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Report to the Committee on Veterans' Affairs, U.S. Senate

August 1989

VA HEALTH CARE

Resource Allocation Methodology Has Had Little Impact on Medical Centers' Budgets

GAO/HRD-89-93

GAO

United States
General Accounting Office
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Human Resources Division

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August 18, 1989

The Honorable Alan Cranston
Chairman, Committee on Veterans' Affairs
United States Senate

The Honorable Frank H. Murkowski
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate

At your request, we examined the Resource Allocation Methodology (RAM) that the Department of Veterans Affairs (VA) uses in its financial management process. The RAM is designed to link medical centers' budgets to actual workload and to provide a financial incentive for centers to improve their efficiency. VA headquarters and field officials have recently expressed concern about the RAM's impact on medical centers' budgets. This report discusses (1) how VA used the RAM to adjust medical centers' budgets, (2) how the adjustments compared to total dollars budgeted for the centers, and (3) how regional directors can help medical centers cope with financial needs arising during the course of a year.

Results in Brief

Since 1985, VA has used the RAM to transfer funds, through its budget formulation process, from less efficient medical centers to those centers judged to be more efficient. The RAM-related adjustments to medical centers' fiscal year 1989 budgets generally represented less than 2 percent of the total dollars budgeted. The budget adjustments were small in relation to the centers' budgets because VA established a maximum amount that a center's budget would be increased or reduced in order to cushion the RAM's financial impact. Also, as medical centers incur expenses during a year that cannot be financed through their existing budgets, the centers' directors can request additional funds from regional directors. The regional directors thus serve as safety nets to help centers cope with financial pressures caused by RAM-related budget adjustments or other factors.

Background

VA provides health care to veterans on an inpatient and outpatient basis. Over 1.1 million veterans receive inpatient care each year through 172 hospitals and 119 nursing homes. Veterans make more than 21 million visits a year to 233 VA outpatient clinics. Most of these facilities are organized into 159 medical centers; each center has at least one hospital and outpatient clinic and most also include a nursing home. Although

For fiscal years 1985 to 1988, each center's rating was compared to the systemwide average; centers that had ratings lower than the average were considered to be the more efficient performers and those with higher ratings were judged to be less efficient. In fiscal year 1989, centers were placed into groups based on such variables as the volume and complexity of patient workload. Comparisons of efficiency were made within each group rather than with the system as a whole.

VA uses these comparisons as a basis for allocating funds to medical centers during the budget formulation process. First, the budgets of the less efficient centers are reduced by prescribed dollar amounts based on the relationship between each center's efficiency rating and the average measured efficiency of the centers in its group. These funds are then allocated to the budgets of the more efficient centers, as dollar gains, in a similar manner. No additional funds are involved.[2]

Cap Helps to Cushion RAM's Impact on Medical Centers' Budgets

To help centers adjust to the Resource Allocation Methodology, VA placed a cap on the amount that a medical center's budget could be increased or reduced during a single year. VA intended that the cap would protect centers from (1) large shifts in their budgets, (2) any undue impact of unreliable clinical and financial data used by the RAM, and (3) any technical problems or imprecision inherent in the RAM. VA plans to phase out the cap but has not decided when this process will begin. According to VA officials, additional experience and technical improvements are needed before the cap is removed.

In prior reports,[3] we identified factors that affect the accuracy of the RAM's efficiency ratings by overstating or understating workload or cost data. These factors include (1) cost reporting systems that collected estimates rather than actual costs of health care provided to individual patients, (2) invalid workload measures, and (3) improper coding of clinical data.

VA officials were aware of these factors when the RAM was adopted, but they believed that the RAM would provide an incentive for the medical

[2]VA Health Care: Resource Allocation Methodology Should Improve VA's Financial Management (GAO/HRD-87-123BR, Aug. 31, 1987) discusses (1) what the methodology is intended to do, (2) how it is intended to work, and (3) what problems were experienced during its early implementation.

[3]Financial Management: An Assessment of the Veterans Administration's Major Processes (GAO/AFMD-86-7, June 27, 1986); VA Health Care: Plans to Ensure Compatibility of Two Medical Management Systems (GAO/HRD-88-45, Dec. 21, 1987); VA Health Care: Resource Allocation Methodology Should Improve VA's Financial Management (GAO/HRD-87-123BR, Aug. 31, 1987).

Table 1: RAM Adjustments to Medical Centers' Budgets (Fiscal Year 1989)

	Less efficient centers		More efficient centers	
RAM budget adjustment	**Number**	**Amount reduced (millions)**	**Number**	**Amount gained (millions)**
Less than $100,000	21	$1.1	11	$.7
$100,001 to $500,000	30	9.0	34	8.8
$500,001 to $1,000,000	13	8.9	19	14.4
More than $1,000,000	19	28.4	17	23.5
Total	**83**	**$47.4**	**81**	**$47.4**

Had a cap not been in place, centers would have experienced significantly larger gains and reductions in fiscal year 1989 as a result of the RAM. For example:

- The funds transferred among centers would have totaled $153.2 million, or 223 percent more than the $47.4 million transferred.
- The number of centers that had gains or reductions greater than $1 million would have increased from 36 to 93.
- The gains or reductions would have represented more than 2 percent of the total dollars budgeted for 101 of the 164 centers, including 36 centers that would have had gains or reductions of between 5 and 10 percent of their total budgets and 6 centers that would have had gains or reductions of more than 10 percent of their budgets.

Regional Directors Help Centers Cope With Budget Shortages

Regional directors can help medical centers cope with budget shortages, including those caused by RAM-related adjustments. The directors have the authority to adjust centers' budgets as they are being implemented during the year. Budget adjustments are made through reserves set aside at the start of a year, supplemental appropriations received during a year, or transfers of funds among centers.

The seven regional directors told us that medical center directors frequently request that adjustments be made to their budgets to meet various operational needs, including unanticipated equipment purchases, facility maintenance expenses, or emergency overtime costs. At the two regions we visited, the directors adjusted medical centers' budgets on numerous occasions during fiscal year 1988. These adjustments were made to the budgets of centers that were judged to be more efficient as well as those judged to be less efficient. The seven regional directors said they consider financial need when deciding whether to approve or

Abbreviations

RAM	Resource Allocation Methodology
VA	Department of Veterans Affairs

RAM Budget Adjustments for Medical Centers in Mid-Atlantic Region (Fiscal Year 1989)

State	Medical centers	RAM adjustment	Budget[a]	RAM adjustment as a percent of budget
Delaware	Wilmington	$−636,211	$34,392,181	−1.8
District of Columbia	Washington	−1,692,505	96,063,762	−1.8
Maryland	Baltimore	683,855	46,273,272	1.5
	Fort Howard	120,524	19,621,265	.6
	Perry Point	159,254	47,225,020	.3
New Jersey	East Orange	1,300,935	101,641,582	1.3
	Lyons	565,392	65,849,518	.9
North Carolina	Asheville	−1,005,735	48,139,481	−2.1
	Durham	−751,603	67,407,982	−1.1
	Fayetteville	−490,528	31,303,054	−1.6
	Salisbury	830,434	59,192,551	1.4
Pennsylvania	Altoona	−48,395	21,886,515	−.2
	Butler	372,902	23,833,274	1.6
	Coatesville	−408,853	60,281,000	−.7
	Erie	90,705	18,026,942	.5
	Lebanon	−56,165	48,089,499	−.1
	Philadelphia	360,276	83,807,823	.4
	Pittsburgh (Highland Drive)	468,821	43,515,247	1.1
	Pittsburgh (University Drive)	−121,185	83,618,524	−.1
	Wilkes-Barre	−58,115	53,717,769	−.1
Tennessee	Mountain Home	327,221	54,213,807	.6
Virginia	Hampton	517,254	55,052,848	.9
	Richmond	−1,761,181	97,619,387	−1.8
	Salem	−712,582	65,400,241	−1.1
West Virginia	Beckley	−339,172	16,752,397	−2.0
	Clarksburg	−395,486	25,996,353	−1.5
	Huntington	−29,748	29,815,986	−.1
	Martinsburg	−54,222	50,239,116	−.1

[a]This represents the total dollars budgeted to medical centers when the RAM adjustment was made.

Appendix IV

RAM Budget Adjustments for Medical Centers in Great Lakes Region (Fiscal Year 1989)

State	Medical centers	RAM adjustment	Budget[a]	RAM adjustment as a percent of budget
Illinois	Chicago (Lake Side)	$813,817	$61,497,165	1.3
	Chicago (West Side)	−86,046	86,195,705	−.1
	Danville	−74,531	54,705,453	−.1
	Hines	−1,814,104	142,620,671	−1.3
	North Chicago	1,109,307	79,904,105	1.4
Indiana	Fort Wayne	267,135	17,052,026	1.6
	Indianapolis	1,084,953	80,014,928	1.4
	Marion	−784,357	40,621,370	−1.9
Michigan	Allen Park	956,333	82,215,751	1.2
	Ann Arbor	−75,563	69,302,016	−.1
	Battle Creek	842,500	57,944,792	1.5
	Iron Mountain	−262,525	18,463,389	−1.4
	Saginaw	−405,514	19,963,894	−2.0
Ohio	Chillicothe	788,907	50,013,827	1.6
	Cincinnati	−290,884	59,067,757	−.5
	Cleveland	1,530,649	129,311,175	1.2
	Columbus Outpatient Clinic	170,843	20,753,958	.8
	Dayton	1,031,220	73,109,874	1.4
Wisconsin	Madison	−52,815	45,755,469	−.1
	Milwaukee	520,688	103,051,625	.5
	Tomah	−45,216	34,756,354	−.1

[a]This represents the total dollars budgeted to medical centers when the RAM adjustment was made.

RAM Budget Adjustments for Medical Centers in Western Region (Fiscal Year 1989)

State	Medical centers[a]	RAM adjustment	Budget[b]	RAM adjustment as a percent of budget
California	Fresno	$−135,570	$35,556,560	−.4
	Livermore	−419,471	21,381,966	−2.0
	Loma Linda	154,922	66,727,921	.2
	Long Beach	1,831,446	147,653,434	1.2
	Los Angeles Outpatient Clinic	189,953	23,976,054	.8
	Martinez	994,318	68,163,634	1.5
	Palo Alto	1,105,382	138,292,751	.8
	San Diego	−759,922	83,051,068	−.9
	San Francisco	−1,167,403	91,332,434	−1.3
	Sepulveda	850,485	75,597,435	1.1
	West Los Angeles	−2,610,111	167,430,614	−1.6
Idaho	Boise	166,393	27,820,001	.6
Nevada	Las Vegas Outpatient Clinic	108,751	10,333,205	1.1
	Reno	−601,505	33,755,180	−1.8
Oregon	Roseburg	326,090	26,647,341	1.2
	Portland	−511,892	107,994,174	−.5
Washington	Seattle	970,310	90,381,761	1.1
	Spokane	−429,399	21,579,448	−2.0
	Tacoma	391,743	35,915,001	1.1
	Walla Walla	84,904	13,329,561	.6

[a]Outpatient clinics in Anchorage, Alaska; Honolulu, Hawaii; and Manila, the Philippines, are excluded from this analysis because they were not subject to the RAM in fiscal year 1989.

[b]This represents the total dollars budgeted to medical centers when the RAM adjustment was made.

Comments From the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

JUL 28 1989

Mr. Lawrence H. Thompson
Assistant Comptroller General
Human Resources Division
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Thompson:

I am responding to your draft report VA HEALTH CARE: Resource Allocation Methodology Has Had Little Impact on Medical Centers' Budgets (GAO, June 28, 1989). We thank Chairman Cranston and Senator Murkowski for their continued interest in the Department of Veterans' Affairs (VA) Resource Allocation Methodology (RAM) and welcome GAO's evaluation of the RAM's use in our financial management process.

We believe the GAO report is factual and is correct in noting that the budget impact of RAM was small because VA established a cap on the amount a medical center's budget could be increased or reduced. While this action was taken to cushion the RAM's financial impact on any one medical center, we believe RAM had some positive impact on center management practices, workload patterns, and creation of useful management tools. For instance during RAM's implementation, VA:

- increased the number of unique individuals served in inpatient, outpatient, and long-term care activities,
- decreased inpatient lengths-of-stay,
- decreased long-term lengths-of-stay for psychiatric patients, and
- created a data-based decision support system and a new array of needed management and analytical tools.

The GAO report also correctly states that VA has several initiatives underway that should help improve the accuracy of RAM such as the decentralized hospital computer program and pilot projects testing new cost accounting systems. We are committed to making these improvements in the RAM.

Sincerely yours,

Edward J. Derwinski
Secretary

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RAM Budget Adjustments for Medical Centers in Southwestern Region (Fiscal Year 1989)

State	Medical centers	RAM adjustment	Budget[a]	RAM adjustment as a percent of budget
Arizona	Phoenix	$1,107,748	$73,395,390	1.5
	Prescott	35,802	21,072,765	.2
	Tucson	821,780	54,395,301	1.5
Arkansas	Fayetteville	−390,723	19,017,048	−2.1
	Little Rock	1,699,396	133,237,784	1.3
Louisiana	Alexandria	−660,846	42,430,003	−1.6
	New Orleans	−1,430,673	78,174,809	−1.8
	Shreveport	114,690	49,453,371	.2
New Mexico	Albuquerque	64,057	71,426,637	.1
Oklahoma	Muskogee	516,904	37,404,773	1.4
	Oklahoma City	849,419	71,174,377	1.2
Texas	Amarillo	360,801	29,159,424	1.2
	Big Spring	270,653	17,436,202	1.6
	Bonham	211,473	15,168,723	1.4
	Dallas	1,611,487	104,024,536	1.5
	El Paso Outpatient Clinic	91,505	9,302,504	1.0
	Houston	1,890,606	115,195,271	1.6
	Kerrville	−490,042	23,255,331	−2.1
	Marlin	85,668	12,444,680	.7
	San Antonio	1,476,884	98,336,896	1.5
	Temple	889,484	59,344,198	1.5
	Waco	−174,688	57,105,515	−.3

[a]This represents the total dollars budgeted to medical centers when the RAM adjustment was made.

RAM Budget Adjustments for Medical Centers in Mid-Western Region (Fiscal Year 1989)

State	Medical centers	RAM adjustment	Budget[a]	RAM adjustment as a percent of budget
Colorado	Denver	$−1,114,105	$68,033,632	−1.6
	Fort Lyon	146,302	22,237,083	.7
	Grand Junction	−15,511	14,047,737	−.1
Illinois	Marion	26,665	24,415,590	.1
Iowa	Des Moines	300,313	39,195,275	.8
	Iowa City	−643,525	49,419,326	−1.3
	Knoxville	−312,050	31,892,722	−1.0
Kansas	Leavenworth	248,288	42,395,029	.6
	Topeka	130,617	50,284,663	.3
	Wichita	406,862	28,136,456	1.4
Minnesota	Minneapolis	−2,152,767	146,593,245	−1.5
	Saint Cloud	−607,120	36,709,473	−1.7
Missouri	Columbia	−60,650	45,531,549	−.1
	Kansas City	−70,344	63,791,568	−.1
	Poplar Bluff	282,693	16,586,878	1.7
	Saint Louis	1,722,574	118,450,980	1.5
Montana	Fort Harrison	216,853	17,771,425	1.2
	Miles City	141,466	9,691,899	1.5
Nebraska	Grand Island	49,633	18,419,651	.3
	Lincoln	−19,223	20,466,639	−.1
	Omaha	−871,752	45,789,532	−1.9
North Dakota	Fargo	−255,738	28,244,450	−.9
South Dakota	Fort Meade	−74,819	22,675,645	−.3
	Hot Springs	−302,627	20,554,644	−1.5
	Sioux Falls	242,073	27,720,765	.9
Utah	Salt Lake City	341,845	64,451,643	.5
Wyoming	Cheyenne	−258,653	13,380,398	−1.9
	Sheridan	−110,327	18,662,274	−.6

[a]This represents the total dollars budgeted to medical centers when the RAM adjustment was made.

RAM Budget Adjustments for Medical Centers in Southeastern Region (Fiscal Year 1989)

State	Medical centers	RAM adjustment	Budget[a]	RAM adjustment as a percent of budget
Alabama	Birmingham	$−1,001,353	$66,621,096	−1.5
	Montgomery	275,220	23,722,754	1.2
	Tuskaloosa	668,763	38,266,741	1.7
	Tuskegee	277,802	51,453,742	.5
Florida	Bay Pines	1,422,817	116,005,804	1.2
	Gainesville	586,646	86,957,529	.7
	Lake City	−485,336	33,456,200	−1.5
	Miami	223,400	120,179,454	.2
	Tampa	244,721	103,230,011	.2
Georgia	Atlanta	−1,096,770	81,361,232	−1.3
	Augusta	1,389,242	89,335,522	1.6
	Dublin	−27,661	35,157,164	−.1
Kentucky	Lexington	−103,582	77,782,396	−.1
	Louisville	21,870	56,128,235	b
Mississippi	Biloxi	−1,203,818	61,720,509	−2.0
	Jackson	1,033,068	60,931,142	1.7
South Carolina	Charleston	−54,210	47,294,686	−.1
	Columbia	476,382	58,531,723	.8
Tennessee	Memphis	−132,406	93,030,955	−.1
	Murfreesboro	−1,020,889	48,828,553	−2.1
	Nashville	−379,545	61,595,017	−.6

[a]This represents the total dollars budgeted to medical centers when the RAM adjustment was made.

[b]Less than 0.1 percent.

RAM Budget Adjustments for Medical Centers in Northeastern Region (Fiscal Year 1989)

State	Medical centers	RAM adjustment	Budget[a]	RAM adjustment as a percent of budget
Connecticut	Newington	$−472,583	$31,490,842	−1.5
	West Haven	−1,085,916	64,149,988	−1.7
Maine	Togus	−815,636	42,700,057	−1.9
Massachusetts	Bedford	−1,012,737	55,020,488	−1.8
	Boston	71,853	86,712,444	.1
	Boston Outpatient Clinic	39,470	24,668,217	.2
	Brockton	1,191,844	94,306,721	1.3
	Northampton	−51,430	36,209,443	−.1
New Hampshire	Manchester	−147,037	28,265,209	−.5
New York	Albany	−83,311	99,536,072	−.1
	Batavia	−161,178	17,674,133	−.9
	Bath	339,449	27,530,467	1.2
	Bronx	−112,369	85,793,080	−.1
	Brooklyn	−2,233,612	115,494,899	−1.9
	Buffalo	−1,712,243	78,258,567	−2.2
	Canandaigua	−288,995	42,662,132	−.7
	Castle Point	−484,689	29,736,330	−1.6
	Montrose	697,153	60,790,421	1.1
	New York	−1,721,676	106,375,784	−1.6
	Northport	−1,510,473	90,737,937	−1.7
	Syracuse	−48,388	45,495,276	−.1
Puerto Rico	San Juan	−532,149	96,386,836	−.6
Rhode Island	Providence	−46,270	44,498,748	−.1
Vermont	White River Junction	−271,904	30,987,518	−.9

[a]This represents the total dollars budgeted to medical centers when the RAM adjustment was made.

Contents

deny such requests. Two directors noted that they had occasionally increased a center's budget because it incurred a RAM-related reduction.

Agency Comments

VA agreed that this report accurately assesses the RAM's impact on medical centers' budgets (see app. VIII). VA affirmed its commitment to completing the initiatives (see p. 4) that are currently underway to improve the RAM's accuracy. Also, VA expressed its belief that the RAM had a positive impact on the centers' management practices, workload patterns, and creation of useful management tools.

We are sending copies of this report to cognizant congressional committees, the Secretary of Veterans Affairs, the Director of the Office of Management and Budget, and other interested parties, and we will make copies available to others on request. Major contributors are listed in appendix IX.

David P. Baine

David P. Baine
Director of Federal Health Care
Delivery Issues

centers to improve the reliability of the workload and cost data reported. VA has several initiatives underway that should help improve the accuracy of the RAM's efficiency ratings, including the decentralized hospital computer program and pilot projects testing new cost accounting systems. Also, data validation committees were established at medical centers to help ensure accurate, timely, and consistent reporting of workload and cost data.

RAM-Related Adjustments Are Small Part of Medical Centers' Budgets

VA has removed funds from the budgets of the less efficient medical centers in each of the 5 years that the RAM has operated. However, the more efficient medical centers received their full RAM gains only in fiscal years 1985 and 1989. The more efficient centers did not receive any RAM gains as part of their initial fiscal year 1986 budget allocation. However, VA officials told us that, after receiving a supplemental appropriation in September 1986, funds equal to the RAM gains were given to regional directors for distribution to medical centers as they deemed appropriate. For fiscal year 1987, VA provided only 50 percent of the RAM dollar gains to the more efficient centers. For fiscal year 1988, the more efficient centers received 80 percent or less of their RAM dollar gains based on the size of their RAM gain in relation to their total budget. VA used the RAM gains that were not provided to the more efficient centers to finance initiatives, such as modernization of existing facilities, that were developed through VA's health care planning process.

As part of the fiscal year 1989 resource allocation process, VA used the RAM to adjust the budgets of 164 medical centers (including five of the eight independently operated clinics). For 83 centers that were determined to be less efficient, VA deducted $47.4 million from their budgets, about 1 percent of the total dollars budgeted for these centers. The reductions ranged from $15,500 to $2.6 million. VA allocated the $47.4 million to the budgets of the 81 more efficient centers; the gains represented about 1 percent of the total dollars budgeted for these centers. The gains ranged from $21,900 to $1.9 million. Most of the centers gained or had reductions of $500,000 or less, as shown in table 1.[4]

[4]Appendixes I through VII show RAM adjustments to the fiscal year 1989 budgets of individual medical centers.

eight outpatient clinics are operated independently, they will be referred to as centers in this report. The medical centers are organized into seven geographic areas, which are administered by regional directors.

Each year, VA receives an appropriation to operate its health care system—about $10.5 billion in fiscal year 1989.[1] VA headquarters generally allocates its annual health care appropriation to medical centers based on their previous expenditures, adjusted for inflation and other new services or activities. This allocation process normally begins about 8 months before the start of a fiscal year.

Beginning in fiscal year 1985, VA modified its allocation process so that a portion of its funds are allocated to medical centers based on their individual performances. To do this, VA developed a management tool, referred to as the RAM, which (1) measures each center's performance and (2) adjusts funding levels based on the measured performance.

Scope and Methodology

In conducting our analysis, we (1) reviewed VA's policies and procedures for implementing the RAM in fiscal years 1985 through 1989, (2) examined medical centers' budgets for these years, and (3) interviewed VA officials, including the seven regional directors. We also visited regional offices in Albany, New York, and Durham, North Carolina, to interview officials and review budget records.

Our audit work was conducted from January 1988 through February 1989. We did not attempt to evaluate how funds transferred under the RAM affected medical centers' operations or whether the RAM accurately measured centers' workloads and expenditures. Our work was performed in accordance with generally accepted government auditing standards.

Operation of the Resource Allocation Methodology

The RAM uses three patient classification models (acute inpatient, outpatient, and long-term care) to measure a center's performance. Within each model, the center's patient workload is classified into categories that are homogeneous with respect to patient characteristics and resource consumption. Workload credits are earned based on the volume and mix of patients treated. Total credits earned are divided into expenditures to determine an efficiency rating.

[1] In June 1989, VA received a supplemental appropriation of $340 million.