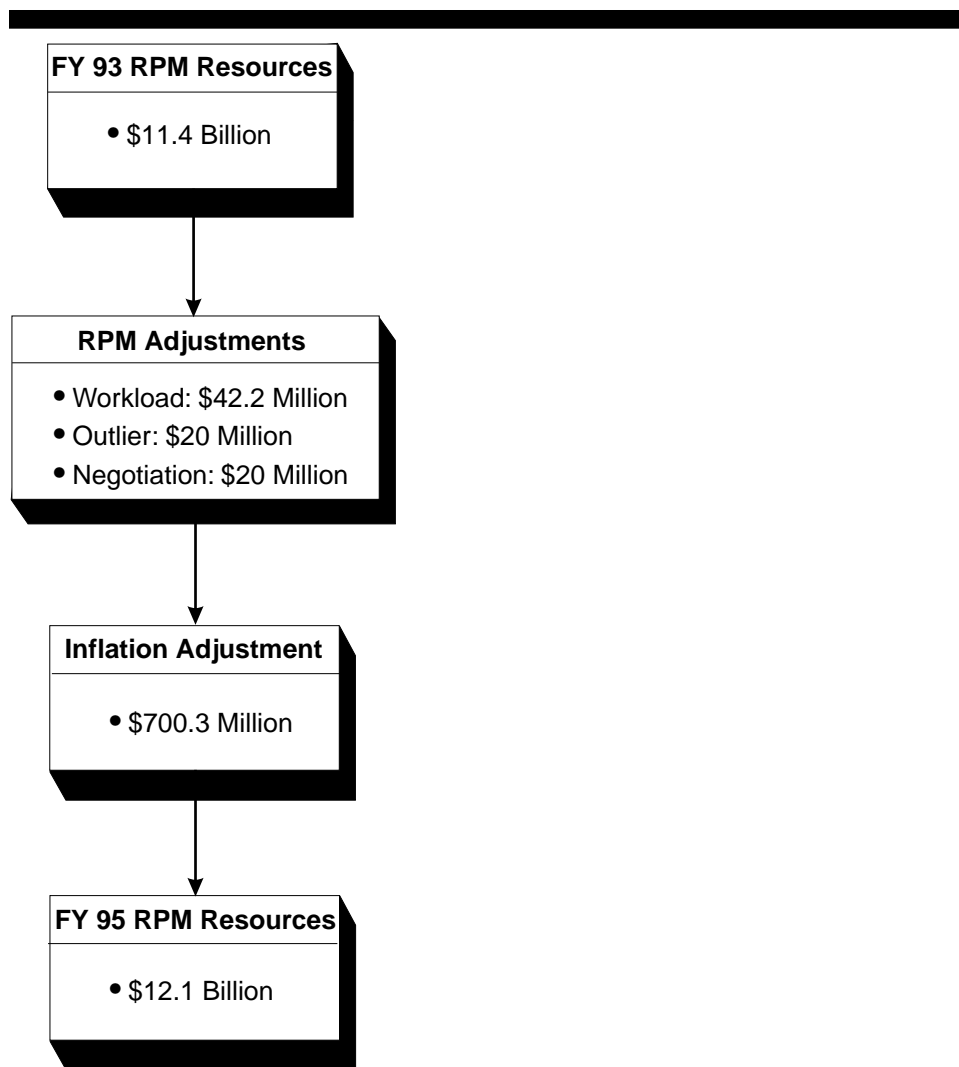
Source: VA RPM data.

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The system increases or decreases occur in three areas—forecasted workload changes, the outlier adjustments, and negotiation adjustments. Facility-specific inflation adjustments are also built into the facility budgets.³⁵ The extent of these changes nationally is shown in figure III.6. Appendix IV contains facility-specific RPM budget adjustments.

³⁵For the purposes of our review, inflation adjustments were not considered part of the RPM system adjustments. The adjustments are discussed further in appendix II.

Figure III.6: RPM Adjustments, Fiscal
Year 1995 Allocations



Source: GAO analysis of RPM data.

Facility Budget Changes Under RPM

The actual impact of the RPM system on historical facility budgets has been small. RPM-related budget adjustments to the facilities' fiscal year 1995 budgets generally represented less than 1 percent of the total dollars budgeted. The maximum real loss any facility had because of RPM adjustments was 1 percent. While one facility gained as much as 3.4 percent in uninflated funds through the process, the average gain was also about 1 percent.

Key VA Decisions Limiting Facility Budget Change

VA's decisions to limit the budget changes of facilities are reflected in two key ways: the manner in which VA decided to fund workload changes and deal with shortfalls between expected resource needs and the actual funds available, and the amount of money VA decided to reallocate among facilities after comparing their workload costs.

Funding of Workload Changes Was Limited

Because the RPM system forecasts showed that facilities would need more money than was actually available, VA officials decided to address the shortfall by funding only a proportion of facilities' expected needs. The implementation rate, however, was applied in a manner to reduce only those funds going for expected workload increases, that is, the costs for workload above and beyond each facility's historical workload base. So, although facilities were funded at 100 percent of their past budgets, the facilities' costs for forecasted additional patients were funded at 17.36 percent. Because VA already reduced expected needs to account for marginal costs associated with workload changes, in effect, a facility with a forecasted increase of one patient received a funding increase of 13 percent of its historical per patient costs.

VA officials also applied the implementation rate to budgeted costs for workload decreases. This had the effect of limiting the amount of resources a facility lost through the process and of giving more money to facilities with decreasing workloads than they were projected to need. Facilities with forecasted decreases received only a funding reduction of 8.8 percent of their historical patient costs for each patient they were expected to lose. One facility that would have lost over \$3 million in fiscal year 1995 because of forecasted workload decreases at the marginal rate lost only about \$533,000 after the implementation rate was applied.

For fiscal year 1995, all facilities received workload adjustments to reflect forecasted patient changes, with 147 facilities receiving additional funds and 20 facilities receiving less funds. The gains ranged from about \$700 to \$1.4 million, and the losses ranged from about \$80 to \$533,000. For fiscal year 1994, 124 facilities received additional funds for workload increases, and 43 received funding reductions for workload decreases. Gains for fiscal year 1994 ranged from about \$1,200 to \$1.6 million, and losses ranged from \$2,300 to \$676,300. See appendix IV for facility-specific RPM budget adjustments.

VA's decision to fully fund historical workload and limit workload changes favors the status quo. For example, VA could have treated historical and forecasted workload equally within its fixed budget. By applying an

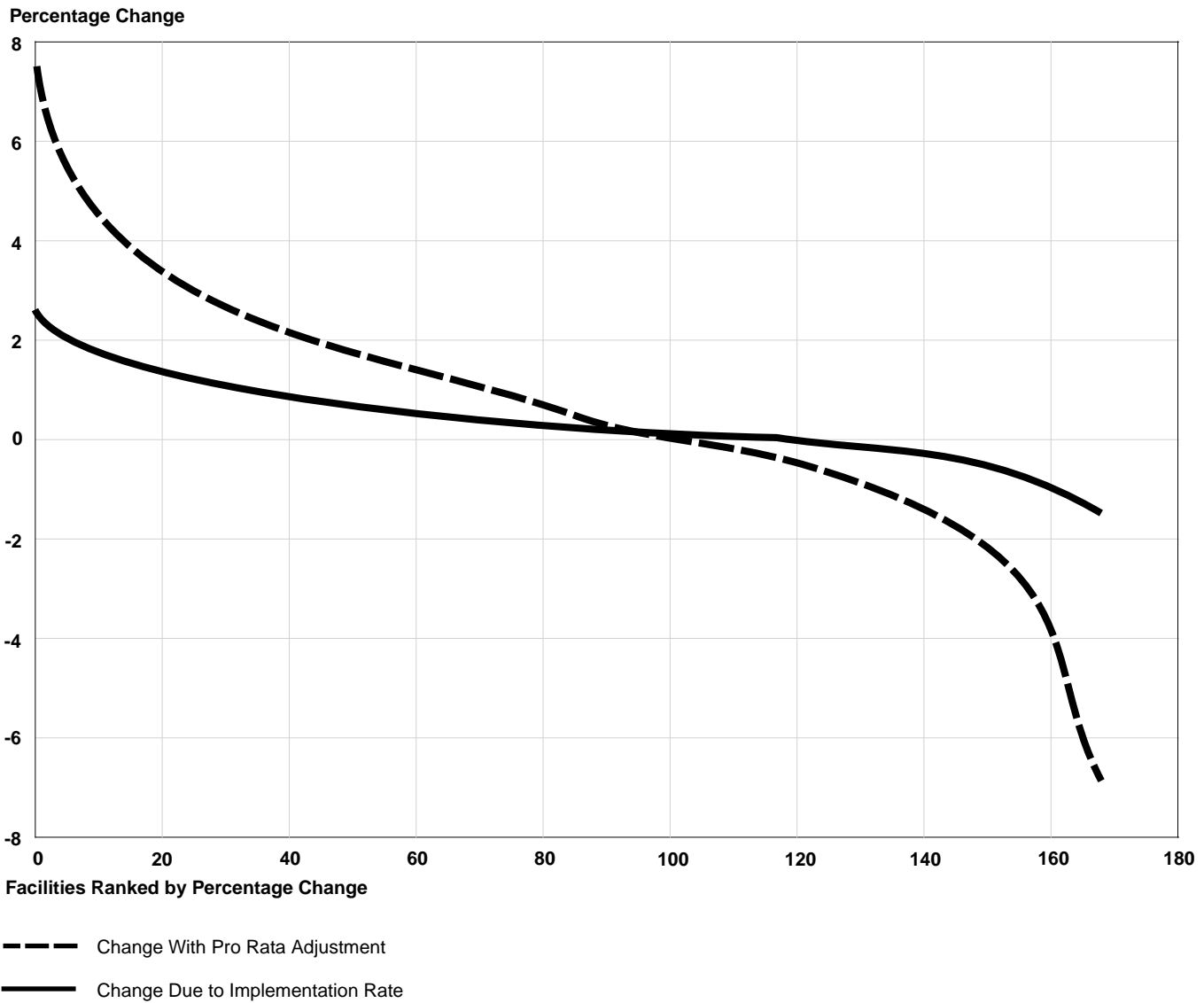
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implementation rate to workload changes, rather than the cost of all workload, VA limited the impact of the budget changes that facilities would have faced if funding were available for all workload. The impact of the implementation rate compared with the impact of taking a pro rata share of each facility's total budget is shown in figure III.7.³⁶

³⁶Analysis does not include regional directors' adjustments because these were considered management decisions apart from the RPM forecast and outlier analyses and were not included in the RPM database. Appendix IV contains all RPM adjustments for each facility.

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Figure III.7: Comparison of Funding Adjustments: Implementation Rate Versus Pro Rata Adjustment



Source: GAO analysis.

VA Efficiency Adjustments
Limited

One of VA's original visions for the RPM system was to use it to lower unit costs or promote efficiency. Through the adjustment process, VA moves resources from the "least efficient" or high-cost facilities to the "most efficient" or low-cost facilities. Despite wide variations in the workload

costs among facilities, VA has limited the reallocation of dollars to promote efficiencies among facilities to a small portion of their overall budgets. Part of the reason for this conservatism is that VA does not have a standard measure for what facilities' unit costs should be. Furthermore, VA has not determined how other elements of workload, such as the timeliness or quality of care, should be considered.

VA officials have chosen to limit the outlier impact on any facility to 1 percent of its historical budget and to limit the total outlier adjustments to \$10 million among all facilities in fiscal year 1994 and \$20 million in fiscal year 1995. In the most recent outlier process (fiscal year 1995), 35 percent of the facilities had their dollar bases adjusted, with 32 high outliers and 27 low outliers. The gains ranged from about \$226,000 to \$2 million, and losses ranged from about \$100,000 to \$1.6 million. Appendix IV contains facility-specific RPM budget adjustments.

VA officials indicated that the reallocation of funds through the outlier process is difficult in part because of the lack of a standard within VA for what unit costs should be. Without such a standard, it is unknown whether high-cost facilities do not represent what costs should be or whether low-cost facilities are actually ideally efficient and should not be made inefficient by providing them with more funds. Further complicating the matter is the concern that workload is also subject to differences in quality of care. Facilities may have higher costs because of quality differences rather than simple inefficiencies, for example.

VA, as part of its VISN plan, is working to agree upon performance measures that could be used in assessing VISN managers' performance. Many measures that VA is currently capturing are being considered, such as those measuring patient satisfaction, inpatient and ambulatory quality of care, and financial management and efficiency. However, whether the measures, once agreed upon, will be used in resource allocation decisions is not specified in VA's VISN plan.

Resource Shifts Over the Last Decade Within VA

The trend over the last decade within VA—not just the 2 years that RPM has been used to allocate resources—has been to limit the extent facilities experienced budget shifts from year to year. Our 1989 report on VA resource allocation and VA analyses of budget changes over the last decade indicate that resource shifts among facilities and regions have been a small percentage of overall budgets since 1985 when VA first implemented RAM.

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In August 1989, we reported that the RAM-related efficiency adjustments to facilities' budgets generally represented less than 2 percent of the total dollars budgeted.³⁷ The adjustments were small in relation to the facilities' budgets because VA established a maximum amount that a facility's budget would be increased or reduced to cushion RAM's financial impact. We also reported that as facilities incurred expenses during the year, facility directors could request additional funds from regional directors. Thus, the regions served as safety nets to help facilities cope with financial pressures.

Had the caps on budget adjustments not been in place, the facilities would have experienced significantly larger gains or reductions as a result of the RAM process. The funds transferred among facilities would have totaled \$153.2 million, or 223 percent more than the \$47.4 million transferred.

VA documentation confirms that the allocations made among VA regions based on the RAM and RPM system data were relatively small, as shown in table III.1.

Table III.1: VA Analysis of Percentage of Budget Reallocations Among Regions

	Percentage change		
	FY 1985-90	FY 1994-95	8 years under RAM/RPM
	6 years under RAM	2 years under RPM	
Region 1	-2	0	-2
Region 2	0	1	1
Region 3	1	1	2
Region 4	-1	1	0
Net change	-1	1	0

Source: VA RPM Financial Advisory Committee.

³⁷GAO/HRD-89-93, Aug. 18, 1989.

RPM Budget Changes by Region and Facility, Fiscal Years 1994 and 1995

Figure IV.1: Eastern Region, Fiscal Year 1995

State	Facility	RPM adjustments				FY 95 historical budget	Percentage RPM increase/decrease FY 1993-95
		Workload	Outlier	Negotiation	Total RPM		
Connecticut	Newington	\$216,859	\$0	\$61,742	\$278,601	\$31,838,195	0.88
	West Haven	511,037	0	541,172	1,052,209	99,545,523	1.06
District of Columbia	Washington	673,467	1,316,204	1,044,661	3,034,332	105,296,256	2.88
Delaware	Wilmington	179,037	0	0	179,037	40,110,926	0.45
Massachusetts	Bedford	353,838	0	0	353,838	67,236,219	0.53
	Boston	(396,659)	0	0	(396,659)	126,964,495	-0.31
	Brockton/West Roxbury	236,376	(1,210,923)	(236,000)	(1,210,547)	131,622,031	-0.92
	Northampton	158,871	0	387,485	546,356	43,402,729	1.26
Maryland	Baltimore	111,566	0	0	111,566	73,546,234	0.15
	Fort Howard	(177,411)	(248,040)	3,852,277	3,426,826	25,571,137	13.40
	Perry Point	363,896	0	382,681	746,577	58,085,727	1.29
Maine	Togus	587,122	(546,985)	(587,000)	(546,863)	55,814,809	-0.98
New Hampshire	Manchester	178,974	0	0	178,974	33,988,004	0.53
New Jersey	East Orange	286,957	(1,103,528)	(287,000)	(1,103,571)	128,317,213	-0.86
	Lyons	361,569	(769,179)	(362,000)	(769,610)	90,491,597	-0.85
New York	Albany	643,014	0	0	643,014	86,688,382	0.74
	Batavia	(52,281)	(201,640)	0	(253,921)	21,917,403	-1.16
	Bath	(62,871)	0	171,843	108,972	34,448,191	0.32
	Bronx	114,724	0	0	114,724	120,129,540	0.10
	Brooklyn	18,410	0	0	18,410	161,703,585	0.01
	Buffalo	56,615	0	0	56,615	99,957,051	0.06
	Canandaigua	319,145	(482,081)	(319,000)	(481,936)	54,781,934	-0.88
	Castle Point	234,708	(383,596)	(235,000)	(383,888)	38,747,035	-0.99
	Montrose	281,135	(740,747)	(281,000)	(740,611)	77,161,128	-0.96
	New York	(64,577)	0	0	(64,577)	140,320,575	-0.05
Pennsylvania	Northport	724,930	0	0	724,930	112,603,170	0.64
	Syracuse	64,450	696,792	470,571	1,231,813	55,743,369	2.21
	Altoona	(10,480)	(189,293)	0	(199,772)	22,269,707	-0.90
	Butler	(74,026)	(276,823)	0	(350,850)	31,818,757	-1.10
	Coatesville	273,737	(665,156)	(274,000)	(665,418)	70,016,365	-0.95
	Erie	133,177	0	0	133,177	22,402,803	0.59
	Lebanon	332,526	712,277	(712,277)	332,526	56,982,122	0.58
	Philadelphia	82,844	(1,038,620)	(83,000)	(1,038,776)	115,402,246	-0.90
Rhode Island	Pittsburgh HD	328,604	655,284	554,103	1,537,990	52,422,685	2.93
	Pittsburgh UD	(69,601)	(952,321)	0	(1,021,922)	105,813,350	-0.97
	Wilkes-Barre	280,474	0	0	280,474	64,452,608	0.44
	Providence	158,524	0	83,927	242,451	48,582,484	0.50
Virginia	Hampton	718,422	0	0	718,422	66,542,573	1.08
	Richmond	1,368,278	0	429,636	1,797,914	117,920,080	1.52
	Salem	456,844	0	0	456,844	79,951,649	0.57
Vermont	White River Junction	238,980	471,037	396,179	1,106,196	37,682,992	2.94
West Virginia	Beckley	(192)	0	0	(192)	21,991,596	0.00
	Clarksburg	42,139	0	0	42,139	31,978,830	0.13
	Huntington	421,616	0	0	421,616	46,864,486	0.90
	Martinsburg	519,988	0	0	519,988	60,775,103	0.86
Region subtotal		\$11,124,756	(\$4,957,337)	\$5,000,000	\$11,167,418	\$3,169,902,894	

(Figure notes on next page)

Appendix IV
RPM Budget Changes by Region and
Facility, Fiscal Years 1994 and 1995

Notes: HD = Highland Drive facility; UD = University Drive facility.

In considering the range of adjustments to facility budgets through RPM reallocations, we did not include the Fort Howard budget increase of 13.4 percent. The Region 1 regional director adjustment for fiscal year 1995 is stated for administrative purposes to be \$3.85 million. However, VA officials told us that the facility did not receive the funds for patient care. Instead, the funds were considered a reserve for regional office use.

Data represent RPM adjustments prior to inflation.

Numbers in parentheses are negative numbers.

Source: VA RPM data.

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RPM Budget Changes by Region and
Facility, Fiscal Years 1994 and 1995**

Figure IV.2: Southern Region, Fiscal Year 1995

State	Facility	RPM adjustments			FY 93 historical budget	Percentage RPM increase/decrease FY 1993-95
		Workload	Outlier	Negotiation		
Alabama	Birmingham	\$418,458	\$0	\$74,206	\$492,664	0.61
	Montgomery	247,367	(253,355)	0	(5,988)	-0.02
	Tuscaloosa	424,581	569,533	0	994,114	2.18
	Tuskegee	579,410	0	122,174	701,584	1.10
Arkansas	Fayetteville (AR)	259,552	341,919	0	601,471	2.20
	Little Rock	305,261	0	0	305,261	0.20
Florida	Bay Pines	817,576	0	0	817,576	0.72
	Miami	971,220	0	0	971,220	0.63
	Gainesville	189,161	0	0	189,161	0.19
	Lake City	456,531	569,106	20,709	1,046,346	2.30
	Tampa	241,799	0	68,835	310,634	0.23
Georgia	Atlanta	188,970	0	390,819	579,789	0.66
	Augusta	659,971	(1,063,310)	596,553	193,214	0.17
	Dublin	34,810	0	264,124	298,934	0.69
Louisiana	Alexandria	(92,244)	0	121,965	29,721	0.06
	New Orleans	(150,162)	0	0	(150,162)	-0.15
	Shreveport	(142,457)	0	0	(142,457)	-0.24
Mississippi	Biloxi	418,719	0	523,980	942,699	1.21
	Jackson	2,503	1,018,383	0	1,020,885	1.25
North Carolina	Durham	438,338	0	161,901	600,239	0.71
	Fayetteville (NC)	442,970	0	0	442,970	1.13
	Asheville	219,649	0	0	219,649	0.39
	Salisbury	655,205	0	0	655,205	0.98
Oklahoma	Muskogee	149,748	0	75,338	225,086	0.57
	Oklahoma City	147,608	0	159,238	306,846	0.37
Puerto Rico	San Juan	(533,007)	1,481,526	351,343	1,299,862	1.10
South Carolina	Charleston	411,874	0	114,144	526,018	0.88
	Columbia (SC)	285,709	0	135,698	421,407	0.59
Tennessee	Memphis	58,602	0	0	58,602	0.05
	Mountain Home	136,473	0	205,233	341,706	0.45
	Murfreesboro	212,791	813,813	0	1,026,604	1.58
	Nashville	260,637	0	495,954	756,591	0.90
Texas	Amarillo	54,959	0	164,966	219,925	0.55
	Big Spring	205,811	0	3,961	209,772	0.95
	Bonham	112,008	252,956	8,362	373,327	1.84
	Dallas	848,816	0	246,296	1,095,112	0.88
	Houston	24,349	2,036,667	0	2,061,016	1.26
	Kerrville	50,329	358,796	0	409,124	1.43
	Marlin	62,159	0	212,482	274,641	1.76
	San Antonio	346,957	0	330,374	677,331	0.56
	Temple	219,214	0	151,345	370,559	0.47
	Waco	290,423	(530,950)	0	(240,527)	-0.39
	El Paso OPC	48,328	0	0	48,328	0.34
Region subtotal		\$10,980,975	\$5,595,083	\$5,000,000	\$21,576,058	\$3,207,300,793

(Figure notes on next page)

Appendix IV
RPM Budget Changes by Region and
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Notes: OPC = outpatient clinic.

Data represent RPM adjustments prior to inflation.

Numbers in parentheses are negative numbers.

Source: VA RPM data.

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RPM Budget Changes by Region and
Facility, Fiscal Years 1994 and 1995**

Figure IV.3: Central Region, Fiscal Year 1995

State	Facility	RPM adjustments				FY 93 historical budget	Percentage RPM increase/decrease FY 1993-95
		Workload	Outlier	Negotiation	Total RPM		
Iowa	Des Moines	\$97,985	(\$369,263)	\$350,000	\$78,722	\$40,137,263	0.20
	Iowa City	522,833	723,137	741,720	1,987,690	57,850,975	3.44
	Knoxville	374,181	0	0	374,181	40,755,199	0.92
Illinois	Chicago (L.Side)	216,658	0	15,434	232,092	74,399,680	0.31
	Chicago (W.Side)	(237,414)	0	121,447	(115,967)	92,934,534	-0.12
	Danville	329,978	0	2,830	332,808	67,880,543	0.49
	North Chicago (Downey)	117,174	(875,633)	26,889	(731,570)	96,223,370	-0.76
	Hines	379,043	0	106,472	485,515	176,729,835	0.27
	Marion (IL)	304,770	372,841	211,628	889,240	29,827,306	2.98
Indiana	Fort Wayne	116,689	0	8,673	125,362	20,793,655	0.60
	Indianapolis	630,851	(899,100)	34,534	(233,715)	97,728,268	-0.24
	Marion (IN)	294,264	(427,976)	0	(133,712)	46,519,091	-0.29
Kansas	Wichita	163,857	0	23,909	187,766	31,611,694	0.59
	Topeka	175,613	0	39,298	214,911	64,174,731	0.33
	Leavenworth	250,359	0	4,210	254,569	48,624,380	0.52
Kentucky	Lexington	117,372	0	0	117,372	98,603,452	0.12
	Louisville	179,781	0	5,853	185,634	67,685,420	0.27
Michigan	Ann Arbor	695,115	0	457,810	1,152,925	86,885,184	1.33
	Battle Creek	535,207	0	2,798	538,005	70,346,823	0.76
	Allen Park	79,200	0	0	79,200	88,900,558	0.09
	Iron Mountain	105,677	0	69,216	174,893	20,490,980	0.85
	Saginaw	169,224	(236,382)	248,225	181,067	25,976,056	0.70
Minnesota	Minneapolis	97,412	0	362,275	459,687	161,591,961	0.28
	St. Cloud	264,458	551,366	0	815,824	44,109,270	1.85
Missouri	Columbia (MO)	207,936	690,615	223,786	1,122,337	55,249,224	2.03
	Kansas City	252,672	0	5,826	258,498	78,518,781	0.33
	Poplar Bluff	174,557	270,968	12,604	458,129	21,677,414	2.11
	St. Louis	360,060	0	74,936	434,996	127,967,160	0.34
North Dakota	Fargo	87,684	0	4,122	91,806	29,909,021	0.31
Nebraska	Grand Island	(62,481)	(169,148)	84,574	(147,056)	16,914,826	-0.87
	Lincoln	71,464	0	41,550	113,014	22,849,627	0.49
	Omaha	46,014	0	67,302	113,316	53,110,899	0.21
Ohio	Chillicothe	352,879	733,167	3,359	1,089,404	58,653,320	1.86
	Cincinnati	(7,026)	0	0	(7,026)	71,109,964	-0.01
	Cleveland	584,147	0	50,846	634,993	155,693,711	0.41
	Dayton	307,982	(872,118)	874,330	310,194	100,243,452	0.31
	Columbus OPC	711	0	0	711	14,345,869	0.00
South Dakota	Sioux Falls	233,938	0	21,561	255,499	35,155,718	0.73
	Fort Meade	200,256	(258,954)	621,685	562,987	29,764,871	1.89
	Hot Springs	117,413	0	0	117,413	25,078,437	0.47
Wisconsin	Madison	299,306	0	17,559	316,865	52,921,810	0.60
	Tomah	234,875	0	6,658	241,533	42,064,105	0.57
	Milwaukee	340,603	(1,097,960)	56,081	(701,276)	120,655,003	-0.58
Region subtotal		\$9,783,278	(\$1,864,440)	\$5,000,000	\$12,918,838	\$2,762,663,440	

(Figure notes on next page)

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RPM Budget Changes by Region and
Facility, Fiscal Years 1994 and 1995

Notes: L. Side = Lakeside facility; W. Side = Westside facility; OPC = outpatient clinic.

Data represent RPM adjustments prior to inflation.

Numbers in parentheses are negative numbers.

Source: VA RPM data.

**Appendix IV
RPM Budget Changes by Region and
Facility, Fiscal Years 1994 and 1995**

Figure IV.4: Western Region, Fiscal Year 1995

State	Facility	RPM adjustments				FY 93 historical budget	Percentage RPM increase/decrease FY 1993-95
		Workload	Outlier	Negotiation	Total RPM		
Alaska	Anchorage	\$194,051	\$0	(\$200,000)	(\$5,950)	\$11,912,260	-0.05
Arizona	Phoenix	402,905	1,021,763	400,000	1,824,668	81,741,074	2.23
	Prescott	288,881	0	0	288,881	30,134,075	0.96
	Tucson	229,018	0	187,000	416,018	73,452,703	0.57
California	Fresno	362,659	0	0	362,659	50,968,054	0.71
	Livermore	292,414	(276,713)	0	15,701	29,437,559	0.05
	Long Beach	321,196	(1,632,715)	0	(1,311,519)	183,451,123	-0.71
	Loma Linda	146,773	0	400,000	546,773	89,223,365	0.61
	Martinez	(49,340)	0	1,500,000	1,450,660	53,640,283	2.70
	Palo Alto	1,243,211	0	0	1,243,211	192,666,261	0.65
	San Francisco	497,045	0	500,000	997,045	113,000,833	0.88
	San Diego	655,810	1,321,700	0	1,977,510	105,736,047	1.87
	Sepulveda	690,466	0	0	690,466	108,833,648	0.63
	West Los Angeles	589,472	0	0	589,472	208,621,136	0.28
Los Angeles OPC	(174,606)	0	0	(174,606)	28,952,292	-0.60	
Colorado	Denver	479,258	1,054,539	527,000	2,060,797	84,363,102	2.44
	Fort Lyon	(27,523)	(261,704)	0	(289,227)	26,704,489	-1.08
	Grand Junction	216,902	231,961	0	448,862	18,556,840	2.42
Hawaii	Honolulu	123,549	0	0	123,549	15,238,957	0.81
Idaho	Boise	63,769	0	0	63,769	33,878,144	0.19
Montana	Fort Harrison	95,485	226,095	0	321,580	18,087,580	1.78
	Miles City	124,187	(99,676)	0	24,511	11,326,811	0.22
New Mexico	Albuquerque	679,819	1,153,781	0	1,833,600	92,302,510	1.99
Nevada	Reno	521,707	0	0	521,707	42,834,038	1.22
	Las Vegas OPC	(78)	0	203,000	202,922	14,432,345	1.41
Oregon	Portland	247,593	0	0	247,593	129,525,022	0.19
	Roseburg	165,502	0	300,000	465,502	33,788,456	1.38
	White City	53,406	0	0	53,406	20,958,988	0.25
Philippines	Manila	3,000	0	0	3,000	1,618,732	0.19
Utah	Salt Lake City	173,549	949,010	0	1,122,559	75,920,779	1.48
Washington	American Lake Tacoma	167,851	0	341,000	508,851	44,458,745	1.14
	Seattle	722,740	0	450,000	1,172,740	103,508,273	1.13
	Spokane	403,507	0	300,000	703,507	26,128,212	2.69
	Walla Walla	53,123	0	0	53,123	17,879,453	0.30
Wyoming	Cheyenne	41,610	(184,641)	92,000	(51,031)	18,650,582	-0.27
	Sheridan	269,811	(219,339)	0	50,472	23,088,349	0.22
Region subtotal		\$10,268,719	\$3,284,060	\$5,000,000	\$18,552,779	\$2,215,021,120	
National total		\$42,157,727	\$2,057,366	\$20,000,000	\$64,215,093	\$11,354,888,247	0.50%

Notes: OPC = outpatient clinic.

Data represent RPM adjustments prior to inflation.

Numbers in parentheses are negative numbers.

Source: VA RPM data.

**Appendix IV
RPM Budget Changes by Region and
Facility, Fiscal Years 1994 and 1995**

Figure IV.5: Eastern Region, Fiscal Year 1994

State	Facility	RPM adjustments				FY 92 historical budget	Percentage RPM increase/decrease FY 1992-94
		Workload	Outlier	Negotiation	Total RPM		
Connecticut	Newington	\$430,666	\$0	\$210,452	\$641,118	\$28,298,967	2.27
	West Haven	701,165	0	630,000	1,331,165	81,882,692	1.63
District of Columbia	Washington	915,079	0	0	915,079	96,814,359	0.95
Delaware	Wilmington	178,529	0	49,562	228,091	35,559,488	0.64
Massachusetts	Bedford	156,266	0	0	156,266	61,879,481	0.25
	Boston	(194,807)	0	0	(194,807)	115,953,355	-0.17
	Brockton/West Roxbury	245,607	(1,183,748)	351,962	(586,180)	118,374,840	-0.50
	Northampton	122,959	0	0	122,959	40,684,327	0.30
Maryland	Baltimore	(21,072)	0	1,108,813	1,087,741	63,524,677	1.71
	Fort Howard	(103,064)	(231,693)	231,693	(103,063)	23,169,252	-0.44
	Perry Point	(117,175)	0	0	(117,175)	52,696,933	-0.22
Maine	Togus	117,563	0	0	117,563	49,109,017	0.24
New Hampshire	Manchester	195,998	0	0	195,998	31,710,028	0.62
New Jersey	East Orange	895,664	0	0	895,664	112,525,423	0.80
	Lyons	(2,277)	0	0	(2,277)	80,398,192	0.00
New York	Albany	595,338	0	0	595,338	78,365,984	0.76
	Batavia	(46,884)	0	870,000	823,116	19,608,370	4.20
	Bath	144,744	0	0	144,744	32,162,468	0.45
	Bronx	264,069	(1,102,019)	0	(837,949)	110,201,874	-0.76
	Brooklyn	1,073,566	0	0	1,073,566	148,957,221	0.72
	Buffalo	398,110	0	0	398,110	92,424,922	0.43
	Canandaigua	270,308	0	75,167	345,475	50,753,564	0.68
	Castle Point	(40,815)	(351,962)	200,000	(192,778)	35,196,238	-0.55
	Montrose	161,995	(711,154)	0	(549,160)	71,115,415	-0.77
	New York	882,370	0	0	882,370	127,610,357	0.69
	Northport	517,214	0	0	517,214	104,375,728	0.50
Syracuse	418,221	0	0	418,221	49,040,047	0.85	
Pennsylvania	Altoona	181,294	0	0	181,294	20,274,201	0.89
	Butler	3,417	(292,146)	0	(288,729)	29,214,588	-0.99
	Coatesville	99,498	0	0	99,498	62,140,152	0.16
	Erie	47,988	0	0	47,988	19,942,462	0.24
	Lebanon	141,001	506,846	300,000	947,847	50,684,564	1.87
	Philadelphia	1,116,228	(1,022,523)	0	93,706	102,252,289	0.09
	Pittsburgh HD	174,683	0	0	174,683	47,764,874	0.37
	Pittsburgh UD	93,616	0	0	93,616	92,892,540	0.10
Wilkes-Barre	65,188	0	0	65,188	60,264,353	0.11	
Rhode Island	Providence	368,221	0	0	368,221	45,498,893	0.81
Virginia	Hampton	(177,304)	0	55,257	(122,047)	62,454,102	-0.20
	Richmond	225,352	0	637,185	862,537	107,750,116	0.80
	Salem	(219,948)	0	0	(219,948)	70,890,886	-0.31
Vermont	White River Junction	159,832	0	0	159,832	35,529,398	0.45
West Virginia	Beckley	(12,535)	0	79,909	67,374	18,917,453	0.36
	Clarksburg	25,985	0	700,000	725,985	28,091,999	2.58
	Huntington	348,907	0	0	348,907	38,012,240	0.92
	Martinsburg	(10,564)	0	0	(10,564)	54,779,761	-0.02
Region subtotal		\$10,790,196	(\$4,388,399)	\$5,500,000	\$11,901,797	\$2,859,748,090	

(Figure notes on next page)

Appendix IV
RPM Budget Changes by Region and
Facility, Fiscal Years 1994 and 1995

Notes: HD = Highland Drive facility; UD = University Drive facility

Data represent RPM adjustments prior to inflation.

Numbers in parentheses are negative numbers.

Source: VA RPM data.

**Appendix IV
RPM Budget Changes by Region and
Facility, Fiscal Years 1994 and 1995**

Figure IV.6: Southern Region, Fiscal Year 1994

State	Facility	RPM adjustments				FY 92 historical budget	Percentage RPM increase/decrease FY 1992-94
		Workload	Outlier	Negotiation	Total RPM		
Alabama	Birmingham	(\$8,182)	\$0	\$451,270	\$443,088	\$73,726,435	0.60
	Montgomery	51,679	0	92,886	144,565	25,222,108	0.57
	Tuscaloosa	(17,129)	0	127,271	110,142	42,289,723	0.26
	Tuskegee	596,999	0	0	596,999	59,642,317	1.00
Arkansas	Fayetteville (AR)	157,745	0	250,000	407,745	24,598,666	1.66
	Little Rock	(119,370)	0	419,211	299,841	139,295,325	0.22
Florida	Bay Pines	658,053	1,036,056	174,195	1,868,304	103,605,597	1.80
	Gainesville	10,257	0	0	10,257	92,971,128	0.01
	Lake City	114,503	0	0	114,503	40,864,013	0.28
	Miami	960,072	0	0	960,072	142,332,813	0.67
	Tampa	643,242	0	866,196	1,509,438	123,524,555	1.22
Georgia	Augusta	82,415	0	86,008	168,423	105,694,346	0.16
	Atlanta	110,885	806,443	94,967	1,012,295	80,644,316	1.26
	Dublin	0	0	22,964	22,964	39,404,957	0.06
Louisiana	Alexandria	(281,186)	0	281,186	0	46,095,349	0.00
	New Orleans	355,543	0	0	355,543	87,997,689	0.40
	Shreveport	(676,282)	0	696,773	20,491	55,360,504	0.04
Mississippi	Biloxi	174,791	693,530	24,631	892,952	69,353,035	1.29
	Jackson	(21,794)	0	0	(21,794)	72,941,142	-0.03
North Carolina	Asheville	(113,822)	0	0	(113,822)	52,193,476	-0.22
	Durham	116,396	0	0	116,396	72,458,075	0.16
	Fayetteville (NC)	45,600	0	23,960	69,560	35,722,042	0.19
	Salisbury	(108,470)	0	0	(108,470)	62,185,387	-0.17
Oklahoma	Muskogee	233,227	0	106,039	339,266	35,234,760	0.96
	Oklahoma City	269,643	0	227,402	497,045	75,561,153	0.66
Puerto Rico	San Juan	427,502	1,073,517	385,061	1,886,080	107,351,729	1.76
South Carolina	Charleston	341,310	0	0	341,310	55,563,075	0.61
	Columbia (SC)	37,621	641,156	151,039	829,816	64,115,645	1.29
Tennessee	Memphis	249,996	0	63,755	313,751	105,397,435	0.30
	Mountain Home	261,947	0	201,093	463,040	66,818,725	0.69
	Murfreesboro	306,248	597,719	22,808	926,776	59,771,931	1.55
	Nashville	14,667	670,115	32,787	717,570	67,011,534	1.07
Texas	Amarillo	220,996	0	38,760	259,756	38,337,474	0.68
	Big Spring	63,526	0	0	63,526	20,635,045	0.31
	Bonham	108,012	184,264	15,358	307,633	18,426,383	1.67
	Dallas	(9,064)	0	344,026	334,962	114,313,003	0.29
	El Paso OPC	48,431	0	0	48,431	12,381,390	0.39
	Houston	791,257	1,526,482	79,355	2,397,094	152,648,186	1.57
	Kerrville	146,713	0	0	146,713	26,780,361	0.55
	Marlin	142,724	0	17,461	160,185	13,860,860	1.16
	San Antonio	475,250	0	986,068	1,461,318	110,573,272	1.32
	Temple	195,385	0	217,470	412,855	72,260,705	0.57
Waco	250,692	0	0	250,692	56,348,285	0.44	
Region subtotal		\$7,308,028	\$7,229,282	\$6,500,000	\$21,037,311	\$2,921,513,949	

(Figure notes on next page)

Appendix IV
RPM Budget Changes by Region and
Facility, Fiscal Years 1994 and 1995

Notes: OPC = outpatient clinic.

Data represent RPM adjustments prior to inflation.

Numbers in parentheses are negative numbers.

Source: VA RPM data.

**Appendix IV
RPM Budget Changes by Region and
Facility, Fiscal Years 1994 and 1995**

Figure IV.7: Central Region, Fiscal Year 1994

State	Facility	RPM adjustments				FY 92 historical budget	Percentage RPM increase/decrease FY 1992-94
		Workload	Outlier	Negotiation	Total RPM		
Iowa	Des Moines	(\$76,259)	\$0	\$0	(\$76,259)	\$37,113,652	-0.21
	Iowa City	220,519	0	0	220,519	52,841,384	0.42
	Knoxville	273,355	0	0	273,355	37,265,045	0.73
Illinois	Chicago (L.Side)	168,080	0	678,500	846,580	68,738,295	1.23
	Chicago (W.Side)	(50,012)	0	352,800	302,788	84,700,768	0.36
	Danville	434,620	0	0	434,620	63,042,748	0.69
	Hines	(346,123)	0	246,700	(99,423)	159,946,385	-0.06
	Marion (IL)	228,635	279,880	370,000	878,515	27,988,005	3.14
	North Chicago (Downey)	162,956	(851,916)	852,000	163,040	85,191,578	0.19
Indiana	Fort Wayne	(27,973)	0	0	(27,973)	18,787,435	-0.15
	Indianapolis	83,328	0	0	83,328	84,424,279	0.10
	Marion (IN)	(61,593)	0	0	(61,593)	43,592,909	-0.14
Kansas	Leavenworth	151,984	0	0	151,984	45,795,015	0.33
	Topeka	215,205	0	0	215,205	59,327,377	0.36
	Wichita	(88,298)	0	0	(88,298)	28,751,686	-0.31
Kentucky	Lexington	87,128	0	24,000	111,128	91,604,086	0.12
	Louisville	(496,090)	0	584,200	88,110	62,924,357	0.14
Michigan	Allen Park	248,221	0	0	248,221	78,450,680	0.32
	Ann Arbor	696,825	0	200,000	896,825	75,880,961	1.18
	Battle Creek	205,134	0	0	205,134	64,881,740	0.32
	Iron Mountain	49,623	0	0	49,623	19,292,806	0.26
	Saginaw	(3,846)	0	58,000	54,154	21,355,494	0.25
Minnesota	Minneapolis	400,650	0	800,000	1,200,650	147,069,021	0.82
	St. Cloud	139,089	0	300,000	439,089	40,545,627	1.08
Missouri	Columbia (MO)	314,746	504,707	1,015,000	1,834,453	50,470,672	3.63
	Kansas City	91,965	0	0	91,965	70,820,728	0.13
	Poplar Bluff	69,507	0	21,500	91,007	19,518,611	0.47
	St. Louis	406,628	0	0	406,628	113,837,207	0.36
North Dakota	Fargo	65,585	0	550,000	615,585	26,347,554	2.34
Nebraska	Grand Island	5,608	0	80,000	85,608	15,740,315	0.54
	Lincoln	145,850	0	0	145,850	20,642,056	0.71
	Omaha	63,650	0	600,000	663,650	48,521,485	1.37
Ohio	Chillicothe	(17,622)	543,901	400,000	926,278	54,390,049	1.70
	Cincinnati	645,930	0	0	645,930	65,783,511	0.98
	Cleveland	668,107	0	184,300	852,407	140,385,750	0.61
	Columbus OPC	228,942	0	0	228,942	13,256,488	1.73
	Dayton	(180,810)	0	38,000	(142,810)	93,066,125	-0.15
South Dakota	Fort Meade	197,960	0	0	197,960	27,271,073	0.73
	Hot Springs	(87,416)	0	0	(87,416)	23,490,371	-0.37
	Sioux Falls	147,250	0	0	147,250	31,970,308	0.46
Wisconsin	Madison	15,634	0	0	15,634	47,881,942	0.03
	Milwaukee	200,021	0	645,000	845,021	109,576,928	0.77
	Tomah	120,977	0	0	120,977	39,256,153	0.31
Region subtotal		\$5,717,670	\$476,572	\$8,000,000	\$14,194,241	\$2,511,738,659	

(Figure notes on next page)

Appendix IV
RPM Budget Changes by Region and
Facility, Fiscal Years 1994 and 1995

Notes: L. Side = Lakeside facility; W. Side = Westside facility; OPC = outpatient clinic.

Data represent RPM adjustments prior to inflation.

Numbers in parentheses are negative numbers.

Source: VA RPM data.

**Appendix IV
RPM Budget Changes by Region and
Facility, Fiscal Years 1994 and 1995**

Figure IV.8: Western Region, Fiscal Year 1994

State	Facility	RPM adjustments				FY 92 historical budget	Percentage RPM increase/decrease FY 1992-94
		Workload	Outlier	Negotiation	Total RPM		
Alaska	Anchorage	\$0	\$0	\$0	\$0	\$8,704,163	0.00
Arizona	Phoenix	358,631	765,579	577,791	1,702,001	76,557,851	2.22
	Prescott	114,257	0	0	114,257	27,341,748	0.42
	Tucson	336,331	0	117,788	454,119	65,225,396	0.70
California	Fresno	379,315	0	(379,315)	0	42,697,343	0.00
	Livermore	254,697	(250,853)	0	3,844	25,085,332	0.02
	Loma Linda	(288,055)	0	295,871	7,816	81,627,406	0.01
	Long Beach	(39,594)	(1,669,161)	882,576	(826,179)	166,916,125	0.49
	Los Angeles OPC	0	0	0	0	23,160,177	0.00
	Martinez	698,964	0	(656,963)	42,001	70,452,328	0.06
	Palo Alto	1,590,928	(1,655,702)	4,774	(60,000)	165,570,210	-0.04
	San Diego	494,166	0	0	494,166	94,483,159	0.52
	San Francisco	882,417	0	(788,157)	94,260	90,270,972	0.10
	Sepulveda	278,677	(976,897)	333,370	(364,851)	97,689,753	-0.37
West Los Angeles	801,359	0	128,000	929,359	187,960,967	0.49	
Colorado	Denver	293,993	0	1,268,766	1,562,759	77,822,972	2.01
	Fort Lyon	(132,070)	0	132,662	592	24,976,890	0.00
	Grand Junction	69,278	0	565,838	635,116	16,872,766	3.76
Hawaii	Honolulu	89,765	0	0	89,765	11,343,258	0.79
Idaho	Boise	44,766	0	300,000	344,766	30,443,914	1.13
Montana	Fort Harrison	(42,354)	164,937	0	122,583	16,493,702	0.74
	Miles City	(54,710)	(98,837)	80,360	(73,187)	9,883,688	-0.74
New Mexico	Albuquerque	554,667	0	91,258	645,925	83,480,747	0.77
Nevada	Las Vegas OPC	0	0	400,000	400,000	10,922,061	3.66
	Reno	332,313	0	(283,190)	49,123	35,376,964	0.14
Oregon	Portland	(170,815)	0	371,933	201,118	116,676,424	0.17
	Roseburg	1,990	0	0	1,990	31,630,803	0.01
	White City	(112,846)	0	118,208	5,362	19,064,907	0.03
Philippines	Manila	22,541	0	221,921	244,462	1,425,144	17.15
Utah	Salt Lake City	141,782	0	610,486	752,268	68,709,004	1.09
Washington	American Lake Tacoma	25,365	0	437,786	463,151	40,950,455	1.13
	Seattle	273,438	0	57,600	331,038	95,842,511	0.35
	Spokane	(83,299)	0	110,637	27,338	23,605,637	0.12
	Walla Walla	46,090	0	0	46,090	15,580,186	0.30
Wyoming	Cheyenne	50,437	0	0	50,437	14,891,193	0.34
	Sheridan	6,939	0	0	6,939	21,230,950	0.03
Region subtotal		\$7,219,363	(\$3,720,934)	\$5,000,000	\$8,498,428	\$1,990,967,106	
National total		\$31,035,257	(\$403,479)	\$25,000,000	\$55,631,777	\$10,283,967,804	0.54

(Figure notes on next page)

Appendix IV
RPM Budget Changes by Region and
Facility, Fiscal Years 1994 and 1995

Notes: OPC = outpatient clinic.

Data represent RPM adjustments prior to inflation.

Numbers in parentheses are negative numbers.

Source: VA RPM data.

VA RPM data.

RPM's Provision for Facility Differences in Veterans' Access to Care

One of the ways that VA facilities adjust to resource limitations is by rationing care to veterans. As a result, there are differences in the provision of care to veterans among facilities. Some facilities have adequate resources to provide services to all categories of veterans; whereas, others find they must curtail their services. They do so by limiting the categories of veterans served, the types of services offered, and the conditions for which veterans can receive care.

When we reported on these differences in 1993, VA responded that the RPM system—under development at the time—would help overcome these differences.³⁸ Specifically, VA officials indicated that to address wide variations in veterans' access to health care systemwide, VA was designing a new resource planning and management process with several objectives, including the elimination of gaps in service to veterans systemwide. The Secretary of VA reiterated in February 1994 correspondence to the Congress that the RPM system would begin to alleviate some of the inconsistencies in veterans' access to care noted in our report. However, this objective has not been incorporated in the RPM model.

Availability of Care Is Uneven

The Congress established general priorities for VA to use when providing outpatient care when resources are not available to care for all veterans. VA, in turn, has delegated rationing decisions to its facilities. Each facility independently chooses when and how to ration care. Our 1993 report found that 118 centers reported rationing care and 40 reported no rationing, as shown in figure V.1.

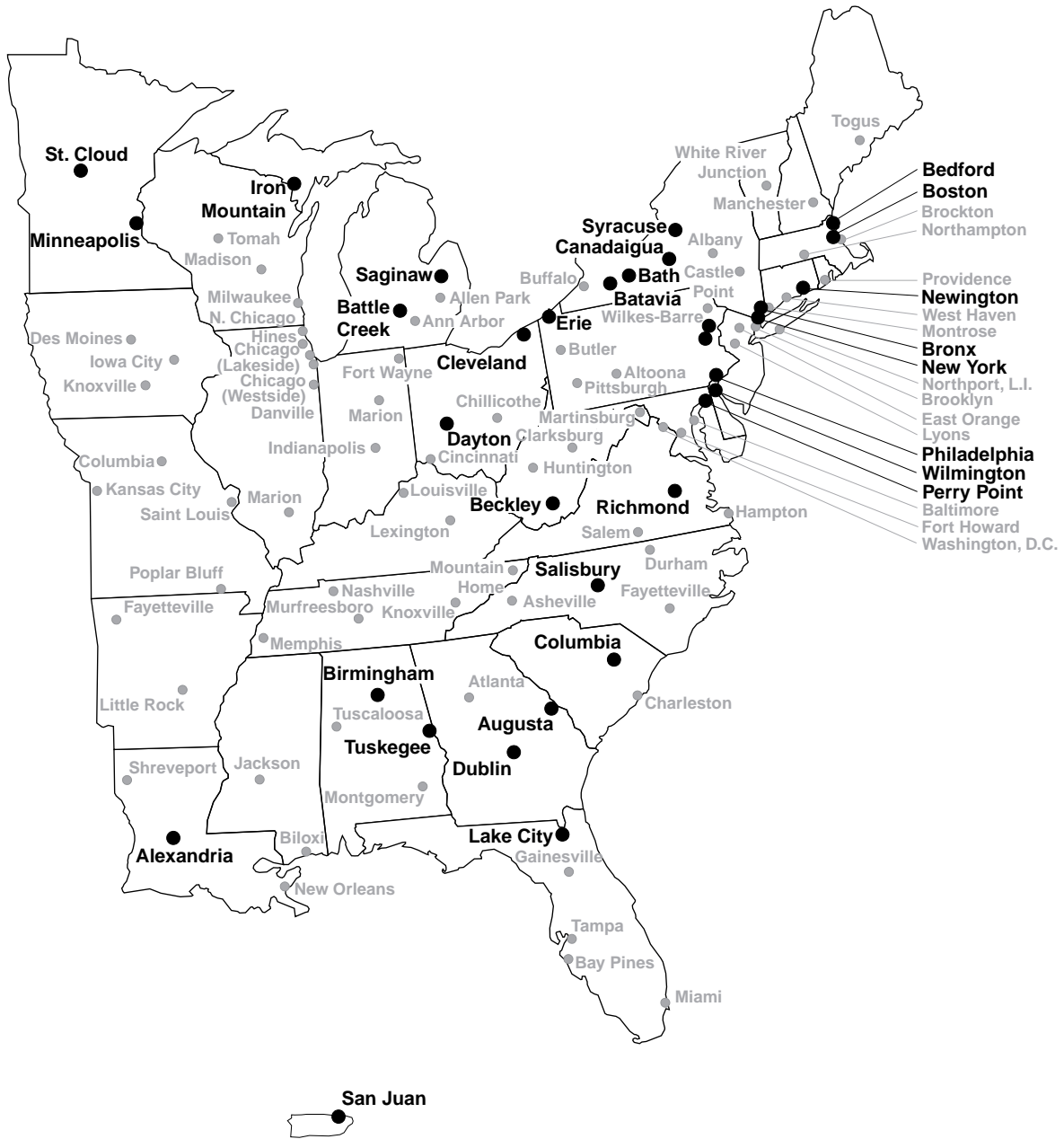
³⁸GAO/HRD-93-106, July 16, 1993.

Appendix V
RPM's Provision for Facility Differences in
Veterans' Access to Care

Figure V.1: Nonrationing VA Medical Centers in Fiscal Year 1991



Appendix V
RPM's Provision for Facility Differences in
Veterans' Access to Care



(Figure notes on next page)

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Source: VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO/HRD-93-106, July 16, 1993).

Because of differences in facility rationing practices, veterans' access to care systemwide is uneven. We found that higher income veterans received care at many facilities, while lower income veterans were turned away at other facilities. Differences in who was served occurred even within the same facility because of rationing. Some facilities that rationed care by medical service or condition sometimes turned away lower income veterans who needed certain types of services and provided care for higher income veterans who needed other services.

Complex eligibility categories complicate the determinations of priorities for care as well as the extent that facilities are providing care to various categories of veterans. VA's priority system considers factors such as the presence and extent of any service-connected disability, the incomes of veterans with nonservice-connected disabilities, and the type and purpose of care needed to determine which eligible veterans receive care within available resources. (An eligible veteran is any person who served on active duty in the uniformed services for the minimum time specified by law and who was discharged, released, or retired under other than dishonorable conditions.) While VA's systems do not allow us to confirm the extent that the rationing we reported in 1993 still exists, available data indicate that the ability of facilities to provide care to discretionary categories of veterans still varies. VA systems record the numbers of unique patients served by facilities who have traditionally been considered "discretionary," that is, nonservice-connected, higher-income veterans. These data show that although up to 13 percent of some facilities' patients were from the discretionary category in fiscal year 1994, other facilities treated none.

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Related GAO Products

VA Decision Support System: Top Management Leadership Critical to Success (GAO/AIMD-95-182, Sept. 29, 1995).

VA's Medical Resource Allocation System (GAO/HEHS-95-252R, Sept. 12, 1995).

VA Health Care: Issues Affecting Eligibility Reform (GAO/T-HEHS-95-213, July 19, 1995).

VA Health Care: Challenges and Options for the Future (GAO/T-HEHS-95-147, May 9, 1995).

VA Health Care: Barriers to VA Managed Care (GAO/HEHS-95-84R, April 20, 1995).

Veteran Affairs: Accessibility of Outpatient Care at VA Medical Centers (GAO/T-HRD-93-29, July 21, 1993).

VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO/HRD-93-106, July 16, 1993).

VA Health Care: Veterans' Efforts to Obtain Outpatient Care From Alternative Sources (GAO/HRD-93-123, June 30, 1993).

VA Health Care: Resource Allocation Methodology Has Had Little Impact on Medical Centers' Budgets (GAO/HRD-89-93, Aug. 18, 1989).

VA Health Care: Resource Allocation Methodology Should Improve VA's Financial Management (GAO/HRD-87-123BR, Aug. 31, 1987).

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