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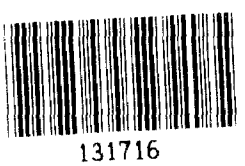
Report to the Chairman, Committee on Veterans' Affairs
United States Senate

September 30, 1986

FINANCIAL MANAGEMENT

An Assessment of the Veterans Administration's Major Processes

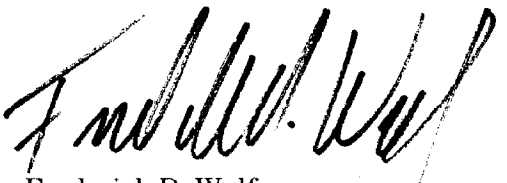


GAO/AFMD-86-7A

Volume 2 of 2

Preface

This is volume 2 of a two-volume report responding to the request of the former Chairman, Senate Committee on Veterans' Affairs, that we describe and assess the Veterans Administration's major financial management processes. This volume contains flowcharts and descriptions of those processes for fiscal year 1986. Changes to the processes for fiscal years 1987 and/or 1988, as provided by VA, are noted in the descriptions where appropriate. Any agency's management processes are dynamic and constantly evolving to adapt to changing circumstances. These descriptions provide a basic outline of the major steps in VA's financial management processes at a single point in time, and can serve as the basis for understanding changes in those processes since that time. Volume 1, under the same title, describes and analyzes the major strengths and weaknesses of VA's major financial management processes and the primary information they use. It is based on information from fiscal years 1984, 1985, and 1986. The report focuses largely on health care and the major construction process (the planning, design, and construction of health care projects costing more than $2 million).



Frederick D. Wolf
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Management Division

Contents

Abbreviations

ADA	Associate Deputy Administrator
ADP	Automated Data Processing
AMIS	Automated Management Information System
APF	Advance Planning Fund
B&F	Office of Budget and Finance
CALM	Centralized Accounting for Local Management
CBO	Congressional Budget Office
CMD	Chief Medical Director
CMDE	Casemix Direct and Education (costs)
COS	Chiefs of Staff
C&P	Compensation and Pension Office
CPM	critical path network

CRG	Consumption Related Group
DMA	Department of Memorial Affairs
DM&S	Department of Medicine and Surgery
DRG	Diagnosis Related Group
FEPAC	Facility Engineering, Planning, and Construction Office
FPS	Facility Planning Service
FSP	Facility Strategic Planning
FTEE	full-time employee equivalents
HCFS	Health Care Facilities Service
HSPS	Health Systems Planning Service
ICD-9-CM	International Classification of Diseases-- 9th revision (1979) Clinical Modification
IFB	invitation for bid
IG	inspector general
JCAH	Joint Commission on the Accreditation of Hospitals
LAOPC	Los Angeles Outpatient Clinic
LB	Long Beach VAMC
LL	Loma Linda VAMC
LVOPC	Las Vegas Outpatient Clinic
MEDIPP	Medical District Initiated Program Planning
NCAOs	National Cemetery Area Offices
NIH	National Institutes of Health
OMB	Office of Management and Budget
OPC	Outpatient Staff System
PA&D	Program Analysis and Development Office
PAID	Personnel Accounting and Integrated Data
PC&A	Program Control and Analysis
PDM	Program Decision Memoranda
PP&E	Office of Program Planning and Evaluation
PRCP	Primary Review Control Point
PROs	Peer Review Organizations
PTF	Patient Treatment File
RCS 10-141	Report of Medical Care Distribution Accounts
RCS 14-4	(now called the RCS 10-141)
RUG	Resource Utilization Group
SD	San Diego VAMC
SEP	Sepulveda VAMC
SERP	Systematic External Review
SPR	Specific Program Reviewers
TAG	Technical Advisory Group
VA	Veterans Administration
VACO	Veterans Administration Central Office
VAMC	Veterans Administration Medical Center
WLA	West Los Angeles VAMC
WWU	weighted work unit

Overview of VA's Central Office Financial Management Processes

Overall responsibility for the Veterans Administration's (VA) financial management process rests primarily with its Central Office (VACO) in Washington, D.C. Until December 1985, this overall process was jointly coordinated by the Offices of Budget and Finance and Program Planning and Evaluation in the Office of the Deputy Administrator. The major steps in this formal process include:

- prepolicy analysis, in which major organizational elements in VA define their goals and objectives;
- program planning and analysis whereby alternative means of achieving these goals and objectives are assessed, using a multiyear perspective (5 years—budget year plus 4), and the programmatic alternatives debated and selected through a review by the Deputy Administrator, assisted by the Offices of Budget and Finance and Program Planning and Evaluation;
- budget formulation, in which the resources initially allocated to programs chosen are refined for budget submission to the Office of Management and Budget (OMB) and the Congress;
- program and budget execution and monitoring, which includes developing program and financial operating plans and monthly budget execution reports that show the variance between planned and actual financial and program performances and explain the major variances; and
- program and financial evaluation, in which VA conducts mid-year and end-of-year assessments of how agency programs and organizations performed against financial and operating plans. Results are analyzed and used to adjust current operating plans, provide support for supplemental budget requests, and develop guidance for the next program planning and budget cycles.

The process that was used in developing the fiscal year 1986 budget submission, as well as changes made for the fiscal years 1987-91 program planning and fiscal year 1987 budget cycles, is explained in the following narrative.

Program/Budget Calls and Plans

The planning/programming process formally begins in late February or early March with the joint call by the Offices of Budget and Finance (B&F) and Program Planning and Evaluation[1] (PP&E) for 5-year program

[1]In late 1985, the name of the Program Planning and Evaluation Office was changed to Program Analysis and Evaluation. Its role in program and budget formulation was eliminated (that role is now centered in the Office of Budget and Finance), but its role in mid-year and end-of-year reviews was retained. Program Analysis is now responsible for all OMB management initiatives for VA, including

plans and budget estimates from each of VA's three operating departments—Memorial Affairs, Veterans Benefits, and Medicine and Surgery—and all staff offices, such as General Counsel and Construction. Guidance consists of two-volumes, one for the Department of Medicine and Surgery (DM&S) and one for all other organizations in VA. The program/budget call requires a total of 8 years of program and budget data. For example, fiscal years 1986-90 submissions would include data on the prior fiscal year (fiscal year 1983), the current year in execution (fiscal year 1984), the current budget request before the Congress (fiscal year 1985), the year for the budget in preparation (fiscal year 1986), plus 4 additional years (fiscal years 1987-90). Budget guidance is based on initial targets issued by OMB in mid-February, shortly after the President's budget is submitted to the Congress each year.

For the fiscal years 1987-91 program budget cycle, B&F and PP&E introduced a structured, formal strategic planning process to facilitate the presentation and discussion of major policy issues that need top management attention—that is, that of VA's Deputy Administrator and Administrator. The intent of the conference was to introduce strategic planning early in the process so that policy decisions reached as a result of these conferences could be used to guide the development of the 5-year program/budget plan.

In the past, many of the top management decisions were made during the June/July program review. If major policy adjustments were made, this left little time to revise program and budget plans prior to submission of VA's budget to OMB in September. For fiscal years 1987-91, VA introduced a planning conference for construction and began preliminary planning for one on automated data processing (ADP) management. Should this effort prove useful, the areas for which policy planning conferences are held may be expanded.

Program plans and budget estimates are due to Planning and Budget around May. They review the submittals, engaging in a continual informal dialogue with the various operating departments and staff offices. They use both internal and external audit reports and studies in their reviews. The program/budget submissions contain both prior actual and current estimated workloads (for example, benefit applications processed, appeals reviewed, patients treated) and budgets (that is, people, money, facilities). Sometime in June, B&F and PP&E notify the

the Financial Integrity Act, productivity improvements, and the Circular A-76 contracting of services initiatives.

departments and staff offices of any "major issues" they intend to raise at the hearings before the Deputy Administrator and recommendations they will propose to the Deputy Administrator for altering department and staff office program and budget submissions.

These recommendations and major issues are also forwarded to the Deputy Administrator, who holds hearings in late June or early July. The Deputy may sustain the position of the individual departments and offices, the recommendations of Planning and Budget, or reach a different conclusion altogether. Departments and staff offices may appeal the Deputy's "preliminary decisions" to the Administrator, but in doing so must present new evidence to support their positions. They may not ask the Administrator to overturn the Deputy Administrator's decision solely on the basis of information already reviewed.

Budget Formulation/ Presentation

The final Program Decision Memoranda (PDM) are issued after the Administrator has decided all appeals. These documents become the basis for final budget preparation (here, the fiscal year 1986 budget) and mark the end of the program/planning phase. Initial budget preparation has already begun, and preliminary budget figures are used on the 5-year program/budget submissions. During this final phase of budget preparation, the process is dominated by B&F and the budget offices of the operating departments. Preparation is guided by the requirements of OMB Circular A-11.

VA's budget is due to OMB no later than September 15 each year. OMB budget examiners review VA's budget and schedule hearings. In preparation for these hearings and/or as a result of them, VA may have to provide additional information to OMB. During its review of the fiscal year 1986 budget, for example, OMB asked VA to provide the estimated cost savings of limiting medical care for veterans who are eligible only because they are 65 and over to those who are indigent. At that time, the law provided that all veterans 65 and over were eligible for VA medical care.[2]

[2]In April 1986, the Congress passed the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272). Title XIX of that law eliminated the automatic eligibility for veterans 65 or over. Under the new law, all veterans, including those 65 and over, who have a nonservice-connected disability and are not otherwise eligible may receive free VA health care only if their annual income is below specified income levels. Such veterans with incomes above that level may receive VA health care on a space-available basis if they agree to pay the applicable cost of their care as determined by VA under the act.

Normally, OMB would transmit its "mark," or changes to VA's budget request, to VA in mid-to-late November. However, for fiscal year 1986, VA did not get its mark until December 31, 1984. VA may appeal its mark, first to the Director of OMB, and then to the President. Once the President has made his decisions, agencies receive final instruction on the preparation of documents for the President's budget and congressional justification books. The VA budget is submitted to the Congress, along with the rest of the President's budget, usually in late January (February 4, 1985, for the fiscal year 1986 budget).

Congressional Review

From January to late August or early September, the Congress reviews VA's budget. The Senate and House Veterans Affairs' Committees and Appropriations Committees hold hearings and report legislation. If the Congress has not passed VA's appropriation prior to the beginning of the fiscal year, VA may operate all or part of the year on a continuing resolution.

Budget Execution

In August, while the Congress is considering VA's budget request, B&F and PP&E issue a call for program and financial operating plans for the fiscal year beginning October 1.[3] The operating departments and staff offices prepare these plans using the numbers in the President's budget request. The program plans indicate anticipated operating levels (that is, patient visits, benefit applications, burials) and the financial plans' anticipated obligation rates.

Due in September, these plans are reviewed by B&F and PP&E. Approved plans form the basis for VA's apportionment requests to OMB in late September. OMB normally apportions VA's budget shortly after the start of the fiscal year. VA, in turn, allots funds to its various offices and programs for obligation. The program and financial operating plans are also the base used in VA's monthly budget execution reports showing planned versus actual program and financial operating performance during the fiscal year. Major variances from the plan are explained in these reports, which are sent to the Administrator and Deputy Administrator of VA, the Congress, OMB, and the Congressional Budget Office (CBO).

[3]Beginning with fiscal year 1987, the call and guidance for the development of program operating plans will originate with the Associate Deputy Administrator for Management, who will also review and approve the plans. The Deputy Associate for Management will also be responsible for reviewing and approving VA's Automated Data Processing and Management Information Systems 5-year plans and budget requests. The VA Controller will continue to be responsible for the guidance and review of financial operating plans, and for the call and review of the 5-year program budget plans, other than ADP and Management Information Systems.

In March of each fiscal year, VA reviews its missions, goals, and objectives in preparation for the mid-year review usually held in April. B&F and PP&E again jointly issue instructions for the preparations for this review, at which the Deputy Administrator and Administrator assess how each department and office has performed against its operating and financial plans.

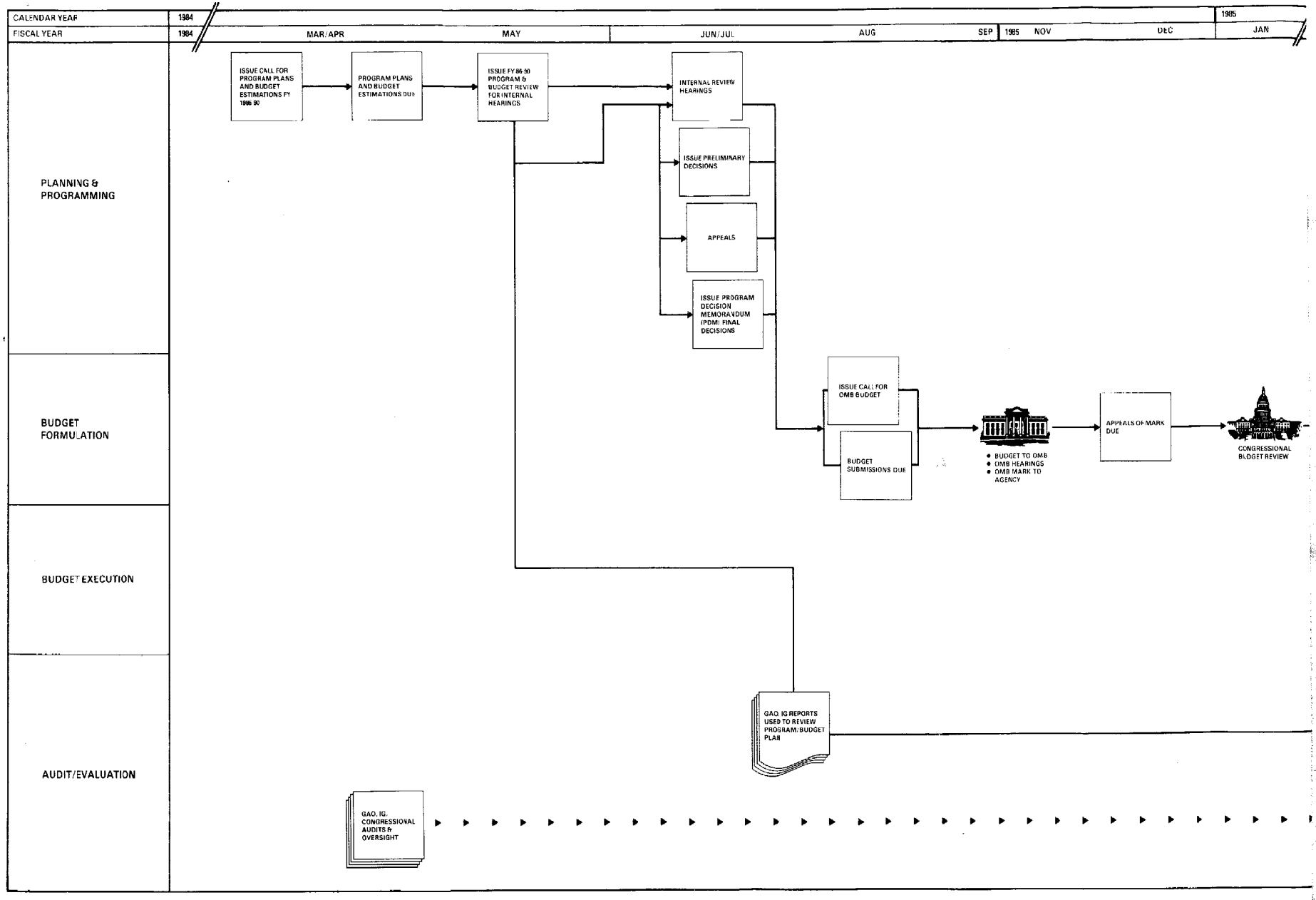
Audit/Evaluation

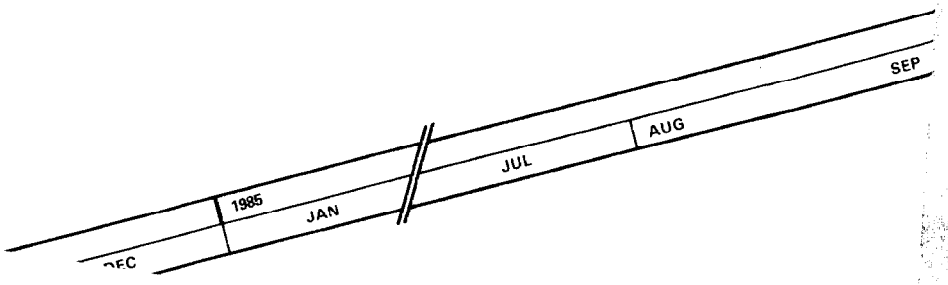
In fiscal year 1984, program and financial reviews were scheduled quarterly. However, for fiscal year 1985, only mid-year and end-of-year reviews were held to minimize paperwork and permit more intensive assessments. The results of the April mid-year review may, if warranted, be used to adjust the program/financial plans for the remainder of the fiscal year, and/or support supplemental budget requests.

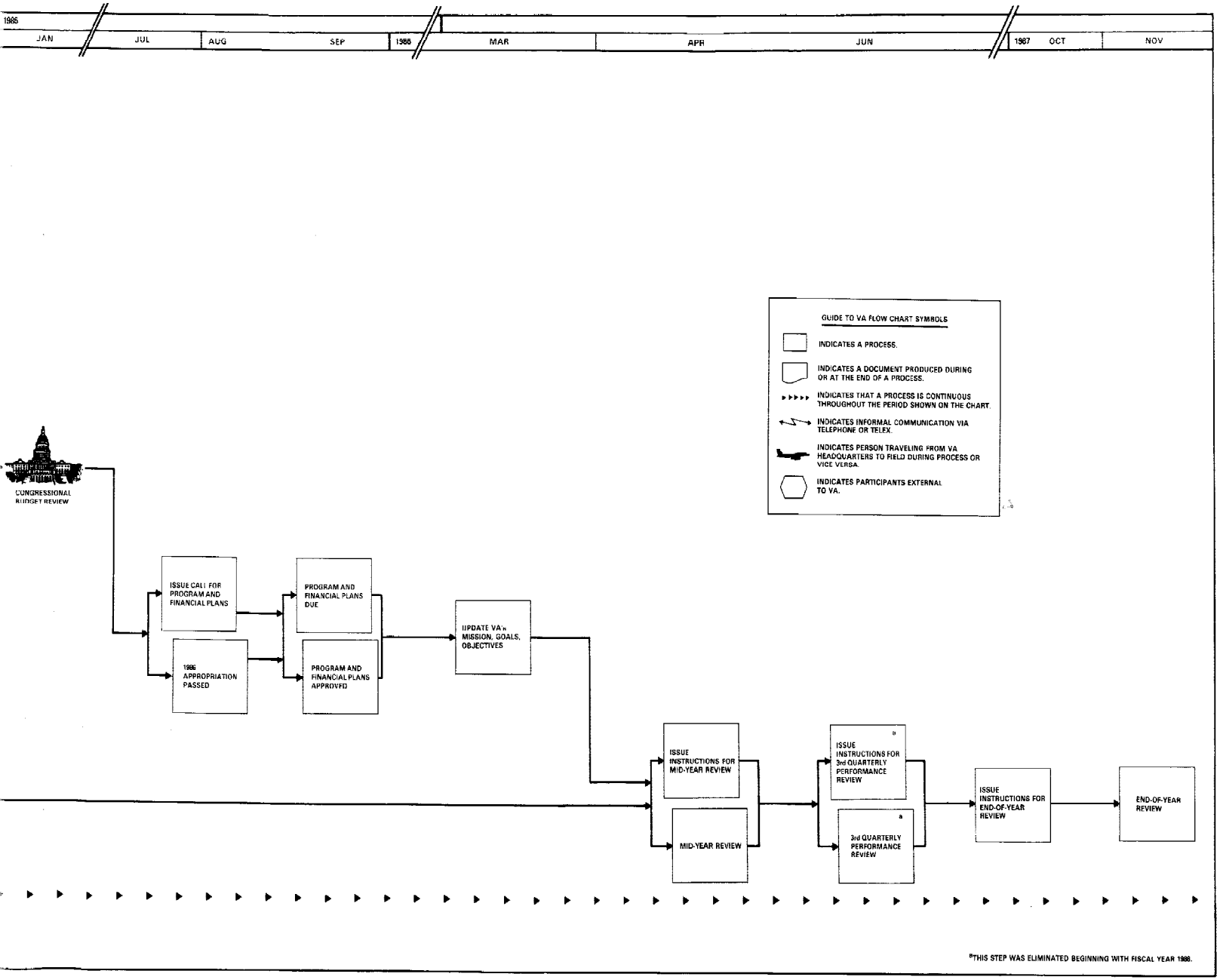
Finally, in November, following the September 30 end of the fiscal year, VA conducts an end-of-year review to assess the program and financial results of the fiscal year just ended. The results of this review are used to adjust, if necessary, the operating and financial plans for the fiscal year in execution, and as input to the development of the program/budget call for the next program plan/budget cycle.

During the entire financial management cycle, a variety of studies by the VA Inspector General (IG), GAO, and the Congress are issued which can be used by VA to improve financial management. Additionally, in compliance with the requirements of the Federal Managers' Financial Integrity Act, each December VA issues an assessment of the internal control weaknesses in its financial management systems that affect the reliability and accuracy of the information produced by those systems. These reports also contain VA's plans to address any identified weaknesses. Further information on VA's plans to improve its financial management systems is found in its annual ADP 5-year plan.

Figure I.1: Central Office Financial Management Processes for FY 1986




1985
JAN
JUL
AUG
SEP



[a]THIS STEP WAS ELIMINATED BEGINNING WITH FISCAL YEAR 1988.

The Department of Memorial Affairs' Financial Management Processes

Planning/Programming

VA's Office of the Deputy Administrator issues the program/budget call in early March. VA's Central Office (VACO), in response to the call, requests from the three National Cemetery Area Offices (NCAOs) their budget requests. Each of the NCAOs is responsible for a segment of the more than 100 field office cemeteries in the country. VACO provides the NCAO directors with guidance for formulating the budget requests, such as interment (burial) estimates and fiscal year 1985 "current services." The current service level is the level of operations for the program if it were to be continued at the current year level without policy changes or new initiatives. The NCAOs are required to submit the budget requests by May 1 each year. The budget requests may exceed the guidance if justification is submitted.

The NCAO directors provide guidance to the field offices and request budgets by April 1 (now May 1) each year. The Central Office develops its fiscal year general operating expense budget after discussing requirements with the Memorial Affairs Director, the Cemetery Service, and the Monument Service.

The NCAO directors review and consolidate the field office budget requests. They can make changes to the field office budget requests after consultation with the field office. They then submit the consolidated budget requests to the Central Office.

The Department of Memorial Affairs (DMA) at the Central Office reviews the budget plan, then submits it to the Office of Program Planning and Evaluation (PP&E) and the Office of Budget and Finance (B&F). These offices review the plan and prepare recommendations for the preliminary budget hearings.

PP&E, B&F, DMA, and the Administrator participate in the preliminary budget hearings held in late June and early July. Various GAO, IG, and congressional reports are used in the reviews.

Budget Formulation

In August, on the basis of the preliminary budget hearings, the DMA prepares the fiscal year budget request for submission to OMB.

The DMA submits its budget request to OMB by September 15 each year. OMB hearings are held on the budget request and OMB allowances ("mark") are provided. The VA has a right to appeal. The fiscal year budget was submitted to the Congress on February 4, 1985.

Budget Execution

About May of each year, the Central Office notifies the NCAO directors that individual Cemetery Operating Plans and a Consolidated Area Plan are due by August 1. The Central Office provides funding and employment guidance based on the President's budget request and budget requests submitted by each NCAO. The guidance includes the anticipated supplemental funding for the General Schedule and Wage Board pay raises, if applicable.

Also in May, the NCAOs request operating plans from the field offices. The operating plans are based on the President's budget and levels agreed to between NCAOs and field offices. In June, the field offices submit their operating plans to the NCAOs. The NCAOs then review the plans and consolidate them into a total area plan.

The Office of the Deputy Administrator issues the call for program and financial plans for the forthcoming fiscal year.

In September, the DMA receives the plans from the NCAOs, consolidates them into one plan, and submits it to Budget Service for review. After all issues are resolved, the Assistant Deputy Administrator for Budget and Finance approves the plan.

The field offices receive the approved operating budget plans in October. Each cemetery (field office) is expected to operate within the approved plan. Each NCAO director is responsible for assuring that area payroll funding is not diverted to non-payroll funding. Reprogramming of payroll funding requires Central Office approval.

Each month the Central Office generates a variance report from Centralized Accounting for Local Management (CALM). This report compares actual obligations with the operating plan and the resulting variances.

Each month the Central Office also prepares a top management variance report based on the CALM variance reports. The major variances are explained in this report. The Central Office distributes this report to the Congress, OMB, CBO, and to various offices within the Central Office.

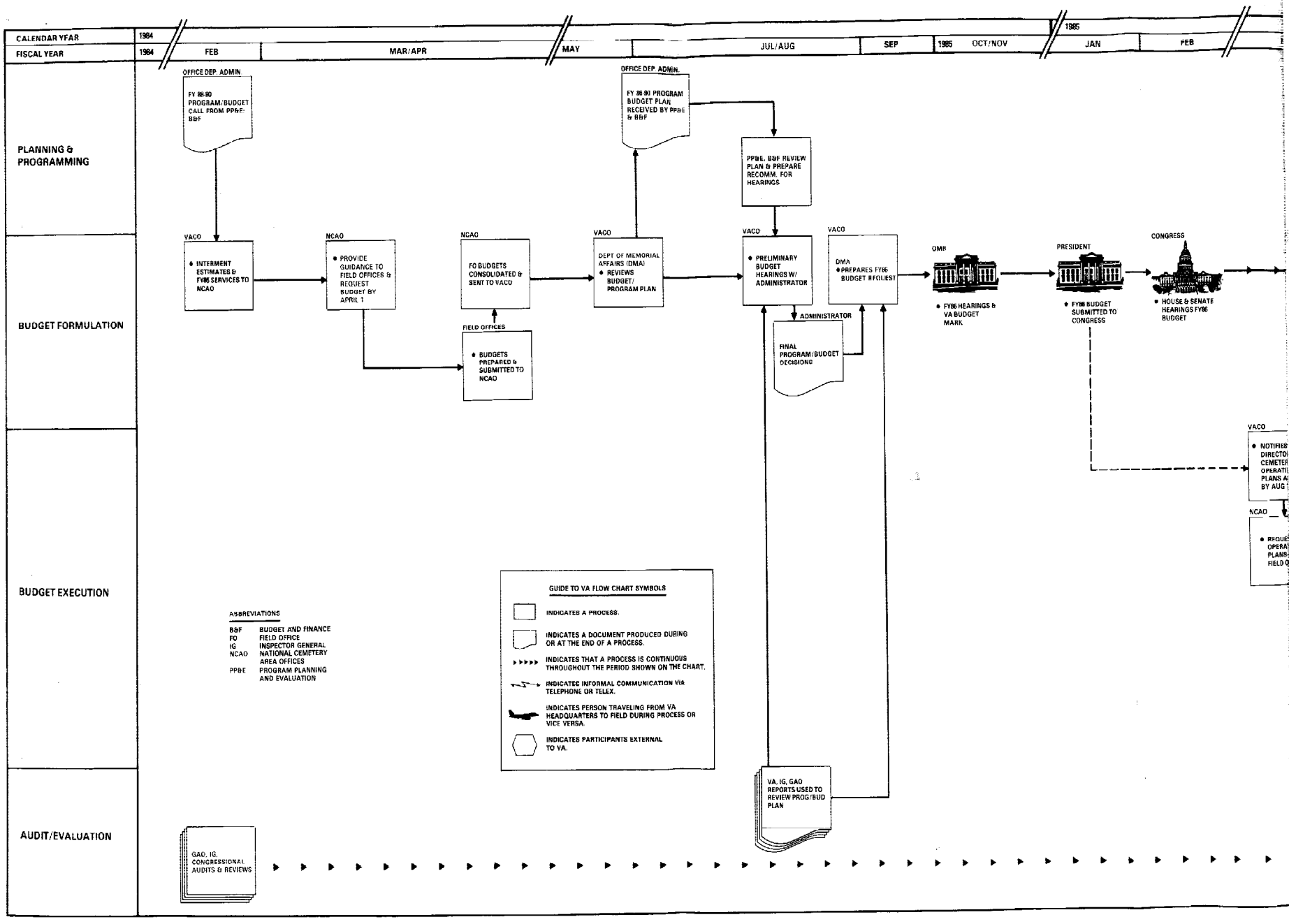
Mid-year and end-of-year reviews of operations are required. The Central Office reviews and adjusts the department plan to make it consistent with current requirements. The Office of the Deputy Administrator reviews and approves the adjusted plan. PP&E and B&F issue guidelines for the end-of-year review in October following the end of the fiscal year. The end-of-year review is held in November and findings are used

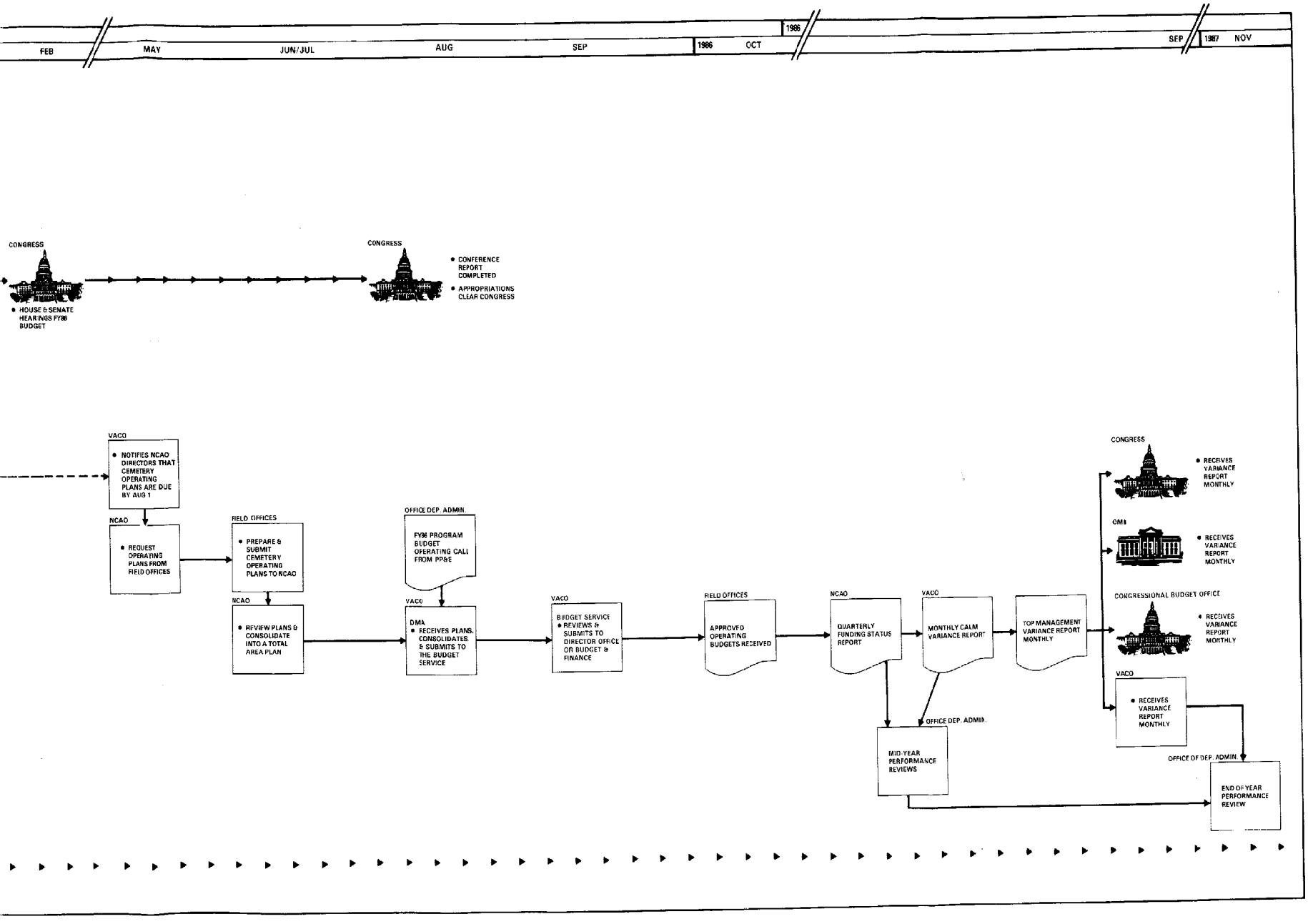
to adjust current operating plans and guidance for developing the next fiscal year's budget. GAO, IG, and congressional reports are used to review the program/budget plans.

Audit/Evaluation

During the entire financial management cycle, a variety of studies by VA's IG, GAO, and the Congress are issued which can be used by VA to improve financial management. Additionally, in compliance with the requirements of the Federal Managers' Financial Integrity Act, each December VA issues an assessment of the internal control weaknesses in its financial management systems that affect the reliability and accuracy of the information produced by those systems. These reports also contain VA's plans to address any identified weaknesses.

Figure II.1: Department of Memorial Affairs' Financial Managment Processes for FY 1986




FEB
MAY
JUN/JUL
AUG
SEP
1986
OCT
1986
SEP
1987
NOV
CONGRESS
• HOUSE & SENATE HEARINGS FY86 BUDGET
CONGRESS
• CONFERENCE REPORT COMPLETED
• APPROPRIATIONS CLEAR CONGRESS
VACO
• NOTIFIES NCAO DIRECTORS THAT CEMETERY OPERATING PLANS ARE DUE BY AUG 1
NCAO
• REQUEST OPERATING PLANS FROM FIELD OFFICES
FIELD OFFICES
• PREPARE & SUBMIT CEMETERY OPERATING PLANS TO NCAO
NCAO
• REVIEW PLANS & CONSOLIDATE INTO A TOTAL AREA PLAN
OFFICE DEP. ADMIN.
FY86 PROGRAM BUDGET OPERATING CALL FROM PP&E
VACO
DMA
• RECEIVES PLANS, CONSOLIDATES & SUBMITS TO THE BUDGET SERVICE
VACO
BUDGET SERVICE
• REVIEWS & SUBMITS TO DIRECTOR OFFICE OR BUDGET & FINANCE
FIELD OFFICES
APPROVED OPERATING BUDGETS RECEIVED
NCAO
QUARTERLY FUNDING STATUS REPORT
VACO
MONTHLY CALM VARIANCE REPORT
TOP MANAGEMENT VARIANCE REPORT MONTHLY
CONGRESS
• RECEIVES VARIANCE REPORT MONTHLY
OMB
• RECEIVES VARIANCE REPORT MONTHLY
CONGRESSIONAL BUDGET OFFICE
• RECEIVES VARIANCE REPORT MONTHLY
VACO
• RECEIVES VARIANCE REPORT MONTHLY
OFFICE DEP. ADMIN.
MID-YEAR PERFORMANCE REVIEWS
OFFICE OF DEP. ADMIN.
END OF YEAR PERFORMANCE REVIEW

budget and submits it to OMB on September 15. OMB hearings are held on the budget and OMB allowances ("mark") are provided, usually in mid to late November. The VA has a right to appeal. The budget is submitted to the Congress in January, and Senate and House hearings begin in March.

Budget Execution

In August, the Office of the Deputy Administrator issues the call for program and financial plans for current year operations.

The field offices use the allowances provided by the Central Office to prepare operating plans. In September, the field offices submit the operating plans to the Central Office, which then reviews and consolidates the plans and submits the current year departmental plan to the Office of the Deputy Administrator for review.

Each month the Budget Staff compares actual obligations with the operating plan and reports the resulting variances. Also each month, B&F prepares a top management report in which the major variances are explained. It then distributes this report to the House and Senate Veteran Affairs and Appropriations Committees, OMB, CBO, and to various offices within the Central Office.

Mid-year and end-of-year reviews of operations are required. The Budget Staff reviews and adjusts the department plan during the year to make it consistent with current requirements. B&F reviews and approves the adjusted plans. Mid-year and end-of-year reviews of operations are required. PP&E[1] and B&F issue guidelines for the end-of-year review in October following the end of the fiscal year. The end-of-year review is held in November and actual deviations to the final plan are explained. GAO, VA IG, and congressional reports are used to review the program/budget plans.

Audit/Evaluation

Throughout this entire 48-month cycle, the VA IG's Office and GAO, and sometimes congressional committees, are conducting audits, evaluations, and other studies of VA's operations. Those studies identify potential means of improving VA's operations and increasing program efficiency. As previously noted, Program Planning and Budget and Finance use these studies to highlight potential savings and improvements in reviewing DM&S' 5-year program/budget plans.

[1]PP&E retained its role in mid-year and end-of-year reviews.

The Department of Veterans Benefits' Financial Management Processes

Planning/Programming

The Department of Veterans Benefits' Budget Staff at the Central Office requests workload and employment estimates from the field offices. The field offices submit the estimates to Compensation and Pension (C&P) budget service during March and April.

VA's Office of the Deputy Administrator issues the 5-year program/budget call in late February or early March. The call involves an update of Department and staff office goals, the formulation of the 5-year program plans and budget estimates necessary to achieve these goals, and the identification of planned actions to be accomplished during the 5-year planning cycle.

The Central Office estimates the benefit payments and the staffing requirements. It has categorized all process steps necessary to produce its end products. About every 2 years the Office performs time and motion studies to determine the average time required to perform each step. Based on the expected workload and these average times, the Office projects its staffing requirements. It estimates the benefit payments from a trend analysis of past benefit payments by periods of service such as World War II, the Vietnam War, etc. The Budget Staff analyzes the average cost per case and caseload for each period of service for the past several years and projects the caseload and average cost per case based on the historical data. The estimate for benefit payments is then derived from the projected caseload and average cost per case.

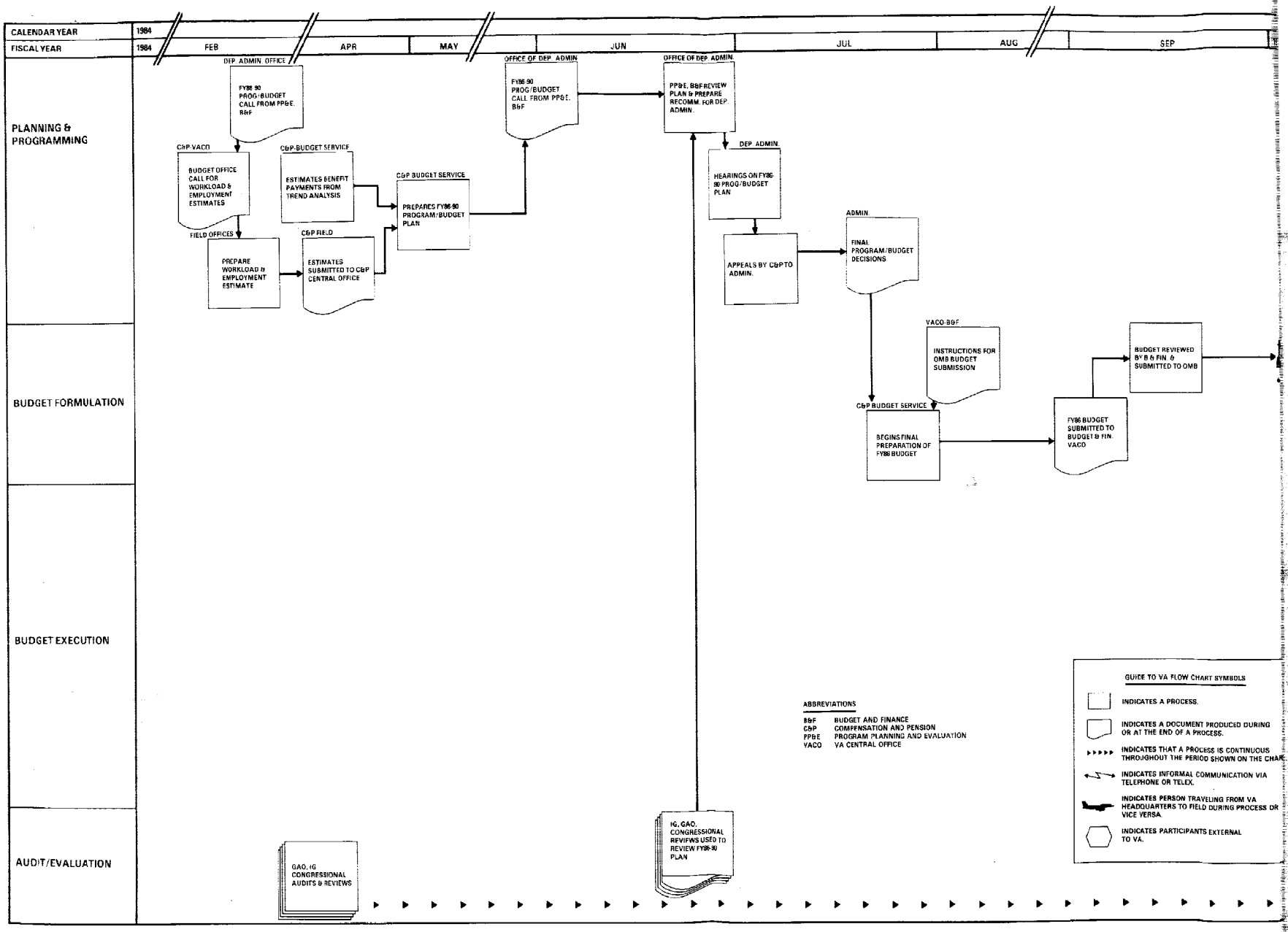
The Central Office and the fields' estimates are compared and the differences are analyzed. Central Office program officials, with the field input, develop final estimates for workload and staffing. The budget staff prepares the 5-year program budget plan based on final decisions and submits it to the Office of Program Planning and Evaluation (PP&E) and the Office of Budget and Finance (B&F) for review. These offices then prepare recommendations for the Deputy Administrator's review. Various GAO, VA IG, and congressional reports are used in the reviews.

The Office of the Deputy Administrator holds hearings on the 5-year program/budget plan in late June and July. Any appeals by the Department of Veterans Benefits are made to this Office. Usually, the Office makes the final program/budget decisions in mid to late July.

Budget Formulation

In August, the Department of Veterans Benefits Budget Staff prepares the OMB budget submission using instructions from B&F. B&F reviews the

Figure III.1: Department of Veterans Benefits' Financial Management Processes for FY 1986



of the VA Deputy Administrator, issued Program/Budget guidance to all VA organizations for fiscal years 1986-1990. This annual guidance contains the VA Administrator's program goals and assumptions, and OMB's inflation, unemployment, and economic growth assumptions for use in developing the 5-year program/budget plans. The guidance also identifies the program performance indicators (such as expected number of outpatient visits) to be used in the program/budget plans.

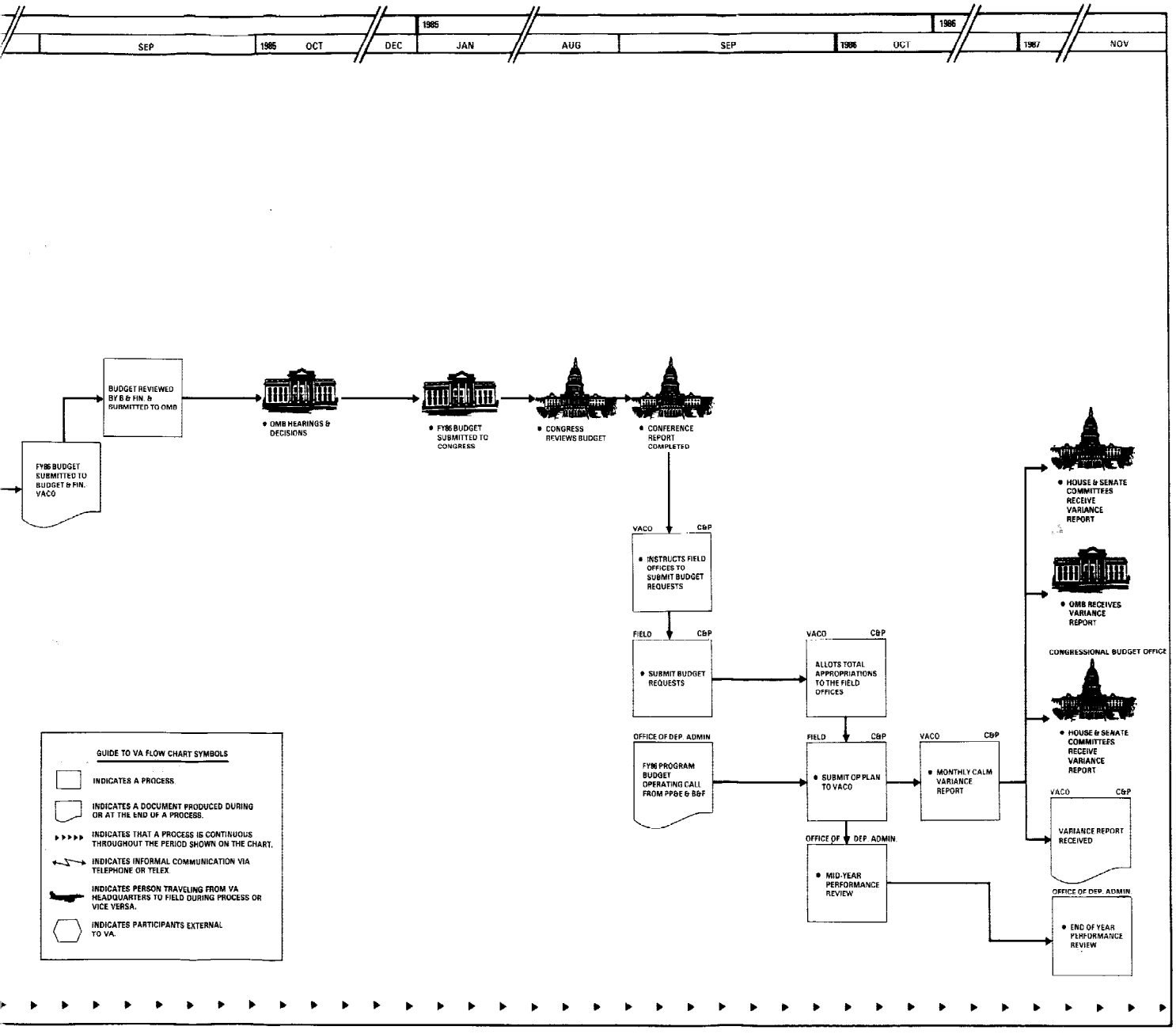
DM&S, in turn, prepares a program budget call for its various organizational components. After review by the DM&S Budget Office and the Chief Medical Director (CMD), these plans are submitted in May for review by PP&E and B&F. These offices analyze the submissions, prepare decision memoranda justifying any changes, and notify DM&S of any proposed changes to their submissions, usually by mid to late June. In conducting their review, these offices use VA IG and GAO reports as sources of potential budgetary savings and management improvements.

Hearings are held before the VA Deputy Administrator in late June or early July, and preliminary Program Budget Decisions are issued shortly thereafter. DM&S may appeal these decisions to the Administrator, but only if it can present new evidence showing why the Deputy Administrator's decision(s) should be reversed or altered. Final Program Budget Decisions are issued by the Administrator in late July.

Budget Formulation/ Presentation

Throughout May and June, the DM&S Budget Office works on the DM&S budget proposal. Any changes required by the Administrator's final Program Budget Decisions are incorporated. In July, OMB issues final instructions for budget preparation for VA and OMB review in Circular A-11. VA's Office of Budget and Finance incorporates any of the OMB requirements into its own budget guidance sent to DM&S (and all other VA organizations) in early August of each year. Final budget preparations continue through August. The budget is reviewed by the Chief Medical Director, then the VA Budget and Finance Office, and finally, the VA Deputy Administrator and Administrator. The VA budget is submitted to OMB for review on September 15 of each year.

OMB holds hearings on VA's budget around October, and a preliminary budget "mark"—OMB's preliminary budget decisions— is given to VA usually around Thanksgiving. VA can appeal this mark first to the OMB Director and then, if it wishes, to the President. Final decisions on appeals are normally made in late December; VA then prepares the


1985
1986
SEP
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JAN
AUG
SEP
1986 OCT
1986
1987
NOV
FY86 BUDGET SUBMITTED TO BUDGET & FIN. VACO
BUDGET REVIEWED BY B & FIN. & SUBMITTED TO OMB
• OMB HEARINGS & DECISIONS
• FY86 BUDGET SUBMITTED TO CONGRESS
• CONGRESS REVIEWS BUDGET
• CONFERENCE REPORT COMPLETED
VACO C&P
• INSTRUCTS FIELD OFFICES TO SUBMIT BUDGET REQUESTS
FIELD C&P
• SUBMIT BUDGET REQUESTS
VACO C&P
ALLOTS TOTAL APPROPRIATIONS TO THE FIELD OFFICES
OFFICE OF DEP. ADMIN.
FY86 PROGRAM BUDGET OPERATING CALL FROM PP&E & B&F
FIELD C&P
• SUBMIT OP PLAN TO VACO
VACO C&P
• MONTHLY CALM VARIANCE REPORT
OFFICE OF DEP. ADMIN.
• MID-YEAR PERFORMANCE REVIEW
• HOUSE & SENATE COMMITTEES RECEIVE VARIANCE REPORT
• OMB RECEIVES VARIANCE REPORT
CONGRESSIONAL BUDGET OFFICE
• HOUSE & SENATE COMMITTEES RECEIVE VARIANCE REPORT
VACO C&P
VARIANCE REPORT RECEIVED
OFFICE OF DEP. ADMIN.
• END OF YEAR PERFORMANCE REVIEW
GUIDE TO VA FLOW CHART SYMBOLS
INDICATES A PROCESS.
INDICATES A DOCUMENT PRODUCED DURING OR AT THE END OF A PROCESS.
INDICATES THAT A PROCESS IS CONTINUOUS THROUGHOUT THE PERIOD SHOWN ON THE CHART.
INDICATES INFORMAL COMMUNICATION VIA TELEPHONE OR TELEX.
INDICATES PERSON TRAVELING FROM VA HEADQUARTERS TO FIELD DURING PROCESS OR VICE VERSA.
INDICATES PARTICIPANTS EXTERNAL TO VA.

Initial target allowances are sent to the regions for review and approval. If necessary, changes are made based on regional comments. The revised target allowances are sent to the districts through the regions. The districts, in turn, review the allowances and distribute them to the medical facilities within the district. The medical facilities review their allowances, develop annual operating plans based upon them, and submit them through the regions to the DM&S Central Office. The districts review the plans and advise the regions on needed changes, if any. During June and July, the DM&S Central Office, assisted by the regions, reviews the hospital operating plans.

In August, PP&E and B&F issue their call for program and financial operating plans. DM&S submits its plan, which is a consolidation of the operating plans for its hospitals, its Central Office, and the regions. PP&E and B&F review the plans and suggest revisions, and the Deputy Administrator makes any final decisions around late August.

Also in late August, if the Congress has passed its appropriation, DM&S sends its apportionment request (that is, its request for how it wants its appropriation allotted every 3 months during the fiscal year) to VA's Office of Budget and Finance, which reviews it, changes it if necessary, and sends it to OMB. OMB reviews and approves the apportionment forms and returns them to VA. VA, in turn, allots (that is, distributes) the funds to DM&S, which allots them to its regions, districts, and hospitals on the basis of the approved operating budgets.

During the fiscal year, hospitals report monthly to the districts and regions on how their actual obligation of funds compare to their operating plans, explaining any variances. If an emergency arises, say a boiler unexpectedly breaks down in the middle of the winter, the region can identify a source of funds from one district or hospital to make the repair or buy the replacement. There are two committees in DM&S' Central Office for reallocating funds during the fiscal year between hospitals and districts. The Resource Advisory Committee has responsibility for requests of more than $1 million, and the Resource Allocation Committee has responsibility for requests of less than $1 million. The regions advise both these committees on district and hospital requests for reallocation of funds during the fiscal year.

Overview of the Department of Medicine and Surgery's Financial Management Processes

The Department of Medicine and Surgery's (DM&S) financial management cycle covers a span of about 48 months. Planning for fiscal year 1986 began in January 1983. The budget was developed in the spring and summer of 1984, reviewed by OMB in the fall of 1984, and submitted to the Congress for review in January 1985. The fiscal year began on October 1, 1985, and end-of-year program and budget review will take place in November 1986.

What follows is an overview of DM&S' financial management process for fiscal year 1986. Changes in this process for subsequent fiscal years are noted as appropriate. More detailed descriptions of three phases of the process—planning/ programming, budget formulation/presentation, and budget execution/monitoring—are found in this appendix and in the accompanying flowcharts, figures IV.3, IV.4, and IV.5.

Medical Care Planning

VA's medical care planning/programming process is called the Medical District Initiated Program Planning process, or MEDIPP. The purpose of MEDIPP is to assess the future medical care needs of eligible veterans and identify the actions necessary to meet those needs. The DM&S Central Office prepares MEDIPP guidance and sends it to the 27 medical districts around January of each year. Beginning in 1985, the seven regions will also provide MEDIPP guidance to the districts within each region.[1]

In early 1983, guidance for developing the November 1983 MEDIPP plans was sent to the districts. These plans contained proposals for inclusion in the DM&S budget requests for fiscal years 1986 through 1990. The districts worked on developing their MEDIPP plans through September 1983. The plans were submitted to the regions for review in October and the DM&S Central Office in November 1983.

From November 1983 through April 1984, the DM&S Central Office reviewed the plans, grouped and ranked MEDIPP proposals, and began making final decisions on which proposals should be included in the 1986 budget request.

At the same time, in March 1984, the Office of Program Planning and Evaluation (PP&E)[2] and the Office of Budget and Finance (B&F), on behalf

[1]Prior to a reorganization in 1985, there were 28 medical districts and 6 regions.

[2]In late 1985, the name of this office was changed to the Office of Program Analysis and Evaluation. Its role in program planning and budgeting was eliminated, and this responsibility now resides with the Office of Budget and Finance.

budget for submission to the Congress in conformance with these decisions.

From late January or early February, when the President submits his budget to the Congress, through late September, the Congress reviews the budget and makes its decisions. A final appropriation should be passed in time for the beginning of the fiscal year on October 1 each year.

Budget Execution/ Monitoring

At the same time that the Congress is reviewing the fiscal year 1986 DM&S budget request, DM&S is beginning the process of allocating that budget to its medical districts and medical facilities. In late February 1985, using its budget request as the base, DM&S began developing fiscal year 1986 operating budgets, called "target allowances," for its 172 hospitals.

Those budgets are based, in part, on each hospital's workload and costs for the preceding fiscal year, as measured by DM&S' Casemix Resource Allocation Methodology. (See pages 67 to 75 for a more detailed discussion of the methodology.) For example, fiscal year 1986 budgets were based on the workload and costs reported for fiscal year 1984, the latest fiscal year for which complete figures were available at the time the operating budgets were developed (which was during the spring of 1985, mid-way through fiscal year 1985).

The casemix methodology adjustment for each hospital's fiscal year 1985 operating budget applied solely to acute hospital care, that is, workload due to the hospitalization of patients. For fiscal year 1986, the casemix adjustment was expanded to include both outpatient and long-term care. To permit a smooth transition to the new system, no hospital's fiscal year 1986 budget was adjusted up or down by more than 3 percent based on the casemix methodology. The percentage of a hospital's budget that is based on the casemix will increase annually. DM&S' goal is eventually to have about 75 percent of a hospital's budget based on the casemix methodology. Until then, the majority of a hospital's operating budget is derived by incrementally adjusting its current budget for expected changes in utility rates, labor costs, supplies, drugs, etc. Changes are also made based on the opening of new or expanded facilities, such as a nursing home or outpatient clinic associated with a hospital.

The Offices of Program Planning and Evaluation[3] and Budget and Finance also conduct mid-year and end-of-program and financial performance reviews. These reviews explore the causes of variances from plans, and what can be done to adjust to them. Adjustments may be made to operating plans, if necessary. Mid-year review can also be used as the basis for distributing any supplemental appropriation that VA may have requested and the Congress approved.

Audit/Evaluation

Throughout this entire 48-month cycle, the VA IG's Office and GAO, and sometimes congressional committees, are conducting audits, evaluations, and other studies of VA's operations. Those studies identify potential means of improving VA's operations and increasing program efficiency. As previously noted, Program Planning and Budget and Finance use these studies to highlight potential savings and improvements in reviewing DM&S' 5-year program/budget plans.

In late 1985, VA's Office of Program Planning and Evaluation was renamed the Office of Program Analysis and Evaluation. Primary among its new duties is responsibility for management improvement initiatives in VA, including those required by OMB, such as productivity improvements.

[3]Though it no longer participates in program planning and budget formulation, the Office of Program Planning and Evaluation (now Program Analysis and Evaluation) retained its role in mid-year and end-of-year reviews, when its responsibilities were redefined in late 1985.

organizations, local congressional delegations, medical schools affiliated with VA, and others who have an interest in VA programs.

Recent Changes in the MEDIPP Process

In the spring of 1985, after our audit work was largely complete, the Chief Medical Director introduced major changes into the MEDIPP process for plans submitted in November 1985 and subsequent years. He divided MEDIPP into two processes: an annual operational plan developed using specific budgetary ceilings and long-term strategic planning that identifies long-term issues without regard to budgetary constraints.

Prior to these changes, district MEDIPP plans included all actions necessary to meet the identified future medical care needs of eligible veterans without regard to budgetary limits. This narrative focuses on the 1984 MEDIPP process—the one we reviewed in detail—and notes, where appropriate, the changes introduced for the 1985 MEDIPP cycle.

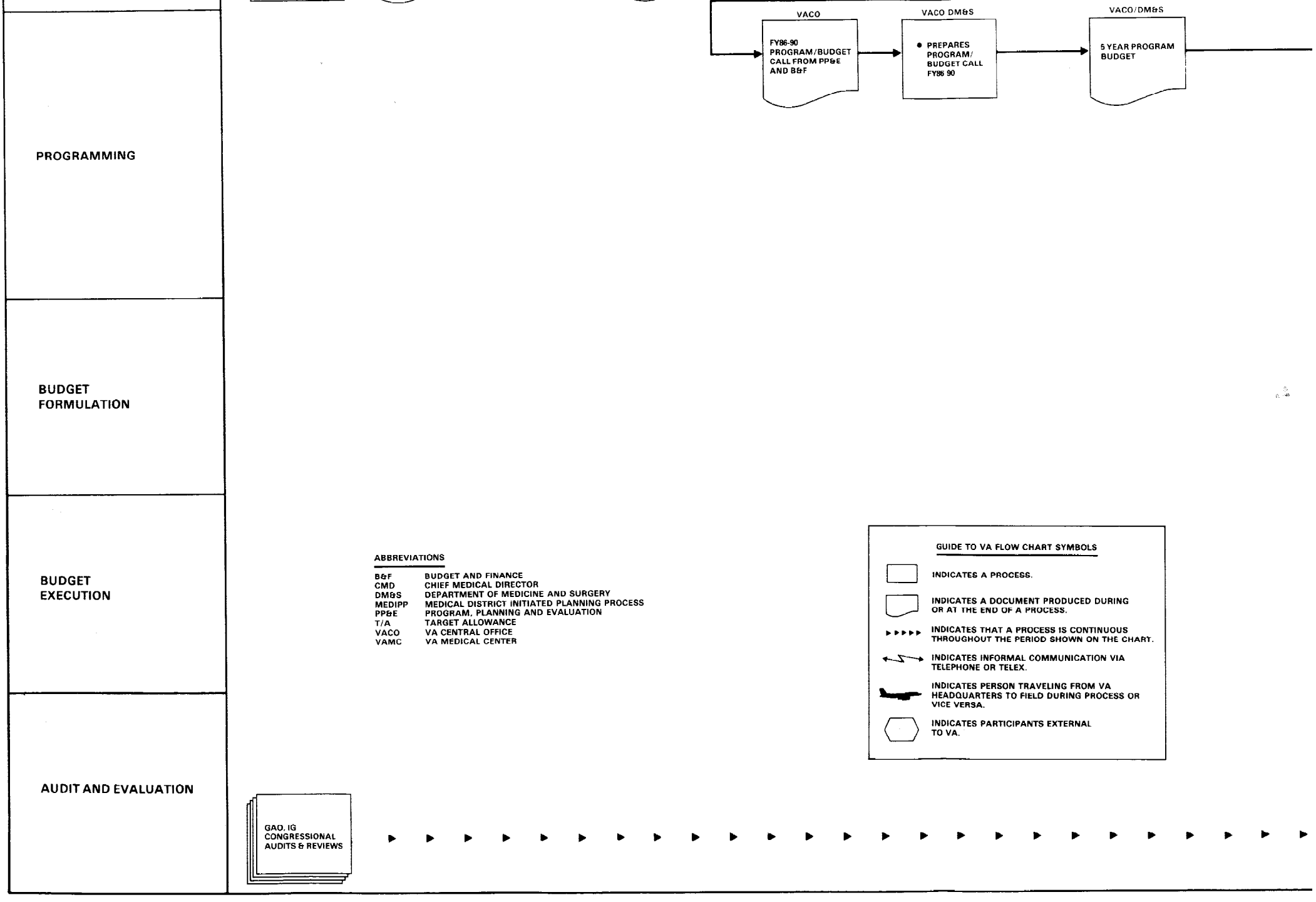
District MEDIPP Processes Vary

Because each medical district has some latitude in how it organizes its MEDIPP process, each district's process is somewhat different. Therefore, we chose to illustrate the process using a single district as an example. (See figure IV.3.) Our description of the 1984 district MEDIPP process is based on the process in District 12, which encompasses all of Florida (except the Panhandle) and several counties in southeastern Georgia. While District 12's process is somewhat more participative than the other 3 districts we visited, the basic elements of the process in each district were quite similar. The description of the changes introduced in 1985 are based on the Chief Medical Director's guidance and explanatory memoranda distributed to the regions and districts in March and May of 1985.

A chronological description of the entire MEDIPP process follows.

Preparing the MEDIPP Guidance

The MEDIPP process begins with the development and distribution of the MEDIPP guidance to the districts. Until 1985, the Program Analysis and Development Office (PAD) in DM&S was responsible for coordinating the MEDIPP process. To provide basic elements of uniformity and comparability in district MEDIPP plans, for the 1984 MEDIPP submissions, the Program Guidance Section of PAD developed a 4-volume set of instructions called the MEDIPP Planning Guidance. Reviewed and approved by the Chief Medical Director, this guidance included (1) the Chief Medical Director's health care goals, mandates, and assumptions, (2) specific


VACO
VACO DM&S
VACO/DM&S
FY86-90 PROGRAM/BUDGET CALL FROM PP&E AND B&F
• PREPARES PROGRAM/ BUDGET CALL FY86 90
5 YEAR PROGRAM BUDGET
PROGRAMMING
BUDGET FORMULATION
BUDGET EXECUTION
AUDIT AND EVALUATION
ABBREVIATIONS
B&F BUDGET AND FINANCE
CMD CHIEF MEDICAL DIRECTOR
DM&S DEPARTMENT OF MEDICINE AND SURGERY
MEDIPP MEDICAL DISTRICT INITIATED PLANNING PROCESS
PP&E PROGRAM, PLANNING AND EVALUATION
T/A TARGET ALLOWANCE
VACO VA CENTRAL OFFICE
VAMC VA MEDICAL CENTER
GUIDE TO VA FLOW CHART SYMBOLS
INDICATES A PROCESS.
INDICATES A DOCUMENT PRODUCED DURING OR AT THE END OF A PROCESS.
INDICATES THAT A PROCESS IS CONTINUOUS THROUGHOUT THE PERIOD SHOWN ON THE CHART.
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INDICATES PARTICIPANTS EXTERNAL TO VA.
GAO, IG CONGRESSIONAL AUDITS & REVIEWS

The Chief Medical Director's memorandum of May 31, 1985, identifies the following elements to be included in the regional guidance to the districts:

- the regional criteria that will be used in reviewing district MEDIPP plans and set regional priorities;
- regional priority planning issues which the district plans should address;
- a plus or minus dollar mark over/under existing target allowances (operating budgets) to be used in developing operating plans;
- a description of the region's MEDIPP plan development, review and implementation process, and time schedule; and
- any other additional guidance, instructions, special studies, or schedules which a Regional Director may wish to establish.

This guidance is distributed to the districts in February of each year, beginning in February 1986. Because the new process was not in place in February 1985, abbreviated guidance was provided in May 1985 for the 1985 MEDIPP process.

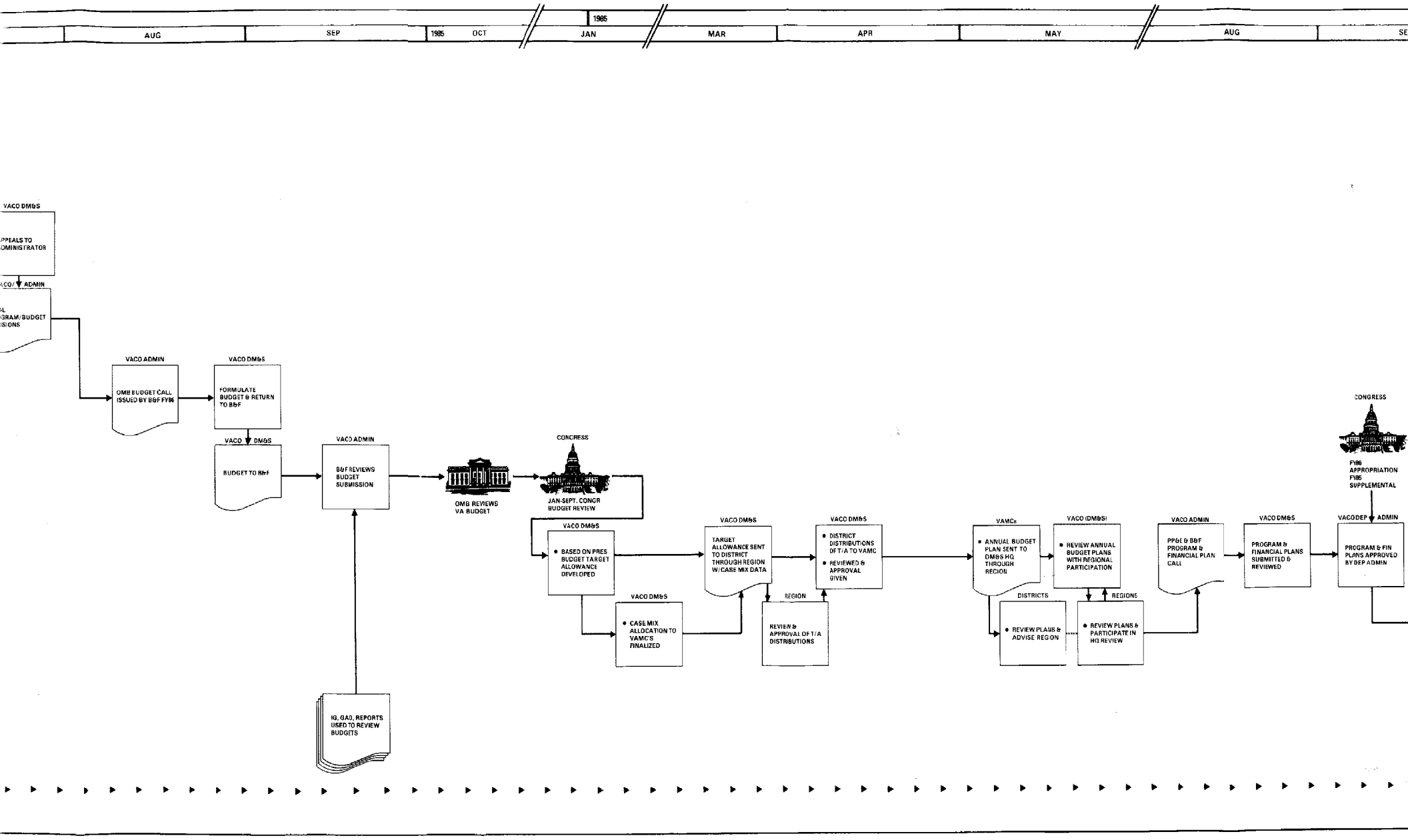
The MEDIPP Process in District 12

The District 12 MEDIPP process is highly participative. A number of internal and external actors participated in the District's 1984 MEDIPP process.

The Major Participants

Internal participants included the Medical District Director, the Medical District Planning Staff, the Medical Center Facility Planning Committees, Technical Advisory Groups, and the District Planning Board. The functions of these groups vary from district to district.

In addition to these participants, a number of other internal groups provide input into the MEDIPP process. The Regional Office played an informal role in the development of the plan and commented formally on the final plan prior to its submission to DM&S Central Office for review. The District Executive Council makes final decisions on the plan prior to its submission to the District Director for review and approval. The District Administrative Council and District Professional Council both provide periodic comment and advice, formal and informal. VA medical centers in the district provide members to all the MEDIPP planning groups.

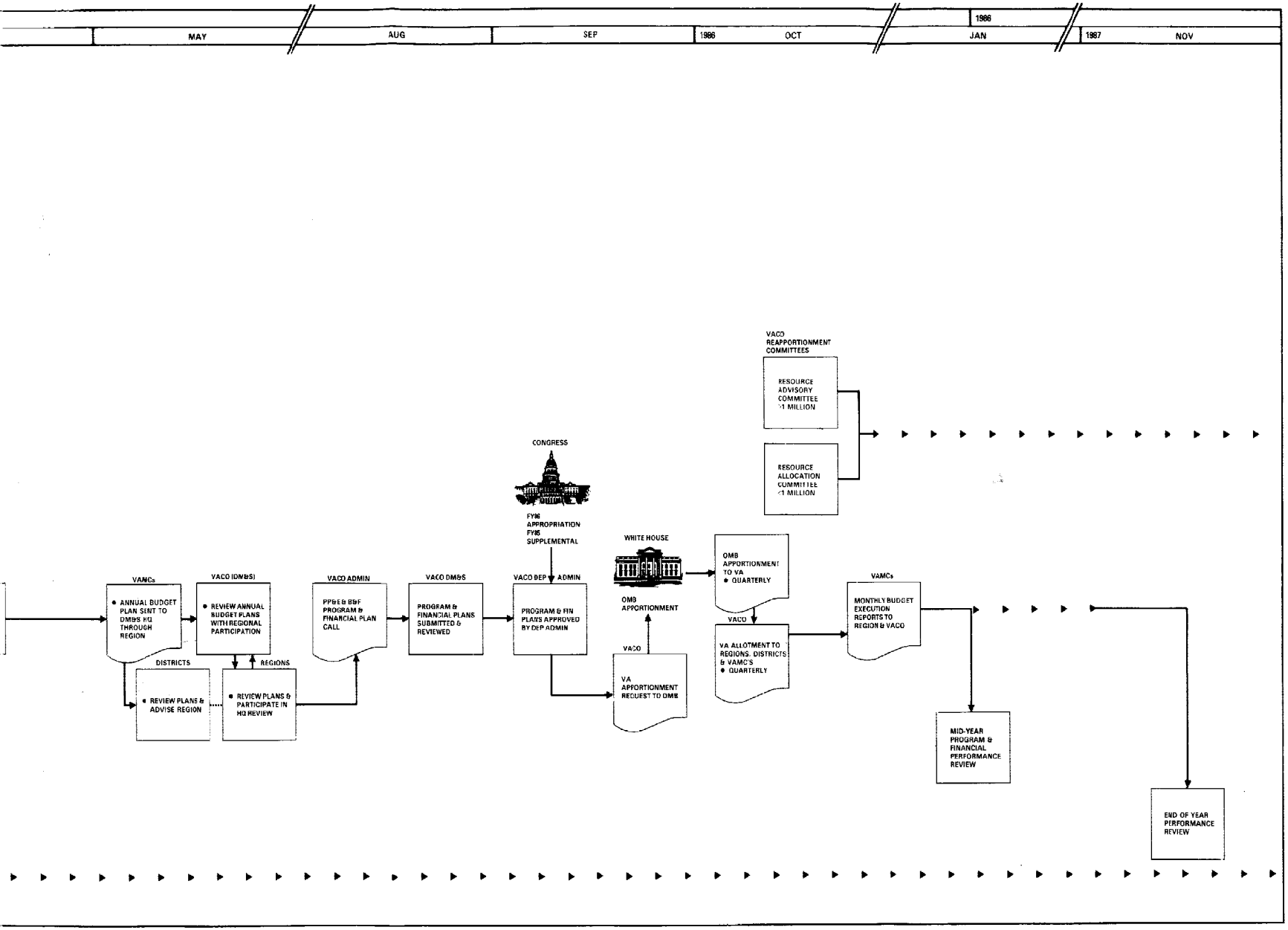

1985
AUG
SEP
1985 OCT
JAN
MAR
APR
MAY
AUG
SE
VACO DM&S
PPEALS TO DMINISTRATOR
CO/ ADMIN
GRAM/BUDGET ISIONS
VACO ADMIN
OMB BUDGET CALL ISSUED BY B&F FY86
VACO DM&S
FORMULATE BUDGET & RETURN TO B&F
VACO DM&S
BUDGET TO B&F
VACO ADMIN
B&F REVIEWS BUDGET SUBMISSION
OMB REVIEWS VA BUDGET
CONGRESS
JAN-SEPT. CONGR BUDGET REVIEW
IG, GAO, REPORTS USED TO REVIEW BUDGETS
VACO DM&S
• BASED ON PRES. BUDGET TARGET ALLOWANCE DEVELOPED
VACO DM&S
• CASE MIX ALLOCATION TO VAMC'S FINALIZED
VACO DM&S
TARGET ALLOWANCE SENT TO DISTRICT THROUGH REGION W/CASE MIX DATA
REGION
REVIEW & APPROVAL OF T/A DISTRIBUTIONS
VACO DM&S
• DISTRICT DISTRIBUTIONS OF T/A TO VAMC
• REVIEWED & APPROVAL GIVEN
VAMCs
• ANNUAL BUDGET PLAN SENT TO DM&S HQ THROUGH REGION
DISTRICTS
• REVIEW PLANS & ADVISE REGION
VACO (DM&S)
• REVIEW ANNUAL BUDGET PLANS WITH REGIONAL PARTICIPATION
REGIONS
• REVIEW PLANS & PARTICIPATE IN HQ REVIEW
VACO ADMIN
PP&E & B&F PROGRAM & FINANCIAL PLAN CALL
VACO DM&S
PROGRAM & FINANCIAL PLANS SUBMITTED & REVIEWED
CONGRESS
FY86 APPROPRIATION FY85 SUPPLEMENTAL
VACO DEP ADMIN
PROGRAM & FIN PLANS APPROVED BY DEP ADMIN

- formulate the final MEDIPP plan and forward it for review and comment to the District's Executive, Planning, and Administrative Councils and the Regional Director.

As examples, the 1984 District 12 and District 26 Planning Board members are listed in tables IV.1 and IV.2, respectively. The District 12 Board has 15 members, with 3 drawn from each medical center in the district. Because of the traveling distance between District 12's medical centers, plus tight travel budgets, the Board is limited to 4 meetings a year. To compensate for this, the District 12 Board communicates via phone more frequently. Since some Board members also work at the same medical centers, there is informal communication throughout the MEDIPP process.

Table IV.1: District 12's 1984 Planning Board

Member	Facility	Discipline
Richard Whittington, M.D. (Chairman)	VAMC Gainesville	Chief of Staff
John H. Beggs, M.D.	VAMC Lake City	
Josh D. Davis, M.D.	VAMC Bay Pines	Mental Hygiene
Larry R. Deal	VAMC Lake City	
Gene F. Duckett	VAMC Lake City	Medical Administration Service
Sue Fletcher, R.N.	VAMC Bay Pines	Nursing
Felipe Knopka, M.D.	VAMC Miami	Ambulatory Care
Jane O'Donnell, R.N.	VAMC Gainesville	Nursing
Eliseo Perez-Stable, M.D.	VAMC Miami	Medicine
German Ramirez, M.D.	VAMC Tampa	Nephrology
Phillip H. Slater	VAMC Miami	Social Work
Dewitt R. Smith, M.D.	VAMC Bay Pines	Rehabilitative Medicine
Richard R. Streiff, M.D.	VAMC Gainesville	Medicine
Jon Straumfjord, M.D.	VAMC Tampa	Laboratory
George Watkins, M.D.	VAMC Tampa	Surgery


MAY
AUG
SEP
1986
OCT
1986
JAN
1987
NOV
VACO REAPPORTIONMENT COMMITTEES
RESOURCE ADVISORY COMMITTEE >1 MILLION
RESOURCE ALLOCATION COMMITTEE <1 MILLION
CONGRESS
FY88 APPROPRIATION FY88 SUPPLEMENTAL
WHITE HOUSE
OMB APPORTIONMENT TO VA • QUARTERLY
OMB APPORTIONMENT
VACO
VA ALLOTMENT TO REGIONS, DISTRICTS & VAMC'S • QUARTERLY
VACO
VA APPORTIONMENT REQUEST TO OMB
VAMCs
• ANNUAL BUDGET PLAN SENT TO DMBS HQ THROUGH REGION
VACO (DMBS)
• REVIEW ANNUAL BUDGET PLANS WITH REGIONAL PARTICIPATION
DISTRICTS
REGIONS
• REVIEW PLANS & ADVISE REGION
• REVIEW PLANS & PARTICIPATE IN HQ REVIEW
VACO ADMIN
PPBE & BBF PROGRAM & FINANCIAL PLAN CALL
VACO DMBS
PROGRAM & FINANCIAL PLANS SUBMITTED & REVIEWED
VACO DEP ADMIN
PROGRAM & FIN PLANS APPROVED BY DEP ADMIN
VAMCs
MONTHLY BUDGET EXECUTION REPORTS TO REGION & VACO
MID-YEAR PROGRAM & FINANCIAL PERFORMANCE REVIEW
END OF YEAR PERFORMANCE REVIEW

- coordinating data gathering to ensure data submitted by the Facilities Planning Committees and Technical Advisory Groups meet MEDIPP guidance and District 12 data requirements.

District Planning Staff are frequently in contact with the various MEDIPP planners throughout the MEDIPP process.

Facility Planning Committee

The districts' medical centers provide members to all the various MEDIPP planning groups. The medical centers are responsible for delivering health care services to veterans in the district and serve as a vital source of data for planning. Each medical center has a Facility Planning Committee whose duties include:

- providing District Planning Staff, Technical Advisory Groups, and the District Planning Board with data generated by the medical center;
- reviewing and commenting on interim and final MEDIPP products;
- reviewing 5-year facility construction plans and all nonrecurring maintenance and repair and minor miscellaneous and minor and major construction projects; and
- identifying future issues to be addressed by the MEDIPP process.

In reviewing facility construction plans, a key role of the Facility Planning Committee is to ensure that those plans reflect the medical care priorities and needs established in MEDIPP.

Technical Advisory Groups

Technical Advisory Groups play an important support role in the district MEDIPP process. These groups allow medical center personnel with special expertise in specific MEDIPP issue areas to use that expertise for the benefit of the MEDIPP process. District 12's Technical Advisory Groups were formed in late January and early February for the 1984 MEDIPP process. The Groups report their findings to the District Planning Board. The findings are used to develop actions to meet specific medical care needs identified in the district's MEDIPP plan.

Developing the MEDIPP Plan

After the MEDIPP planning process has started in January/February, and all the various groups and individuals responsible for the planning process have been organized, the task of gathering the data to build the MEDIPP plan begins.

The 1984 and 1985 Medical District Initiated Program Planning (MEDIPP) Processes

Initiated in 1981, the Medical District Initiated Program Planning process, or MEDIPP, is the Department of Medicine and Surgery's (DM&S) process for evaluating the future health care needs of eligible veterans, and identifying the actions necessary to meet those needs. The MEDIPP process is largely decentralized and highly participative.

The Purpose of MEDIPP

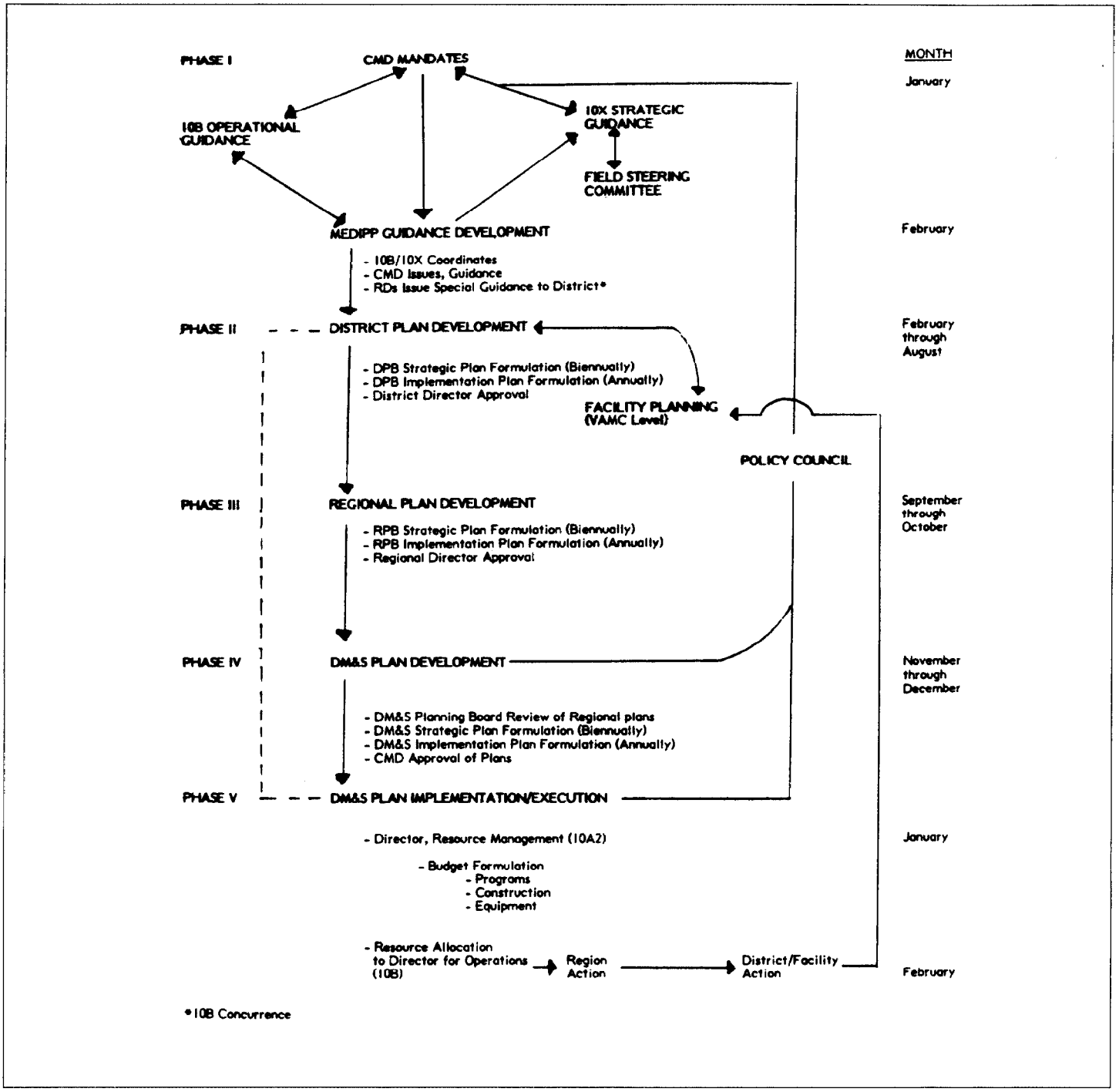
MEDIPP is basically centered in VA's 27 medical districts, whose MEDIPP plans are required to identify: (1) the health care needs of the total number of eligible veterans expected to request care during the planning period and (2) the best means of distributing resources among the district's medical care facilities to meet those needs. According to VA's Chief Medical Director, each district views the facilities within the district as one unit, and strives to plan services among facilities so that, to the extent possible, eligible beneficiaries can receive all needed care within the district.

Operating under guidance from the DM&S Central Office and the region, a clinically-oriented District Planning Board serves as the forum for analyzing planning information and recommending the future programs and services to be provided in each VA medical facility in the district. The Board is assisted by the District Planning Staff and Technical Advisory Groups established to examine specific clinical issues within the districts. Additionally, the Medical District Director has the responsibility for developing the district plan, facilitating the flow of information both internal and external to VA, and resolving conflicts within the district.

District MEDIPP plans are submitted in November of each year for review by the regions, central program offices, a national planning board, the Chief Medical Director, and the VA Administrator, who makes the final decisions on the plans. The MEDIPP plans submitted in November of 1984 were used in developing the fiscal year 1986 budget allocations to each district's medical facilities and identifying budgetary initiatives to be included in VA's fiscal year 1987 medical care budget request.[4] There is a wide-range of participation in the development of these plans at all organization levels within VA—by consumer groups, veterans service

[4]This time lag simply reflects the normal timetable of the federal budgetary process. Fiscal year 1986 began on October 1, 1985; the VA's fiscal year 1987 budget request was due to OMB September 15, 1985; and VA submitted it to the Congress in February 1986.

Figure IV.2: MEDIPP Planning Process Model



Source: VA's DM&S' 1985 MEDIPP Guidance from the Chief Medical Director.

instructions on the methodologies district planners were to use in developing their MEDIPP plans, and (3) the format for the final MEDIPP submission.

Beginning with the 1985 MEDIPP cycle, the Chief Medical Director divided MEDIPP into two processes—strategic planning and operational planning. The time horizon for strategic planning extends to the year 2000. Strategic planning identifies the long-term medical care needs of veterans and the changes needed to meet those needs. Strategic plans will be submitted every other year, beginning in November 1986.

Operational Planning, to be done annually, requires the districts to develop an operational plan for the next fiscal year that will meet the short-term changes in eligible veterans' health care needs. (Plans submitted in November 1985, at the beginning of the 1986 fiscal year, were used to develop district and medical center operating budgets for fiscal year 1987, which begins October 1, 1986.) These plans were developed using specific budgetary ceilings. For example, using the fiscal year 1986 operating budgets as a base, districts developed the operating plans submitted in November 1985 using three different assumptions about budgetary growth—5-percent growth, zero-percent growth, and a decline of 5 percent.

As a result of these changes, responsibility for DM&S Central Office MEDIPP guidance has now been given jointly to two offices. Based on the Chief Medical Director's issues, mandates, and assumptions, the Associate Deputy Chief Medical Director for Program Development and Planning develops the strategic planning guidance, including clinical program standards, criteria, productivity, priorities, projection models, and data needs. Using the Chief's strategic goals, mandates, and assumptions, the newly established Director for Operations develops, approves, and issues operational planning guidance including Regional Director guidance unique to the districts within each of the seven regions. (Concurrent with these changes, the Chief Medical Director reorganized the districts and regions. Prior to 1985, there were 28 medical districts and 6 regions. There are now 27 districts and 7 regions.)

The addition of regional guidance is a significant change in MEDIPP. Prior to 1985, the Regional Directors had a relatively small role in MEDIPP, limited primarily to commenting on district MEDIPP plans. Those comments were forwarded to VA headquarters with the district plans.

Regional Review: The Expanded Role

The District Planning Board submits the "final" MEDIPP plan to the Regional Director for review and comment. Prior to 1985, the Regional Director officially commented on the plan and sent his comments to the Medical District Director, who attached the Regional Director's comments onto the districts' MEDIPP submission to the DM&S' Central Office whether or not the comments resulted in any alteration to the plan.

Beginning with the 1985 district MEDIPP submissions, the review role of the regional offices has been significantly enhanced. Regional offices now review district plans for adherence to both Central Office and regional guidance, and consolidate the district plans into a single regional plan, with a single set of regional priorities, for Central Office review. In recognition of the regions' expanded role, the regional plans should highlight important, national issues requiring DM&S Central Office review and direction. Regional Planning Boards have been established for this purpose, as well as for developing regional guidance.

The major purposes of the change include (1) reducing the number of plans that the Central Office must review (from 27 to 7) so that it can focus on the most important national health care planning issues and (2) improving the linkage between planning and budgeting by increasing the planning role of the Regional Directors, who already play a major role in allocating operating budgets to hospitals and districts.

The Central Office Review Process

The Health System Planning Service (HSPS) of Program Analysis and Development coordinates the DM&S Central Office MEDIPP review process, which begins with the technical review in October, and continues until the scheduled feedback to districts on their MEDIPP submissions in April. HSPS has formulated a schedule for the Central Office review process that was changed once during the 1984 Central Office review cycle, putting the review process approximately a week behind its original schedule.

The technical review components of the MEDIPP plan are sent to the Program Analysis and Development Office for evaluation. The technical review components of the MEDIPP plan are the data profiles and analyses tables and the problem resolution forms.

The 1984 data profile and analysis tables provided quantified data on current, projected, and planned bed levels and workload for the districts for the years 1990, 1995, and 2000.

External Groups

External groups include District Veteran Review Groups, state legislators, state agency personnel, medical school deans, federal legislators and their staffs, and local community groups. These external groups serve as constituent advisory groups and they comment on the districts' MEDIPP plans.

The VA Central Office was scheduled to distribute the 1984 MEDIPP guidance to the districts in late January-early February. Instructions actually reached the districts in late April 1984.

The District Director's Role

After receiving the instructions, the District Director incorporates his/her particular district goals and objectives into the instructions and distributes them to the District Planning Staff and District Planning Board. In addition to having line authority over the district MEDIPP process and final responsibility for the district MEDIPP submission, the District Director's responsibilities also include:

- coordinating the MEDIPP process at the district level;
- approving a District Planning Board;
- supervising the District Planning Staff;
- reviewing interim MEDIPP products; and
- presenting proposed MEDIPP actions to District Veteran Review Groups.

The District Planning Board's Role

The District Planning Board is the principal group responsible for formulating a district's MEDIPP plan. Planning Board members are clinical and professional staff members drawn from medical facilities within the district.

A District Planning Board's organization and functions vary among the districts. For example, due to budget constraints and travel distances, District 12's Planning Board met approximately 4 times during its 1984 MEDIPP process, while the District 26 Board met approximately 13 times during the 1984 process. The functions of the District 12 Planning Board are to:

- develop and adopt a work program for the district's MEDIPP cycle;
- appoint Technical Advisory Groups to assist in the MEDIPP process;
- set data requirements for data requested from district medical centers;
- formulate interim MEDIPP products and forward them to district medical centers for review;
- prioritize all district MEDIPP actions; and

- distributing the problem resolution forms to Specific Program Reviewers for evaluation and recommendation;
- synthesizing reviewers' evaluations and compiling medical district and national program summaries based on the form's proposed actions;
- identifying non-defensible (that is, those not considered adequately justified) proposed actions and developing recommendations to alleviate the concerns; and
- presenting a national program perspective to the Primary Review Control Point Panel.

Each Primary Review Control Point has a number of Specific Program Reviewers evaluating its problem resolution forms. The size of the program determines how many reviewers are assigned to evaluate the forms. A reviewer uses the following criteria when evaluating a district's forms:

- technical-review results,
- program-specific guidance,
- internal data bases, and
- Primary Review Control Point-suggested criterion.

The reviewer only makes a defensible/non-defensible recommendation to the Primary Review Control Point, but the Control Point makes the defensible/non-defensible decision on a problem resolution form action. The reviewers contact regional and district staff members to clarify/eliminate any problems with a specific form. After the 34 Control Points make their decision on the forms, the district can appeal the decision to the Panel.

There are 14 members and 3 Primary Review Control Points on the Panel.[7] The Panel has a number of functions in addition to hearing appeals. It discusses program directions affecting district and national trends and bed section reports and reviews all defensible actions.

A district may appeal a non-defensible decision to the Panel. For 1984 plans, the Regional Director represented the district during the Panel appeal process. The Panel may also call on Specific Program Reviewers for more detailed information as to why they deemed certain problem resolution forms non-defensible.

[7]The 1984 Primary Review Control Point Panel members included: Dr. Brown, Chairman; Dr. Mitts, Senior Advisor; Dr. Conrad; Dr. Hughes; Dr. Mather; M. Quant; Dr. Boren; Dr. Worthen;* J. Travers;* R. Cooper; Dr. Love;* C. Yarborough; J. Gregg; and R. McCracken. (Those names marked by asterisks (*) indicate members who also serve as Primary Review Control Points.)

Table IV.2: District 26's 1984 Planning Board

Member	Facility	Discipline
Ransom J. Arthur, M.D. (Chairman)	WLA	Chiefs of Staff Council
Norman E. Hensley	SD	AD Council/ADP
Chitha Hulugalle, M.D.	LVOPC	Medicine
Susan L. Moss, R.N.	LL	Nursing
Jane M. Serino, R.D.	LL	Dietetics
Frederic A. Wyle, M.D.	LB	Medicine
David W. Ganoe	LB	Engineering
Dorothy W. Geary, M.S.W.	LB	Social Work
Ramona DeJesus	LAOPC	Chief Medical Administration Officer (Member- at-Large)
Thomas W. Ziegler, M.D.	SD	Nephrology
Wayne L. Pfeffer	SD	Fiscal
Krishan Kapur, D.M.D.	SEP	Dentistry
Danile B. Auerbach, M.D.	SEP	Psychiatry
Lawrence R. Freedman, M.D.	WLA	Medicine
Gerald McKenna, M.D.	WLA	Psychiatry
Ex Officio Members		
William K. Anderson Medical District Director	WLA	Hospital Administration
Wm. P. Longmire, Jr., M.D.	WLA	VA Distinguished Physician in Surgery
Frank Terry	Office of Public & Consumer Affairs	Public & Consumer Affairs
District Staff		Staff Support

WLA = West Los Angeles VAMC
SD = San Diego VAMC
LVOPC = Las Vegas Outpatient Clinic
LAOPC = Los Angeles Outpatient Clinic
SEP = Sepulveda VAMC
LB = Long Beach VAMC
LL = Loma Linda VAMC

District Planning Staff's Role

A full-time District Planning Staff serves as the support staff for the district MEDIPP Planning Board. The Staff's responsibilities include:

- performing data analysis of veteran health service needs;
- serving as liaison between the medical centers and the Planning Board;
- reviewing and distilling the MEDIPP instructions and disseminating pertinent data requirements to MEDIPP planners; and

Task Force I took the over 2,000 approved MEDIPP actions generated by the 1983 MEDIPP process and grouped those actions into 52 MEDIPP initiatives. This task force was not used in the 1984 MEDIPP process.

Comments from national veterans organizations are also reviewed and considered.

The Chief Medical Director briefs the VA Administrator on the proposed MEDIPP actions. The Chief informs the Administrator about all new program starts and program terminations affecting medical center bed levels. The Administrator must approve the DM&S proposed bed levels and workload for the MEDIPP long range planning horizon (that is, for the years 1990, 1995, and 2000). The Administrator's briefings were scheduled in April 1984 for the 1983 MEDIPP plan and April 1985 for the 1984 plan. However, they did not take place until mid-summer in both years.

The Administrator is also briefed on any "politically sensitive" initiatives proposed by the MEDIPP process. The Chief has a large degree of input into a decision to affirm or deny such MEDIPP actions, but the Administrator has the final authority to exclude or include a MEDIPP initiative in VA's budget.

At the time of the Administrator's briefing, feedback to the Medical District Director on the district plan is scheduled. But, the 1983 MEDIPP plan feedback was received by the districts in September 1984, 5 months late. Feedback on the 1984 MEDIPP plans was also provided several months behind schedule.

Task Force II took the 52 1983 MEDIPP initiatives and ranked them by priority based on criteria (Chief Medical Director mandates, agency plan objectives, etc.) developed by the task force itself, and submitted the results to the DM&S Central Office unit responsible for budget formulation.

This task force prioritized all the 1983 MEDIPP actions in order to facilitate the conversion of the proposed initiatives into the VA budget. The Medical District Director for District 12 was the Chairman of this task

There are a number of data bases available to MEDIPP planners. The main data bases[5] used in MEDIPP planning are the Patient Treatment File (PTF) for inpatients, the Automated Management Information System (AMIS) and the Outpatient Staff System (OPC) for outpatients, the VA Annual Patient Census data file for all patients, and the RCS 10-141 cost distribution reports (formerly the RCS 14-4) for cost analysis.

Since the individual members of all MEDIPP planning groups work together in the various medical centers, there is an abundance of informal communication regarding the MEDIPP plan, according to MEDIPP participants in the districts we visited. Informal communication occurs through personal contact, phone conferences, and electronic mail. (Figure IV.2 illustrates some of these informal communication flows.)

Through informal communication, the District Director participates throughout the MEDIPP process; but among the districts we visited, the Director in District 12 was the most active. In addition to responsibilities listed earlier, the District Director is also responsible for representing the district before various constituency groups. In District 12, these included state legislators, state agency personnel (particularly those responsible for state nursing home planning), medical school deans, and veterans groups. District 12 also keeps local members of Congress and their staffs abreast of MEDIPP development and initiatives.

[5]Additional data sources for MEDIPP planning include: Centralized Accounting for Local Management (CALM), internal and Personnel Accounting and Integrated Data (PAID) System. External data sources for MEDIPP planning include: the National Institutes of Mental Health, 1980 Decenial Census, Medical Statistical Service, State Home Program Information, Survey of Medical Programs, Nursing Home Care Study, Area Resource File, National Nursing Home Survey, Survey of Institutionalized Persons, Health Interview Survey, Hospital Discharge Survey, National Center for Health Statistics, and Mental Health and Behavioral Science Services.

From March through September, the Facility Planning Committees and Technical Advisory Groups supply information to the District Planning Staff who in turn formulate interim MEDIPP products for the District Planning Board to review. The Board reviews the interim products during its periodic meetings and also makes sure the planning process is proceeding according to the district's work plan. Once all pertinent data have been gathered and interim products are completed, a "Draft" MEDIPP document is prepared. The "Draft" MEDIPP plan is reviewed by the medical centers; Veteran Review Groups; and the District's Executive, Professional, and Administrative Councils.

The Board considers all comments, alters the plan as appropriate, and adopts a "final" MEDIPP plan for submission to the region and the DM&S Central Office. While the District Director has the authority to alter this "final" plan, the continuous informal communication that characterizes the process makes it unlikely that the Board will adopt a plan contrary to the Director's views.

The Director of District 26 did not brief veteran groups on the initial 1984 draft because when the draft was ready in mid-August 1984, he had not yet received Central Office feedback on the 1983 MEDIPP plan, which was due in April. Though they had some informal feedback on the results of the DM&S Central Office review of their 1984 plans, districts had not received final, official decisions until September 1984, 1 month before the 1985 operating plans were due.

The cost estimation methodology component of the 1984 MEDIPP instructions was updated by the Program Guidance Section in late August and was received by the districts in September, 9 months after the MEDIPP cycle was initiated and 1 month before the due date for the initial submission to the region and the DM&S Central Office. Since the cost estimation methodology is critical to estimating resource needs, its late arrival put an extra burden on planning staffs.

The Regional Office Liaison for District 12 sits in on the District Planning Board's MEDIPP presentation to the District Executive, Administrative, and Professional Councils. In addition to attending the MEDIPP presentation to the various councils, the Regional Office Liaison is periodically in phone contact with District Planners during the planning process.

The problem resolution forms each represent a proposed action for correcting a medical district problem. The form contains goals, objectives, actions, and a timetable by which a district proposes to alleviate a problem.

A single form, developed to alleviate a district problem, may contain more than one action. For example, a form to meet a district's outpatient needs through 1990 may contain 25 separate actions as a proposed solution. It may also contain only one action, such as a piece of replacement equipment. The form does not necessarily have to contain resource estimates (for example, it could propose increasing staff awareness of disaster planning).

For the 1984 MEDIPP submission, problem resolution forms focus on the 1987-1991 fiscal years. There is a 3-year lag between submitting a form and resources being tied to that action (that is, 1984 MEDIPP actions are for 1987-1991 planning years). In order to properly relate resources to future actions, the forms may contain dates beyond 1991.

The district sends the technical review components of the plan to Program Analysis and Development via a computer time sharing hook-up with the National Institutes of Health (NIH). The district liaison staff members doing the technical review can access the NIH system and manipulate the district data for analysis. The district liaisons review the data for accuracy, proper format, and reasonableness. If the liaisons need clarification on any part of a district's submission, they contact regional or district office staff to assist in alleviating any discrepancies.

The final MEDIPP plan is submitted to the Central Office for review on November 1. The Health Systems Planning Service of Program Analysis and Development received the 27 1984 MEDIPP plans and distributed them to the Primary Review Control Points.

There are 34 major program areas within DM&S.[6] Each program has a Primary Review Control Point. A Control Point's functions include:

[6]The 34 DM&S major program areas are: Academic Affairs; Administration; Agent Orange; Ambulatory Care; Audiology and Speech Pathology; Blind Rehabilitation; Chaplain; Dental; Dietetics; Emergency Management and Resource Sharing Service; Extended Care; Facility Engineering, Planning, and Construction; Laboratory Service; Management Support; Medical Information Management Office; Medical Inspector and Evaluation Office; Medicine; Mental Health and Behavior Science; Neurology; Nuclear Medicine; Nursing; Optometry; Pharmacy; Podiatry; Prosthetics; Radiology; Readjustment Counseling; Recreation; Rehabilitation; Research; Resource Management; Social Work; Spinal Cord Injury; and Surgery.

MEDIPP Initiatives Grouped and Prioritized

MEDIPP initiatives are those programs or projects which the districts—either as a result of Chief Medical Director mandates, constituent prerogatives, or district-assessed needs—feel should reasonably be undertaken to bring health care to the veterans of their primary service area.

MEDIPP started with guidance in January 1983 and culminated with approximately 2,500 individual initiatives which have passed various levels of review and have been approved as worthy of being undertaken.

Starting in April and continuing into May, all of the approved initiatives were aggregated into 1 of 57 groups and the groups were then prioritized. The Budget Formulation Office is involved in assuring that budgetary implications of funding one group versus another are taken into account. It is impossible for all of the groupings to be funded; however, funding one grouping over another may make better use of limited resources. This is especially true in cases where the prioritized difference between the groupings is not very great.

Off-MEDIPP Initiatives

The last two categories that make up the DM&S budget are the off-MEDIPP initiatives from either the national or the program office perspective. Also included in these categories would be congressional issues. An example of an off-MEDIPP initiative developed in 1984 for the 1986 budget is readjustment counseling. DM&S planners knew that this initiative was necessary and it had the Chief Medical Director's full support, so the only real question was how much to spend on counseling of Vietnam era veterans. Other examples of this type of initiative would be items that the program office believed were necessary but that were not addressed by any of the district MEDIPP plans. These types of initiatives were unusual, however, because there is communication back and forth during the MEDIPP process which covers most areas of interest.

The four categories of budget input are going through final development during the months of February through May. Near the end of this process, the four will be brought together to get a feel for what the final budget will look like. The uncontrollable and supplemental needs will be funded in full because these are items that DM&S must fund in order to continue general operations. According to VA, off-MEDIPP and MEDIPP items are then funded solely upon each item's priority as determined by the Chief Medical Director. While DM&S Budget Formulation has a dollar target to build toward, it is the Chief who makes the final decisions. He will determine the reasonableness of the DM&S budget request. The DM&S

The Panel considers the Regional Director's input and any other pertinent data it has requested, then makes a decision either to uphold the non-defensible decision or reverse it. If still unresolved, a district may appeal to the Program Review Board.

The Program Review Board[8] is composed of 11 members. Six Board members also sit on the Primary Review Control Point Panel. In addition to a number of other functions, the Board reaches consensus on the recommendations concerning the problem resolution strategies submitted via the MEDIPP process and on suggested improvements in the next MEDIPP cycle.

The chairmen of the Panel and the Board brief the Chief Medical Director regarding all the proposed MEDIPP actions (problem resolution forms) submitted via the MEDIPP process, additional policy issues, and other areas of concern. The Chief Medical Director was scheduled to be briefed on the 1983 MEDIPP plan in March 1984 and on the 1984 plan in March 1985. However, neither briefing took place until early summer in both years.

The Primary Review Control Points and other program officials are briefed on the outcome of the MEDIPP process and, in particular, on the status of problem resolution forms affecting their program areas.

In District 12, the Medical District Director meets with members of Congress and/or their staffs to discuss proposed MEDIPP actions that will affect District 12.

National veterans organizations are briefed regarding MEDIPP actions. Comments from veterans organizations are expected in April. In District 12, the Medical District Director contacts District Veteran Review Groups regarding District 12 proposed MEDIPP actions.

For the 1983 MEDIPP process, two task forces were formed to group (Task Force I) and rank (Task Force II) approved MEDIPP actions for budget formulation.

[8]The 1984 Program Review Board members included: Dr. Mitts, Chairman;* J. Gregg;* Dr. Brown;* Dr. Conrad;* M. Randall, District 12 Director; J. Caldwell; Dr. Musser; D. Kadovach; J. Travers;** Dr. Matvole; and R. McCracken.* (*These members also serve as members of the Primary Review Control Point Panel). (**This member also serves as a member of the Primary Review Control Point Panel as well as being a Primary Review Control Point.)

on OMB Circular A-11, to develop the OMB submission and supporting schedules. Once the departmental budgets have been put into OMB form, it is up to B&F to consolidate these into the VA budget request.

VA presented its budget for fiscal year 1986 to OMB on September 15, 1984, thus beginning the OMB budget review process. Depending on the OMB analyst reviewing the submission, there could be some very specific questions to DM&S about its budget request. These questions are sent to VA prior to the hearings so that the VA departments have an opportunity to prepare their answers for the hearings. According to Budget Formulation, during 1984's hearings, there were very few specific, technical questions because the OMB analyst was familiar with the DM&S budget. The budget hearings are attended by the VACO Controller and PP&E, B&F, and DM&S Budget Formulation officials. Others in attendance include some DM&S program officials depending on what questions OMB has requested answered. In VA's case, the hearings normally last about 1 week and are held in October. In addition to the questions for the hearing, there may be some written questions which must be answered and submitted to OMB prior to its final discussion on the VA budget.

Under normal conditions, the OMB Director's Brief, which ends the initial OMB review of the VA budget and directly precedes the issuance of the VA passback, or "final mark," takes place around late November. For fiscal year 1986, however, the VA did not get its passback until December 31, 1984. This was due in part to major decisions about cuts which had to be taken in the VA budget to help reduce the federal deficit.

The VA passback is received by the VACO Controller and then sent out to the VA departments. DM&S Budget Formulation reviews the passback to determine the changes made during the OMB review. DM&S program officials help review the changes to determine if an appeal will be made. These decisions are reviewed at the VACO level and a consolidated appeal is developed. Also around January, VACO, PP&E, and B&F send out a call to the VA departments to prepare their congressional justifications.

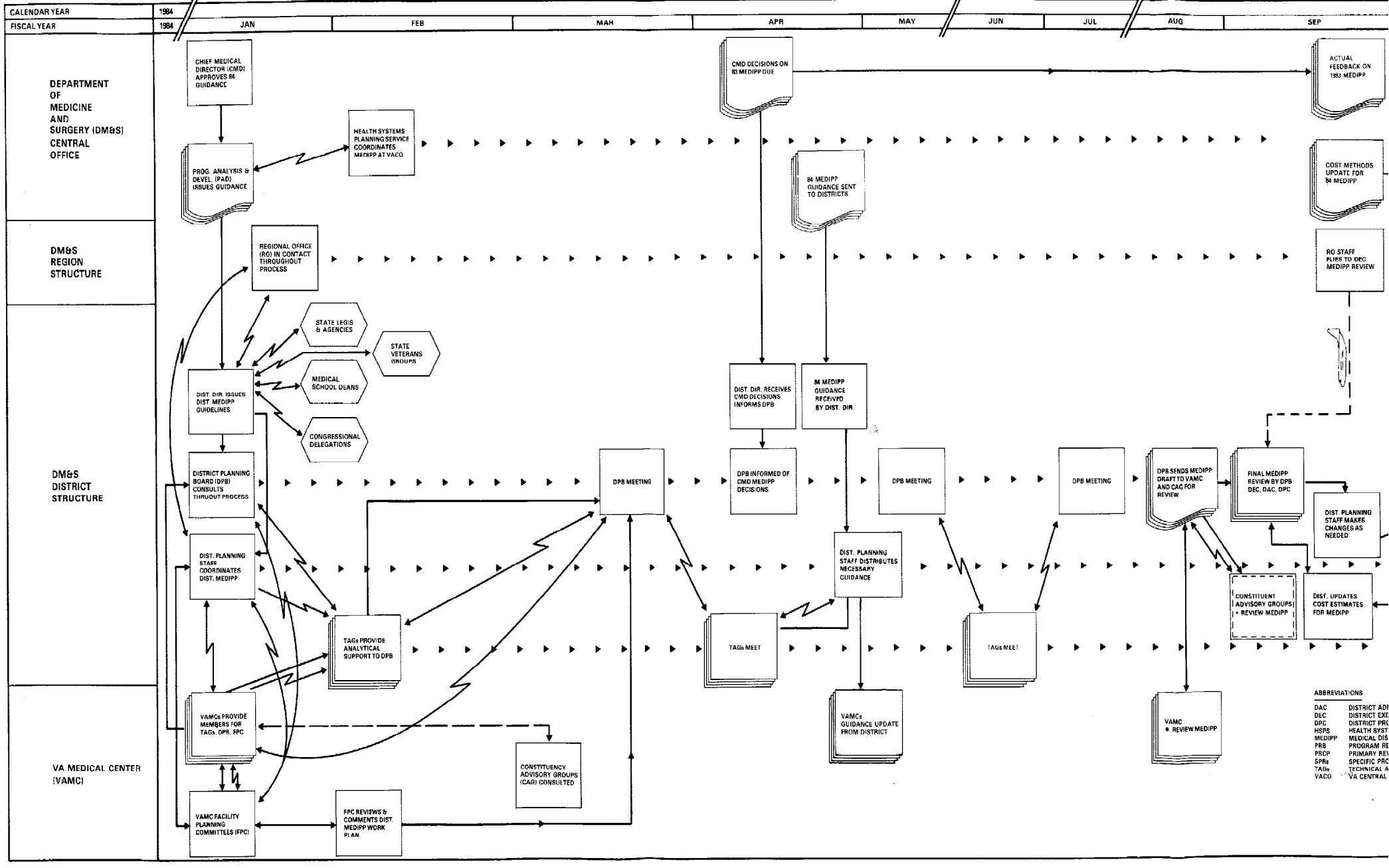
The Controller and B&F present the consolidated VA appeal of the OMB budget decisions.

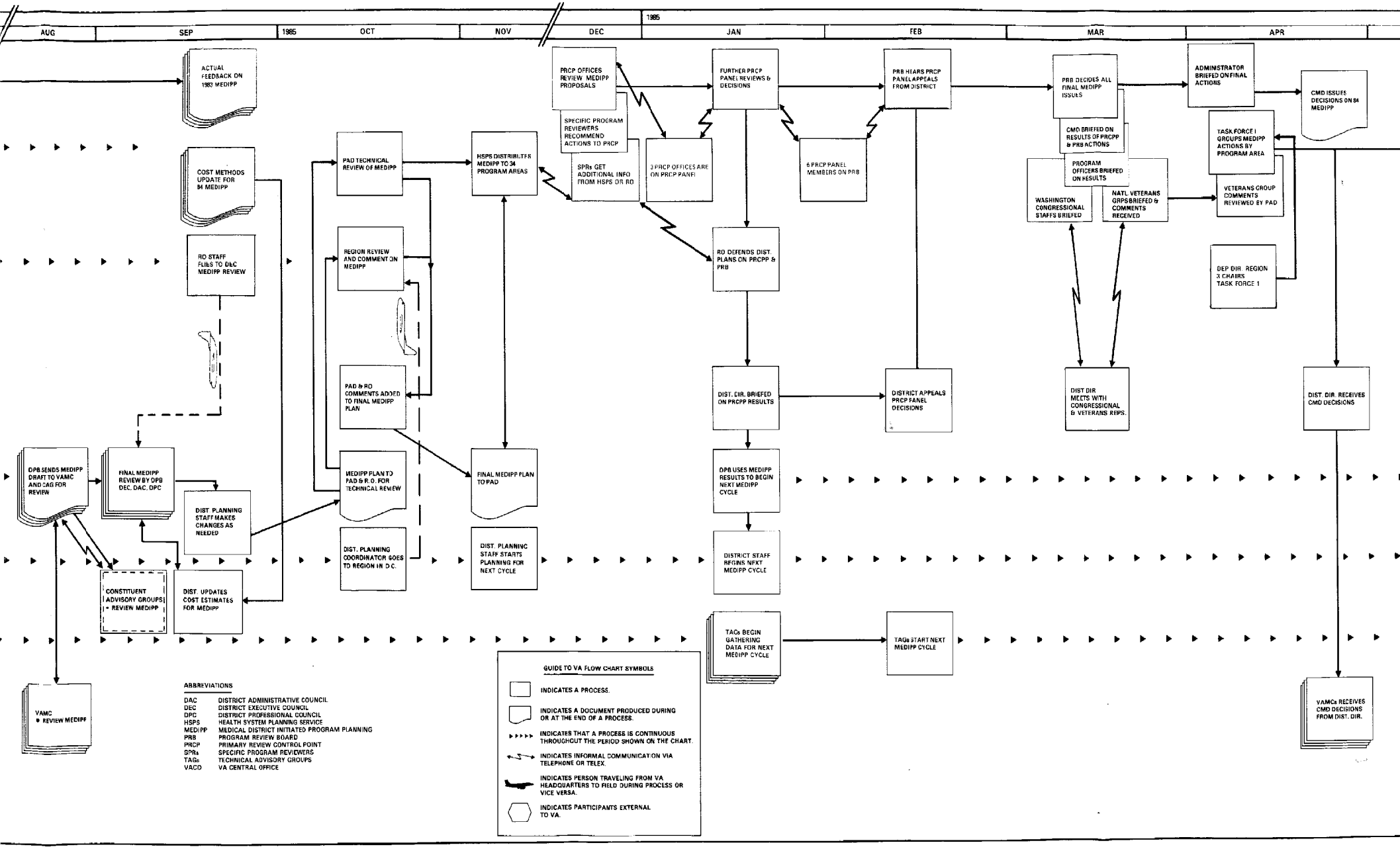
OMB hears the VA appeal then finalizes what will be sent in by the President for VA in the President's budget. This budget is then sent back to DM&S so that the Budget Formulation Office can finalize its preparation of the congressional justification based on the President's budget. The

force. This task force was not used for 1984 MEDIPP plan review. Instead, program officials and Program Analysis and Development prioritized MEDIPP initiatives for the 1984 MEDIPP submission.

Once the Central Office MEDIPP review process is complete, the MEDIPP initiatives generated from the MEDIPP process are sent to DM&S Budget Formulation for analysis and incorporation into the DM&S budget submission to the Administrator.

Figure IV.3: Department of Medicine and Surgery's 1984 MEDIPP Process (FY 1987-1991)




AUG
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DEC
1986
JAN
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MAR
APR
ACTUAL FEEDBACK ON 1983 MEDIPP
COST METHODS UPDATE FOR 84 MEDIPP
RO STAFF FLIES TO DEC MEDIPP REVIEW
OPB SENDS MEDIPP DRAFT TO VAMC AND CAG FOR REVIEW
FINAL MEDIPP REVIEW BY OPB DEC, DAC, DPC
DIST. PLANNING STAFF MAKES CHANGES AS NEEDED
CONSTITUENT ADVISORY GROUPS • REVIEW MEDIPP
DIST. UPDATES COST ESTIMATES FOR MEDIPP
VAMC • REVIEW MEDIPP
PAD TECHNICAL REVIEW OF MEDIPP
REGION REVIEW AND COMMENT ON MEDIPP
PAD & RO COMMENTS ADDED TO FINAL MEDIPP PLAN
MEDIPP PLAN TO PAD & R.O. FOR TECHNICAL REVIEW
DIST. PLANNING COORDINATOR GOES TO REGION IN D.C.
HSPS DISTRIBUTES MEDIPP TO 34 PROGRAM AREAS
FINAL MEDIPP PLAN TO PAD
DIST. PLANNING STAFF STARTS PLANNING FOR NEXT CYCLE
PRCP OFFICES REVIEW MEDIPP PROPOSALS
SPECIFIC PROGRAM REVIEWERS RECOMMEND ACTIONS TO PRCP
SPRs GET ADDITIONAL INFO FROM HSPS OR RO
3 PRCP OFFICES ARE ON PRCP PANEL
6 PRCP PANEL MEMBERS ON PRB
FURTHER PRCP PANEL REVIEWS & DECISIONS
RO DEFENDS DIST. PLANS ON PRCPP & PRB
DIST. DIR. BRIEFED ON PRCPP RESULTS
OPB USES MEDIPP RESULTS TO BEGIN NEXT MEDIPP CYCLE
DISTRICT STAFF BEGINS NEXT MEDIPP CYCLE
TAGs BEGIN GATHERING DATA FOR NEXT MEDIPP CYCLE
PRB HEARS PRCP PANEL APPEALS FROM DISTRICT
DISTRICT APPEALS PRCP PANEL DECISIONS
TAGs START NEXT MEDIPP CYCLE
PRB DECIDES ALL FINAL MEDIPP ISSUES
CMD BRIEFED ON RESULTS OF PRCPP & PRB ACTIONS
PROGRAM OFFICERS BRIEFED ON RESULTS
WASHINGTON CONGRESSIONAL STAFFS BRIEFED
NATL VETERANS GRPS BRIEFED & COMMENTS RECEIVED
DIST DIR MEETS WITH CONGRESSIONAL & VETERANS REPS.
ADMINSTRATOR BRIEFED ON FINAL ACTIONS
TASK FORCE I GROUPS MEDIPP ACTIONS BY PROGRAM AREA
VETERANS GROUP COMMENTS REVIEWED BY PAD
DEP DIR. REGION 3 CHAIRS TASK FORCE 1
CMD ISSUES DECISIONS ON 84 MEDIPP
DIST. DIR. RECEIVES CMD DECISIONS
VAMCs RECEIVES CMD DECISIONS FROM DIST. DIR.
ABBREVIATIONS
DAC DISTRICT ADMINISTRATIVE COUNCIL
DEC DISTRICT EXECUTIVE COUNCIL
DPC DISTRICT PROFESSIONAL COUNCIL
HSPS HEALTH SYSTEM PLANNING SERVICE
MEDIPP MEDICAL DISTRICT INITIATED PROGRAM PLANNING
PRB PROGRAM REVIEW BOARD
PRCP PRIMARY REVIEW CONTROL POINT
SPRs SPECIFIC PROGRAM REVIEWERS
TAGs TECHNICAL ADVISORY GROUPS
VACO VA CENTRAL OFFICE
GUIDE TO VA FLOW CHART SYMBOLS
INDICATES A PROCESS.
INDICATES A DOCUMENT PRODUCED DURING OR AT THE END OF A PROCESS.
INDICATES THAT A PROCESS IS CONTINUOUS THROUGHOUT THE PERIOD SHOWN ON THE CHART.
INDICATES INFORMAL COMMUNICATION VIA TELEPHONE OR TELEX.
INDICATES PERSON TRAVELING FROM VA HEADQUARTERS TO FIELD DURING PROCESS OR VICE VERSA.
INDICATES PARTICIPANTS EXTERNAL TO VA.

the allocation process to district and VAMC representatives. The regions are the focal point for all target allowance allocations and have approval authority over all district allocations. The process, however, is a cooperative one with all of the players having a say in the final VA medical center allocations.

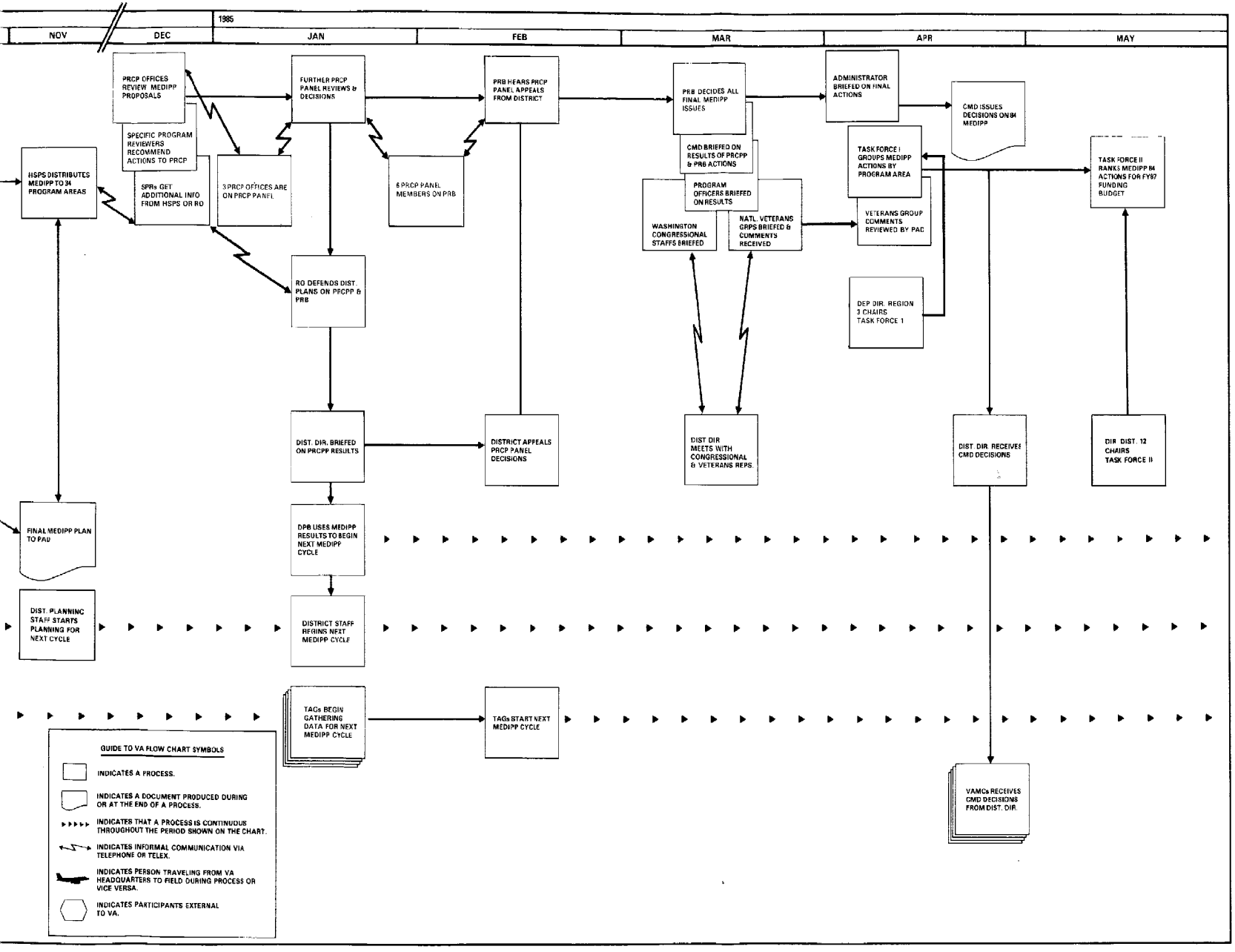
After the regions, districts, and VAMCs have made their final target allowance allocations, the results are sent to the Associate Deputy Chief Medical Director for executive review and approval.

Approved target allowance amounts are forwarded to DM&S Budget Administration and to all VA medical centers through the regional and district offices.

After the VA medical centers have received their approved target allowance totals, usually in April, they begin to develop their monthly spending plans. These plans are based on historical spending levels as well as the VAMCs' estimates of workload and full-time employee equivalents (FTEE) for the coming year. Information to develop the plans comes from CALM, VA's basic non-personnel accounting system; from VA cost distribution reports, the RCS 14-4S (now called RCS 10-141); and the VA's payroll accounting system, PAID. When the VAMCs have developed their estimates of the workload and FTEE based on their target allowance amounts, they forward these estimates to Budget Administration for its review and approval. The regions also get involved in the development of the workload and FTEE estimates. Some districts, such as District 12, are also involved in their development.

The development of the VAMC monthly spending plan is a cooperative effort among VAMC, region, and district personnel. Using target allowance ceilings; estimated, approved workload and FTEE data; and any last minute changes in obligation by the VAMCs, the three groups determine what they believe will be the most likely monthly spending amounts for the coming fiscal year. A cut-off date is established for inclusion of current workload, FTEE, and obligation data into the final spending plans. (For the fiscal year 1985 financial operating plan, the cut-off date was May 25, 1984.)

Final spending plans are developed with direct input from the regions and in some cases the districts would also add their input. Once the region approves the plan, a copy of the plan is sent to DM&S Budget Administration for review. In addition, a copy is sent to the district so that it can make any changes it believes are necessary. The district copy


1985
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FEB
MAR
APR
MAY
PRCP OFFICES REVIEW MEDIPP PROPOSALS
SPECIFIC PROGRAM REVIEWERS RECOMMEND ACTIONS TO PRCP
SPRs GET ADDITIONAL INFO FROM HSPS OR RO
3 PRCP OFFICES ARE ON PRCP PANEL
FURTHER PRCP PANEL REVIEWS & DECISIONS
6 PRCP PANEL MEMBERS ON PRB
PRB HEARS PRCP PANEL APPEALS FROM DISTRICT
PRB DECIDES ALL FINAL MEDIPP ISSUES
CMD BRIEFED ON RESULTS OF PRCPP & PRB ACTIONS
PROGRAM OFFICERS BRIEFED ON RESULTS
WASHINGTON CONGRESSIONAL STAFFS BRIEFED
NATL. VETERANS GRPS BRIEFED & COMMENTS RECEIVED
ADMINISTRATOR BRIEFED ON FINAL ACTIONS
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TASK FORCE I GROUPS MEDIPP ACTIONS BY PROGRAM AREA
VETERANS GROUP COMMENTS REVIEWED BY PAC
DEP DIR. REGION 3 CHAIRS TASK FORCE 1
TASK FORCE II RANKS MEDIPP 84 ACTIONS FOR FY87 FUNDING BUDGET
HSPS DISTRIBUTES MEDIPP TO 34 PROGRAM AREAS
RO DEFENDS DIST. PLANS ON PRCPP & PRB
DIST. DIR. BRIEFED ON PRCPP RESULTS
DISTRICT APPEALS PRCP PANEL DECISIONS
DIST DIR MEETS WITH CONGRESSIONAL & VETERANS REPS.
DIST. DIR. RECEIVES CMD DECISIONS
DIR. DIST. 12 CHAIRS TASK FORCE II
FINAL MEDIPP PLAN TO PAD
DPB USES MEDIPP RESULTS TO BEGIN NEXT MEDIPP CYCLE
DIST. PLANNING STAFF STARTS PLANNING FOR NEXT CYCLE
DISTRICT STAFF BEGINS NEXT MEDIPP CYCLE
TAGs BEGIN GATHERING DATA FOR NEXT MEDIPP CYCLE
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INDICATES PARTICIPANTS EXTERNAL TO VA.

Based on the financial operating plan, Budget Administration develops the apportionment request for DM&S and sends it to Budget and Finance for consolidation into the VA apportionment request. Budget and Finance then sends the request to OMB for review and approval.

On or about the 1st of October, OMB gives VA its spending ceiling for the first quarter of the new fiscal year. The remainder of the funds appropriated for the fiscal year can be apportioned by OMB or held back for a later date. The ceilings established by OMB are passed down to Budget and Finance which allots DM&S its portion. DM&S Budget Administration then allots the VAMCs their quarterly spending ceiling. The allotment includes the funds for the operation of the regions and the districts whose funds all go through the VAMC operations.

On October 1, the VAMCs began to spend according to their DM&S approved spending plans. This is normally prior to the VACO Budget and Finance and Controller final reviews and approvals of DM&S's consolidated financial operating plan. However, these reviews usually don't affect the spending plans appreciably.

If needed, due to unforeseen circumstances during the fiscal year, it may become necessary to reapportion budget authority among VAMCs. DM&S has two committees established to review and decide on such matters. The Resource Advisory Committee, chaired by the Deputy Chief Medical Director, with final approval being given by the Chief Medical Director, decides on reapportionments over $1 million. The Resource Allocation Committee, chaired by the Associate Deputy Medical Director, with final approval given by the Deputy Chief, decides on reapportionments under $1 million.

During the fiscal year, as VAMC operations are carried out, various reports and analyses are performed and data are tracked to insure operations are proceeding as planned. Some information, such as obligation levels, is tracked on a continuous basis while other information is produced and tracked on a weekly, monthly, quarterly, or yearly basis. VAMCs issue monthly budget execution reports which are reviewed, analyzed, and tracked by the regions, DM&S Budget Administration, and VACO Budget and Finance. The region in turn develops quarterly obligation and status of funds reports which are tracked up through the VA Central Office. Monthly variance reports showing planned versus actual budget results are sent to OMB and also to the congressional appropriations committees for their review. The Offices of Program Analysis and Evaluation and Budget and Finance perform a mid-year performance review

The Budget Formulation Process

The DM&S budget formulation process begins in February when the Veterans Administration Central Office (VACO), Program Planning and Evaluation (PP&E),[9] and Budget and Finance issue a program/budget call to all VA departments. The PP&E and B&F budget call is based on initial dollar targets issued by OMB to VA in late January.

The budget call is issued to DM&S Budget Formulation. It is then up to Budget Formulation to meet with PP&E and B&F to discuss what type of information the Administrator wants for his July/August budget review. Once Budget Formulation is assured that it knows what the Administrator wants, it develops its own budget call to be issued to the DM&S program offices.

The issuance of the DM&S budget call is the culmination of the planning and programming phases. This is where dollars are placed against program initiatives. Most of the information that will make up DM&S' request has already been thoroughly developed and the only thing that must be worked out is the presentation of the material.

Essentially there are four categories of budget information which will be brought together to make up the 1986 DM&S portion of the VA budget. The categories are:

(1) uncontrollable and supplemental needs,

(2) MEDIPP initiatives,

(3) off-MEDIPP initiatives with a national perspective, and

(4) off-MEDIPP initiatives with a program perspective.

Uncontrollable and Supplemental Needs

The Budget Formulation Office develops the uncontrollable and supplemental needs, which are the spending levels that would be required to keep DM&S operating in such a manner as to satisfy all current requirements including an adjustment for inflation in the next fiscal year. Approximately 90 percent of the DM&S 1986 budget was built using these requirements.

[9]In late 1985, the name of Program Planning and Evaluation was changed to Program Analysis and Evaluation. Its role in program planning and budgeting was eliminated. Its role in mid-year and end-of-year program/budget performance reviews was retained.

budget as it leaves DM&S will not increase. From this point on it will be cut as it continues through the budget process.

Once the Chief has made his budget decisions and his budget request is finalized, it is sent to PP&E and B&F for review. This departmental review includes the DM&S Program Officer and Budget Formulation Office input on any questions of concern or points of clarification from PP&E and B&F. This is similar to the process that will take place at OMB later.

The PP&E and B&F review looks at specific DM&S initiatives and determines which ones are reasonable and their funding amounts. These recommendations are then sent back to DM&S as a complete package.

Budget Formulation takes the VACO recommendation and determines the changes made to its original departmental budget. Once the changes have been determined, B&F meets with the Chief Medical Director and the heads of the DM&S program offices to discuss which changes they will try to reverse and which ones they will let stand.

As soon as DM&S has developed a united stance on which initiative changes to argue at VACO, it goes back up to PP&E and B&F to discuss these changes. At this time the Deputy Administrator, who currently handles budget development, becomes involved in the process. This review also includes DM&S input. Once the review has been completed, VACO will send DM&S its budget "mark." This is VACO's recommended spending ceiling for the DM&S budget. The issuance of the DM&S budget "mark" begins a new round of discussions within DM&S regarding what changes it will appeal to VACO. In July, OMB issues Circular A-11 budget guidance to all executive agencies. The circular explains how the President wants the budget presented for OMB review. In addition, OMB issues its revised dollar targets to agencies for their use in formulating their budgets.

DM&S gets its final VA internal appeal of its budget beginning in August. The Deputy Administrator hears the discussion and makes final decisions on the departmental budgets. In very rare circumstances, the Administrator may become involved if there is an impasse between the Deputy Administrator and one of the VA departments.

The Program Decision Memoranda (PDM) are issued by the Administrator and are his approved spending levels for the VA departmental initiatives. The PDM become the basis for the OMB budget submission, as they are sent back to the VA departments and put into OMB budget form. Budget Formulation uses the PDM and guidance from PP&E and B&F, based

President's budget request for VA is used as the baseline for allocating medical center budgets in budget execution.

DM&S sends its departmental budget along with the congressional justification to PP&E and B&F for consolidation and review. This consolidated VA congressional budget is then sent for review to OMB.

Normally the President sends his budget to the Congress 15 days after the Congress begins its new calendar in January. For fiscal year 1986, that meant that the President would give his budget to the Congress on January 28, 1985. However, the President's budget went to the Congress on February 4, 1985.

The President's budget and the budget justification developed by the agencies are used by the Congress to begin its budget review process.

The Acute Care Model

In the casemix system for acute care, each medical case is classified using a Diagnosis Related Group (DRG). The DRG assignment is based on the attending physician's diagnosis of the patient's condition as well as any clinical procedures used to treat that patient. VA has assigned a weight to each DRG to reflect the relative costliness of treating the average patient in that category. These weights, when aggregated for a fiscal year, can be used as a basis for measuring a hospital's productivity (that is, its clinical workload).

For fiscal year 1985, fiscal allocations for inpatient psychiatry, acute medicine, and surgery services were based on the casemix methodology. These services encompass approximately 40 percent of a hospital's budget. The remaining 60 percent, which includes overhead and outpatient and long-term care, were determined using the historical method: recurring base + percentage for inflation + additional funding for new programs.

There are two parallel data flows in the casemix system:

(1) patient care information which is used to classify cases into DRGs, for acute care (Resource Utilization Groups for intermediate and long-term care and Consumption Related Groups for ambulatory care) and

(2) medical care cost information.

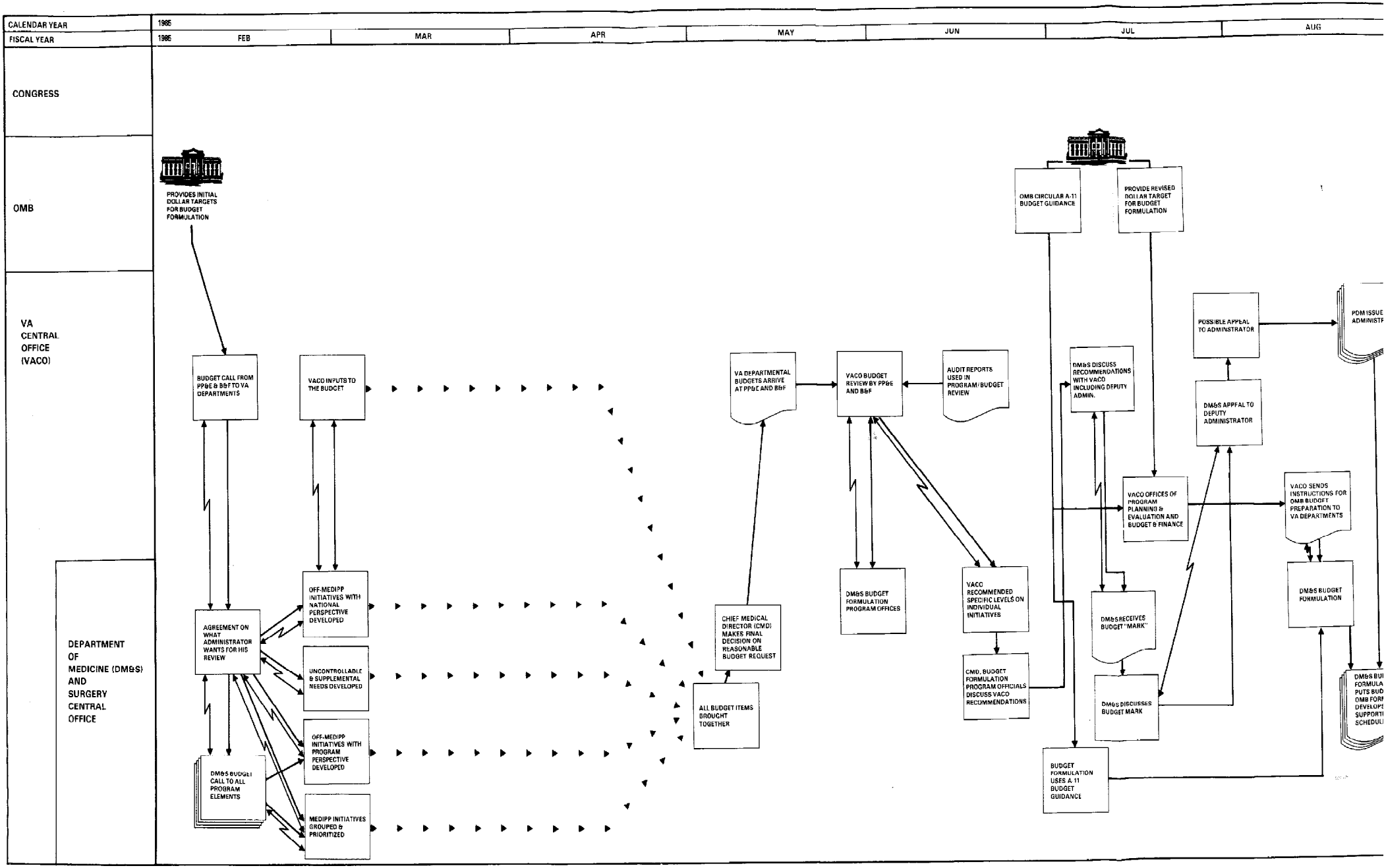
These data flows merge to determine a positive or negative adjustment to each medical center's recurring balance (line 1) in its fiscal year target allowance.

Patient Care Information Data Flow

When a patient enters a VA hospital for treatment, the attending physician records the primary diagnosis as well as any comorbidities (other medical conditions that may prolong the patient's stay in the hospital) on the patient's medical chart. All treatment procedures are also documented.

When the patient is discharged, the attending physician dictates a discharge summary which consolidates all of the information on the medical chart, including all surgical procedures and any medical complications that arose during the course of treatment, and the primary diagnosis responsible for the major portion of the patient's hospital stay.

Figure IV.4: Department of Medicine and Surgery's Budget Formulation Process for FY 1986



average patient with a particular condition. A hospital receives a greater number of units if it is affiliated with a medical school in order to reflect the greater resource utilization of a teaching hospital.

After all patient data has been entered into the PTF, the computer in Austin totals all of the work units for each hospital as well as for the entire VA system. These work units include not only those from the PTF, but also units for patients treated but not yet discharged from the hospital (in accounting terms, "work-in-progress"). There is also an adjustment to reflect salary differentials in different geographic areas.

Changes to the Acute Care Work Units for Fiscal Year 1986

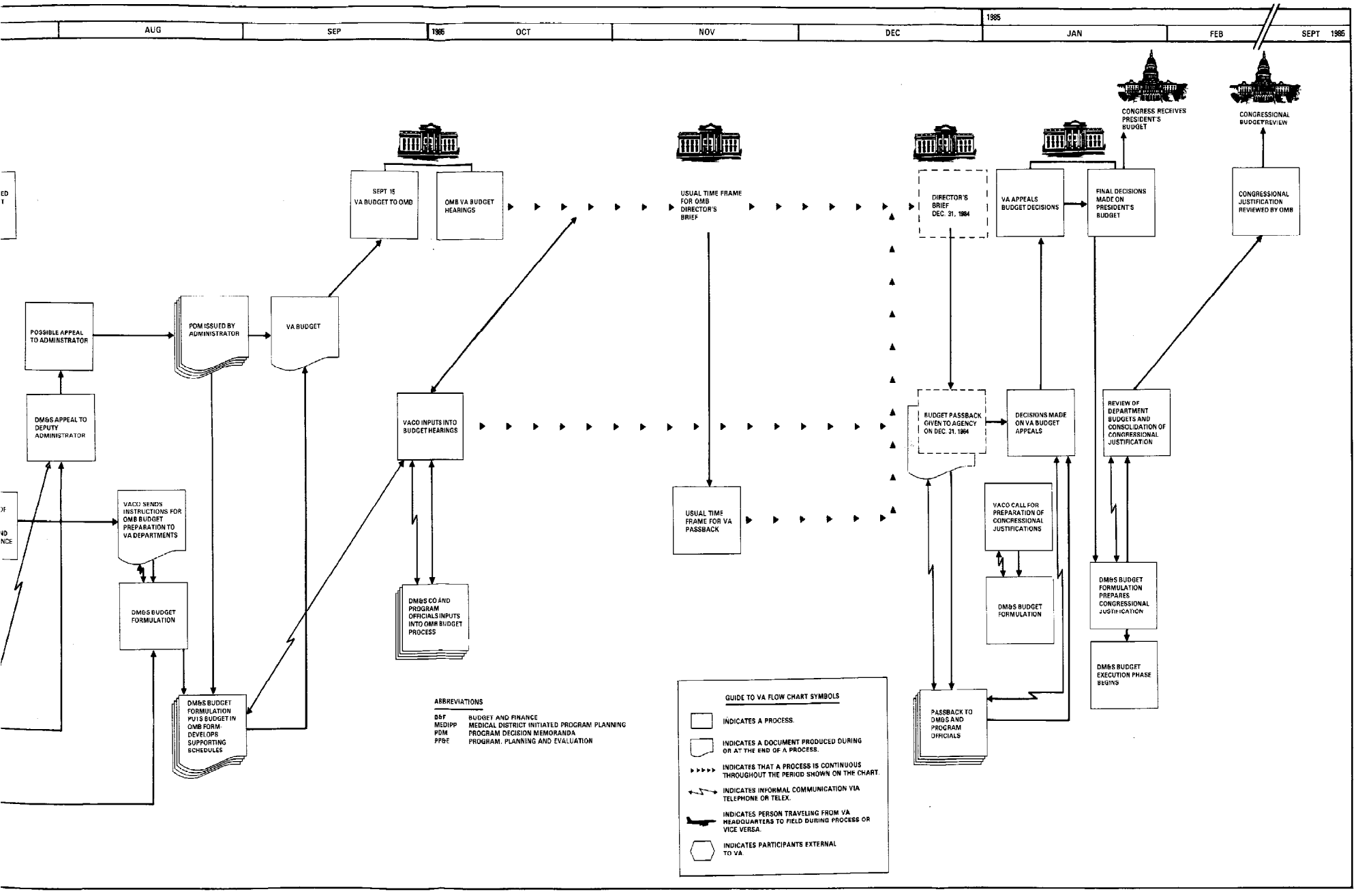
Beginning with fiscal year 1986, blind rehabilitation will be excluded from the acute care model and treated as a "pass-through" cost. (Spinal cord injury and kidney dialysis remain exclusions from the model.) Also in 1986, transfers between bed sections within a hospital are included in the work unit calculations. For example, transfers from either medicine or surgery bed sections to psychiatry now result in full work unit credit to the medicine or surgery bed sections. The final discharge from the psychiatry bed section will also earn full credit as a DRG.

Medical Care Cost Data Flow

Medical care expenditures are accumulated throughout the year by hospital cost centers. The Personnel Accounting Integrated Data (PAID) system accumulates all medical center staff costs, while the Centralized Accounting for Local Management (CALM) system accumulates all other costs (for example, drugs and laboratory supplies).

At the end of each month and quarter, the CALM system interfaces with PAID to produce the CALM 830 Cost Center Listing. The report summarizes by cost center and subaccount (for example, diagnostic radiology) the cumulative costs-to-date for the fiscal year and the quarter. It breaks out the personal service (with corresponding full-time employee equivalents) and all other costs for each cost center and subaccount on the same basis.

Moreover, at the end of each quarter, each medical center service chief provides its fiscal service (its budget office) with percentage distributions of where their employees' time was spent and where costs were incurred. The categories to which these percentages are spread are program/function cost accounts (for example, laboratory service spreads its costs to general medicine, neurology, etc.). The status of these accounts


AUG
SEP
1985
OCT
NOV
DEC
1985
JAN
FEB
SEPT 1985
SEPT 15 VA BUDGET TO OMB
OMB VA BUDGET HEARINGS
USUAL TIME FRAME FOR OMB DIRECTOR'S BRIEF
DIRECTOR'S BRIEF DEC. 31, 1984
VA APPEALS BUDGET DECISIONS
FINAL DECISIONS MADE ON PRESIDENT'S BUDGET
CONGRESS RECEIVES PRESIDENT'S BUDGET
CONGRESSIONAL BUDGET REVIEW
CONGRESSIONAL JUSTIFICATION REVIEWED BY OMB
POSSIBLE APPEAL TO ADMINISTRATOR
POM ISSUED BY ADMINISTRATOR
VA BUDGET
DM&S APPEAL TO DEPUTY ADMINISTRATOR
VACO INPUTS INTO BUDGET HEARINGS
BUDGET PASSBACK GIVEN TO AGENCY ON DEC. 31, 1984
DECISIONS MADE ON VA BUDGET APPEALS
REVIEW OF DEPARTMENT BUDGETS AND CONSOLIDATION OF CONGRESSIONAL JUSTIFICATION
VACO SENDS INSTRUCTIONS FOR OMB BUDGET PREPARATION TO VA DEPARTMENTS
USUAL TIME FRAME FOR VA PASSBACK
VACO CALL FOR PREPARATION OF CONGRESSIONAL JUSTIFICATIONS
DM&S BUDGET FORMULATION
DM&S BUDGET FORMULATION PREPARES CONGRESSIONAL JUSTIFICATION
DM&S BUDGET EXECUTION PHASE BEGINS
DM&S CO AND PROGRAM OFFICIALS INPUTS INTO OMB BUDGET PROCESS
DM&S BUDGET FORMULATION PUTS BUDGET IN OMB FORM-DEVELOPS SUPPORTING SCHEDULES
PASSBACK TO DM&S AND PROGRAM OFFICIALS
ABBREVIATIONS
B&F BUDGET AND FINANCE
MEDIPP MEDICAL DISTRICT INITIATED PROGRAM PLANNING
PDM PROGRAM DECISION MEMORANDA
PP&E PROGRAM, PLANNING AND EVALUATION
GUIDE TO VA FLOW CHART SYMBOLS
INDICATES A PROCESS.
INDICATES A DOCUMENT PRODUCED DURING OR AT THE END OF A PROCESS.
INDICATES THAT A PROCESS IS CONTINUOUS THROUGHOUT THE PERIOD SHOWN ON THE CHART.
INDICATES INFORMAL COMMUNICATION VIA TELEPHONE OR TELEX.
INDICATES PERSON TRAVELING FROM VA HEADQUARTERS TO FIELD DURING PROCESS OR VICE VERSA.
INDICATES PARTICIPANTS EXTERNAL TO VA.

$$\frac{\text{National total CMDE accounts}}{\text{National total weighted work units}} \times \text{Medical center's total work units} = \text{Total national reimbursement rate cost}$$

$$\frac{\text{Medical center's total CMDE account}}{\text{Medical center's total weighted work units}} \times \text{Medical center's total work units} = \frac{\text{Total medical center CMDE cost}}{\pm \text{ Adjustment}}$$

In effect, the Central Office calculates an average cost per weighted work unit for the entire VA system and for each individual medical center. If a hospital's average cost per work unit is lower than the national average, the center's target allowance will be increased by an amount equal to the difference in average cost times the number of work units produced that year. If a hospital's average cost is higher, its adjustment will be negative. Since the system is designed to allocate a portion of the VA's national budget for medical care (which is fixed), some medical centers, by definition, must gain funds and some must lose.

However, in order to prevent a disruptive redistribution of funds among the medical centers early in the implementation of the casemix methodology, the adjustment for fiscal year 1985 was capped by the lesser of the following:

(1) 20 percent of expected CMDE - actual CMDE

Expected CMDE = national average cost per work unit x hospital's total work units

Actual CMDE = hospital's average cost per work unit x hospital's total work units or

(2) 1 percent of a hospital's CMDE

With the fiscal year 1986 addition of ambulatory and intermediate and long-term care models to the casemix methodology, the maximum adjustment (plus or minus) to a facility's recurring operating budget increased to 3 percent (from 1 percent) of total expected Casemix dollars or 60 percent (from 20 percent) of the net change between actual and expected CMDE.

The Budget Execution Process

The budget execution phase of the DM&S financial management process begins when the President gives his budget to the Congress in January of each year.

Using the President's budget for VA medical care as a ceiling and the preliminary casemix allocations for each medical center, DM&S Budget Administration begins to develop target allowances for each medical center for the fiscal year beginning October 1. Target allowances are the spending ceilings provided each medical center. The casemix allocations are based on Diagnosis Related Groups (DRGs). Each diagnosis is assigned a given number of weighted work units, costs associated with acute medical care are accumulated, and the average cost per weighted work unit is derived by dividing the two. Casemix allocations for fiscal year 1985 were based on about 40 percent of a medical center's total target allowance.[10] (For a complete description of the methodology, see Casemix Methodology narrative and its accompanying flowchart on pages 67 to 77.) The actual casemix adjustment in 1986 was limited to plus or minus 3 percent of a hospital's recurring budget (line 1 of the target allowance).

The remaining 60 percent of the target allowance is based largely on recurring expenses and overhead. The cut-off date for inclusion of these items in a medical center's target allowance for the coming fiscal year is February. (For the fiscal year 1985 target allowance, the cut-off date was February 17, 1984.)

The Budget Administrator releases the target allowances to the Associate Deputy Chief Medical Director for his review and approval.

Medical Centers may appeal to the Chief Medical Director for an exemption from the casemix allocation they have received from Budget Administration. Any changes to a medical center's allotment are passed from the Chief to Budget Administration, and the medical center's target allowance modified accordingly. An example of an exemption would be construction which greatly curtailed a medical center's operations.

The target allowances are sent to the regions. The regions then allocate to the districts which in turn allocate the target allowance to the VA medical centers (VAMCs). The regions hold a meeting or meetings to describe

[10]For fiscal year 1986, casemix modules were added for (1) ambulatory care and (2) long-term and intermediate care. This brought to 55 percent the share of a hospital's budget covered by the casemix methodology.

Work unit allocations for the standard, or "low-use," outpatient population are also made on a per capita basis, with a different rate for each of the eight age groups. The number of visits per person, per year is assumed to increase with age, and the methodology reflects this. For example, the fiscal year 1984 20-percent sample of outpatients showed that veterans under age 25 averaged 2.65 outpatient visits per person, per year. In contrast, veterans age 85 and older averaged 5.17 visits per person, per year. Again, allowances are made for facilities that provide more than the national average number of visits per year in each age category. This rate is set at a per visit work unit value of 50 percent of the national average rate per visit for all VA facilities.

The model includes all ambulatory care services except readjustment counseling and hospital based home care and dialysis. Like the acute care model, the ambulatory care model includes adjustments for salary differentials in different geographic locations, and for teaching facilities. In addition, the model includes special work unit values for five types of ambulatory services: CAT scans (a type of computerized diagnostic scan of all or part of the body); cancer chemotherapy visits; radiation therapy visits; blood and blood product transfusions; and ambulatory surgery.

The Intermediate and Long-Term Care Model

The long-term care model is based in part on research which indicates that a significant portion of the cost of long-term care is closely associated with the amount of nursing care the patient's physical and functional condition requires. VA developed weighted work units for intermediate and long-term care based on a September 1983 survey sent to each VA medical facility to collect patient physical, functional, and treatment data. Although data were collected on long-term care patients in eight different facility types, for the purposes of the model, only long-term care patients in intermediate medicine[12] and nursing home beds were analyzed.

VA tested the applicability of two existing models by (1) grouping patients, (2) calculating average nursing time per group, (3) converting these average nursing times to group weighted work unit values, (4) assigning the weighted work units to each group's members, (5) calculating work unit costs, and (6) calculating allocation levels by multiplying total facility work units by the unit cost. VA determined that the

[12]Intermediate medicine beds in VA roughly correspond to private sector hospital-based skilled nursing facilities.

usually receives cursory review because the district has been involved on an informal basis throughout its development. Any district changes, however, are forwarded to DM&S Budget Administration, by the end of June, for review and inclusion in the plans if Budget Administration believes the changes are necessary.

After Budget Administration receives the final plans and any suggested district changes, it elicits the help of regions and program offices in a final review of the VAMC spending plans. Also, during July, the Office of Budget and Finance (B&F) in VA's Central Office (VACO) sends out a call to all VA departments to finalize their financial operating plans, the DM&S basis of which is the VAMC monthly spending plans. The call is simultaneous with that of the Office of Program Planning and Evaluation (PP&E) for submittal of the departmentwide program plans to that office.

The DM&S Budget Administration review, which takes place during July and August, is used to compare the VAMC monthly spending plans with the original target allowance amounts. The target amounts are adjusted for any changes taking place between the February cut-off date, for inclusion of recurring items, and the May cut-off date, for inclusion of current obligation, FTEE, and workload data. Budget Administration would also be modifying the spending plans to reflect any current decision which might affect medical center spending. The period July through August would also be used by DM&S Budget Administration to begin consolidating the VAMC spending plans into the departments' financial operating plan for September submittal to VACO's Office of Budget and Finance.

Under normal circumstances, the VA appropriation and passage of supplemental actions by the Congress would take place during August or in early September. The details of the spending bills are passed from the Congress to Budget and Finance and finally to the departments. When DM&S Budget Administration receives the details, it reviews them and then proceeds to make changes in VAMC specific spending plans warranted by the congressional action. These changes are all incorporated into the financial operating plan prior to its receipt by Budget and Finance.

Once all inputs have been added to the individual VAMC spending plan; all the plans have been consolidated; and the operating expenses for DM&S headquarters, the regions, and the districts have been consolidated, the resulting financial operating plan is forwarded to Budget and Finance for review and approval.

and usually in November, after the close of the fiscal year, they hold an end-of-year performance evaluation. These two reviews are used to assess how the VA departments (including DM&S) have performed based on the financial operating plans developed prior to the beginning of the fiscal year.

Figure IV.6: Casemix Resource Allocation Methodology for Acute Care

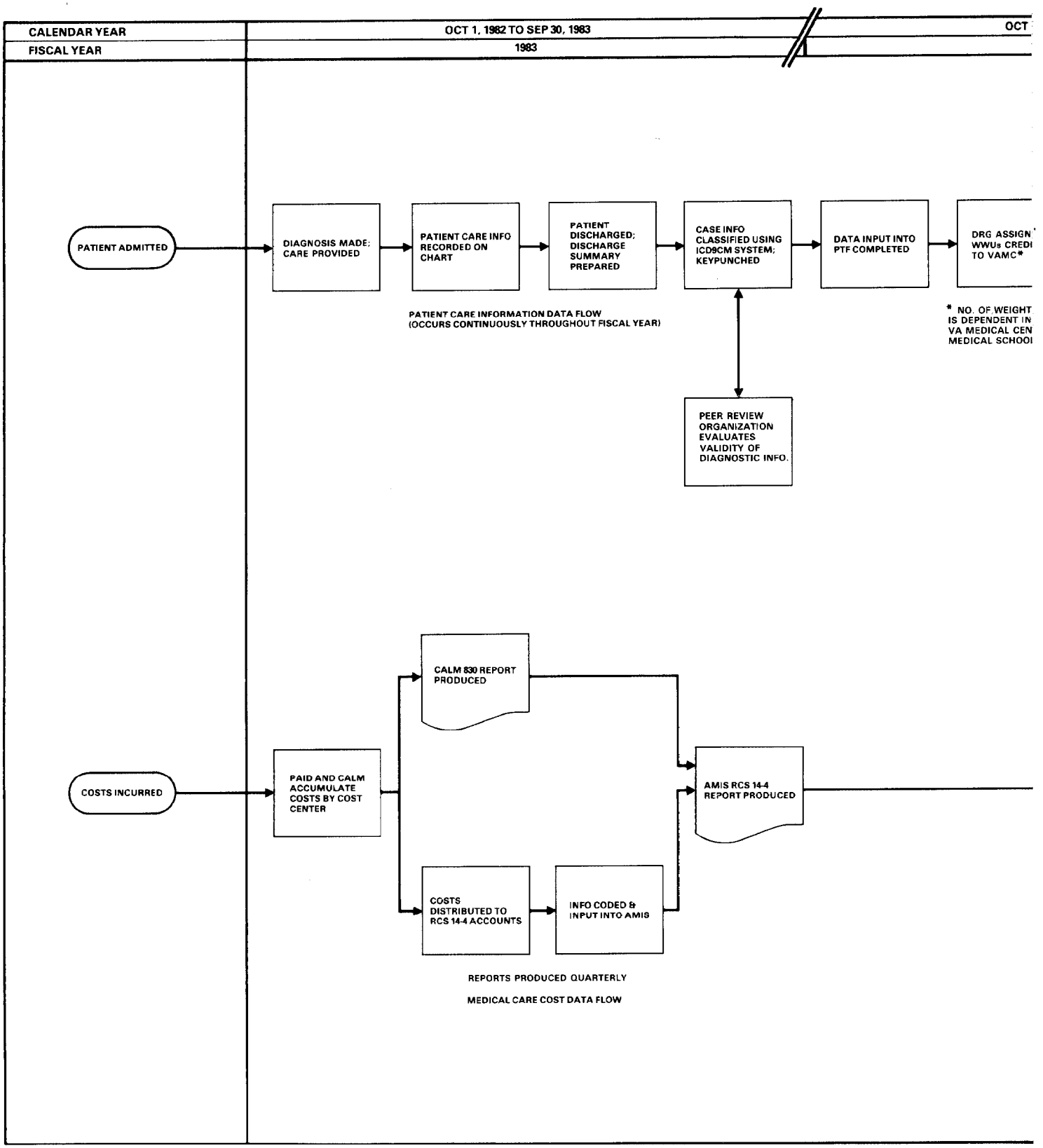
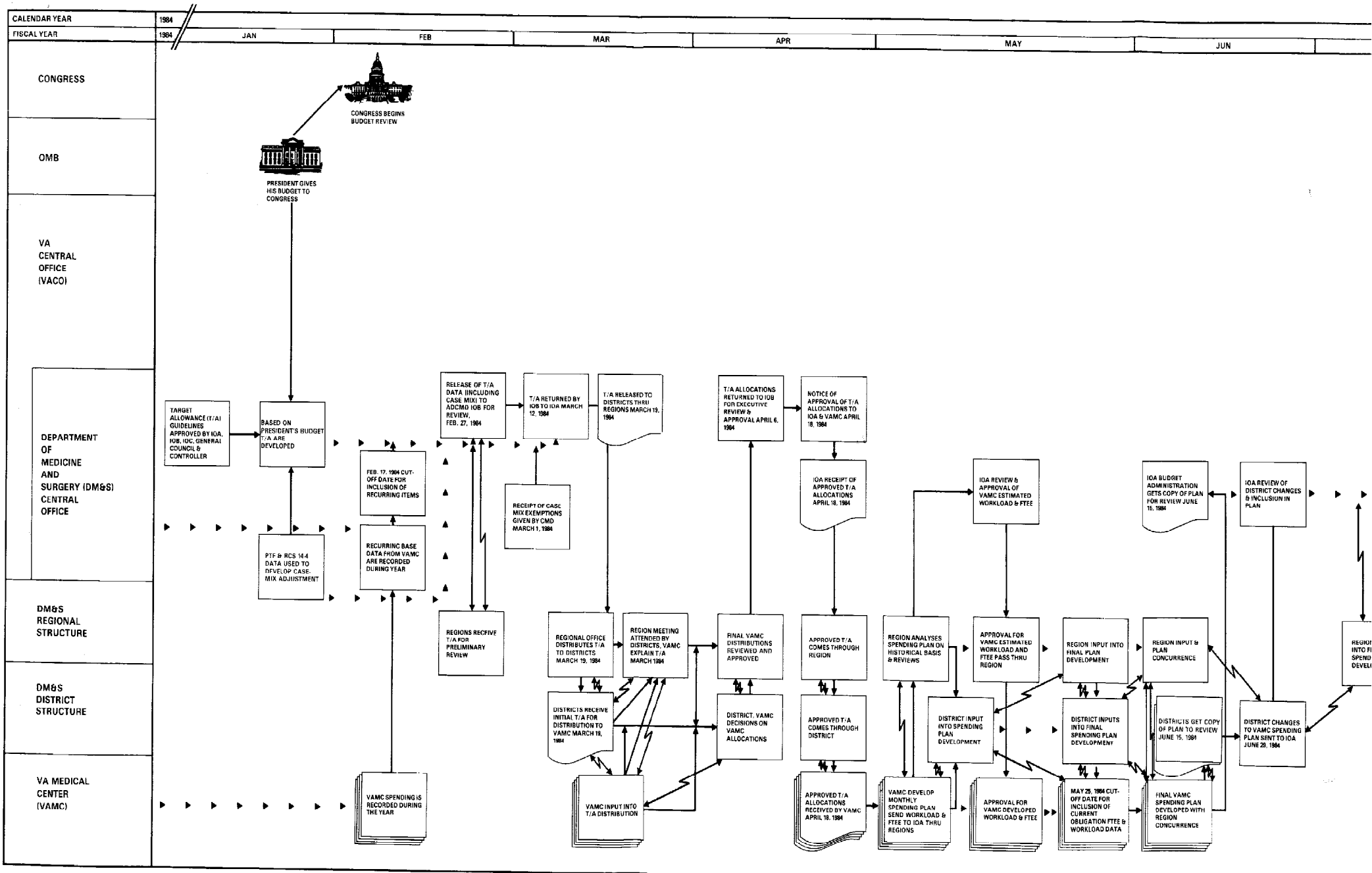


Figure IV.5: Department of Medicine and Surgery's Budget Execution Process for FY 1985



FSP project teams Central Office personnel with medical district personnel to help a VA medical center (VAMC) generate more reliable information for the facility planning process.

(6) Advance Planning Fund Studies—Needs are also identified from Advance Planning Fund studies. These studies involve the specific development of activities associated with individual projects. These needs are in the form of correcting deficiencies not involved in an earlier Advance Planning Fund study, or other items that surface as a result of building one project.

Based on the preceding inputs, each VAMC proposes projects to correct deficiencies. Through their "Annual MEDIPP Evaluation of Medical District Goals and Objectives," the medical districts review and assess proposals. Project priorities are set by each Medical District Executive Committee. Also at this stage, there is informal telephone communication between the Facility Planning Service in DM&S and VACO MEDIPP Planners, Regional Directors, and VAMCs.

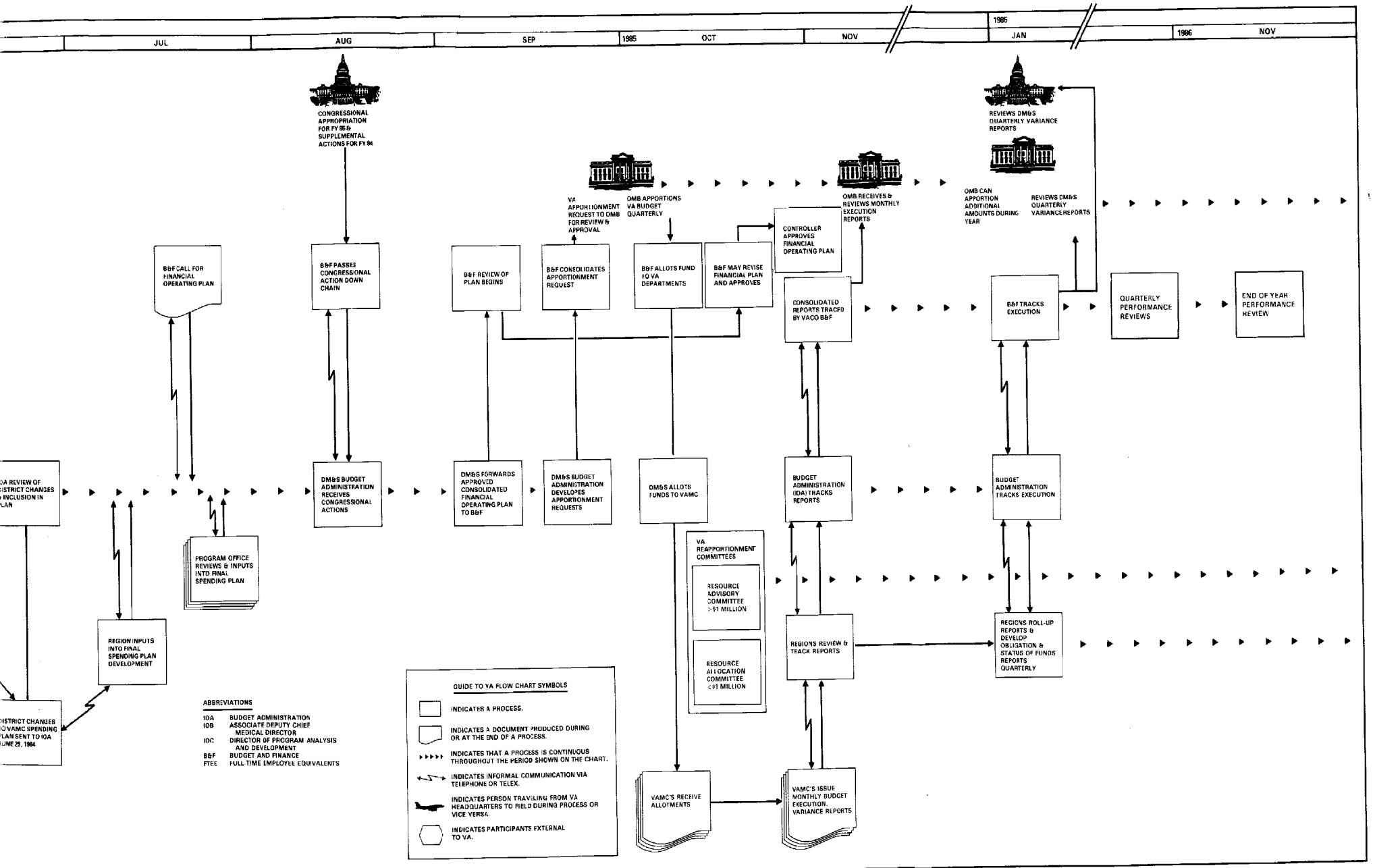
Each district's annual MEDIPP submission is then approved by the VA Administrator.

Annual 5-Year Facility Plan

January Fiscal Year 19X1

Each VAMC must submit an annual 5-year facility plan; due dates are staggered, with some coming due each quarter. The 5-year facility plan contains projects that respond to program planning requirements noted in MEDIPP and also some major project proposals not covered in MEDIPP (for example, fire and safety code requirements, electrical deficiencies). Facility plans are reviewed by the district and region; however, each VAMC deals directly with the Facility Planning Service (FPS), in the Department of Medicine and Surgery (DM&S), in its submission of plans. The formalized process involves review, comments, and signatures of reviewers. FPS also has informal discussions with each

- VAMC Director,
- Medical District Director, and
- Regional Director.


JUL
AUG
SEP
1985
OCT
NOV
1986
JAN
1986
NOV
CONGRESSIONAL APPROPRIATION FOR FY 85 & SUPPLEMENTAL ACTIONS FOR FY 84
REVIEWS DM&S QUARTERLY VARIANCE REPORTS
VA APPORTIONMENT REQUEST TO OMB FOR REVIEW & APPROVAL
OMB APPORTIONS VA BUDGET QUARTERLY
OMB RECEIVES & REVIEWS MONTHLY EXECUTION REPORTS
OMB CAN APPORTION ADDITIONAL AMOUNTS DURING YEAR
REVIEWS DM&S QUARTERLY VARIANCE REPORTS
B&F CALL FOR FINANCIAL OPERATING PLAN
B&F PASSES CONGRESSIONAL ACTION DOWN CHAIN
B&F REVIEW OF PLAN BEGINS
B&F CONSOLIDATES APPORTIONMENT REQUEST
B&F ALLOTS FUND TO VA DEPARTMENTS
B&F MAY REVISE FINANCIAL PLAN AND APPROVES
CONTROLLER APPROVES FINANCIAL OPERATING PLAN
CONSOLIDATED REPORTS TRACED BY VACO B&F
B&F TRACKS EXECUTION
QUARTERLY PERFORMANCE REVIEWS
END OF YEAR PERFORMANCE REVIEW
OA REVIEW OF ISTRICT CHANGES INCLUSION IN LAN
DM&S BUDGET ADMINISTRATION RECEIVES CONGRESSIONAL ACTIONS
DM&S FORWARDS APPROVED CONSOLIDATED FINANCIAL OPERATING PLAN TO B&F
DM&S BUDGET ADMINISTRATION DEVELOPES APPORTIONMENT REQUESTS
DM&S ALLOTS FUNDS TO VAMC
BUDGET ADMINISTRATION TRACKS REPORTS
BUDGET ADMINISTRATION TRACKS EXECUTION
PROGRAM OFFICE REVIEWS & INPUTS INTO FINAL SPENDING PLAN
REGION INPUTS INTO FINAL SPENDING PLAN DEVELOPMENT
VA REAPPORTIONMENT COMMITTEES
RESOURCE ADVISORY COMMITTEE >$1 MILLION
RESOURCE ALLOCATION COMMITTEE <$1 MILLION
REGIONS REVIEW & TRACK REPORTS
REGIONS ROLL-UP REPORTS & DEVELOP OBLIGATION & STATUS OF FUNDS REPORTS QUARTERLY
ISTRICT CHANGES O VAMC SPENDING LAN SENT TO IOA UNE 29, 1984
ABBREVIATIONS
IOA BUDGET ADMINISTRATION
IOB ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR
IOC DIRECTOR OF PROGRAM ANALYSIS AND DEVELOPMENT
B&F BUDGET AND FINANCE
FTEE FULL TIME EMPLOYEE EQUIVALENTS
GUIDE TO VA FLOW CHART SYMBOLS
INDICATES A PROCESS.
INDICATES A DOCUMENT PRODUCED DURING OR AT THE END OF A PROCESS.
INDICATES THAT A PROCESS IS CONTINUOUS THROUGHOUT THE PERIOD SHOWN ON THE CHART.
INDICATES INFORMAL COMMUNICATION VIA TELEPHONE OR TELEX.
INDICATES PERSON TRAVELING FROM VA HEADQUARTERS TO FIELD DURING PROCESS OR VICE VERSA.
INDICATES PARTICIPANTS EXTERNAL TO VA.
VAMC'S RECEIVE ALLOTMENTS
VAMC'S ISSUE MONTHLY BUDGET EXECUTION VARIANCE REPORTS

- the Chief Medical Director,
- the Controller, and
- the Office of Construction.

Also, the VA Administrator must formally approve the list before it is sent to OMB and the Congress.

August Fiscal Year 19X3

FPS is also responsible for defending any approved project before the Congress during the budget process. At this point, the Project Management Service, in DM&S, becomes the driving force behind the construction process. Data package development involves compilation of data on

(1) Workload projections (personnel, bedsizing, space)— Prepared by Health Systems Planning Service (HSPS), in DM&S, and the District Director.

(2) Staffing increments—Developed by Project Management Service and the VAMC Director based on workload projections.

The data package is reviewed by Project Management Service and Health Care Facilities Service (HCFS), in the Office of the Associate Deputy Administrator for Logistics.

HCFS then develops space projections, which are based on functional elements in the data package (for example, cardiology unit and X-ray unit).

August Fiscal Year 19X4

Once space requirements have been developed, a project architect can be assigned to prepare conceptual layouts which will be reviewed by

- the VAMC,
- the Controller,
- the Associate Deputy Administrator for Logistics, and
- the Office of Construction's Planning and Administrative offices.

The Facility Engineering, Planning, and Construction Office (FEPAC), in DM&S, selects a conceptual layout for the construction project.

The Casemix-Based Resource Allocation Methodology

In 1983, the Department of Medicine and Surgery (DM&S) introduced the Casemix-based Resource Allocation Methodology (methodology) for use in determining a portion of each VA medical facility's operating budget. Beginning with fiscal year 1985, a growing portion of each medical facility's budget is based on the methodology, which measures both a facility's clinical workload, or casemix, and the relative efficiency with which the facility provides direct medical care services to treat that casemix. The system is designed to reward the efficient use of resources and to penalize inefficient use. VA medical facilities whose direct medical care costs (that is, their direct cost of providing patient care), as measured by the methodology, are lower than the national average, receive a positive adjustment to their recurring operating budget (line 1 of the target allowance), while those facilities whose costs are higher than the national average receive a negative adjustment. The adjustment for fiscal year 1985 applied only to acute medical care cost. For fiscal year 1986, components for (1) ambulatory care and (2) intermediate and long-term care were added to the methodology and the adjustment. The goal is to eventually base about 75 percent of a medical center's[11] recurring operating budget on the methodology.

Prior to the introduction of the methodology, hospital budgets were primarily based on prior year budgets, plus adjustments for inflation and the expected increased costs of operating new or expanded facilities. The methodology's underlying premise is that by encouraging hospitals to seek the least costly form of appropriate care, costs will be lowered, patients will be discharged from hospitals sooner, and therefore a greater number of patients can be treated with the same resources. Peer Review Organizations will review the quality of care provided after the methodology is implemented to ensure that the methodology's cost-cutting incentives do not compromise the quality of care.

Certain facilities and/or programs may be exempted from the application of any or all three of the resource allocation models in fiscal year 1986 if approved by the Chief Medical Director. These exclusions must first be approved and recommended by the Regional Director and an Interim Executive Committee on Exemptions.

[11] VA refers to all VA hospitals as medical centers. VA has 172 hospitals and 160 medical centers. A medical center may consist of one or more hospitals, one or more outpatient clinics, a nursing home, and a domiciliary. Five outpatient clinics and one domiciliary are independent of any medical center. In this appendix, we use the terms hospital and medical center interchangeably.

Budget Execution

October Fiscal Year 19X6

Budget execution begins with the architect/engineer's preparation of final working drawings and a critical path method network for construction goals. The project's actual percentage completion is reviewed against those goals monthly by the resident engineer, the Associate Deputy Administrator for Logistics, and, with consent of the review, payment is authorized by the Project Director.

Medical records technicians in Medical Administrative Service review the discharge summaries for every patient and code the information using the International Classification of Diseases, 9th revision, clinical modification (ICD-9-CM) classification system. Keypunch operators keypunch the data from the code sheets and the data is transmitted to the VA's centralized data processing center in Austin, Texas.

Periodically, Peer Review Organizations (PROs) staffed by clinicians who are not employed by the hospital will audit selected patient records (such as the medical chart and discharge summary) to ensure that:

- all diagnoses are included and the primary diagnosis is correct,
- all complications and comorbidities are included, and
- all treatment procedures are documented so that the correct DRG is assigned.

In addition, Peer Reviewers are expected to ensure that the quality of health is not sacrificed due to the increased pressure for economy brought about by the casemix system. Specifically, the reviewers will examine patient records to determine whether:

- the hospital admission was appropriate,
- the appropriate amount of hospital resources were used to treat the patient (for example, lab tests were appropriate), and
- the patient's length of stay in the hospital was appropriate.

The reviewers will determine if deficiencies exist in the quality of the medical record or patient care, and make recommendations for improvement. As of 1985, the PROs had not yet been fully activated, but were being established.

Patient care data is input into the Patient Treatment File (PTF), the VA's automated discharge abstract system. While this process occurs continuously throughout the fiscal year, there is normally a backlog of undictated discharge summaries at each hospital. Thus, input continues through October until a Central Office mandated fiscal year cut-off date is reached.

The computer assigns a DRG classification based on the patient's ICD-9-CM coding as documented in the PTF. Based on the DRG assignment, the computer credits the hospital with a predetermined number of weighted work units. The number of units assigned reflects the relative amount of resources which should be expended to provide treatment to the

is reported in the RCS 10-141 Report of Medical Care Distribution Accounts.

Fiscal Service codes the percentage breakdowns and transmits the data to the VA data processing center in Austin, Texas, where it is entered into the Automated Management Information System (AMIS).

Utilizing the cost information in the CALM 830 report and the cost distribution percentages provided by the service chiefs, AMIS distributes the total expenses reflected in each cost center to the appropriate program/function cost accounts to produce the RCS 10-141 Report of Medical Care Distribution Accounts. This report generates cost for each major program area (for example, surgical ward cost, acute psychiatry) and breaks the information down further into supporting cost centers. Costs are broken down by Personal Services and All Other Cost on a fiscal year-to-date basis.

Full-time equivalent employee breakdowns are also provided. In addition, AMIS service workload data (produced in another process) is used to calculate workload unit costs for the hospital and the entire VA medical system for comparative purposes. The final RCS 10-141 report (fiscal year 4th quarter) is used to calculate the casemix adjustment because it includes the total costs for the year.

In fiscal year 1985, only the fiscal allocations for inpatient psychiatric, acute medicine and surgery services were based on the casemix methodology (about 40 percent of each medical center's budget). The cost of these services is summarized in 15 of the more than 100 RCS 10-141 distribution accounts. These accounts, which are entitled Casemix Direct Education (CMDE) cost accounts, are totaled for each hospital and the entire system.

The Casemix Resource Allocation Adjustment

The casemix system produces a plus or minus adjustment to a hospital's budget. Utilizing the work unit data accumulated in the patient care information data flow and the CMDE cost data in the medical care cost data flow, the Central Office calculates the adjustment to each hospital's (medical center) budget as follows:

most in need of major construction. The proposed projects are prioritized within designated categories in order that similarities between the scopes of "like category" projects can be compared. The designated categories are: replacement/modernization; nursing home care; clinical improvements; outpatient improvements; fire and safety; and all others.

Within each category, a combination of objective and subjective evaluations of various "primary" and "secondary" factors is applied to each project and a rationale for priority setting is established. Primary factors include those considerations determined to be most important in terms of the delivery of quality medical care. These factors include: patient safety; demonstrated need based on demographic analyses of current and projected inpatient workloads and outpatient visits; space and functional deficiencies in patient and clinical areas; compliance with patient privacy and handicap access standards; and the medical delivery role of the medical center in the VA system. Secondary factors are also vital to the operational functioning of a health care facility but impact indirectly on patient care. Secondary factors encompass the size, age, and condition of patient care buildings; energy conservation; and the condition of non-patient support functions such as the laundry, boiler plant, and warehouse. Applying these factors to each project and evaluating the strengths of each factor results in a relative ranking of each project against the other projects in the same category.

In response to a congressional request, VA developed a new prioritization methodology to rank construction projects in priority order. This methodology is described in a VA report issued in June 1985 entitled, A Methodology for Prioritizing Major Construction Projects in the Veterans Administration. The FY 1987-1991 Five Year Medical Facility Construction Needs Assessment will be the first construction plan that fully reflects the results of the new methodology.

FPS coordinates the development of the needs assessment and initiates the assessment by meeting with the Office of Construction, specifically, HCFS and Program Control and Analysis (PC&A), to determine which of the projects in the "Major Project Inventory" will be ready for construction funding in the coming budget year. The "Major Project Inventory" is a list of major projects that have been approved from the 5-year facility plans during the preceding fiscal year.

Only projects in the first year of the "Major Project Inventory" that have completed the Advance Planning Fund and preliminary planning

Hospitals have the right to appeal their adjustment to the Central Office.

The CMDE adjustment is added to (or subtracted from) each hospital's recurring base in its target allowance to calculate an adjusted recurring funding level for its budget.

Currently, efforts are underway in both the Central Office and in the VAMCs to improve the accuracy of the information in both the Patient Treatment File and the RCS 10-141 reports used in determining the acute care casemix adjustment for each hospital.

Models Introduced for Fiscal Year 1986

As already discussed, DM&S added ambulatory and intermediate and long-term care models to its casemix methodology for fiscal year 1986. VA adopted the preexisting DRG categories for use in its acute care model, but no such widely accepted workload measurement existed for ambulatory or intermediate and long-term care. Thus, VA had to develop its own clinical workload measurement systems for these models. However, costs for both new models, like the acute care model, are based on the RCS 10-141 Report of Medical Care Distribution Accounts. Also, like the acute care model, each model's national average cost per work unit is derived by dividing total reported work units for all facilities by the total reported RCS 10-141 costs for each type of care.

The Ambulatory Care Model

The ambulatory care model's weighted work unit values were developed using VA's 20-percent sample of outpatient visits, plus fiscal year 1984 quarterly outpatient workload surveys. In the model, outpatients are classified into two Consumption Related Groups (CRGs):

- long-term care (high-use) psychiatric patients—those patients who have had more than three individual psychiatric treatment sessions or more than six group therapy sessions in a single year and
- all other patients, who are considered to be short-term (low-use) patients.

The distinction is based on the estimated costs of treating "high-use" psychiatric patients. Work unit allocations for these patients are made on a per capita basis with allowances for those facilities that provide more than the national average number of visits per person, per year for "high-use" patients. These allowances are set at a per visit work unit value of 50 percent of the model's calculated national average rate per visit for all VA facilities.

Fries/Cooney Resource Utilization Group model was simpler and more statistically stable for the VA patient population.

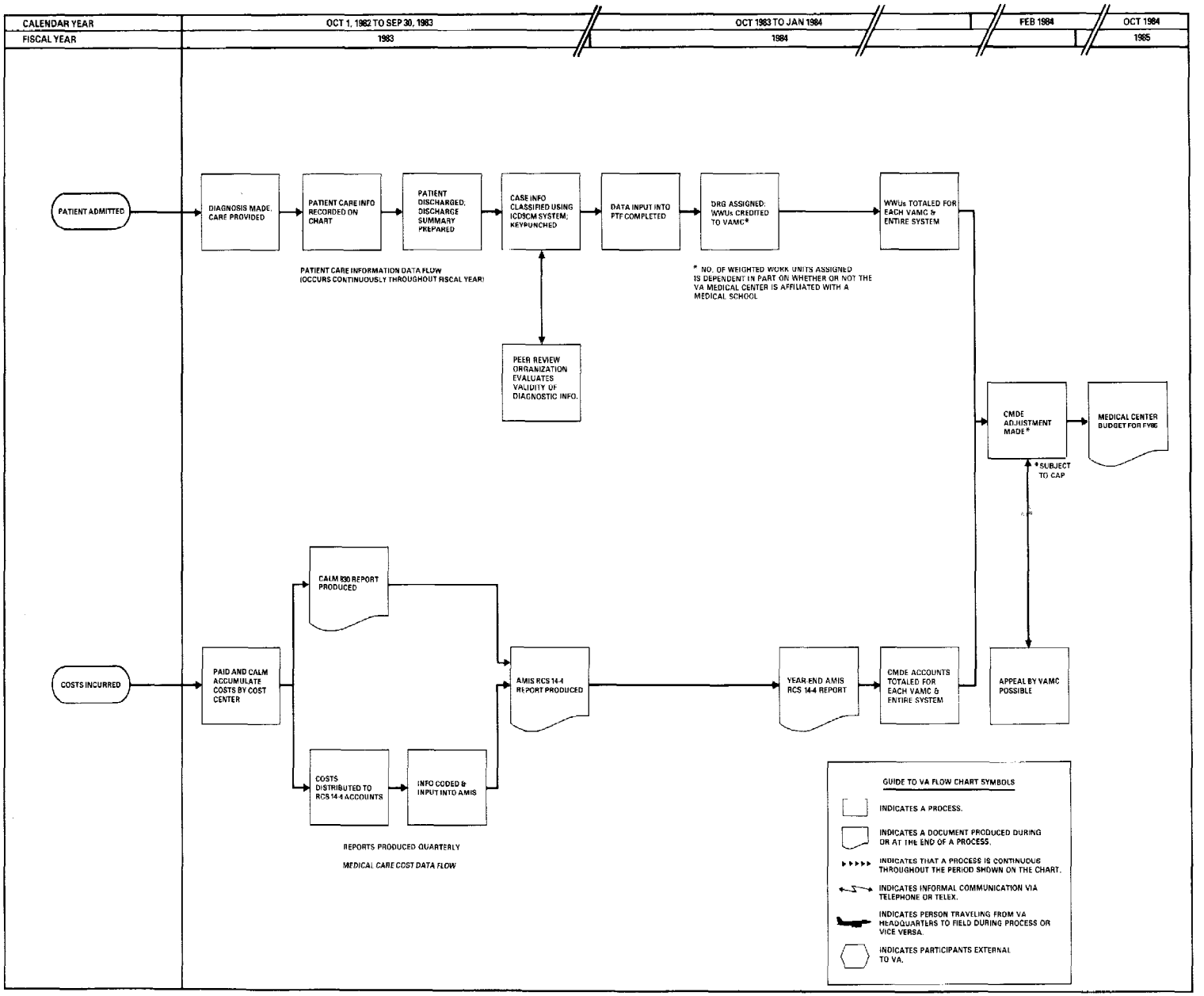
Because VA found that about half of its direct long-term care costs do not vary predictably with a patient's nursing care requirements, the intermediate and long-term care model divides the weighted work unit value for each of the nine Resource Utilization Groups into two parts—half is based on fixed costs and half on the average number of direct nursing care minutes required by each Resource Group as determined by the 1983 survey. The maximum weighted work unit value, like the acute care model's DRG work unit scale, was set at 1,000.

To discourage admission and retention of patients who do not need nursing care, patients will be assigned an Activities of Daily Living Score of zero to six as a measurement of their capacity for physical activity. Patients having a score of zero—those capable of the most activity—would have a work unit value of 254, or one-half that for Resource Group 1, the Group with the lowest work unit value (507).

To encourage rehabilitation, patients whose condition improves during the year would be counted at the highest work unit value for which their condition qualified them during the fiscal year. Thus, facility work unit credits would not decline as a patient moves to a lower valued Resource Group during the fiscal year.

VA plans to conduct periodic surveys (at unspecified intervals) to update the data used to assign patients' Activities for Daily Living Scores and group them by Resource Utilization Group. Each facility's total intermediate and long-term care work units for each fiscal year will be calculated by multiplying their average Resource Group value for all patients treated times the total number of patients treated during the last survey.

Figure IV.6: Casemix Resource Allocation Methodology for Acute Care



requirements for bedsizing and space. All information is recorded on worksheets provided by the Project Management Service.

Workload data is reviewed by FPS and the VAMC Director and then used to develop staffing increments and estimated full time equivalent employees.

The Assistant Chief Medical Directors review the staffing data and forward it to the Project Management Service for approval.

Based upon the preceding, the Project Management Service develops draft data packages, which provide information necessary for the funding and construction of health care facilities.

These offices also meet to verify the contents of the data package (for example, admissions, and MEDIPP projections). If a dramatic change in bedsizing or fundamental design is required, the entire data package may need to be redeveloped.

Space requirements are developed by HCFS in conjunction with the VAMC. They are based on functional elements in the data package (for example, cardiology unit). The requirements are then reviewed by the Budget and Project Management Services.

Project data (scope, data package, and initial space requirements) are reviewed during a visit to the proposed construction site with

- HCFS, specifically the Project Management Service,
- Land Management Service, in the Office of the Associate Deputy Administrator for Logistics,
- Architectural Service, in the Office of the Associate Deputy Administrator for Logistics, and
- Engineering Service, in DM&S, as required.

Concepts for alternatives for layouts are prepared by

- HCFS,
- Land Management Service,
- Architectural Service, and
- Engineering Service.

During the development of conceptual alternatives, the space program and data package are finalized.

Overview of the Major Construction Process

Planning

November Fiscal Year 19X1

The major construction process[1],[2] begins with the identification of a need for a project to correct deficiencies. These deficiencies are identified primarily by the following means:

(1) Accreditation—Deficiencies found during a Systematic External Review (SERP), or findings by the Joint Commission on the Accreditation of Hospitals (JCAH). SERPs are more adapted to the specific needs of VA and usually occur prior to JCAH reviews.

(2) Internal Facility Review—Deficiencies found by environmental upgrading, life safety code inspections, and space deficiencies.

(3) Medical District Initiated Program Planning (MEDIPP)— Medical districts identify needs through the MEDIPP planning process and the accompanying data on: inpatient workload, bedsizing, and outpatient workload. Also, medical districts sometimes revise their missions, which may necessitate changes in their facilities.

(4) Special Studies—Special studies are outside of normal project development, and are usually initiated by the Congress or the VA Administrator. These studies assess the need for replacement or modernization of facilities. Some studies are also initiated by the VA IG and GAO.

(5) Facility Strategic Planning (FSP)—This planning process began as an offshoot of the 5-year facility plans and serves as a needs identifier. The

[1]Timelines are estimated for this and all phases of the major construction process, and are used for illustrative purposes only. Actual time frames have not been established for this process.

[2]There are four types of construction projects in VA: (1) major—projects with an estimated cost of $2 million or more; (2) minor—projects with an estimated cost of between $500,000 and $2 million; (3) minor miscellaneous—projects for which the total project cost does not exceed $500,000; and (4) nonrecurring maintenance—projects for nonrecurring maintenance work or repair, replacements or additions to building service equipment, and/or minor improvements where the minor improvement portion of the project is between $15,000 and $100,000. This appendix and report deal only with VA's major construction process. In volume 1 of this report, at page 122, a typographical error in footnote 3 incorrectly states that the minimum cost of minor construction projects is $400,000 rather than $500,000. Also, on page 130 of volume 1, there is an incorrect statement. The first sentence at the top of that page should read: The VA construction process does not have a highly structured, formal organization in which each organizational element is differentiated by task, level, or project type. (Emphasis indicates change in wording.)

The Chief Medical Director and the VA Administrator must approve the selected conceptual alternative.

Annual 5-Year Construction Needs Assessment

June 30 Fiscal Year 19X1

FPS prepares the annual Five Year Medical Facility Construction Needs Assessment, which is an assessment of VA major construction priority requirements for 5 years within the projected resource levels.

The preparation of this assessment also involves formal discussions with

- the Office of Management and Budget (OMB),
- the VA Administrator,
- the Chief Medical Director,
- the Office of Budget and Finance (Controller), in the Office of the Administrator,
- the Associate Deputy Administrator for Logistics, and
- the Office of Construction.

The Five Year Medical Facility Construction Needs Assessment is approved by the VA Administrator and sent to the Congress by June 30 of each year.

Programming

Fiscal Year Advance Planning Fund Selection

November/December Fiscal Year 19X2

Projects included in an approved Five Year Medical Facility Construction Needs Assessment are also included on an Advance Planning Fund list. The fiscal year 1986 Fund list will build the fiscal year 1989 budget. The target deadline for the Fund list is November. The decision used to be made the following February, but VACO has changed its deadline due to increased requests for lists by the House Appropriations Committee. Fund selection involves formal telephone discussions between FPS and

- OMB,
- the VA Administrator,

Budget Formulation

Fiscal Years 19X4 and 19X5

Preliminary planning begins when a concept is approved and includes

- finalization of space program and data package,
- statement of environmental and historical impact from construction of the project, and
- cost range target development for the project. (The design cost target is provided to the Project Director, in the Office of the Associate Deputy Administrator for Logistics, and used during negotiations with the architect/engineer.)

The fiscal year 1985 HUD-Independent Agencies Appropriations Act provided funds to undertake working drawings for construction projects before they are approved for funding by the Congress. After project requirements and preliminary planning through the APF process are completed, final designs are begun based on the conceptual alternative chosen. This design work includes preparation of preliminary working drawings, project specifications, and other related technical services. According to VA, allowing a project to proceed directly from the advance planning stage to working drawings will save an average of 15 months in the construction process, thereby saving additional inflation costs. It also reduces design changes, permits earlier occupancy of the constructed facility, and provides a more accurate project cost estimate. The funds requested to support the Design Fund in each fiscal year will be used to develop working drawings for projects to be requested for funding in the next fiscal year.

Budget Formulation

Fiscal Year 19X5

Prior to these changes, preliminary plans were prepared for a proposed project and used to refine the project's scope and to develop an estimated project cost. Based on this information, projects were recommended for inclusion in a budget request by the Chief Medical Director and approved by the VA Administrator. The working drawings developed with the Design Fund will now be used for the same purpose.

plans and to determine which projects should begin through the Advance Planning Fund process.

The Congress reviews and normally approves the budget by the following October, and the appropriated funds are made available. During the budget approval process, the Office of Construction and the architect/engineer negotiate a working drawings contract so that work may begin as soon as funds are available. This action allows design to begin as early as possible and minimizes the effects of escalation on the construction funds. This entire budget process requires about 15 months.

Jointly, the Associate Deputy Administrator (ADA) for Logistics and the Chief Medical Director (CMD) prepare a list of projects that will comprise the major construction budget request. Once prepared, the list is sent to the Controller for inclusion in VA's budget submittal to the Congress.

During working drawings development, drawings and specifications are prepared for formal advertising of a construction project. These documents are a graphic and narrative representation of a construction project. Working drawings are prepared either by the Office of Construction or the architect/engineer.

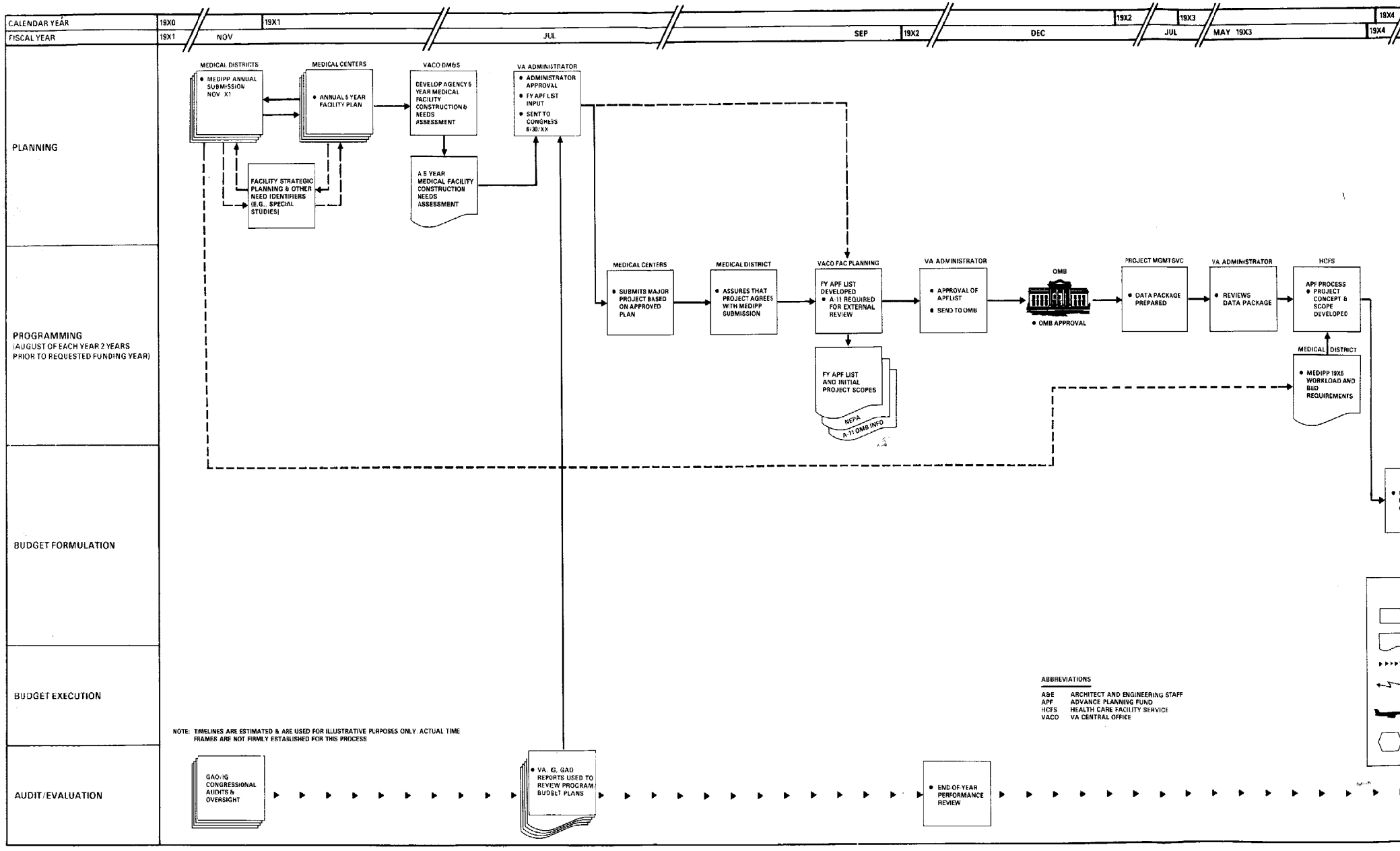
Once final working drawings are completed, the Office of Construction verifies bidding documents, obtains the VA Administrator's approval to issue invitations for bid, and issues drawings for bidding.

Budget Execution

The budget execution phase of the major construction process begins with a bidding conference and contract award on an approved concept.

With the exception of a small number of minority set-aside contracts, all construction procurement for projects administered by VACO is competitive through formal advertising. After the VA Administrator has approved advertising for a project, invitations for bid (IFB) are distributed to prospective bidders and within VA. A bid synopsis is also sent to the Commerce Business Daily. Bidding documents are issued to all prospective bidders who respond to the IFB. To facilitate the bidding process for major projects, a prebid conference may be held in which various aspects of the project phasing and the contract provisions are explained to the contractors, subcontractors, and suppliers. The bids are opened on the designated date at the facility or in VACO, in accordance with VA

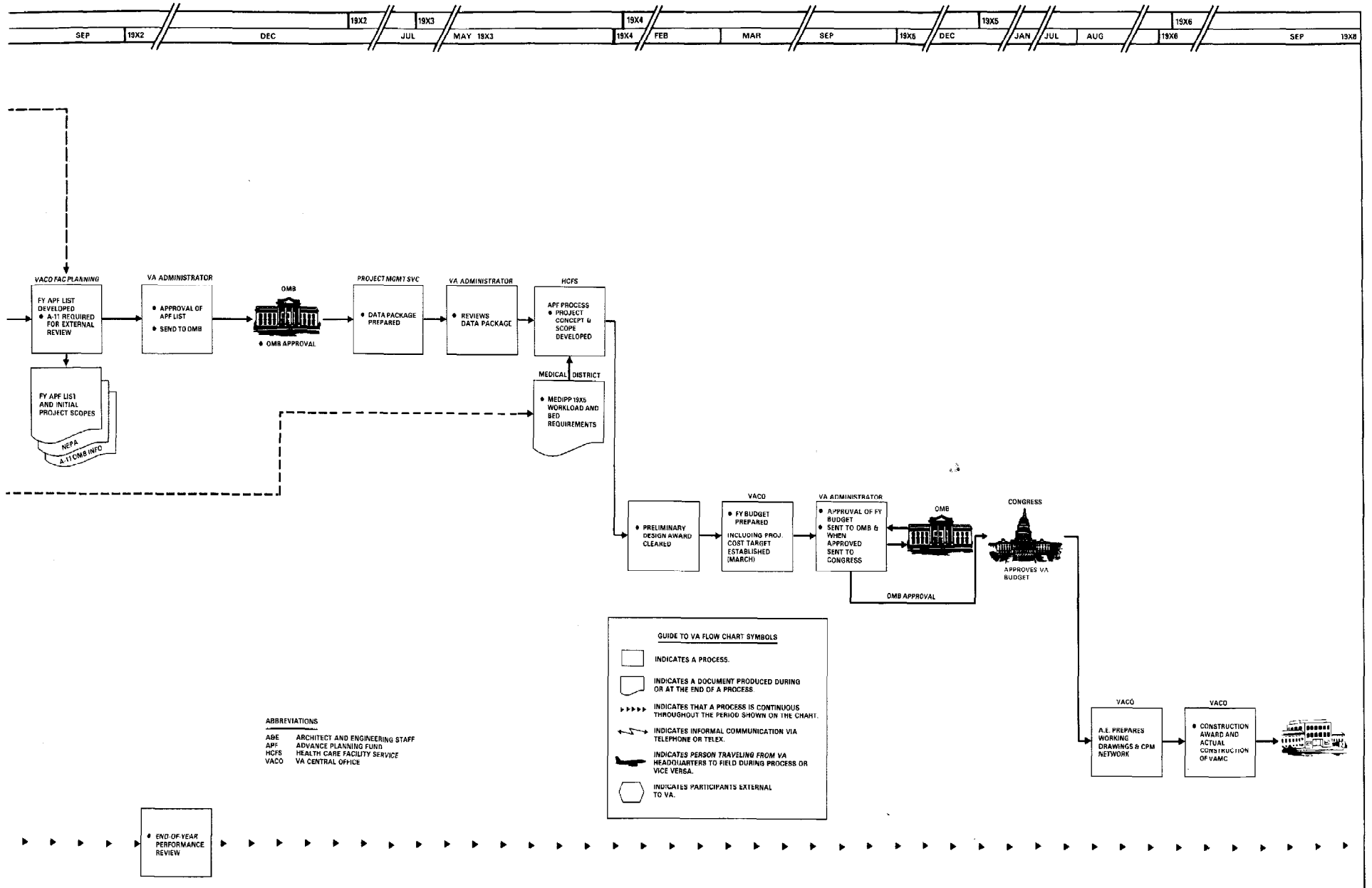
Figure V.1: Major Construction Program Overview



- the Project Management Service,
- the resident engineer,
- the Regional Director, or
- the VAMC Director.

The design changes must go through the consensus review process before they are approved. Consensus review may involve all levels of VACO in the decision. For example, depending upon the dollar value, scope change, or programmatic change of the design, the VA Administrator, Associate Deputy Administrator for Logistics, and DM&S may be involved in the decision.

After a facility is completed, a final inspection is conducted and items that need to be completed are identified. VA then takes custody of the new facility and the Office of Construction transfers the structure to the operating department. Approximately 1 year after completion, a post-occupancy evaluation often is scheduled. The results of this evaluation are used in making refinements to criteria and requirements, which will be reflected in future project planning.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DEC
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JUL
19X3
MAY 19X3
19X4
FEB
MAR
SEP
19X5
DEC
JAN
JUL
AUG
19X6
19X6
SEP
19X6
VACO FAC PLANNING
FY APF LIST DEVELOPED
• A-11 REQUIRED FOR EXTERNAL REVIEW
FY APF LIST AND INITIAL PROJECT SCOPES
NEPA
A-11 OMB INFO
VA ADMINISTRATOR
• APPROVAL OF APF LIST
• SEND TO OMB
OMB
• OMB APPROVAL
PROJECT MGMT SVC
• DATA PACKAGE PREPARED
VA ADMINISTRATOR
• REVIEWS DATA PACKAGE
HCFS
APF PROCESS
• PROJECT CONCEPT & SCOPE DEVELOPED
MEDICAL DISTRICT
• MEDIPP 19X5 WORKLOAD AND BED REQUIREMENTS
• PRELIMINARY DESIGN AWARD CLEARED
VACO
• FY BUDGET PREPARED
INCLUDING PROJ. COST TARGET ESTABLISHED (MARCH)
VA ADMINISTRATOR
• APPROVAL OF FY BUDGET
• SENT TO OMB & WHEN APPROVED SENT TO CONGRESS
OMB
OMB APPROVAL
CONGRESS
APPROVES VA BUDGET
VACO
A.E. PREPARES WORKING DRAWINGS & CPM NETWORK
VACO
• CONSTRUCTION AWARD AND ACTUAL CONSTRUCTION OF VAMC
• END-OF-YEAR PERFORMANCE REVIEW
ABBREVIATIONS
A&E ARCHITECT AND ENGINEERING STAFF
APF ADVANCE PLANNING FUND
HCFS HEALTH CARE FACILITY SERVICE
VACO VA CENTRAL OFFICE
GUIDE TO VA FLOW CHART SYMBOLS
INDICATES A PROCESS.
INDICATES A DOCUMENT PRODUCED DURING OR AT THE END OF A PROCESS.
INDICATES THAT A PROCESS IS CONTINUOUS THROUGHOUT THE PERIOD SHOWN ON THE CHART.
INDICATES INFORMAL COMMUNICATION VIA TELEPHONE OR TELEX.
INDICATES PERSON TRAVELING FROM VA HEADQUARTERS TO FIELD DURING PROCESS OR VICE VERSA.
INDICATES PARTICIPANTS EXTERNAL TO VA.

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Planning

January Fiscal Year 19X1

The planning phase[3] of the major construction process begins with the review by the Medical District Directors of the 5-year facility plans. Annually, each VAMC prepares a 5-year facility plan, called the Five Year Medical Facility Construction Needs Assessment, which represents its long-range strategy for meeting its programmatic needs for new construction, renovation, and repair. The Medical District Director reviews each plan to ensure congruence with the overall mission of VA, the medical district and its MEDIPP plan, and the facility. Once the District Director concurs with the plan, it is forwarded to VACO through the Regional Director. The plans are submitted on a staggered basis so that one-fourth of the VAMCs turn in their plans each quarter.

The Facility Construction Planning Office coordinates the VACO review of the 5-year facility plans. The initial review for comments takes place concurrently and involves the Assistant and Associate Chief Medical Directors, the Office of Construction, and the Facility Engineering, Planning, and Construction Office (FEPAC).

FPS revises the facility plans based upon the comments received. Once a final plan is prepared, it is submitted for a serial review and concurrence to the Program Analysis and Development staff (PA&D), in DM&S; the Regional Director; and the Director of FEPAC. Through delegation from the Chief Medical Director (CMD), the Director of FEPAC has final authority to approve the plans. Once approved, the plans are returned to the VAMCs for implementation.

Development of the Needs Assessment

May Fiscal Year 19X1

Once a year, a needs assessment is made for all VAMCs requesting major construction projects (a project with an estimated cost of more than $2 million). The needs assessment is a process for prioritizing projects within fiscal years and for developing the "list of ten"—the 10 VAMCs

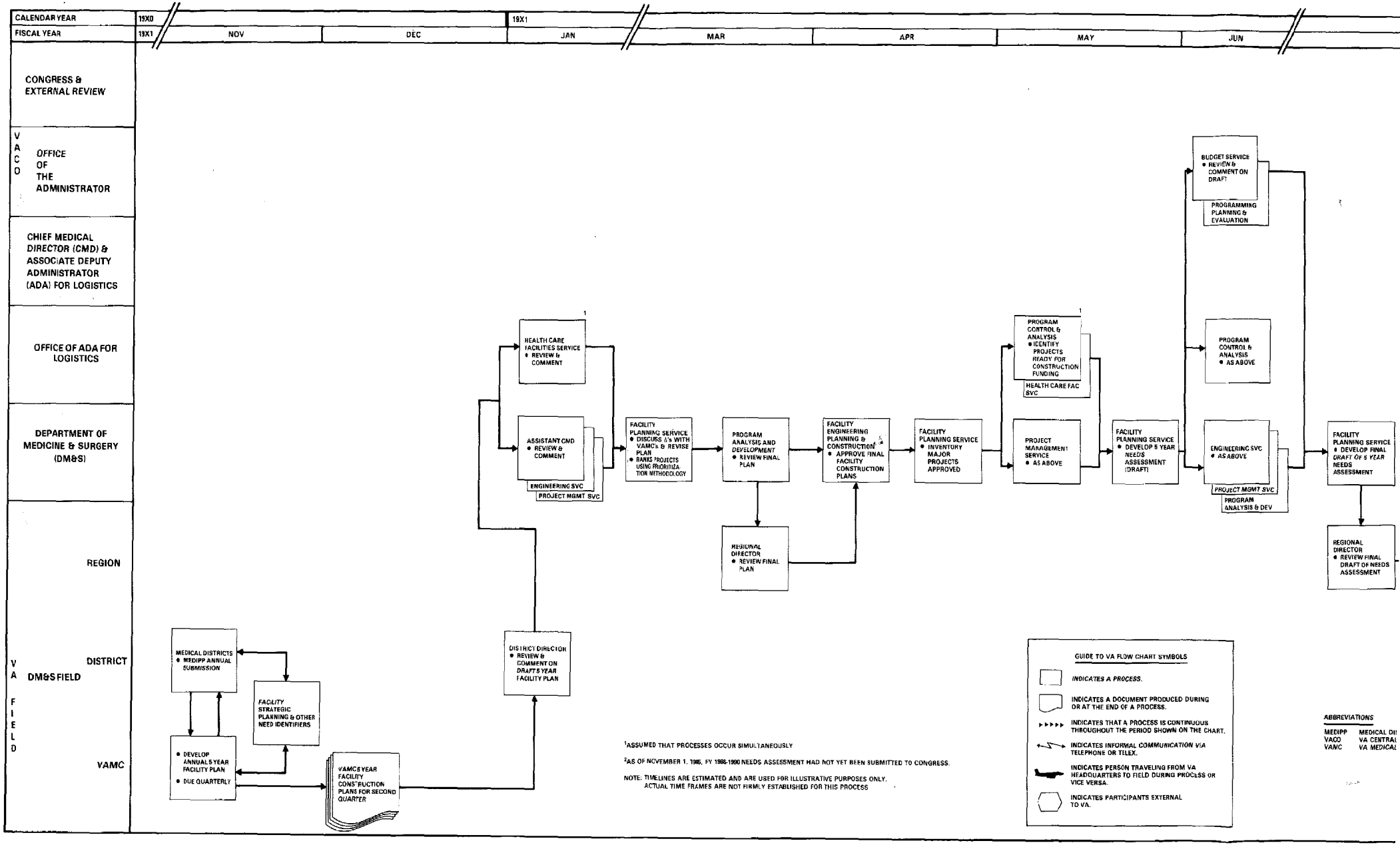
[3]Timelines are estimated for this and all phases of the major construction process and are used for illustrative purposes only. Actual time frames have not been established for this process.

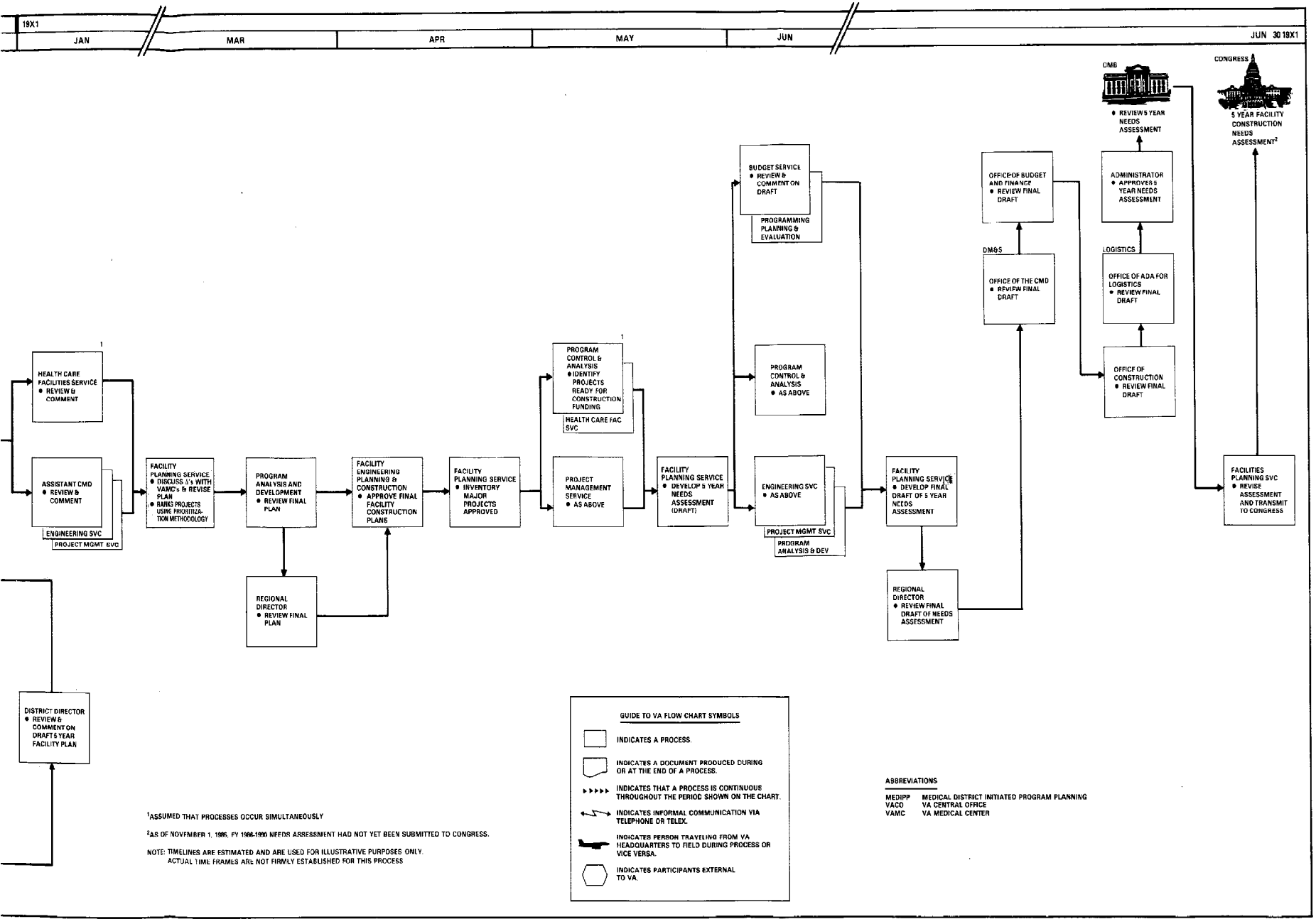
processes by November 30 of the year before the submission of the President's budget can be considered for construction funding. For example, assume the "Major Project Inventory" is for fiscal years 1986-1990. Only those projects that have been approved for fiscal year 1986 and have completed the Advance Planning Fund and preliminary planning processes by November 30, 1984, can be considered for inclusion in the President's budget submitted in January 1985. Based upon the evaluations of primary and secondary factors and the "Major Project Inventory," FPS develops a draft needs assessment which is then circulated for concurrent review to Engineering Service, in DM&S; Project Management Service; PA&D; Regional Directors; Budget Service, in the Office of the Administrator; and the Office of Program Planning and Evaluation, in the Office of the Administrator.

FPS prepares a revised needs assessment and then submits it for concurrence to the Chief Medical Director, the Controller, the Office of Construction, and the Associate Deputy Administrator (ADA) for Logistics. Once agreement has been reached, the needs assessment is given to the VA Administrator for his approval. The needs assessment is also sent to OMB for its approval and then to the Congress in June of each year.

The end product of the planning phase is an approved 5-year construction plan for each VAMC and a nationwide needs assessment for major construction projects.

Figure V.2: Major Construction Planning




19X1
JAN
MAR
APR
MAY
JUN
JUN 30 19X1
CMB
CONGRESS
REVIEW 5 YEAR NEEDS ASSESSMENT
5 YEAR FACILITY CONSTRUCTION NEEDS ASSESSMENT[2]
HEALTH CARE FACILITIES SERVICE
• REVIEW & COMMENT
ASSISTANT CMD
• REVIEW & COMMENT
ENGINEERING SVC
PROJECT MGMT SVC
FACILITY PLANNING SERVICE
• DISCUSS Δ's WITH VAMC's & REVISE PLAN
• RANKS PROJECTS USING PRIORITIZATION METHODOLOGY
PROGRAM ANALYSIS AND DEVELOPMENT
• REVIEW FINAL PLAN
REGIONAL DIRECTOR
• REVIEW FINAL PLAN
FACILITY ENGINEERING PLANNING & CONSTRUCTION
• APPROVE FINAL FACILITY CONSTRUCTION PLANS
FACILITY PLANNING SERVICE
• INVENTORY MAJOR PROJECTS APPROVED
PROGRAM CONTROL & ANALYSIS
• IDENTIFY PROJECTS READY FOR CONSTRUCTION FUNDING
HEALTH CARE FAC SVC
PROJECT MANAGEMENT SERVICE
• AS ABOVE
FACILITY PLANNING SERVICE
• DEVELOP 5 YEAR NEEDS ASSESSMENT (DRAFT)
BUDGET SERVICE
• REVIEW & COMMENT ON DRAFT
PROGRAMMING PLANNING & EVALUATION
PROGRAM CONTROL & ANALYSIS
• AS ABOVE
ENGINEERING SVC
• AS ABOVE
PROJECT MGMT SVC
PROGRAM ANALYSIS & DEV
FACILITY PLANNING SERVICE
• DEVELOP FINAL DRAFT OF 5 YEAR NEEDS ASSESSMENT
REGIONAL DIRECTOR
• REVIEW FINAL DRAFT OF NEEDS ASSESSMENT
OFFICE OF BUDGET AND FINANCE
• REVIEW FINAL DRAFT
DM&S
OFFICE OF THE CMD
• REVIEW FINAL DRAFT
ADMINISTRATOR
• APPROVES 5 YEAR NEEDS ASSESSMENT
LOGISTICS
OFFICE OF ADA FOR LOGISTICS
• REVIEW FINAL DRAFT
OFFICE OF CONSTRUCTION
• REVIEW FINAL DRAFT
FACILITIES PLANNING SVC
• REVISE ASSESSMENT AND TRANSMIT TO CONGRESS
DISTRICT DIRECTOR
• REVIEW & COMMENT ON DRAFT 5 YEAR FACILITY PLAN
GUIDE TO VA FLOW CHART SYMBOLS
INDICATES A PROCESS.
INDICATES A DOCUMENT PRODUCED DURING OR AT THE END OF A PROCESS.
INDICATES THAT A PROCESS IS CONTINUOUS THROUGHOUT THE PERIOD SHOWN ON THE CHART.
INDICATES INFORMAL COMMUNICATION VIA TELEPHONE OR TELEX.
INDICATES PERSON TRAVELING FROM VA HEADQUARTERS TO FIELD DURING PROCESS OR VICE VERSA.
INDICATES PARTICIPANTS EXTERNAL TO VA.
ABBREVIATIONS
MEDIPP MEDICAL DISTRICT INITIATED PROGRAM PLANNING
VACO VA CENTRAL OFFICE
VAMC VA MEDICAL CENTER
[1]ASSUMED THAT PROCESSES OCCUR SIMULTANEOUSLY
[2]AS OF NOVEMBER 1, 1985, FY 1986-1990 NEEDS ASSESSMENT HAD NOT YET BEEN SUBMITTED TO CONGRESS.
NOTE: TIMELINES ARE ESTIMATED AND ARE USED FOR ILLUSTRATIVE PURPOSES ONLY.
ACTUAL TIME FRAMES ARE NOT FIRMLY ESTABLISHED FOR THIS PROCESS

Programming

The programming phase[4] of the major construction process begins with the development of the Advance Planning Fund (APF) list by Facility Construction Planning. The APF Fund was established by the Congress in 1978. As designed, the Fund enables VA to explore various corrective strategies, propose alternative conceptual approaches, and enhance decisionmaking for the advance development of future construction projects, for example, to develop design concepts and prepare preliminary plans.

Facility Planning Service (FPS) uses the approved needs assessment to prepare a draft Fund list.

The draft list is concurrently reviewed for reasonableness and magnitude by Budget Service, the Program Control and Analysis Staff, Project Management Service, and the Regional Directors.

As part of the review by the Program Control and Analysis staff, Health Care Facilities Service (HCFS) also reviews the draft list to determine if any of the projects listed (1) can be combined, (2) conflict with other projects, or (3) conflict with known criteria. The list is then forwarded to FPS for revision.

Once revised, the list is submitted for a serial review and concurrence to the Chief Medical Director, the Office of Construction, the Controller, and the Associate Deputy Administrator for Logistics. The list is then forwarded to the VA Administrator for his approval. Once approved, the list is transmitted to OMB for its review.

FPS revises the list based upon the comments received. Once a final plan is prepared, it is submitted to the Congress.

The Project Management Service requests workload data from the VAMCs to support the Fund list. The VAMCs must complete worksheets sent by the Service. This request is the start of the data package development process.

The Health Systems Planning Service (HSPS) completes the workload data by using data identified in the annual MEDIPP submission. HSPS uses prescribed methods, for example, the VA bedsizing model, to calculate

[4]Timelines are estimated and are used for illustrative purposes only. Actual time frames are not firmly established for this process.

An in-process review may take place by the Project Management Service and the VAMC Director to ensure that the conceptual alternatives satisfy medical needs.

Based upon this review, conceptual layouts may be revised by the Land Management Service.

The Estimating Service, in the Office of Construction, prepares a statement of anticipated cost for each conceptual layout.

Next, conceptual alternatives are reviewed by five offices

(1) the Controller,

(2) the Associate Deputy Administrator (ADA) for Logistics,

(3) the Office of Construction,

(4) the VAMC, and

(5) the Facility Engineering, Planning, and Construction Office (FEPAC).

Each office has its own criteria for its recommendation of a conceptual alternative. As part of the normal development process, the Office of Construction reviews the conceptual alternatives' costs and the scheduling of each alternative to ensure that

- preliminary drawings can be completed in the budget years,
- no separate funding categories exist that should be consolidated, and
- other projects will not hinder the construction of each alternative.

A conceptual alternative is selected by the mutual agreement of five offices

(1) the FEPAC,

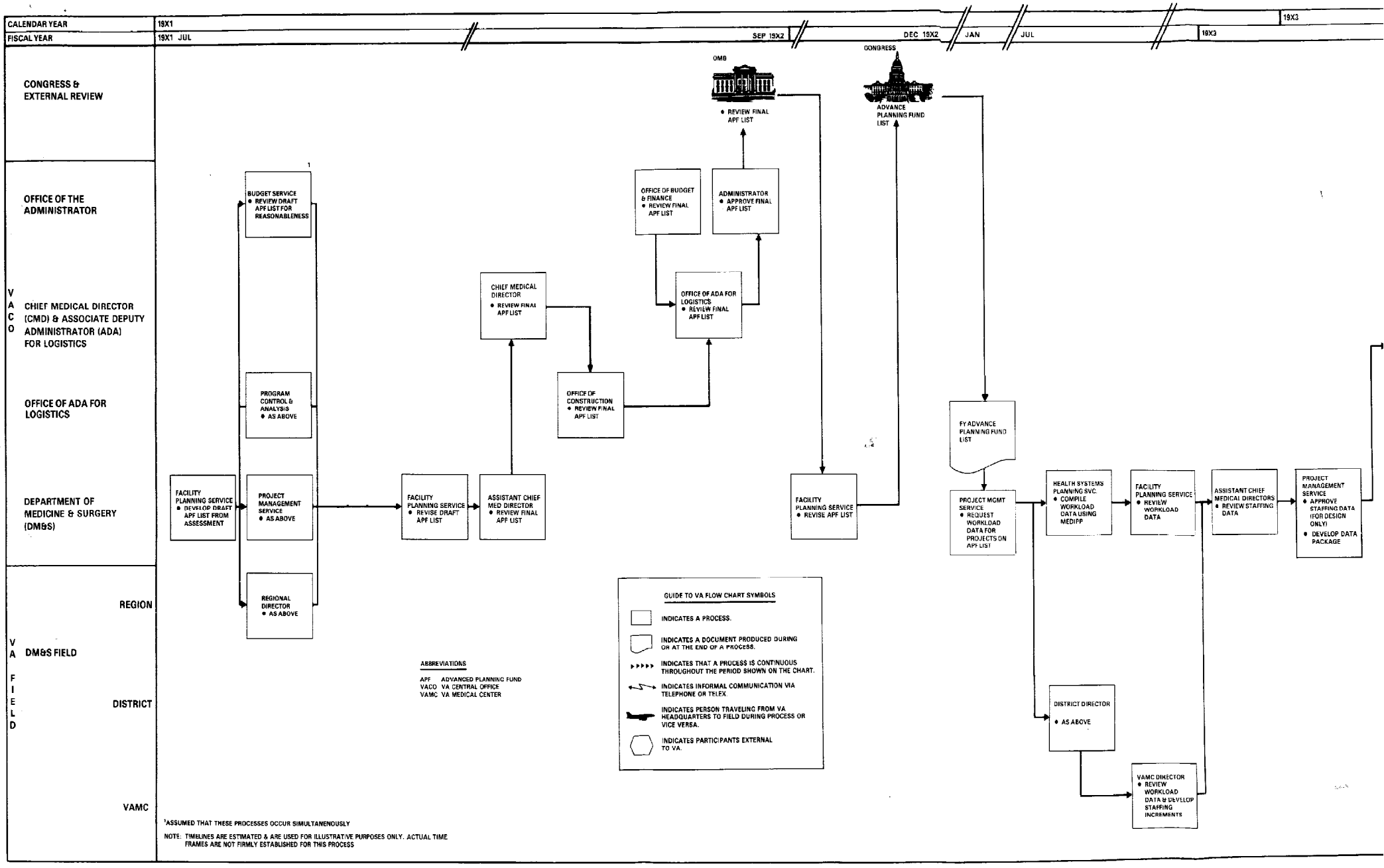
(2) the Assistant Chief Medical Directors,

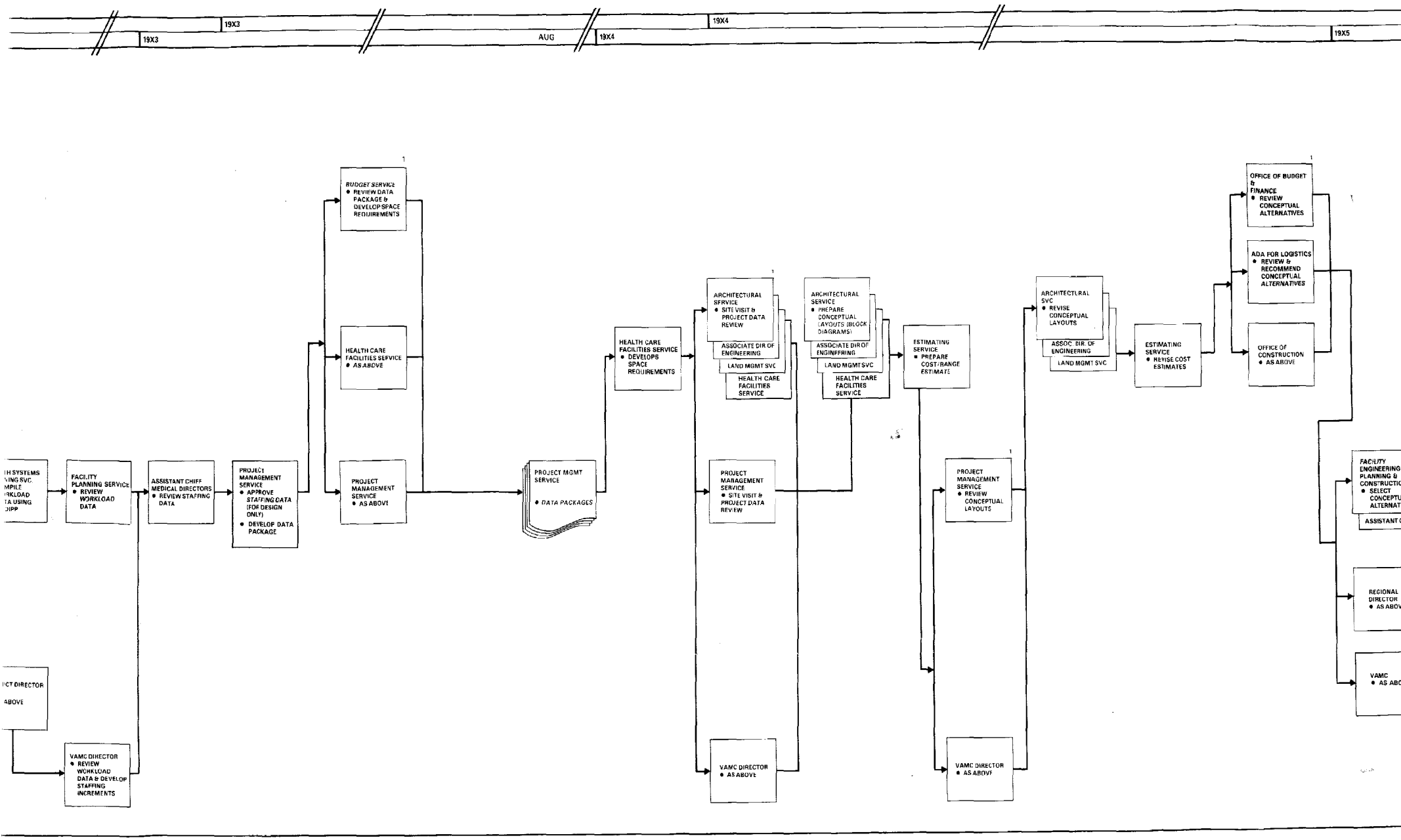
(3) the Regional Director,

(4) the VAMC, and

(5) the Office of Construction.

Figure V.3: Major Construction Programming




19X3
19X3
AUG
19X4
19X4
19X5
BUDGET SERVICE
• REVIEW DATA PACKAGE & DEVELOP SPACE REQUIREMENTS
HEALTH CARE FACILITIES SERVICE
• AS ABOVE
PROJECT MANAGEMENT SERVICE
• AS ABOVE
FACILITY PLANNING SERVICE
• REVIEW WORKLOAD DATA
ASSISTANT CHIEF MEDICAL DIRECTORS
• REVIEW STAFFING DATA
PROJECT MANAGEMENT SERVICE
• APPROVE STAFFING DATA (FOR DESIGN ONLY)
• DEVELOP DATA PACKAGE
VAMC DIRECTOR
• REVIEW WORKLOAD DATA & DEVELOP STAFFING INCREMENTS
PROJECT MGMT SERVICE
• DATA PACKAGES
HEALTH CARE FACILITIES SERVICE
• DEVELOPS SPACE REQUIREMENTS
ARCHITECTURAL SERVICE
• SITE VISIT & PROJECT DATA REVIEW
ASSOCIATE DIR OF ENGINEERING
LAND MGMT SVC
HEALTH CARE FACILITIES SERVICE
PROJECT MANAGEMENT SERVICE
• SITE VISIT & PROJECT DATA REVIEW
VAMC DIRECTOR
• AS ABOVE
ARCHITECTURAL SERVICE
• PREPARE CONCEPTUAL LAYOUTS (BLOCK DIAGRAMS)
ASSOCIATE DIR OF ENGINEERING
LAND MGMT SVC
HEALTH CARE FACILITIES SERVICE
ESTIMATING SERVICE
• PREPARE COST/RANGE ESTIMATE
PROJECT MANAGEMENT SERVICE
• REVIEW CONCEPTUAL LAYOUTS
VAMC DIRECTOR
• AS ABOVE
ARCHITECTURAL SVC
• REVISE CONCEPTUAL LAYOUTS
ASSOC. DIR. OF ENGINEERING
LAND MGMT SVC
ESTIMATING SERVICE
• REVISE COST ESTIMATES
OFFICE OF BUDGET & FINANCE
• REVIEW CONCEPTUAL ALTERNATIVES
ADA FOR LOGISTICS
• REVIEW & RECOMMEND CONCEPTUAL ALTERNATIVES
OFFICE OF CONSTRUCTION
• AS ABOVE
FACILITY ENGINEERING PLANNING & CONSTRUCTIO
• SELECT CONCEPTU ALTERNAT
ASSISTANT C
REGIONAL DIRECTOR
• AS ABOV
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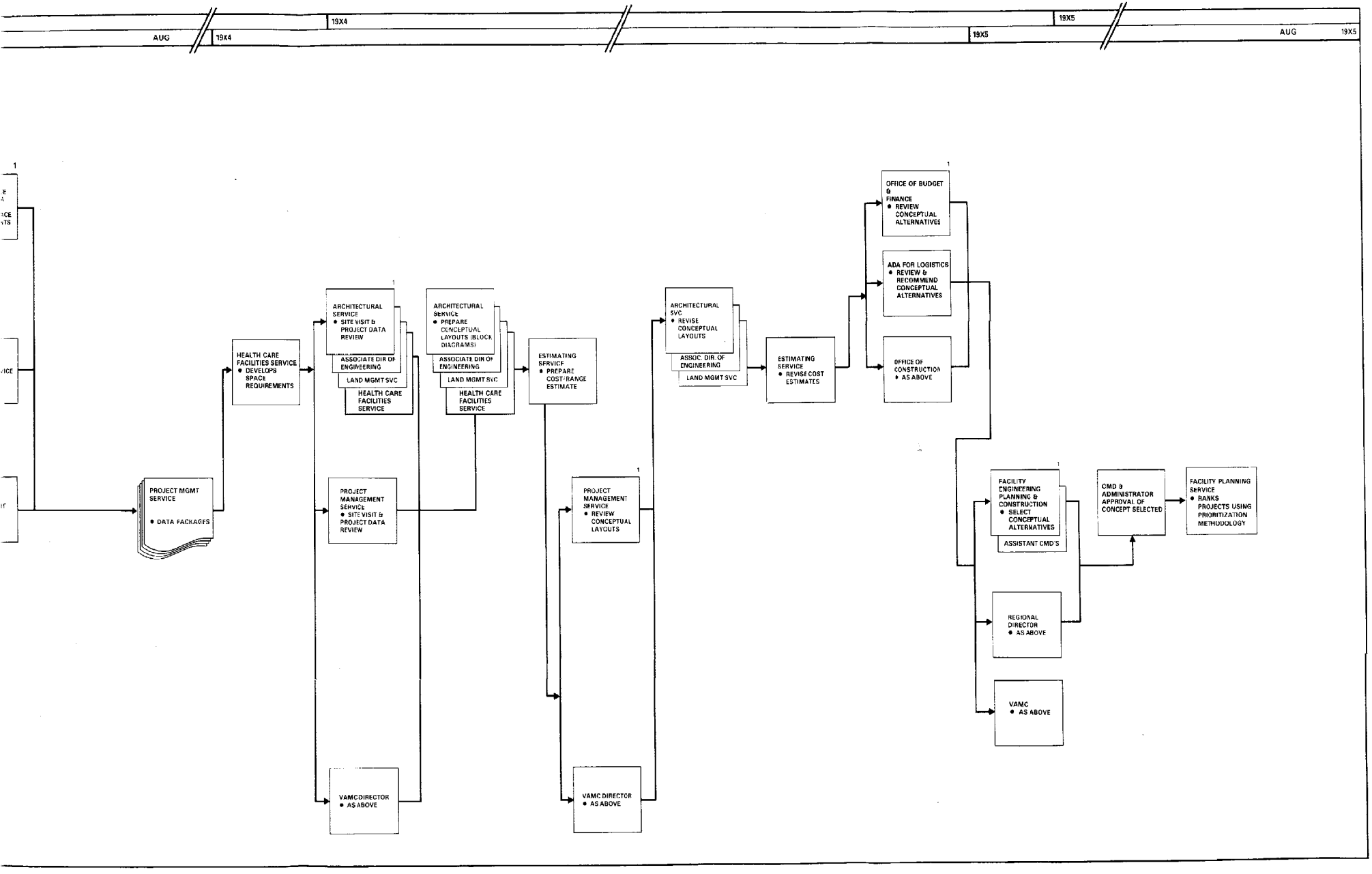
• AS ABO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AUG
19X5
PROJECT MGMT SERVICE
• DATA PACKAGES
HEALTH CARE FACILITIES SERVICE
• DEVELOPS SPACE REQUIREMENTS
ARCHITECTURAL SERVICE
• SITE VISIT & PROJECT DATA REVIEW
ASSOCIATE DIR OF ENGINEERING
LAND MGMT SVC
HEALTH CARE FACILITIES SERVICE
ARCHITECTURAL SERVICE
• PREPARE CONCEPTUAL LAYOUTS (BLOCK DIAGRAMS)
ASSOCIATE DIR OF ENGINEERING
LAND MGMT SVC
HEALTH CARE FACILITIES SERVICE
PROJECT MANAGEMENT SERVICE
• SITE VISIT & PROJECT DATA REVIEW
VAMC DIRECTOR
• AS ABOVE
ESTIMATING SERVICE
• PREPARE COST/RANGE ESTIMATE
PROJECT MANAGEMENT SERVICE
• REVIEW CONCEPTUAL LAYOUTS
VAMC DIRECTOR
• AS ABOVE
ARCHITECTURAL SVC
• REVISE CONCEPTUAL LAYOUTS
ASSOC. DIR. OF ENGINEERING
LAND MGMT SVC
ESTIMATING SERVICE
• REVISE COST ESTIMATES
OFFICE OF BUDGET & FINANCE
• REVIEW CONCEPTUAL ALTERNATIVES
ADA FOR LOGISTICS
• REVIEW & RECOMMEND CONCEPTUAL ALTERNATIVES
OFFICE OF CONSTRUCTION
• AS ABOVE
FACILITY ENGINEERING PLANNING & CONSTRUCTION
• SELECT CONCEPTUAL ALTERNATIVES
ASSISTANT CMD'S
REGIONAL DIRECTOR
• AS ABOVE
VAMC
• AS ABOVE
CMD & ADMINISTRATOR APPROVAL OF CONCEPT SELECTED
FACILITY PLANNING SERVICE
• RANKS PROJECTS USING PRIORITIZATION METHODOLOGY

Budget Formulation/ Execution[5]

Because the development of preliminary working drawings is a critical first step in developing a reliable budget estimate for a project, we have included preliminary design work in the budget formulation phase.

Prior to the establishment of the Design Fund in the 1985 HUD-Independent Agencies Appropriations Act, preliminary planning for the development of working drawings began when a concept was approved and a statement of estimated cost was developed. Preliminary planning involves

(1) preparation of a statement of environmental and historical impact and

(2) development of a design cost target for the project. (The Project Director uses the design cost target when negotiating with the architect/engineer.)

Preliminary plans normally consist of completed floor layouts, including equipment drawings, and delineations of engineering systems.

The advent of the Design Fund in 1985 permits VA to move directly from the adoption of a design concept to the development of preliminary working drawings. VA believes this should eliminate an average delay of 15 months in the construction process, saving additional costs due to inflation, reducing design changes, permitting earlier occupancy of the constructed facility, and providing a more accurate project cost estimate. The funds requested to support the Design Fund each fiscal year will be used in the working drawing development of projects to be requested in the next fiscal year.

Cost estimates are developed and refined frequently during this development. After the preliminary plans are completed, the cost estimate is used in VA's budget submission. Budget preparation normally occurs during the period from June to October of each fiscal year. In October, the budget is submitted to OMB for review and amendments. OMB reviews the entire VA budget, returns the revised budget to VA, and receives any VA appeals before the President submits the budget to the Congress in January. During OMB's review, VA receives guidance on future spending levels, called "caps," which OMB will accept. These caps are used by the Office of Construction and VA departments to develop the 5-year facility

[5]Timelines are estimated, and are used for illustrative purposes only. Actual time frames are not firmly established for this process.

and federal regulations. The bids are evaluated and the VA Administrator's approval is requested to award the contract to the lowest responsible bidder.

The contract is awarded after approval of the VA Administrator. On almost all VACO projects, a resident engineer, representing the Office of Construction, is stationed at the facility to provide on-site supervision. The contracting officer (project director) in VACO is responsible for the project's completion, and the resident engineer reports to the contracting officer. Project supervisors, assigned by the contracting officers, are in charge of project management. They coordinate with VA staff, the resident engineer, and the contractor in all aspects of the project and make periodic inspections at the construction site to ensure satisfactory progress.

The general contractor who won the bid prepares a network for construction. This critical path method (CPM) network establishes time frames for completion of each stage.

The CPM network is reviewed by Project Control and Analysis (PC&A) and the resident engineer and then approved by the project director.

The Critical Path Method Division, in the Office of Construction, then inputs the approved CPM network into an automated system that will be used for top management, progress payments, schedule control, and time extension analysis.

Next, the general contractor prepares shop drawings and material submission estimates from the approved concept.

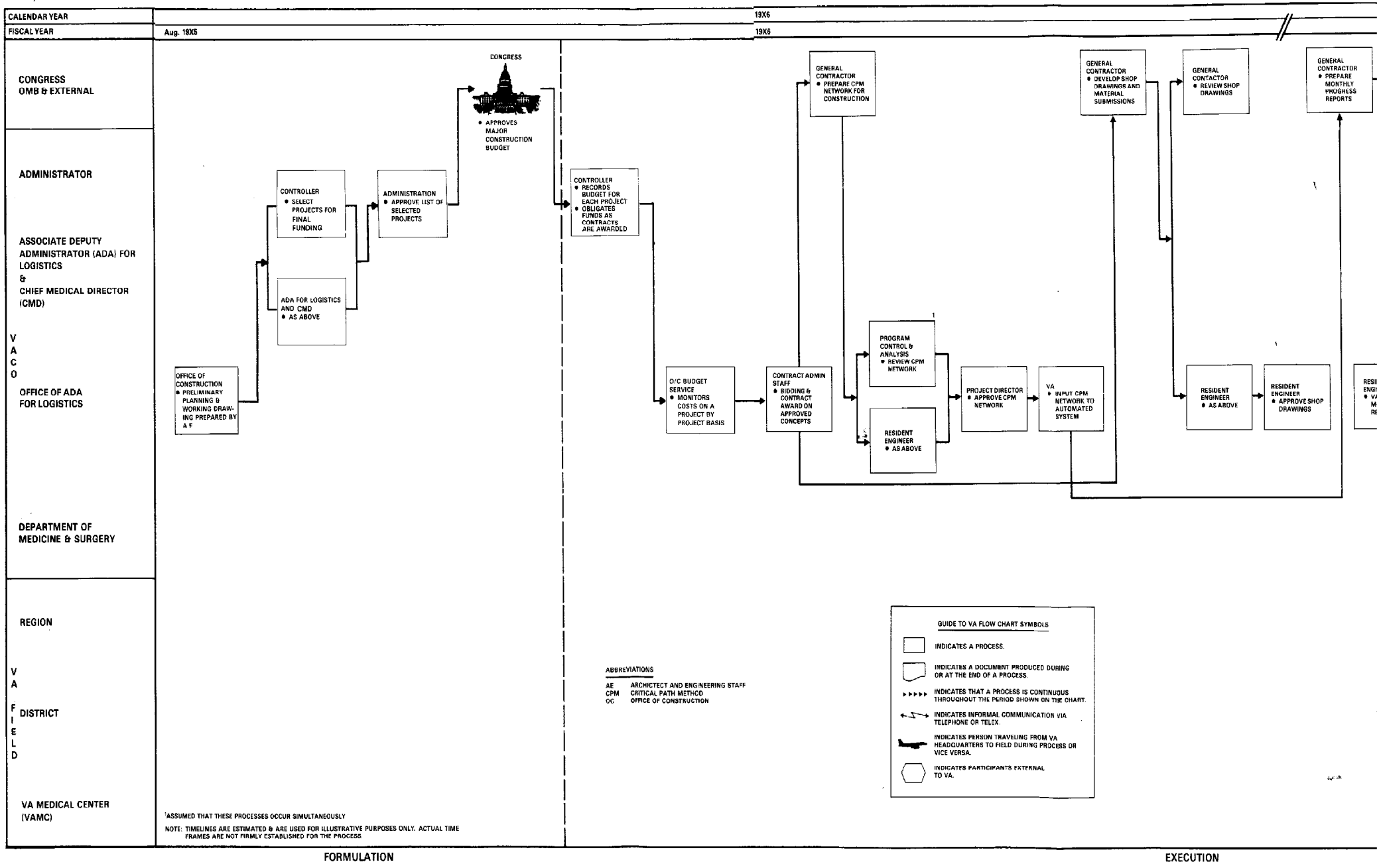
The shop drawings are reviewed by the contractor himself and the resident engineer who then approves them for construction.

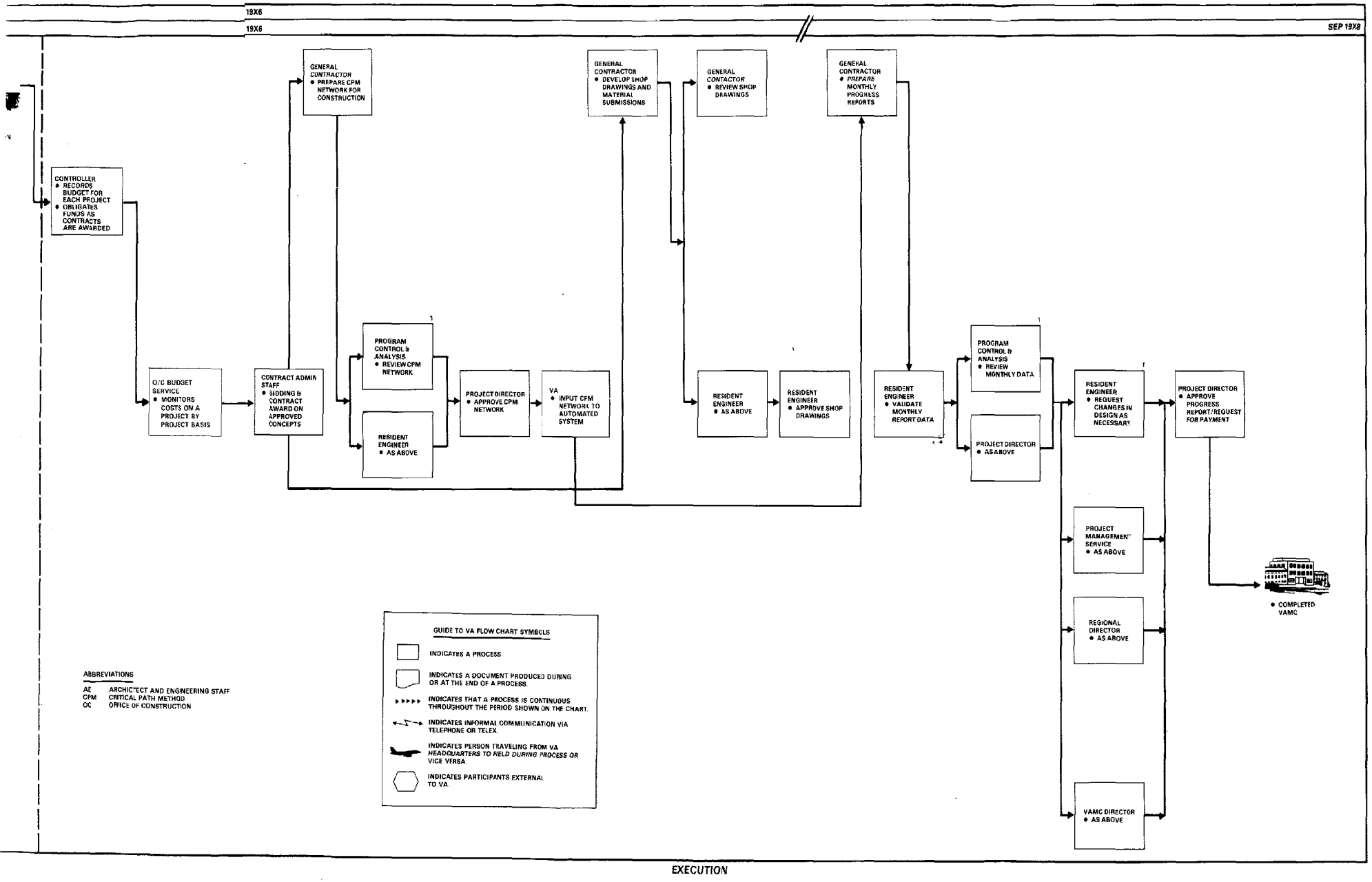
The general contractor must prepare monthly progress reports. The data in the monthly reports is validated and "signed off" on by the resident engineer and then reviewed by the project director and PC&A.

The project director approves the progress report that serves as the contractor's request for payment. The payments are tied to the approved network, which is monitored by the Office of Construction.

Changes in design are requested as necessary by

Figure V.4: Major Construction Budget Formulation/Execution




19X6
19X6
SEP 19X8
CONTROLLER
• RECORDS BUDGET FOR EACH PROJECT
• OBLIGATES FUNDS AS CONTRACTS ARE AWARDED
O/C BUDGET SERVICE
• MONITORS COSTS ON A PROJECT BY PROJECT BASIS
CONTRACT ADMIN STAFF
• BIDDING & CONTRACT AWARD ON APPROVED CONCEPTS
GENERAL CONTRACTOR
• PREPARE CPM NETWORK FOR CONSTRUCTION
PROGRAM CONTROL & ANALYSIS
• REVIEW CPM NETWORK
RESIDENT ENGINEER
• AS ABOVE
PROJECT DIRECTOR
• APPROVE CPM NETWORK
VA
• INPUT CPM NETWORK TO AUTOMATED SYSTEM
GENERAL CONTRACTOR
• DEVELOP SHOP DRAWINGS AND MATERIAL SUBMISSIONS
GENERAL CONTRACTOR
• REVIEW SHOP DRAWINGS
RESIDENT ENGINEER
• AS ABOVE
RESIDENT ENGINEER
• APPROVE SHOP DRAWINGS
GENERAL CONTRACTOR
• PREPARE MONTHLY PROGRESS REPORTS
RESIDENT ENGINEER
• VALIDATE MONTHLY REPORT DATA
PROGRAM CONTROL & ANALYSIS
• REVIEW MONTHLY DATA
PROJECT DIRECTOR
• AS ABOVE
RESIDENT ENGINEER
• REQUEST CHANGES IN DESIGN AS NECESSARY
PROJECT DIRECTOR
• APPROVE PROGRESS REPORT/REQUEST FOR PAYMENT
• COMPLETED VAMC
PROJECT MANAGEMENT SERVICE
• AS ABOVE
REGIONAL DIRECTOR
• AS ABOVE
VAMC DIRECTOR
• AS ABOVE
GUIDE TO VA FLOW CHART SYMBOLS
INDICATES A PROCESS.
INDICATES A DOCUMENT PRODUCED DURING OR AT THE END OF A PROCESS.
INDICATES THAT A PROCESS IS CONTINUOUS THROUGHOUT THE PERIOD SHOWN ON THE CHART.
INDICATES INFORMAL COMMUNICATION VIA TELEPHONE OR TELEX.
INDICATES PERSON TRAVELING FROM VA HEADQUARTERS TO FIELD DURING PROCESS OR VICE VERSA.
INDICATES PARTICIPANTS EXTERNAL TO VA.
ABBREVIATIONS
AE ARCHITECT AND ENGINEERING STAFF
CPM CRITICAL PATH METHOD
OC OFFICE OF CONSTRUCTION
EXECUTION

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