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Report to Congressional Requesters

April 2011

VA HEALTH CARE

Need for More Transparency in New Resource Allocation Process and for Written Policies on Monitoring Resources

GAO-11-426

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GAO Accountability • Integrity • Reliability

Highlights

Highlights of GAO-11-426, a report to congressional requesters

Why GAO Did This Study

Through fiscal year 2010, the Department of Veterans Affairs (VA) permitted its 21 health care networks to develop their own methodologies for allocating resources to medical centers. These methodologies varied considerably. Concerned that network methodologies were not fully transparent to VA headquarters, in fiscal year 2011, VA implemented a new single process for all networks to use to determine allocations to medical centers. VA headquarters retains overall responsibility for oversight of VA's resources, including ensuring networks do not spend more than the resources available.

GAO was asked to review how VA networks allocate resources and how VA oversees these resources once they are allocated. In this report, GAO describes (1) VA's new process for networks to use in determining allocations to medical centers, and (2) how VA centrally monitors these resources. To do this work, GAO reviewed VA documents describing the new process and VA's monitoring efforts, in light of federal internal control standards, and interviewed VA officials.

What GAO Recommends

GAO recommends that VA (1) require networks to provide rationales for all adjustments made to allocations proposed by VA's resource allocation model, and (2) develop written policies to document practices for monitoring resources. VA concurred with these recommendations.

View GAO-11-426 or key components. For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov.

What GAO Found

VA's new resource allocation process uses a standardized model, but the transparency of networks' decisions for allocating resources to medical centers is limited. The new process involves three steps. First, VA headquarters proposes medical center allocation amounts to networks using a standardized resource allocation model. The model includes a standardized measure of workload that recognizes the varying costs and levels of resource intensity associated with providing care for each patient at each medical center. Second, network officials review the proposed amounts and have the flexibility to adjust them if they believe that certain medical centers' resource needs are not appropriately accounted for in the model. Third, networks report final medical center allocation amounts to VA headquarters and any adjustments made to the allocation amounts proposed by the model. VA headquarters did not ask networks to report reasons for each adjustment made to allocation amounts; networks reported reasons for some adjustments, but not for others. VA officials said that the new network resource allocation process was not intended to be used to question networks' decision making, but to increase the transparency of networks' allocation decisions to VA headquarters while maintaining network flexibility. However, absent rationales from networks on all adjustments made to medical center allocation amounts, transparency for decisions made through the allocation process is limited. Furthermore, understanding why networks make adjustments is key in determining if any modifications to the model are needed for subsequent years. VA officials told GAO that they intend to conduct annual assessments of the new resource allocation process, including a review of adjustments to the model, to identify areas for improvement.

VA centrally monitors the resources networks have allocated to medical centers to ensure spending does not exceed allocations, but does not have written policies documenting these practices for monitoring resources. VA monitors resources through two primary practices—automated controls in its financial management system and regular reviews of network spending. Specifically, VA's financial management system electronically tracks the amount of resources that networks and medical centers have available—the resources allocated, less the resources already spent—and prevents medical centers from spending more than what they have available by rejecting spending requests in excess of available resources. In addition, each month VA headquarters officials compare each network's spending with what the network planned to spend and determine whether spending is on target, and whether any differences from the plan are significant. However, VA headquarters does not have written policies documenting the agency's practices for monitoring resources, which is not consistent with federal internal control standards. These standards state that internal controls should be documented, and all documentation should be properly managed, maintained, and readily available for examination. Without written policies, there is an increased risk of inconsistent monitoring of VA network and medical center resources.

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Abbreviations

VA	Department of Veterans Affairs
VERA	Veterans Equitable Resource Allocation

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Accountability * Integrity * Reliability

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Congressional Requesters

The Department of Veterans Affairs (VA) received appropriations of about $48.2 billion for health care services for fiscal year 2011.[1] Each year, VA allocates most of the appropriations for health care services to its 21 health care networks through a national, formula-driven system, called the Veterans Equitable Resource Allocation (VERA).[2] The networks in turn allocate resources received through VERA to their respective medical centers, as part of their role in overseeing all medical centers within their networks.

In fiscal year 2010, nearly 6 million patients received care through 153 VA medical centers across the 21 networks.[3] Networks vary in terms of veteran enrollment, geographic location, types of services offered by their medical centers, and the number of their medical centers designated as urban and rural. The decentralized structure of the VA health care system was set up to allow networks to respond to local health care needs, such as changing demographics of the veteran population in their regions, and increasing demand for ambulatory care.

Through fiscal year 2010, VA headquarters permitted networks to develop their own methodologies for allocating resources to medical centers, and these methodologies varied considerably among the 21 networks. For example, some networks' methodologies were based solely on the previous year's allocations for its medical centers with an adjustment for inflation, while some networks' methodologies determined allocations based on the patient workload of their medical centers. Concerned that network methodologies for allocating resources to medical centers were

[1]The Consolidated Appropriations Act, 2010, provided advance appropriations for fiscal year 2011 for VA health care services. See Pub. L. No. 111-117, div. E, tit. II, 123 Stat. 3034, 3298-3300 (2009). Among other things, the Department of Defense and Full-Year Continuing Appropriations Act, 2011, rescinded 0.2 percent of the amount provided as advance appropriations. See Pub. L. No. 112-10, div. B, tit. I, § 1119, 125 Stat. 38 (2011).

[2]VA allocates the remaining resources to networks and medical centers outside of the VERA system for such things as prosthetics and sets aside resources so that they are available for contingencies that may arise during the year.

[3]Medical centers typically include one or more hospitals as well as other types of health care facilities such as outpatient clinics and nursing homes.

not fully transparent to VA headquarters, VA developed and implemented a new process in fiscal year 2011 for all networks to use in determining their allocations to medical centers.

Although VA networks retain responsibility for resource allocation decision making, VA headquarters retains overall responsibility for oversight and management of VA's resources. For example, VA headquarters is ultimately responsible for ensuring that networks and medical centers do not spend more than the resources available to them. You expressed interest in how VA networks allocate resources to medical centers and how VA oversees these resources once they are allocated. In this report, we describe (1) VA's new process for networks to use in determining allocations to medical centers, and (2) how VA centrally monitors resources networks have allocated to medical centers.

To describe VA's new process for allocating resources from networks to medical centers in fiscal year 2011, we reviewed VA documents describing the process and interviewed VA officials from the Veterans Health Administration's Office of Finance and Office of Operations and Management about the process. In addition, we reviewed VA data detailing the fiscal year 2011 allocations for each of VA's 21 networks to determine the effect of the new process on medical center allocations. We assessed the reliability of the fiscal year 2011 allocation data by interviewing agency officials knowledgeable about the data and the new process used to determine the allocations. We also interviewed VA officials about the tests of reliability that they conducted on the data. We determined that the data we used were sufficiently reliable for the purposes of this report. In addition, we reviewed information on the methodologies that networks used for fiscal years 2004 through 2010. We also reviewed VA guidance regarding the allocation of resources from networks to medical centers.

To describe how VA centrally monitors resources networks have allocated to medical centers, we reviewed documents from VA about its monitoring efforts. Specifically, we reviewed VA's procedures related to financial management and information tracked through VA's financial systems, in light of federal internal control standards, as documented in GAO's *Standards for Internal Control in the Federal Government*.[4] In addition, we interviewed officials from the Office of Finance and Office of

[4]GAO, *Internal Control: Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

Operations and Management about VA's monitoring efforts and financial management systems.

For both objectives, we also interviewed officials from VA networks and medical centers. We conducted in-person interviews with officials from four VA networks—Network 5 (Baltimore), Network 8 (Bay Pines), Network 10 (Cincinnati), and Network 20 (Portland)—and interviews with officials from at least one medical center from each of these networks to understand VA networks' implementation of the new allocation process, the variety of methodologies used in prior years, and the effect of VA headquarters' monitoring on networks. We conducted telephone interviews with officials from two additional networks—Network 16 (Jackson) and Network 23 (Minneapolis)—to understand their implementation of the new allocation process and the effect of VA headquarters' monitoring. We selected this judgmental sample of networks and medical centers to obtain a diverse mix of perspectives, based on variation in several factors, including geographic location and number of veterans enrolled, and to obtain perspectives from officials representing medical centers in both urban and rural areas.

We conducted this performance audit from April 2010 through April 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Appropriations for VA's health care services are made through three separate appropriations accounts: Medical Services, Medical Support and Compliance, and Medical Facilities.[5] VA allocates resources from these appropriations to its networks and medical centers for general purposes and specific purposes at the beginning of each fiscal year.[6] Seventy-eight

[5]In addition, VA receives appropriations for information technology, medical and prosthetic research, and construction, which support the delivery of health care services.

[6]In addition, medical centers may receive resources from third-party collections, such as insurance companies, and from veterans' copayments for services and prescription drugs. VA credits these sums to a collections fund and may transfer them to its Medical Services account, from which they are provided to medical centers. See 38 U.S.C. § 1729A; Pub. L. No. 112-10, div. B, tit. I, § 1101(a) (6), 125 Stat. 38 (2011); Pub. L. No. 111-117, § 215, 123 Stat. 3034, 3305 (2009).

percent, or approximately $37.8 billion, of the nearly $48.2 billion in VA's advance appropriations for health care services for fiscal year 2011 were allocated to VA's 21 networks for general purpose patient care. VA also allocates resources to networks and medical centers for specific purposes, such as prosthetics, transplant care, and preventive and primary care initiatives. For fiscal year 2011, 22 percent, or approximately $10.4 billion, of VA's advance appropriations for health care services were provided to networks and medical centers for specific purposes. Of its total health care resources, VA sets aside approximately $500 million at the beginning of each fiscal year to allocate to networks and medical centers as needed throughout the year to respond to contingencies and emergencies.

Allocation of General Purpose Resources from VA Headquarters to Networks

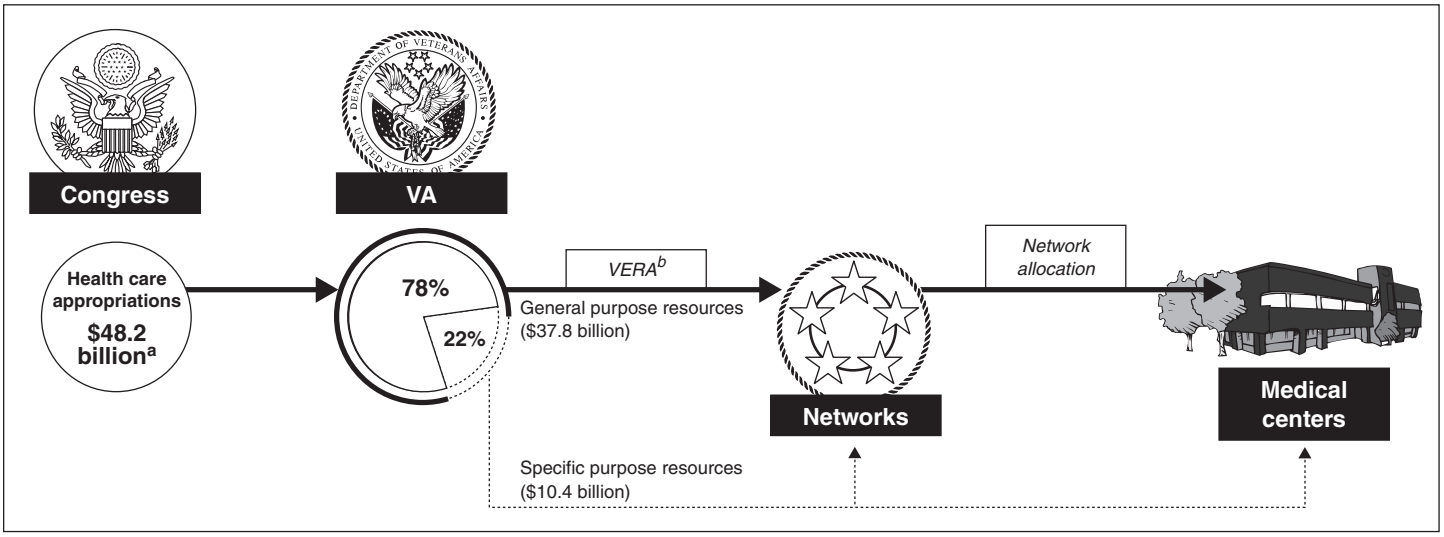
VA uses the VERA system to allocate general purpose resources to its networks each fiscal year. Introduced in fiscal year 1997, VERA uses a national formula-driven approach that considers the number and type of veterans served (patient workload), the complexity of care provided (case-mix), and certain geographic factors, such as local labor costs, in determining how much each VA network should receive. VERA determines how much each network will receive according to each network's activities and needs in the following areas: patient care, equipment, nonrecurring maintenance, education support, and research support. We have previously reported that VERA is a reasonably sound methodology for VA to allocate resources to networks, although we have made recommendations to improve the methodology, some of which VA has incorporated.[7] VA assesses its VERA model annually to determine any needed changes to the model, which may include incorporating new components.

Allocation of General Purpose Resources from Networks to Medical Centers

Once VA applies VERA to determine how much networks will receive, networks determine how these resources will be allocated to their individual medical centers. (See fig. 1.) Networks do not provide resources directly to medical centers; rather VA headquarters retains responsibility for providing these resources based on network allocation decisions.

[7]GAO, *VA Health Care: Resource Allocation Has Improved, but Better Oversight Needed*, GAO/HEHS-97-178 (Washington, D.C.: September 1997). GAO, *VA Health Care: More Veterans Are Being Served, but Better Oversight Is Needed*, GAO/HEHS-98-226 (Washington, D.C.: August 1998). GAO, *VA Health Care: Allocation Changes Would Better Align Resources with Workload*, GAO-02-338 (Washington, D.C.: February 2002).

Figure 1: Allocation of VA's Health Care Resources, Fiscal Year 2011



Source: GAO, Art Explosion (medical centers image).

[a]Appropriations for VA health care services are made through three separate appropriations accounts: Medical Services, Medical Support and Compliance, and Medical Facilities.

[b]The Veterans Equitable Resource Allocation (VERA) system uses a national formula-driven approach that considers the number and type of veterans served (patient workload), the complexity of care provided (case-mix), and certain geographic factors, such as local labor costs, in determining how much each VA network should receive.

Prior to fiscal year 2011, VA permitted networks to develop and use their own methodologies for determining how to allocate general purpose resources to medical centers. VA headquarters provided general guidance to networks on the principles they should use when determining their allocation methodologies. For fiscal year 2010, for example, VA's guidance stated that networks were expected to allocate resources to medical centers in a manner that must, among other things, be readily understandable and result in predictable allocations, and support the goal

of improving equitable access to care and ensure appropriate allocation of resources to facilities to meet that goal.[8]

Given the relative autonomy that the 21 networks have under VA's decentralized health care system, they developed varying allocation methodologies. For example, networks varied in the factors they considered in determining medical center allocations. These factors included prior year funding, patient workload, performance, and facility square footage. Nonetheless, VA headquarters required networks to report descriptions of their allocation methodologies, including a description of how the methodology met VA's guiding principles for network allocation. Each network was also required to report the total amount of resources it retained at the network level—the portion of network general purpose resources set aside before allocations were made to medical centers at the beginning of the fiscal year—such as resources for network operations, network initiatives, and emergencies.

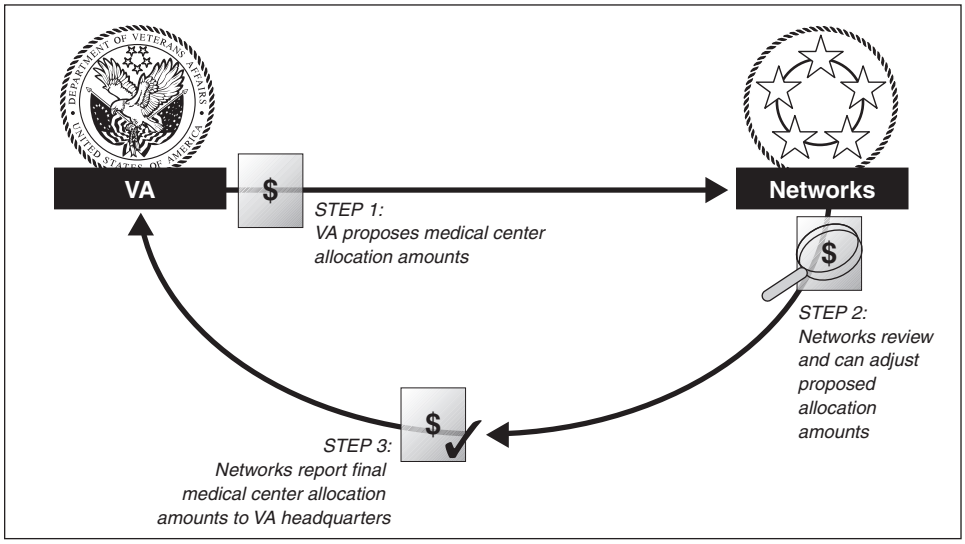
VA's New Allocation Process Uses a Standardized Model, but Transparency of Networks' Allocation Decisions Is Limited

In fiscal year 2011, VA implemented a new resource allocation process that includes a standardized model for networks to use in allocating general purpose resources to their medical centers. The model was designed to provide consistency in the allocation process across networks and still allow networks the flexibility to make adjustments to medical center allocations. However, VA headquarters did not require networks to report reasons for all of the adjustments networks made to their medical centers' allocations, which limits the transparency of networks' allocation decisions.

[8]The guidance also stated that network allocation systems must support high quality health-care delivery in the most appropriate setting; support integrated patient-centered operations; provide incentives to ensure continued delivery of appropriate complex care; provide adequate support for VA's research and education missions; be consistent with eligibility requirements and priorities; be consistent with the network's strategic plans and initiatives; promote managerial flexibility and innovation; and encourage increases in alternative revenue collections. Department of Veterans Affairs, *Veterans Equitable Resource Allocation 2010, VERA 10 Includes all Veteran Users: Equitable Funding Across 21 Health Care Networks*, pg. 109. (Washington, D.C.: May 2010).

The new process involves three steps—first, VA headquarters proposes medical center allocation amounts to networks using a standardized resource allocation model;[9] second, network officials review these amounts and can adjust them based on the needs of their medical centers that are not reflected in the initial allocation amounts proposed by headquarters; and third, after making any adjustments, networks report final medical center allocation amounts to VA headquarters in a consistent format. (See fig. 2.)

Figure 2: VA's New Process for Networks to Use in Determining Allocations to Medical Centers



Source: GAO.

Step One: VA Proposes Allocation Amounts. VA headquarters provides networks with a spreadsheet that includes a standardized model that proposes allocation amounts for each medical center. The model includes four main components covering different aspects of the resources

[9]In the spring of 2010, VA formed an internal workgroup to recommend options for a new standardized network allocation process. The workgroup recommended a standardized allocation model, which VA adopted for use in fiscal year 2011. The workgroup was comprised of officials from VA headquarters, networks, and medical centers.

needed for network and medical center operations, which combined determine the amount of resources allocated to each medical center.[10]

- **Resources Retained for Network Initiatives**. The new model requires networks to report the amounts and purposes of all resources they do not allocate to medical centers at the beginning of the fiscal year. Networks retain and manage resources for network-level initiatives that are allocated to medical centers throughout the fiscal year, such as to offset start-up costs for new medical centers or clinics or for the network's consolidation of services shared across medical centers including contracting services, accounting, and laundry. Additionally, networks retain resources for the administrative costs associated with operating the network, such as salaries for network employees. Historically, VA had asked networks to identify the amount of resources retained at the network level, but they did not ask networks to report the purposes of these resources.

- **Resources Retained for the Network's Emergency Reserve**. Networks may retain resources in an emergency reserve to respond to medical center emergencies throughout the year. The new model limits the amount of resources retained by each network to respond to medical center emergencies to 1.5 percent of the total allocation amount. Networks may reduce the amount retained for emergencies, but they cannot exceed the 1.5 percent limit. Networks have used these resources to help cover unanticipated medical center costs, such as those associated with natural disasters, which required resources beyond what a medical center had been initially allocated. In our review of the fiscal year 2011 allocation models, the 21 networks' reserve amounts ranged from about 0.1 percent to the 1.5 percent limit, with an average reserve amount of 1.2 percent. While networks were asked in prior years to report their emergency reserve amounts, VA had not required that this amount be reported separately from other resources retained at the network level, making it challenging in the past for VA headquarters to know how much the network retained in reserve specifically for emergencies. In fiscal year 2010, 1 network did not put any resources in reserve, and the remaining networks' reserves ranged from 0.2 percent to 3.7 percent of their total allocation. Furthermore, VA had not established a cap on emergency reserve amounts prior to fiscal year 2011.

[10]Another component of the new model relates to capital resources, such as those for medical center equipment and maintenance costs. As in prior years, these resources are allocated at the network's discretion.

- **Resources for Research Support, Education, and High Cost Patients**. Under the new model, medical centers' resources for research support, education, and high cost patients—patients whose treatment costs exceed a VA established threshold[11]—are determined solely by VERA. VERA calculates these amounts based on specific medical center characteristics. For example, the amount of resources allocated to medical centers for education is based on the number of residents at each medical center in the current academic year. Although these amounts were also calculated using VERA in prior years, networks had the ability to adjust them. Under the new model, networks are no longer involved in determining how to allocate these resources, which allows VA headquarters to ensure that these resources are allocated consistently across all networks.

- **Resources for Patient Care Determined by a Standardized Measure of Workload**. The new model uses a standardized measure of patient workload—which VA refers to as patient weighted work.[12] Prior to fiscal year 2011, each network was allowed to use its own preferred workload measure, and the measures used ranged from a simple count of individual patients to a more complex statistical regression model. In fiscal year 2010, 9 of the 21 networks used a workload measure similar to patient weighted work. VA officials told us they chose patient weighted work because it establishes an equitable measure of workload among medical centers that vary significantly in their geographic location, and types and costs of services provided. According to VA officials, the patient weighted work measure lessens the impact of cost differences between medical centers, by recognizing the varying costs and levels of resource intensity associated with providing care for each patient at each VA medical center. For example, patient weighted work would result in more resources being allocated to a medical center that provides more complex care, such as open heart surgery, than a workload measure based solely on a count of each individual patient, which would not account for the additional costs

[11]VA provides networks with an additional allocation for patients whose annual costs exceed a certain threshold. In fiscal year 2011, VA set this threshold at $107,000.

[12]Patient weighted work is determined using facility workload (FacWork) as a base measure. FacWork measures workload by taking into account the range of resources required to care for different classes of patients, as determined by age and case-mix. Patient weighted work accounts for additional factors including high cost procedures; geographic cost differences between medical centers; and the complexity of medical centers as measured by the size of their patient population, the complexity of medical services provided, and the extent to which they have research and education programs, among other factors.

associated with more complex care. Furthermore, officials told us that the patient weighted work measure is easily understandable by networks, medical centers, and stakeholders, such as veterans or VA employees.

Step Two: Networks Review and Can Adjust Proposed Medical Center Allocation Amounts. After receiving the spreadsheet from headquarters, network officials determine the allocation amounts for network initiatives and reserves, which affect the total amount of resources available for allocation to medical centers. Network officials then review and can make adjustments to the model's proposed allocation amounts for medical centers, as needed.[13] According to VA headquarters officials, these adjustments allow each network the flexibility to change the allocation amounts if they believe that certain medical centers' resource needs are not appropriately accounted for in the model.

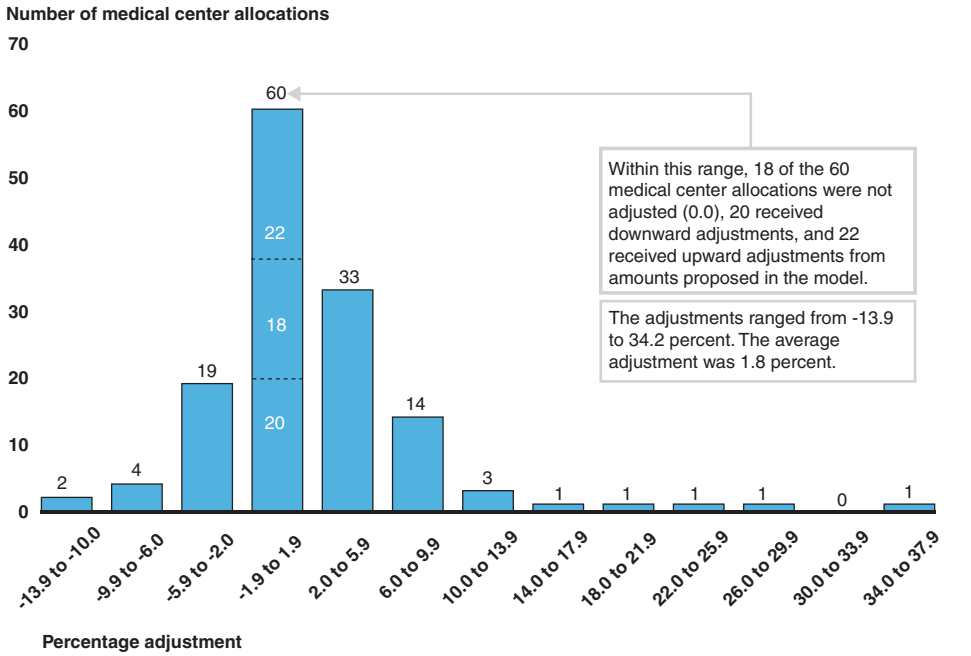
We reviewed the 21 networks' allocation spreadsheets, including the adjustments networks made to the medical center allocation amounts proposed by the new model. In our review, we found that, for fiscal year 2011, of the 140 medical center allocations,[14] 122 were adjusted from amounts proposed by the model—77 medical center allocations received an upward adjustment and 45 received a downward adjustment.[15] The remaining 18 medical center allocations were not adjusted. (See fig. 3 for networks' percentage adjustments to proposed allocations for medical centers.)

[13]Network adjustments to proposed allocation amounts for medical centers cannot increase or decrease the network's total allocation for the fiscal year.

[14]Because some medical centers in VA are combined, they receive a single allocation. Therefore, the number of medical center allocations is less than the total number of medical centers—153—that VA operated in fiscal year 2011.

[15]Regardless of adjustments from the amounts proposed in the model, in fiscal year 2011, 132 out of 140 medical center allocations represented an increase from the prior year's allocation.

Figure 3: Percentage of Network Adjustments to VA's Proposed Medical Center Allocation Amounts, Fiscal Year 2011



Source: GAO analysis of VA data.

Note: Because some medical centers in VA are combined, they receive a single allocation. Therefore, the 140 medical center allocations represented in this figure is less than the total number of medical centers—153—that VA operated in fiscal year 2011.

Officials from the six networks we interviewed told us that they adjusted the allocation amounts when they anticipated that one or more of their medical centers' resource needs would not be met by the amounts proposed in the model. Without these adjustments, network officials believed that some medical centers may not have been able to maintain the level of medical services for veterans in their service areas as they did previously. For example,

- Officials from one network told us they made adjustments that resulted in redistributing resources from other medical centers in the network to a rural medical center because the new model's measure of workload would not have appropriately determined the resources that the rural medical center needed to operate. According to network officials, this medical center has several community-based outpatient clinics that have not been cost effective to operate but nonetheless provide critical access to care for rural veterans. Therefore, the network made adjustments to the amounts

proposed in the model to ensure the medical center had sufficient resources to continue to provide access to veterans in these areas.

- Officials from another network told us that the fiscal year 2011 amount proposed in the model for one of its medical centers was 11 percent lower than the medical center's fiscal year 2010 allocation, and for another medical center, the fiscal year 2011 allocation amount was 18 percent higher than the amount in fiscal year 2010. Network officials told us that the former medical center would not be able to absorb such a cut in resources without negatively impacting services offered, and the latter medical center would not be able to spend the additional resources it would have received under the model within the fiscal year. Network officials told us that the model's proposed decreases to allocation amounts for some of its medical centers may have been due to inefficiencies in medical center operations, but adjustments were necessary to ensure these medical centers got the resources they needed to continue to operate. Network officials stated that they will likely continue to make adjustments in the future, but they plan to work with their medical centers to increase their efficiency and ensure that their resource needs are more in line with what the model provides.

- More generally, VA headquarters officials stated that some medical centers have resource needs that set them up to be recurring outliers to the model. For example, officials said that the outpatient clinic in Anchorage, Alaska, has significantly higher costs of care and therefore its resource needs likely will continue to exceed the amounts generated by the model.[16] VA headquarters officials explained that the Anchorage clinic and other outlier medical centers exist to ensure equitable access to care for veterans in all areas and that VA therefore expects that some will incur unavoidable high costs.[17] Network officials described certain factors contributing to particularly high costs at this clinic, including a heavy reliance on expensive community-based care and relatively high transportation costs associated with transporting patients from their homes to the medical center or between medical centers for more complex care or available services.

[16]This clinic is an independent outpatient clinic that receives resources in the same manner as medical centers.

[17]In addition to the general purpose resources allocated through the model, VA allocated specific purpose resources to this medical center to meet its resource needs.

VA headquarters officials told us they expected networks to make adjustments to the amounts proposed in the model for fiscal year 2011, but they also expected networks' allocations to medical centers to come closer to the amounts provided by the model over time. If certain medical centers continue to require significant adjustments to the amounts proposed in the model, this could be an indicator that the medical centers warrant further review or attention. VA officials said adjustment information could be used together with information from VA's managerial accounting systems (designed to help identify areas for management improvement or redesign) to identify areas for improving the medical centers' efficiency.

Step Three: Networks Report Final Allocation Amounts to VA Headquarters. Lastly, networks report to VA headquarters their final medical center allocation amounts, including the amounts and purposes of resources retained for network initiatives and the amount retained for network emergency reserves, using the original allocation spreadsheet that VA provided. Additionally, networks report any adjustments to the medical center allocation amounts proposed by the model. VA headquarters officials told us that the spreadsheets submitted by the networks provide headquarters with consistent information on all 21 networks' medical center allocations to more easily track network allocation decisions. However, VA did not collect information on the reasons for each adjustment networks made to proposed allocation amounts through the spreadsheet. Although VA provided networks a list of acceptable rationales for adjustments for fiscal year 2011, VA did not require networks to report these rationales for their adjustments in the spreadsheet.[18] As such, networks may have reported rationales for some adjustments, but networks also made adjustments for which they may not have reported a rationale. For example, one network reported detailed rationales for all adjustments to its medical center allocations (ranging from -13 percent to 34 percent), while another network did not report rationales for any of the adjustments it made to its medical center allocations (ranging from -14 percent to 17 percent). Officials said that the new network resource allocation process was not intended to be used to question networks' decision making, but rather to increase the

[18]For fiscal year 2011, VA's list of acceptable rationales included adjustments to account for staffing realignments, significant revenue changes, providing care in rural areas, and the impact of the new model. VA officials told us that if networks wanted to make an adjustment for a rationale not included in the list, they would need to obtain approval from VA headquarters.

transparency of networks' allocation decisions to VA headquarters while maintaining network flexibility for allocation decisions. However, absent rationales from networks for each adjustment made to medical center allocation amounts, transparency for decisions made through the new allocation process is limited.

VA officials told us they have begun to review the fiscal year 2011 allocation process and intend to conduct annual assessments of the network allocation process. VA officials said that this review will help them identify potential ways to improve the model for fiscal year 2012. VA officials told us they plan to complete their assessment by the end of fiscal year 2011. Additionally, VA officials told us that they plan to conduct an assessment of the network allocation process each subsequent year, including a review of adjustments to the model, to identify areas for improvement. VA officials stated that understanding these adjustments is key to identifying potential areas where the model could be modified and to respond to changing health care needs.

VA Monitors Resources to Ensure Spending Does Not Exceed Allocations, but Lacks Written Policies Documenting Practices for Monitoring Resources

VA monitors the general purpose resources networks have allocated to medical centers to ensure spending does not exceed allocations, but does not have written policies documenting these practices for monitoring resources. VA's lack of written policies documenting its monitoring is inconsistent with internal control standards applicable to all federal agencies and could put the agency's stewardship of federal dollars at risk.

VA centrally monitors the resources networks have allocated to medical centers through two primary practices—(1) automated controls in its financial management system, and (2) regular reviews of network spending. These practices help VA headquarters officials to manage VA resources to prevent network and medical center spending from exceeding their allocations and help to ensure that the agency does not violate the Antideficiency Act.[19] By monitoring network and medical center resources throughout the fiscal year, VA is able to recognize additional or changing needs that might not have been apparent when resources were initially allocated, and to work with networks to realign resources as

[19]The Antideficiency Act prohibits federal agencies from making obligations or expenditures in excess of the appropriations available, among other things. See 31 U.S.C. § 1341(a)(1).

appropriate, within the limits of the respective appropriations—Medical Services, Medical Support and Compliance, and Medical Facilities.

Specifically, VA headquarters officials told us that the agency maintains a financial management system that has automated controls in place that prevent networks and medical centers from spending more than their available resources. VA's financial management system electronically tracks the amount of resources that networks and medical centers have available—that is, the resources they were allocated, less the resources already spent.[20] When medical centers want to spend some of their resources, they enter requests for the obligation of funds into the system.[21] If the amount entered exceeds what is available to them, the request is rejected by the system, and cannot be processed.

VA headquarters officials also told us they monitor resources by regularly reviewing network spending—which includes the total spending of all medical centers within a network. On a monthly basis, they monitor resources by comparing each network's spending with its operating plan, which shows the network's plan for its medical centers' spending of resources for each month of the fiscal year, summarized at the network level and broken down by spending category—such as travel, personnel, and equipment costs—and appropriations account. Each network submits an operating plan to VA headquarters at the beginning of the fiscal year and revises the plan throughout the year as needed. VA headquarters officials told us they determine whether spending is on target with the operating plan or not, and whether any differences from the plan are significant.[22] VA headquarters officials told us that if they find differences that are significant, they contact network officials to discuss the differences, such as if the network appears to be behind on its spending in

[20]VA headquarters makes resources available to its networks on a quarterly basis, for use by medical centers; as such, the network's total allocation for the fiscal year is not available at the beginning of the fiscal year.

[21]An obligation is a definite commitment that creates a legal liability for the payment of goods and services ordered or received. An agency incurs an obligation, for example, when it awards a contract.

[22]VA headquarters officials told us they use a red/yellow/green color-coding system in their reviews of network spending. In this system, networks are coded as red if their spending is different from their operating plans, with a major impact on operations. Networks are coded as yellow if their spending is different from their operating plans, but with a minor impact on operations. Networks are coded as green if their spending is on target with their operating plans.

a particular category, based on what the network planned to spend in its operating plan. For example, a network may mention that one of its medical centers has a large contract pending that will be awarded later in the year. VA headquarters officials told us that they do not have specific criteria for which differences between what has been spent and what the network had planned to have spent would warrant further investigation; rather, they rely on their experience and judgment to know when a network may be in danger financially, based on their review of the network's spending and their regular communication with network officials. Officials also told us that they have biweekly teleconferences with network financial officers and meet with them in person on a quarterly basis to discuss any financial concerns.

However, VA does not have written policies documenting the agency's practices for monitoring the resources networks allocate to medical centers. For example, VA does not have a written policy documenting that one of its primary practices for monitoring is the automated controls in its financial management system. In addition, VA does not have a written policy that states the overall purpose and specific objectives of their monthly reviews of network spending compared with each network's operating plan.

VA's lack of written policies related to its monitoring of network and medical center resources is inconsistent with federal internal control standards and could put the agency's stewardship of federal dollars at risk. Internal control standards state that internal controls should be documented and all documentation should be properly managed and maintained, and readily available for examination.[23] Such policies are an integral part of a federal agency's stewardship of government resources. Without written policies that clearly define VA's objectives for monitoring resources and document existing practices, there is an increased risk that these internal control activities may not be performed, may be performed inconsistently, or may not be continued when knowledgeable employees leave, which can lead to unreliable monitoring of VA network and medical center resources.

[23]GAO/AIMD-00-21.3.1.

Conclusions

Although networks make decisions about how resources are allocated to medical centers, VA headquarters retains overall responsibility for oversight and management of VA's resources, including the process networks use to allocate resources. To its credit, VA has taken steps to increase the transparency for how networks allocate resources to medical centers, while maintaining network flexibility for allocation decisions. However, to make network decisions more transparent to VA headquarters, and to achieve its goal of having networks' allocations to medical centers come closer to the amounts proposed by VA's resource allocation model over time, VA headquarters must understand the specific reasons for any adjustments that networks make to the model. Understanding why networks made adjustments is key in determining if any modifications to the model are needed for subsequent years. Further, evaluations of the model are important to determine the viability of the allocation model each year and serve as a platform for making annual modifications to it, where warranted. VA's plan to conduct annual assessments of the allocation process will provide it the opportunity to identify and implement any modifications to the model—as medical centers' resource needs change over time—to ensure the process and its various components continue to be viable each year.

In addition, VA's current practices for monitoring help to ensure that network and medical center spending does not exceed allocations. However, without written policies to document its objectives for monitoring resources—including its existing practices—VA cannot ensure that monitoring will be performed consistently and reliably. For example, if current employees left the agency and new employees were asked to take on these monitoring activities, VA would not have policies to guide them. These new employees might be unable to perform these activities, or might perform them in a manner inconsistent with how the agency has performed them in the past, resulting in unreliable monitoring. Such possibilities could place VA's stewardship of federal dollars at risk. By documenting this information in a manner consistent with federal internal control standards, VA would have greater assurance that the practices developed by the current leadership will be maintained during management changes over time.

Recommendations for Executive Action

To increase the transparency of the new network allocation process, and to ensure that internal control activities are performed and that the resources networks allocate to medical centers are monitored consistently and reliably, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following two actions:

- require networks to provide rationales for all adjustments made to the allocation amounts proposed by the model in VA's resource allocation process; and

- develop written policies, consistent with federal internal control standards, to formalize existing practices for monitoring resources networks have allocated to medical centers.

Agency Comments

We provided a draft of this report to VA for comment. In its written comments, reproduced in appendix I, VA generally agreed with our conclusions, and concurred with our recommendations. VA stated that beginning in fiscal year 2012 the agency will require networks to provide rationales for all adjustments made to medical centers' allocation amounts proposed by the new resource allocation model. VA also stated that beginning in fiscal year 2012 it will provide written guidance consistent with federal internal control standards to formalize its existing practices for monitoring resources networks allocate to medical centers.

We are sending copies of this report to the Secretary of Veterans Affairs and interested congressional committees. The report also will be available at no charge on GAO's Web site at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff members who made major contributions to this report are listed in appendix II.

Randall B. Williamson
Director, Health Care

List of Requesters

The Honorable Jeff Miller
Chairman
The Honorable Bob Filner
Ranking Member
Committee on Veterans' Affairs
House of Representatives

The Honorable Jerry McNerney
Ranking Member
Subcommittee on Disability Assistance and Memorial Affairs
Committee on Veterans' Affairs
House of Representatives

The Honorable Michael Michaud
Ranking Member
Subcommittee on Health
Committee on Veterans' Affairs
House of Representatives

The Honorable Joe Donnelly
Ranking Member
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

The Honorable John Boozman
United States Senate

The Honorable Jerry Moran
United States Senate

The Honorable Brian P. Bilbray
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The Honorable Corrine Brown
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The Honorable Vern Buchanan
House of Representatives

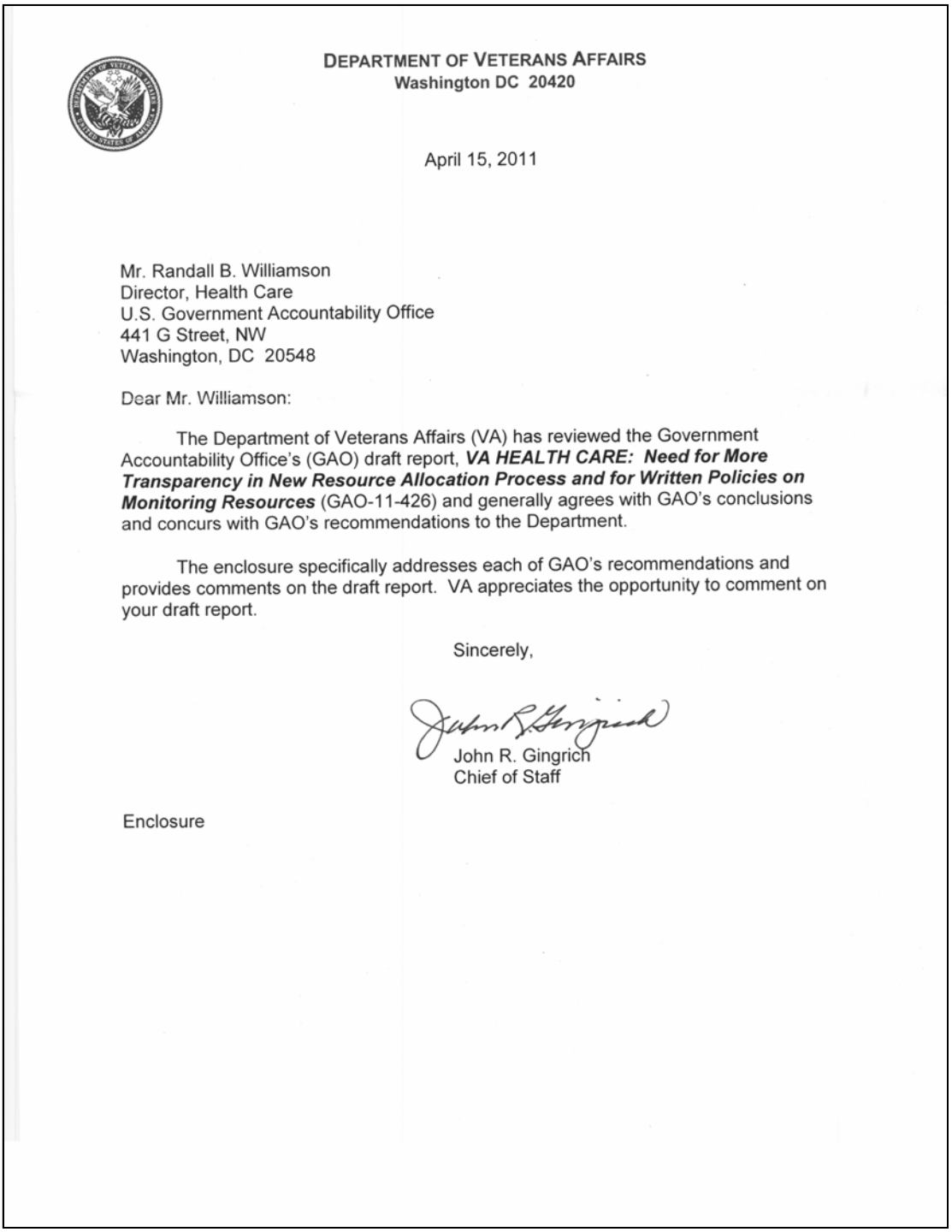
The Honorable Doug Lamborn
House of Representatives

The Honorable David P. Roe
House of Representatives

The Honorable Cliff Stearns
House of Representatives

The Honorable Timothy J. Walz
House of Representatives

Appendix I: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

April 15, 2011

Mr. Randall B. Williamson
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Williamson:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***VA HEALTH CARE: Need for More Transparency in New Resource Allocation Process and for Written Policies on Monitoring Resources*** (GAO-11-426) and generally agrees with GAO's conclusions and concurs with GAO's recommendations to the Department.

The enclosure specifically addresses each of GAO's recommendations and provides comments on the draft report. VA appreciates the opportunity to comment on your draft report.

Sincerely,

John R. Gingrich
Chief of Staff

Enclosure

Enclosure

**Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
*VA HEALTH CARE: Need for More Transparency in New Resource Allocation Process and for Written Policies on Monitoring Resources***
(GAO-11-426)

GAO recommendation: To increase the transparency of the new network allocation process, and to ensure that internal control activities are performed and that the resources networks allocate to medical centers are monitored consistently and reliably, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following two actions:

Recommendation 1: Require networks to provide rationales for all adjustments made to the allocation amounts proposed by the model in VA's resource allocation process.

VA response: Concur. Beginning with the fiscal year (FY) 2012 allocation process, the Veterans Health Administration (VHA) Chief Finance Officer (CFO) will require Veterans Integrated Service Network (VISN) Directors to provide rationales for all adjustments to amounts provided to medical facilities from those amounts initially proposed by VHA's resource allocation model.

Recommendation 2: Develop written policies, consistent with Federal internal control standards, to formalize existing practices for monitoring resources networks have allocated to medical centers.

VA response: Concur. Beginning with the FY 2012 VHA budget execution cycle, VHA's CFO will provide written guidance consistent with Federal internal control standards to formalize existing practices for monitoring FY 2012 and future resources that VISNs allocate to medical centers.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Randall B. Williamson, (202) 512-7114 or williamsonr@gao.gov

Staff Acknowledgments

In addition to the contact named above, Janina Austin, Assistant Director; Jennie F. Apter; Jessica Morris; Lisa Motley; and Julie T. Stewart made key contributions to this report.

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