GAO

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

Health, Education and Human Services Division

B-265811

September 12, 1995

The Honorable John McCain
United States Senate

Dear Senator McCain:

At your request, we are currently reviewing the Veterans Health Administration's (VHA) process for allocating the medical care appropriation to its medical facilities across the nation--the Resource Planning and Management System (RPM).[1] Historically, VHA allocated resources by making incremental changes to each facility's prior year budget. After recognizing the need to better link resources to each facility's actual workload, VHA in 1985 implemented the Resource Allocation Methodology (RAM). VHA officials indicated that because the RAM allocations were generally based upon workload as defined by clinical diagnoses, facilities soon recognized that their allocations would be increased as the number of procedures performed increased. This open-ended expansion of workload led to budgeting problems and concerns about inappropriate care being provided.

RPM--first used to allocate fiscal year 1994 facility budgets--was intended to improve upon past allocation systems. VHA's stated goals for RPM are to (1) improve VA's resource allocation methodology, (2) move from retrospective to prospective workload management, and (3) reform medical care budgeting. Accordingly, RPM was designed to be patient-based, forward-looking, and policy-driven. It defines workload as patients served, rather than procedures performed--hence, VHA's characterization of RPM as "capitation-based"--and it uses projections of future workload to determine what resources are needed. A VHA strategic plan was also intended to be the driving force

[1]For fiscal year 1996, the Department of Veterans Affairs (VA) is seeking an appropriation of about $17 billion to maintain and operate 173 hospitals, 376 outpatient clinics, 136 nursing homes, and 39 domiciliaries.

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behind RPM, giving it a set of goals, performance standards, and workload priorities.

You asked us to review VHA's allocation process, expressing a concern about the equity of the process in ensuring that facility funding meets the medical needs of a changing veteran population.[2] As part of our efforts to keep you informed about our ongoing review of RPM, we have regularly briefed your staff on our progress toward issuing a report later this year. As a result of our most recent briefing, you asked us to provide you with preliminary information on the way VHA is using RPM to better link resources to workload by

-- examining the variations that RPM data show in facility operating costs to determine the reasons for those variations, and

-- allocating resources among facilities so that veterans within the same priority categories have the same availability of care, to the extent practical, throughout the VA health care system.

In summary, RPM appears to be an improvement over VA's previous resource allocation systems. Specifically, it creates forecasts of expected workload and provides data, such as differences in operating costs, that VHA could use in better matching resources to anticipated workload. It also reduces the ability of facilities to "game" the system by providing or seeming to provide more or more costly procedures. However, our work to date suggests that VHA has made limited use of RPM in understanding the reasons for those differences and in changing allocations from what facilities received in the past. Furthermore, VHA has not used RPM to allocate resources in a way that considers differences in veterans' access to care throughout the system.

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[2]You also raised a specific concern about funding at the Carl T. Hayden Medical Center in Phoenix, which we have explored as part of our work.

USE OF RPM TO EXPLORE WHY OPERATING COSTS VARY

Although the RPM data show significant differences in facility operating costs, VHA has not, as it originally planned, developed processes to allow a better understanding of potential reasons for those variations. Originally, VHA intended to assess reasons for variations in costs among facilities through a formal review and evaluation process, including structured site surveys of facilities with especially high and low operating costs. VHA had said that such a process would be useful to identify efficiencies that could be applied at other facilities and to identify potential quality problems caused by limited resources.[3] VHA hoped to further explore the impact of resources on quality by linking RPM cost data with quality indicators. Officials told us that without a better understanding of the reasons for the variations or a clear standard against which to measure the costs, they had little basis for determining which, if any, facilities were receiving too few or too many resources. We have had some difficulty finding out why VHA has not analyzed the variations as planned; the main reasons seem to be the generally lower priority attached to that effort and the uncertainty about who would conduct the analyses and how the analyses would be done. We hope to have more information about this matter in our detailed report.

Our initial assessment of RPM data shows that facility costs vary widely, even after facilities of similar mission and size are grouped and adjustments are made to account for

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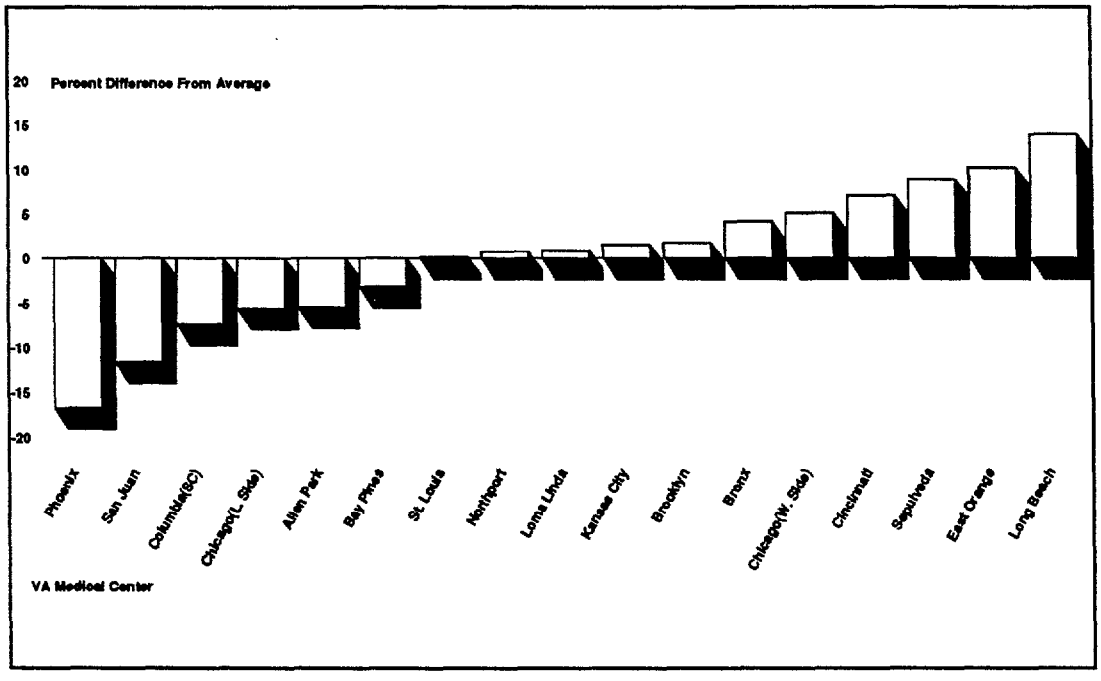
[3]The closest VHA has come to conducting such a review was through one of the six Technical Advisory Groups (TAGs) it formed for its RPM patient categories, such as primary care or chronic mental illness. The Chronic Mental Illness TAG has done some limited data analysis (that is, length of stay, discharge cost, and costs/day differences) to develop further explanatory data on facility cost variations in the care of chronic mental illness patients. The directive establishing the TAGs' purpose, role, operation, and management within RPM, including their role in studying cost, practice, and quality variations among facilities, had not been formalized at the time of our review.

differences such as case mix, locality costs, salaries, training, and research. For example, adjusted costs per standardized workload measure in one facility group ranged from $3,024 to $4,141 with the average cost being $3,635; facilities ranged from about 17 percent below average to about 14 percent above average in cost. (See fig. 1.)

Figure 1: Adjusted Facility Operating Costs per Standardized Workload Measure in VHA's Facility Group Five, Fiscal Year 1993



Nonetheless, VHA officials appear to have used RPM to change facilities' historical budgets only minimally during the two budget cycles in which RPM has been used. For example, we estimate that the maximum loss to any facility's historical budget in fiscal year 1995 was only about 1 percent and that the average gain was also about 1 percent.

While the optimal amount of resources that should be shifted is unclear, the facilities most disadvantaged by not

shifting more resources are those that (1) historically have received less funding for comparable workload and (2) have a faster growing number of patients. For example, because VHA lacked resources to fund all facilities' expected needs, it chose to limit the resources given to facilities with growing workloads. On the other hand, for facilities with decreasing workloads, VHA chose not to reduce their funding in proportion to the expected decreases in workload. These decisions led to only small adjustments in the funding for the projected cost of increased workload, while facilities with decreasing workloads received more resources than they were projected to need. For example, VHA forecasted that the Carl T. Hayden Medical Center needed an additional $2.3 million for fiscal year 1995 based on expected increases in workload. However, the center actually received an additional $400,000 as a result of workload adjustments arising from RPM.[4] By contrast, the San Juan facility had the greatest decline in workload within Carl T. Hayden's facility group. Its declining workload led to a projected $3 million decrease in budget needs, yet the facility's budget decreased only $500,000.

USE OF RPM TO REDUCE INCONSISTENCIES IN AVAILABILITY OF CARE

We reported in 1993[5] that veterans' access to outpatient care at VHA facilities varied widely--veterans within the same priority categories received outpatient care at some

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[4]Carl T. Hayden and other medical centers also received funds outside the RPM process. Carl T. Hayden received approximately $124 million in fiscal year 1995, of which about $90 million came through the RPM allocation process. In fiscal year 1994, it received approximately $117 million, of which $78 million came through RPM. The percentage of Carl T. Hayden's budget received outside the process was comparable to (within about 3 percent of) the national average.

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

facilities but not at others.[6] Using a questionnaire to medical centers, we found then that of 158 centers queried, 118 reported they rationed outpatient care for nonservice-connected conditions in fiscal year 1991 and 40 reported no rationing. This rationing generally occurred in fiscal year 1991 because resources did not always match veterans' demands for care. Medical centers rationed care by limiting the categories of veterans served,[7] the medical services offered, and the conditions for which they could receive care.

When we reported on these differences in 1993, VA officials responded that RPM--under development at the time--would help overcome these differences. Specifically, 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 for veterans systemwide. In February 1994 correspondence to the Congress, the Secretary of Veterans Affairs reiterated that RPM would begin to alleviate some of the inconsistencies in veterans' access to care noted in our report.

In our current review, however, we are finding that overcoming these kinds of inconsistencies in availability of care has not been incorporated as a specific goal of RPM.

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[6]As 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. (An eligible veteran is any person who served on active duty in the uniformed services for the minimum amount of time specified by law and who was discharged, released, or retired under other than dishonorable conditions.)

[7]When medical centers rationed care by veteran category, they generally followed the priorities set by the Congress: they limited care first to higher income veterans, then to lower income veterans, and finally to veterans with a service-connected disability.

Perhaps because reducing inconsistency has not been established as an RPM goal, the system does not use data on the eligibility category of veterans served at a facility. RPM predicts costs and workload without regard to facility differences in the provision of discretionary care, that is, without regard to the priority category of the veterans being served.

Although the lack of relevant data prevents us from confirming whether the kind of rationing reported in our 1993 report persists, we see indications that inconsistencies still exist. For example, fiscal year 1994 data showed a difference in the extent to which facilities treated nonservice-connected higher income veterans:[8] at some facilities 13 percent of veterans treated fell into that category, while other facilities provided no care to such veterans.

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We discussed the draft of this letter with VA's Deputy Undersecretary for Health and other VA officials who generally agreed with its contents. These officials noted, however, that resource allocation is an inherently complex and difficult process, that VA's implementation of RPM is still evolving, and that they expect to use the process to make substantially increased budget adjustments for facilities in the next fiscal year. They indicated that VHA faces many challenges that make implementation of the process difficult, including complex eligibility requirements, mandates to care for certain specialized populations of veterans, and the inability of facilities to change personnel levels quickly. They also cited several current initiatives that they expect to help in the implementation of the resource allocation process, including the restructuring of the VA health system into Veterans Integrated Service Networks, the implementation of VA's Decision Support System, and the linking of planning, policy, and performance measurement responsibilities within one organizational office.

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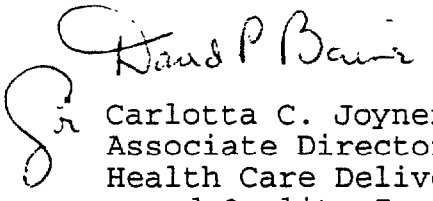
[8]A "higher income" veteran is one whose income was above the means test threshold, which as of January 1995 was $20,469 for a single veteran, $24,565 for a veteran with one dependent, plus $1,368 for each additional dependent.

We are sending copies of this correspondence to the Secretary of Veterans Affairs and other interested parties. The information contained in it was developed by Frank Pasquier, Assistant Director; Linda Bade; Katherine Iritani; Douglas Sanner; and Evan Stoll. Please contact me at (202) 512-7101 or Mr. Pasquier at (206) 287-4861 if you or your staff have any questions.

Sincerely yours,



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