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United States General Accounting Office

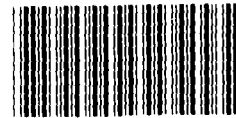
GAO

Report to Congressional Requesters

May 1986

VA HEALTH CARE

Allocation of Resources to Medical Facilities in the Sun Belt



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**Human Resources Division
B-207930**

May 6, 1986

The Honorable Paula Hawkins
United States Senate

The Honorable Lawton Chiles
United States Senate

Your letters of January 10, 1985 (Senator Hawkins), and April 3, 1985 (Senator Chiles), expressed interest in whether veterans at Veterans Administration (VA) medical facilities in Florida and other Sun Belt areas have equal access to care compared to patients at VA facilities in other areas of the country. You were concerned that VA, in allocating health care resources to its medical centers, did not fully consider growth of the veteran population in the Sun Belt or the seasonal migration of veterans to the Sun Belt during winter months.

As you requested and as clarified in subsequent discussions with your offices, this report provides information on:

- Changes in the veteran population, veterans' demand for health care from VA, VA medical facility workload, and obligation of VA health care dollars from fiscal years 1981 to 1985. We compared VA facilities in the Sun Belt to VA facilities in the rest of the country. (For our definition of the Sun Belt area, see p. 8.)
- Seasonal fluctuations in demand for care and outpatient workloads at VA facilities in the Sun Belt and the rest of the country. We compared a judgmental selection of Sun Belt facilities to a judgmental selection of facilities outside the Sun Belt.
- The extent to which VA medical centers in Miami and Tampa, Florida, and Boston, Massachusetts, provided veterans with timely access to needed care during the winter of 1984-85.
- The extent to which VA considers changes in veteran demand for care when allocating health care resources to its medical centers.

Our review was performed between February and November 1985 at VA's central office, at medical district 12, which covers most of Florida, and at medical facilities in Miami, Tampa, and Boston. To compare changes in veteran population and demand and in facility workload and obligations, we relied on statistical data contained in VA reports or furnished by VA officials. We did not verify the accuracy of VA's statistics nor assess the reliability of VA's computer systems that generated them.

A prior GAO report¹ identified both internal control and automated data processing weaknesses in VA's management information systems. VA statistics, however, represent the only sources of the data you requested. Except as noted above, our work was conducted in accordance with generally accepted government auditing standards.

Following is a summary of the results of our work. More detailed information on our results and the scope and methodology of our work appears in appendixes I through IV.

Changes in Veteran Population and Health Care Demand, Workload, and Funding

From 1981 to 1985, the veteran population in the Sun Belt increased by less than 1 percent, while the veteran population in the rest of the country declined almost 4 percent. The demand for VA health care (as measured by the number of applications for care processed by VA facilities) increased more in the Sun Belt than elsewhere (see table 1). However, the increased workload (as measured by inpatients treated and outpatient visits) was greater for VA facilities in the rest of the country than for those in the Sun Belt. VA funding to its Sun Belt facilities increased slightly more than did its funding to facilities in the rest of the country (see app. I).

Table 1: Sun Belt and Other VA Health Facilities Compared: Population, Demand, Workload, Funding, 1981-85

Measure	Percentage changes		
	Sun Belt	Other	U.S. total
Veteran population	+0.6	-3.7	-2.4
VA health care facilities:			
Applications processed	+11.0	+7.0	+8.5
Inpatients treated	+1.2	+6.8	+4.9
Outpatient visits	+10.8	+13.2	+12.4
Funds obligated	+41.1	+37.7	+38.8

Winter Months Busier in Sun Belt

The 24 facilities in the Sun Belt that we sampled were generally busier in January, February, and March than they were during the rest of the year. The 13 facilities we sampled in the rest of the country were generally no busier during this time. We were not able to determine, however, whether veterans migrating to the Sun Belt during the winter months caused these increases in demand and workloads because VA records do not identify permanent residence of veterans applying for care (see app. II).

¹Veterans Administration Financial Management Profile (GAO/AFMD-85-34, Sept. 20, 1985).

Timely Access to Needed Care Reviewed

Seeking an indication of whether certain VA medical centers gave veterans timely access to needed care, we reviewed a sample of veterans' applications submitted between December 1984 and March 1985 for care at the VA medical centers in Miami, Tampa, and Boston.

We first identified cases in which a veteran did not receive needed care within one day of his or her application. Our Chief Medical Advisor then reviewed each such case file to identify the veteran's medical condition and the examining physician's diagnosis, and judged from a medical viewpoint whether the care was provided in a timely way. In each case where his judgment varied from that of VA medical personnel, our Chief Medical Advisor discussed the individual circumstances of the case with VA personnel before arriving at a final conclusion as to whether or not the care was inappropriately delayed.

More often than the center in Boston, the centers in Miami and Tampa denied or delayed access to care beyond what our Chief Medical Advisor felt was reasonable (see table 2). The denials and delays were caused by eligibility restrictions, administrative errors, lack of available services, or medical judgments that treatment could be delayed. (See app. III.)

Table 2: Access to Care at Three Centers Compared

Cases	At VA medical centers in		
	Miami	Tampa	Boston
Case files reviewed	89	87	100
Applicants needing care	76	84	73
Applicants not receiving timely access to needed care	14	12	4

The results of a survey VA conducted in April 1985 to determine the extent of unmet need in all VA facilities corroborated our findings at these three facilities.

VA System for Resource Allocation Changed

Until fiscal year 1985, the system VA used to allocate its health care appropriation among the 160 VA medical centers was based on historical workloads adjusted for inflation and program changes. In fiscal year 1985, however, VA began using a system based on the number of veterans each center treated (regardless of whether they were permanent residents of the area served by the center) and the severity of their illnesses. Although the system is designed to provide incentives for centers to become more efficient and has resulted in funds being redirected

into the Sun Belt, it does not take into account demand for health care not being met. (See app. IV.)

We gave a draft of this report to VA on March 3, 1986, for its comments. In a letter dated April 14, 1986, the Administrator of Veterans Affairs informed us that VA had no comments. We are sending copies of this report to the Administrator of Veterans Affairs, the Director of the Office of Management and Budget, the chairmen and ranking minority members of the congressional committees concerned with VA, and other interested parties. We will make copies available to others upon request.



Richard L. Fogel
Director

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Abbreviations

DRG	diagnosis related group
GAO	General Accounting Office
VA	Veterans Administration
WWU	weighted work unit

Changes in Veteran Population and Health Care Demand, Workload, and Funding

In their requests to us, Senators Hawkins and Chiles stated that the veteran population has shifted and is continuing to shift to Florida. They wished to know whether this shift in the veteran population had overburdened existing Sun Belt VA medical facilities—particularly those in Florida—because VA resources had not shifted accordingly.

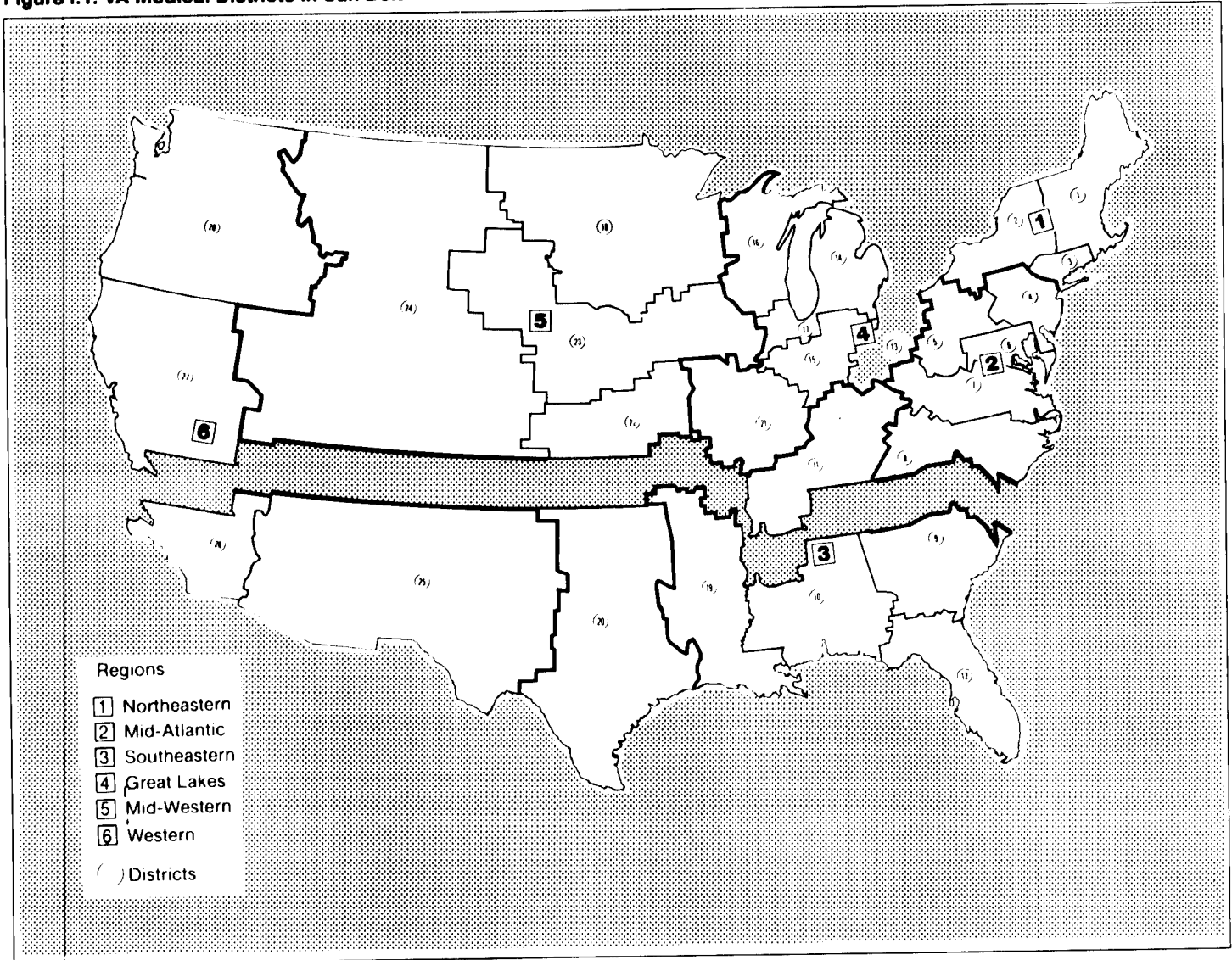
Scope and Methodology

To respond to these concerns, we compared changes between fiscal years 1981 and 1985 in veteran populations and in demands for medical care (applications processed), health care workloads (inpatients and outpatients treated), and VA funds obligated, contrasting VA facilities in the Sun Belt with those outside it.

We searched the available literature for a definition of the Sun Belt area. Although we found no precise definitions, most sources included Alabama, Arkansas, Arizona, Florida, Georgia, Louisiana, Mississippi, New Mexico, Oklahoma, South Carolina, Texas, Southern California, and Clark County, Nevada. Therefore, we defined the Sun Belt as VA's medical districts that include these areas (districts 9, 10, 12, 19, 20, 25, and 26, as shown in fig. I.1).

Appendix I
 Changes in Veteran Population and Health
 Care Demand, Workload, and Funding

Figure I.1: VA Medical Districts in Sun Belt



To determine fluctuations in the veteran population, we obtained data from VA's Office of Information Management and Statistics. For information on changes in veterans' applications for medical care and facility workloads, we extracted data from VA's Summary of Medical Programs and its Automated Management Information System reports. And, to determine variations in funds obligated by VA facilities, we used budget statistics furnished by VA's Office of Budget and Finance.

We did not verify the accuracy of these VA statistics nor assess the reliability of VA's computer systems that generated them. A prior GAO report¹ identified both internal control and automated data processing weaknesses in VA's management information systems. However, VA's statistics represent the only sources of the data requested.

Our analyses of veteran population, applications processed, outpatient and inpatient treatments, and funding covered VA facilities in the continental United States only. We excluded a VA hospital in San Juan, Puerto Rico, and outpatient clinics in Mayaguez, Puerto Rico; Manila, the Philippines; Honolulu, Hawaii; and Anchorage, Alaska.

Veteran Population and Health Care Demand, Workload, Funding Analyzed

The Sun Belt veteran population increased about 0.6 percent from 1981 to 1985 while the population in other parts of the country declined by about 3.7 percent. At the same time, demand for medical services at Sun Belt VA facilities increased by 11 percent compared with 7 percent at VA facilities elsewhere. However, Sun Belt facilities experienced a lower percentage increase in outpatient visits and inpatients treated than did VA facilities outside the Sun Belt. Nonetheless, funding for Sun Belt facilities increased more than for VA facilities elsewhere in the country.

Further, the Sun Belt's share of the total veteran population increased between 1981 and 1985, going from 29 to 30 percent of all veterans. Also, VA medical facilities in the Sun Belt experienced increases in their share of the total VA demand for medical care, from 36 to 37 percent, and funding, from 30 to 31 percent. Conversely, workload at Sun Belt VA medical facilities decreased; for inpatients treated, from 34 to 33 percent of the overall VA workload and for outpatient visits, from 34 to 33 percent of the VA total. (See table I.1.) Tables I.3 through I.7 provide details, by VA medical district, for each such measure.

¹Veterans Administration Financial Management Profile (GAO/AFMD-85-34, Sept. 20, 1985).

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Changes in Veteran Population and Health
Care Demand, Workload, and Funding

Table I.1: Sun Belt and Other VA Health Facilities Compared: Population, Demand, Workload, Funding (Fiscal Years 1981-85)^a

Measure	Sun Belt VA districts		Other VA districts	
	No.	Percent of U.S. total	No.	Percent of U.S. total
Veteran population:				
1981	8,256,030	29	20,068,090	71
1985	8,309,470	30	19,333,550	70
Percent change	+0.6		-3.7	
VA facilities:				
Applications processed				
1981	955,753	36	1,682,663	64
1985	1,060,463	37	1,801,183	63
Percent change	+11		+7	
Outpatient visits				
1981	5,201,634	34	10,315,824	66
1985	5,763,267	33	11,677,612	67
Percent change	+10.8		+13.2	
Inpatients treated				
1981	356,011	34	679,713	66
1985	360,328	33	726,077	67
Percent change	+1.2		+6.8	
Funding obligations				
1981	\$1,845,545,000	30	\$4,217,739,000	70
1985	\$2,604,862,000	31	\$5,809,790,000	69
Percent change	+41.1		+37.7	

^aStatistical data shown for fiscal years, except for population data, which are as of March 31.

Another way to measure change is on a per-thousand veteran basis. Results of this analysis (see table I.2) seem to corroborate data in table I.1 in that Sun Belt veterans created a greater demand and that facility funding was greater per veteran. In either analysis, however, a straight comparison of VA funding to veteran population and facility workload could be misleading because it excludes consideration of types or severity of patient illnesses treated by individual VA facilities.

Appendix I
Changes in Veteran Population and Health
Care Demand, Workload, and Funding

Table I.2: Sun Belt and Other VA Facilities Compared: Demand, Workload, Funding Per Veteran (Fiscal Years 1981-85)

Measure	Fiscal year	Sun Belt VA districts	Other VA districts
Applications for medical care processed at VA facilities (per 1,000 veterans)	1981	115.76	83.85
	1985	127.62	93.16
	Percent change	+10.2	+11.1
Outpatient visits at VA facilities (per 1,000 veterans)	1981	630.04	514.04
	1985	693.58	604.01
	Percent change	+10.1	+17.5
Inpatients treated at VA facilities (per 1,000 veterans)	1981	43.12	33.87
	1985	43.36	37.56
	Percent change	+0.6	+10.9
Funds obligated by VA facilities (per veteran)	1981	\$223.54	\$210.17
	1985	\$313.48	\$300.50
	Percent change	+40.2	+43.0

Demand for Care Suppressed

According to various VA officials in Florida, applications actually processed do not reflect total veteran demand for VA medical care. VA's Southeastern Regional Director, Florida District Director, and directors of the Miami and Tampa medical centers said that veteran demand had been suppressed. VA defined suppressed demand as that which is never expressed because veterans are discouraged from applying for VA medical care.

The Miami medical center and the Orlando outpatient clinic, a satellite² of the Tampa medical center, had taken specific actions to discourage applications from veterans without service-connected medical needs. In May 1981, the Miami medical center wrote to all veterans on its rolls advising them of its policy to discontinue outpatient services for veterans without service-connected conditions. As a result, the Miami Chief of Ambulatory Care said applications for care dropped. Although the medical center rescinded this policy in October 1981, the veterans were not advised of the rescission.

Also, the director of the Orlando outpatient clinic advised veterans through various veterans' service organizations that veterans without service-connected conditions were ineligible for outpatient care. The clinic director attributed his low rate (12 percent) of applications from veterans without service-connected conditions to these actions. At both

²Satellite clinics are geographically separate from a medical center but administratively part of it.

Miami and Tampa, officials told us that repeated denials of care to veterans without service-connected conditions tended to discourage applications from this category of veterans over time.

Conversely, the Boston medical center initiated a promotional campaign to stimulate demand. With assistance from veteran organizations, the center announced the availability of its services and requested assistance in recruiting new patients. It advertised its services through a mail campaign and sponsored a "red carpet" day to recruit disabled veterans to its facility.

Neither the VA district 12 in Florida nor the Miami or Tampa medical centers had records or studies showing the existence or extent of suppressed demand, but they cited Florida's high nondiscretionary³ workload as evidence of it. For example, in fiscal year 1984, 78.2 percent of outpatient visits in VA medical district 12 were nondiscretionary compared to 63.6 percent in the Sun Belt as a whole and 58.9 percent elsewhere. During the same period, the national VA average was 60.5 percent.

³The medical centers we visited defined nondiscretionary outpatient workload as veterans whom VA must treat. Generally, they included emergency patients, high-priority veterans (those with service-connected disabilities), and veterans requiring medical examinations to determine the need for further care.

**Appendix I
Changes in Veteran Population and Health
Care Demand, Workload, and Funding**

**Table I.3: Veteran Population by VA
Medical District (March 31, 1981-March
31, 1985)**

Medical district	Veteran population		Percent change
	1981	1985	
Non-Sun Belt districts			
1	1,125,160	1,097,130	-2.5
2	822,010	756,550	-8.0
3	1,732,810	1,679,430	-3.1
4	2,002,900	1,953,830	-2.4
5	836,390	789,550	-5.6
6	835,870	826,120	-1.2
7	667,160	645,940	-3.2
8	845,330	854,980	1.1
11	820,200	787,730	-4.0
13	1,200,340	1,146,930	-4.4
14	1,165,890	1,088,290	-6.7
15	604,990	579,480	-4.2
16	615,940	601,300	-2.4
17	1,016,720	972,090	-4.4
18	749,300	722,890	-3.5
21	707,530	678,240	-4.1
22	452,530	440,760	-2.6
23	647,190	618,450	-4.4
24	770,210	759,430	-1.4
27	1,337,140	1,276,220	-4.6
28	1,112,480	1,058,220	-4.9
Total	20,068,090	19,333,560	-3.7
Sun Belt districts			
9	918,180	935,180	1.9
10	745,540	719,500	-3.5
12	1,317,320	1,387,850	5.4
19	815,530	800,960	-1.8
20	1,836,950	1,888,390	2.8
25	761,510	786,910	3.3
26	1,861,000	1,790,680	-3.8
Total	8,256,030	8,309,470	0.6
Total	28,324,120	27,643,030	-2.4

Appendix I
 Changes in Veteran Population and Health
 Care Demand, Workload, and Funding

**Table I.4: Applications for Medical Care
 Processed by VA Medical Districts
 (Fiscal Years 1981-85)**

Medical district	Applications processed, fiscal year		Percent change
	1981	1985	
Non-Sun Belt districts			
1	87,743	81,468	-7.2
2	75,423	81,042	7.4
3	201,857	177,500	-12.1
4	78,724	98,849	25.6
5	36,851	51,871	40.8
6	71,817	70,534	-1.8
7	66,868	97,685	46.1
8	82,615	76,765	-7.1
11	107,978	110,109	2.0
13	107,285	128,055	19.4
14	56,124	56,702	1.0
15	42,948	41,143	-4.2
16	40,626	48,873	20.3
17	116,040	119,541	3.0
18	50,656	62,913	24.2
21	69,128	77,340	11.9
22	49,915	45,158	-9.5
23	65,076	73,645	13.2
24	65,486	69,532	6.2
27	123,677	148,870	20.4
28	85,826	83,588	-2.6
Total	1,682,663	1,801,183	7.0
Sun Belt districts			
9	96,924	141,492	46.0
10	86,485	99,678	15.3
12	155,007	170,566	10.0
19	114,342	116,699	2.1
20	221,850	213,990	-3.5
25	102,580	119,995	17.0
26	178,565	198,043	10.9
Total	955,753	1,060,463	11.0
Total	2,638,416	2,861,646	8.5

Appendix I
Changes in Veteran Population and Health
Care Demand, Workload, and Funding

Table I.5: Inpatients Treated at VA
Facilities by VA Medical District (Fiscal
Years 1981-85)

Medical district	Inpatients treated, fiscal year		Percent change
	1981	1985	
Non-Sun Belt districts			
1	44,372	45,335	2.2
2	29,134	30,739	5.5
3	56,944	58,129	2.1
4	38,260	42,198	10.3
5	23,352	25,543	9.4
6	26,730	27,335	2.3
7	30,408	32,771	7.8
8	34,158	36,290	6.2
11	43,895	44,995	2.5
13	28,985	33,152	14.4
14	25,935	26,674	2.8
15	20,163	24,424	21.1
16	24,755	25,910	4.7
17	35,820	41,843	16.8
18	27,838	29,547	6.1
21	27,608	31,021	12.4
22	23,342	27,396	17.4
23	35,596	37,551	5.5
24	29,834	28,667	-3.9
27	36,380	40,536	11.4
28	36,204	36,021	-0.5
Total	679,713	726,077	6.8
Sun Belt districts			
9	39,767	39,727	-0.1
10	41,685	42,389	1.7
12	58,643	51,590	-12.0
19	45,081	48,642	7.9
20	82,687	85,728	3.7
25	34,485	37,422	8.5
26	53,663	54,830	2.2
Total	356,011	360,328	1.2
Total	1,035,724	1,086,405	4.9

Appendix I
 Changes in Veteran Population and Health
 Care Demand, Workload, and Funding

Table I.6: Outpatient Visits to VA
 Facilities by VA Medical District (Fiscal
 Years 1981-85)

Medical district	Outpatient visits, fiscal year		Percent change
	1981	1985	
Non-Sun Belt districts			
1	988,727	1,046,084	5.8
2	483,467	532,054	10.0
3	1,167,130	1,297,608	11.2
4	753,286	795,398	5.6
5	299,258	335,203	12.0
6	455,092	523,271	15.0
7	379,155	519,371	37.0
8	353,995	378,955	7.1
11	498,426	531,625	6.7
13	488,194	612,813	25.5
14	412,225	473,724	14.9
15	216,860	273,460	26.1
16	322,298	317,558	-1.5
17	647,878	748,338	15.5
18	327,696	384,430	17.3
21	348,409	357,326	2.6
22	276,976	313,780	13.3
23	353,410	413,388	17.0
24	356,595	413,867	16.1
27	694,233	801,382	15.4
28	492,514	607,977	23.4
Total	10,315,824	11,677,612	13.2
Sun Belt districts			
9	450,400	468,071	3.9
10	398,622	439,767	10.3
12	832,256	946,609	13.7
19	501,618	571,225	13.9
20	1,064,271	1,207,096	13.4
25	497,607	559,300	12.4
26	1,456,860	1,571,199	7.8
Total	5,201,634	5,763,267	10.8
Total	15,517,458	17,440,879	12.4

Appendix I
 Changes in Veteran Population and Health
 Care Demand, Workload, and Funding

**Table I.7: VA Funds Obligated by VA
 Medical District (Fiscal Years 1981-85)**

Medical district	Funds obligated, fiscal year		Percent change
	1981	1985	
	Dollars in thousands		
Non-Sun Belt districts			
1	\$ 309,536	\$ 419,693	35.6
2	207,375	266,515	28.5
3	426,555	557,547	30.7
4	305,638	408,526	33.7
5	141,599	191,713	35.4
6	175,923	244,613	39.0
7	171,978	251,852	46.4
8	166,779	234,843	40.8
11	218,313	311,844	42.8
13	240,190	318,063	32.4
14	144,080	203,393	41.2
15	135,774	179,892	32.5
16	145,299	198,355	36.5
17	252,752	350,930	38.8
18	143,838	206,544	43.6
21	130,304	183,014	40.5
22	124,293	171,481	38.0
23	150,885	203,308	34.7
24	164,652	228,127	38.6
27	253,981	362,316	42.7
28	207,995	317,221	52.5
Total	\$4,217,739	\$5,809,790	37.7
Sun Belt districts			
9	\$ 209,035	\$ 276,058	32.1
10	198,972	280,492	41.0
12	274,447	400,562	46.0
19	196,836	299,347	52.1
20	386,780	544,195	40.7
25	165,459	250,694	51.5
26	414,016	553,514	33.7
Total	\$1,845,545	\$2,604,862	41.1
Total	\$6,063,284	\$8,414,652	38.8

Effects of Seasonal Fluctuations on VA Facilities

Senators Hawkins and Chiles expressed concern that permanent migration of veterans to Florida and other Sun Belt areas had overburdened existing VA facilities and services. Further, they believed the overburdened condition was exacerbated by veterans who migrate from northern states during winter months. They asked us to provide information on seasonal fluctuations in use of Florida and other Sun Belt VA facilities as compared to facilities outside the Sun Belt.

Scope and Methodology

To identify fluctuations in medical care demand and workload during winter months, we used VA's Automated Management Information System reports, which showed applications for care processed and outpatient visits by medical facility. We defined the winter quarter to include January, February, and March. We assumed that, were a facility's demand and workload stable, it would normally experience 25 percent of its annual applications and outpatient visits in each quarter. But, if veterans migrating from other areas during the winter months were creating additional demand and workloads for Sun Belt facilities, we expected to see such facilities accounting for larger percentages of their applications processed and outpatient visits in the winter quarter. Conversely, we expected to see decreases in VA facilities outside the Sun Belt at the same time. We compared winter fluctuations in applications processed and outpatient visits at a judgmental sample of 24 VA facilities in the Sun Belt and 13 facilities in the rest of the country for fiscal years 1981 through 1984.

Demand, Workload Up During Winter at Sun Belt Facilities

Among the VA facilities we sampled, those in the Sun Belt generally experienced greater than the expected 25-percent distribution of applications and outpatient visits in the winter months; in other areas of the country, the levels were generally about 25 percent. But we did not determine whether the increases at Sun Belt facilities were caused by veterans migrating to the Sun Belt during winter months, because VA records do not show patients' permanent addresses.

The increased winter applications and outpatient visits occurred primarily in satellite outpatient clinics. For example, in fiscal year 1984, 7 of the 11 Sun Belt facilities processing more than 26 percent of their applications during winter quarters were satellite outpatient clinics. Likewise, 9 of the 14 facilities in the Sun Belt with more than 26 percent of their outpatient visits during the winter quarter of fiscal year 1984 were satellite clinics.

Both applications and outpatient visits remained relatively stable in VA facilities sampled from outside the Sun Belt during the winter quarter. The Lowell, Massachusetts, outpatient clinic was the only non-Sun Belt facility that routinely experienced increased demand in the winter (for 3 of the 4 sampled years). At the other non-Sun Belt facilities, however, demand generally remained within 1 percent of our expected normal quarterly distribution of 25 percent. Of the 13 non-Sun Belt facilities sampled, no more than two experienced less than 24 percent of their annual demand during the winter quarter in any of the 4 years.

Similarly, outpatient visits at non-Sun Belt facilities generally remained stable. For example, in 3 of the 4 sampled years, all the non-Sun Belt facilities had visits within 1 percent of the expected 25-percent distribution during the winter quarter.

The percentage of applications processed and the outpatient visits experienced by each VA medical facility in our sample during the winter quarter of fiscal years 1981 through 1984 are shown in tables II.1 and II.2, respectively. For each facility, the data are expressed as percentages of its annual applications and outpatient visits.

Observations

VA medical facility records do not identify veterans' permanent residences, thus we were unable to determine whether veterans applying for or receiving care in the busier winter months were permanent residents of Sun Belt areas. The VA application form asks only for the veteran's address. Officials at the Miami medical center and at the central office told us that veterans usually give a local address.

"Snowbirds" (seasonal migrants to the Sun Belt) are generally healthy and place little additional pressure on local health care services, according to a 1982 research study on the effect of such migration on social services in Tucson, Arizona.¹ Further, in our study, the Tampa medical center director did not attribute routine increased demand at the Orlando outpatient clinic to seasonal migration. Rather, he said a larger share of the total veteran population is permanently migrating to Florida and overloading existing facilities.

¹"The Impact of Seasonal Population Fluctuations on Service Delivery," D. J. Monahan and V. L. Greene, *The Gerontologist*, Vol. 22, No. 2, 1982.

**Appendix II
Effects of Seasonal Fluctuations on
VA Facilities**

**Table II.1: Demand for Care at Selected
VA Facilities: Applications Processed in
Winter Quarter, 1981-84**

Location of VA medical facility	Percentage of annual applications			
	1981	1982	1983	1984
Florida:				
Bay Pines	26	25	25	28
Ft. Myers ^a	33	31	30	20
Gainesville	26	25	25	27
Jacksonville ^a	29	24	26	27
Lake City	26	25	25	26
Miami	25	26	26	26
Oakland Park ^a	•	48 ^b	36	29
Orlando ^a	28	27	28	27
Riviera Beach ^a	33	24	27	30
St. Petersburg ^a	28	29	37	• ^c
Tampa	26	27	26	26
No. of facilities more than:				
1 percent above 25 percent	5	5	5	6
1 percent below 25 percent	0	0	0	1
Elsewhere in Sun Belt:				
Augusta, Georgia	26	23	27	23
Augusta (Lenwood), Georgia	25	25	27	27
Charleston, South Carolina	25	26	28	20
Corpus Christi, Texas ^a	30	26	26	27
Las Vegas, Nevada ^a	20	23	29	31
Long Beach, California	30	22	26	26
McAllen, Texas ^a	33	19	27	30
Phoenix, Arizona	24	24	29	27
San Diego, California	26	25	26	26
San Diego, California ^a	25	22	29	25
San Antonio, Texas	26	25	26	26
San Antonio, Texas ^a	28	31	25	24
Tucson, Arizona	26	27	26	26
No. of facilities more than:				
1 percent above 25 percent	4	2	7	5
1 percent below 25 percent	1	5	0	2
Outside Sun Belt:				
Ann Arbor, Michigan	25	24	24	26
Boston, Massachusetts	24	24	25	23
Brooklyn, New York	25	25	25	25
Brooklyn (St. Albans), New York	26	26	25	24
Brooklyn, New York ^a	•	25 ^b	26	26

**Appendix II
Effects of Seasonal Fluctuations on
VA Facilities**

Location of VA medical facility	Percentage of annual applications			
	1981	1982	1983	1984
Chicago (Westside), Illinois	26	24	25	25
Lincoln, Nebraska	26	26	26	24
Lowell, Massachusetts ^a	29	24	29	27
Minneapolis, Minnesota	26	24	25	26
Northport, New York	25	23	25	24
Pittsburgh, Pennsylvania	25	24	24	25
St. Paul, Minnesota	21	21	19	26
Wood, Wisconsin	24	24	26	25
No. of facilities more than:				
1 percent above 25 percent	1	0	1	1
1 percent below 25 percent	1	2	1	1

^aSatellite outpatient clinic.

^bOpened during the fiscal year.

^cClosed during the fiscal year.

**Appendix II
Effects of Seasonal Fluctuations on
VA Facilities**

**Table II.2: Workload at Selected VA
Facilities: Outpatient Visits Made in
Winter Quarter, 1981-84**

Location of VA medical facility	Percentage of annual visits			
	1981	1982	1983	1984
Florida:				
Bay Pines	27	25	23	26
Ft. Myers ^a	28	26	27	28
Gainesville	25	25	26	26
Jacksonville ^a	27	25	25	25
Lake City	25	25	25	26
Miami	26	25	26	25
Oakland Park ^a	•	26 ^b	26	27
Orlando ^a	26	26	25	25
Riviera Beach ^a	28	25	26	27
St. Petersburg ^a	26	25	34	^c
Tampa	26	25	25	26
No. of facilities more than:				
1 percent above 25 percent	4	0	2	3
1 percent below 25 percent	0	0	1	0
Elsewhere in Sun Belt:				
Augusta, Georgia	25	25	27	26
Augusta (Lenwood), Georgia	26	25	26	27
Charleston, South Carolina	26	26	25	23
Corpus Christi, Texas ^a	26	25	27	24
Las Vegas, Nevada ^a	27	25	26	27
Long Beach, California	25	25	26	26
McAllen, Texas ^a	30	30	28	27
Phoenix, Arizona	26	25	27	27
San Diego, California	25	25	25	25
San Diego, California ^a	25	24	26	26
San Antonio, Texas	26	25	25	26
San Antonio, Texas ^a	27	26	27	26
Tucson, Arizona	26	26	25	27
No. of facilities more than:				
1 percent above 25 percent	3	1	5	5
1 percent below 25 percent	0	0	0	1
Outside Sun Belt:				
Ann Arbor, Michigan	25	22	24	25
Boston, Massachusetts	25	24	25	26
Brooklyn, New York	26	24	24	24
Brooklyn (St. Albans), New York	26	24	24	25
Brooklyn, New York ^a	•	24 ^b	25	26
Chicago (Westside), Illinois	25	24	24	24

**Appendix II
Effects of Seasonal Fluctuations on
VA Facilities**

Location of VA medical facility	Percentage of annual visits			
	1981	1982	1983	1984
Lincoln, Nebraska	25	23	25	25
Lowell, Massachusetts ^a	26	25	25	25
Minneapolis, Minnesota	25	23	25	25
Northport, New York	25	24	25	24
Pittsburgh, Pennsylvania	25	23	24	24
St. Paul, Minnesota	25	24	25	26
Wood, Wisconsin	25	23	24	24
No. of facilities more than:				
1 percent above 25 percent	0	0	0	0
1 percent below 25 percent	0	5	0	0

^aSatellite outpatient clinic.

^bOpened during the fiscal year.

^cClosed during the fiscal year.

Denial of Timely Access to Needed Medical Care

Senators Hawkins and Chiles expressed concern that veterans in Florida and other Sun Belt areas may not receive equal access to VA medical care compared to veterans outside the Sun Belt. Accordingly, they asked us to review admitting practices at VA facilities in Miami and Tampa, Florida, and compare them to the practices of VA facilities outside the Sun Belt. We selected VA's Boston Medical Center for comparison; its workload was about the same size as those in Miami and Tampa, and the facility is located in a metropolitan area.

Scope and Methodology

At the medical centers in Miami, Tampa, and Boston, we randomly selected 100 veterans applying for care between December 1984 and March 1985. We examined medical certificates, progress notes, and other data in the applicants' medical records to determine whether the VA examining physician had concluded care was needed. We identified cases where care was not provided within 1 day of the veteran's application. Our Chief Medical Advisor reviewed these cases to identify denials of and delays in providing needed care and to determine causes and any potential health risks. Where he questioned the medical judgment resulting in denial or delayed care, he discussed each case with an appropriate VA physician. We did not contact patients or trace medical histories to determine if in fact they suffered from any delays or denials.

To determine the existence of any patterns, we also reviewed (1) medical center letters to veterans who had been denied care or had their care delayed, so we could determine the reasons for such denials and delays, and (2) various correspondence relative to the medical center's practice of admitting patients for care. Additionally, we interviewed officials in Florida's Division of Veteran Affairs and local representatives of the Disabled American Veterans, Veterans of Foreign Wars, and Paralyzed Veterans' Association on veterans' access to care at VA medical centers.

Extent of Denied or Delayed Care

Based on our review and that of our Chief Medical Advisor, we believe that the three medical centers either denied or delayed medical care to 30 of the 276 veterans whose applications we reviewed (see table III.1).

Appendix III
Denial of Timely Access to Needed
Medical Care

Table III.1: Timely Access to Medical Care: Miami, Tampa, Boston Medical Centers Compared

VA medical center	Files reviewed ^a	Applicants needing care	Disposition		
			Timely care provided	Care denied	Care delayed
Miami	89	76	62	9	5
Tampa	87	84	72	5	7
Boston	100	73	69	2	2
Total	276	233	203	16	14

^aEleven files in Miami and 13 in Tampa were not available at the time of our review.

Officials at the centers attributed the denials and delays to various factors: (1) veteran ineligibility for care, (2) physician judgment that needed care would adversely affect other conditions or could be delayed, given the patient's condition, (3) needed treatment not available at the medical centers, and (4) administrative errors. The distribution of causes is shown in table III.2.

Table III.2: Causes of Denied or Delayed Medical Care Among Three VA Medical Centers

Cause	Miami		Tampa		Boston	
	Denial	Delay	Denial	Delay	Denial	Delay
Ineligibility	2	0	4	0	0	0
Medical judgment	1	2 ^a	0	5 ^a	1	2 ^a
Service not available at center	4	0	1	0	1	0
Administrative error	2	3	0	2	0	0
Total	9	5	5	7	2	2

^aIn these nine cases, our Chief Medical Advisor disagreed with VA medical personnel's decisions to delay providing needed care.

Of the 30 applicants who did not receive timely access to needed care, 24 were veterans who applied for treatment of nonservice-connected illnesses (see table III.3). Further, the denied or delayed care was typically for routine outpatient care that was not an emergency. We found only one case where a veteran with a nonservice-connected problem who needed acute care was denied the care. In this case, the center lacked the long-term psychiatric program needed.

**Appendix III
Denial of Timely Access to Needed
Medical Care**

Table III.3: Eligibility Status of Veterans Denied Timely Access to Needed Care: Miami, Tampa, Boston Facilities Compared

VA medical center	Service-connected		Nonservice-connected		Total	
	Denials	Delays	Denials	Delays	Denials	Delays
Miami	2	2	7	3	9	5
Tampa	0	0	5	7	5	7
Boston	1	1	1	1	2	2
Total	3	3	13	11	16	14

**Eligibility an Issue in Many
Denials/Delays**

Eligibility for veterans to receive medical care from VA facilities is established in 38 U.S.C. 612. VA's manual, M-1, Part I, governs its provision of medical care to veterans and establishes priorities among veterans for care. Generally, veterans with service-connected conditions have the highest priority for care in VA facilities and those without service-connected conditions have a low priority.

For veterans without service-connected conditions, however, an examining VA physician must determine that medical services are necessary to evaluate or treat a disability that would normally require hospital admission or that, if untreated, would reasonably be expected to require hospital care in the immediate future. Further, the routine treatment of a chronic condition that would not require hospitalization if left untreated is inadequate justification for placing or retaining veterans without service-connected illnesses in an outpatient-ambulatory care program.

VA's Tampa and Miami medical centers denied medical care to six veterans in our sample who applied for routine treatment of nonservice-connected conditions. For example, the Miami medical center considered one nonservice-connected patient to be ineligible for reading glasses at VA expense. In another case, the center denied a 10-percent service-connected (for tuberculosis) veteran an audiogram because his condition (hearing loss) was not service-connected.

At the Tampa medical center, four nonservice-connected veterans were denied care for asthma, stabilized hypertension, suspected vocal lesion, and an abdominal complaint, respectively, because they were considered to have chronic conditions. According to Tampa's Medical Center Director and the Assistant Chief of the Medical Administration Service, these veterans are eligible for acute care or hospitalization but are not

eligible to receive continuous routine outpatient treatment except to obviate the need for future hospitalization.

Our review of Tampa medical center correspondence explaining why medical care was not provided showed that the center denied or delayed care to at least 212 veterans between October 1982 and August 1985. Forty-five percent of the denials were for routine outpatient care to veterans without service-connected disabilities. The remaining 55 percent involved denials and delays of a wide range of services, including payment for private hospitalization; nursing home care; eyeglasses, hearing and speech aids, and orthopedic shoes; and dental services. Only 8 of the 212 veterans had service-connected disabilities, VA records indicated. According to a Florida Division of Veterans Affairs official, the typical complaint of Florida veterans, particularly those from the Tampa area, was that veterans without service-connected disabilities were being denied routine outpatient care.

**Medical Judgment Also a
Factor**

At each of the three centers, VA physicians denied or delayed care to veterans because the physicians believed that needed treatment could aggravate other conditions or that more expeditious treatment was not required. For example:

At the Miami medical center: The admitting physician denied treatment to one veteran with hiccups, saying the treatment could have had a potential hypertensive effect on the veteran's dialysis treatment. Another patient waited 46 days for a dermatology clinic appointment for treatment of an enlarged mole. The Associate Chief of Staff for Ambulatory Care at Miami stated that the patient's condition did not warrant an earlier appointment. Our Chief Medical Advisor, however, believed VA should have scheduled an earlier clinic appointment, as the mole could have been cancerous, and if so, earlier treatment would have been desirable. In a third case, a patient with postsurgical nerve pain waited 55 days for a scheduled clinic appointment. The examining physician said an earlier appointment was not needed. Our Chief Medical Advisor saw no potential health risk from this delay.

At the Tampa medical center: Five veterans in our sample did not receive timely access to needed care. In each case, the admitting physicians determined that immediate treatment was not required. In one case, a veteran with colon polyps waited 20 days for admission; in another, a patient with basal cell carcinoma (a form of cancer) waited

69 days; and in a third, a patient waited 16 days for admission for treatment of a bladder tumor. In each case, the admitting physician viewed admission as elective rather than emergent. However, our Chief Medical Advisor said that, in all three cases, given the patients' histories of cancer, they should have been admitted immediately because cancer can spread quickly. In two additional cases, veterans waited 126 and 71 days respectively for clinic appointments. One needed fusion of his fingers and the other had pain from lumbar radicalpathy (a disease of the nerve roots in the lower back area). Our Chief Medical Advisor saw no potential health risk resulting from these delays.

At the Boston medical center: Medication was denied to one veteran because the physician was concerned that the patient would become addicted to the drug. The center also delayed care to two veterans. One, with painless hematuria (blood in the urine), was examined, given medication, and scheduled for follow-up in the urology clinic 63 days later; another, with an anxiety disorder, was given a psychiatric appointment 2 weeks later. Boston's Associate Chief of Staff for Ambulatory Care said that both clinics were heavily overbooked and the patients were given the earliest available appointments, as emergency treatment was not indicated. Our Chief Medical Advisor said that, although painless hematuria in the patient was not a severe problem, a 2-month delay was inappropriate. Also, he said that 2 weeks is an unreasonable time for a patient with severe anxiety disorder to wait for an appointment.

**Some Services Not
Available**

Five veterans were denied treatment for venereal disease because the three medical centers did not routinely provide this treatment. According to each center's policy, the patients were referred to community facilities for treatment and venereal disease case follow-up investigations. A sixth veteran who was in a short-term community alcoholism program was denied long-term care at the Miami medical center because the center had no long-term alcoholism program.

**Administrative Errors
Blamed**

The Miami medical center failed to schedule one veteran for a follow-up examination after prescribing medication for hypertension. Our Chief Medical Advisor said a follow-up examination should have been performed to determine the patient's reaction to the medication. Miami's Associate Chief of Staff for Ambulatory Care agreed and stated that an administrative error had precluded the follow-up. Similarly, because of administrative oversight, another veteran who was taking medication

for hypertension was not scheduled for a clinic appointment as requested by the admitting physician.

In three additional cases, patients received delayed appointments at the Miami medical center because physicians did not complete consultation reports properly. One patient with a chronic pain in his hip waited 73 days for a clinic appointment; another patient with ankle trauma (no fracture) waited 79 days. The third patient waited 25 days for an appointment for shingles.

Through administrative errors, the Tampa medical center also delayed care to two veterans. One veteran with probable basal cell carcinoma waited 21 days for a clinic appointment because the admitting physician indicated "see as soon as possible" rather than "emergent." Consequently, the scheduler gave the patient the next available appointment, which was 21 days later. Our Chief Medical Advisor said that treatment for potential cancer should be provided as early as possible because the condition usually spreads over time and becomes more serious and difficult to treat. Another veteran who had complained of headaches after drinking beer canceled his application after waiting over 4 hours for the medical center to find his medical chart.

Results of VA Survey

VA's Health Services Research and Development Service conducted a survey of the experience of all VA facilities (except the clinic in Manila) in meeting veterans' demand for VA medical care. Although VA's methodology for measuring unmet demand differed from ours, its results also show that VA was unable to meet a larger portion of veterans' demand at its medical centers in Miami and Tampa than in Boston.

For VA's survey, VA staff at each facility reviewed the charts of all patients who applied for care during the week of April 21, 1985, but were neither admitted, scheduled for admission, nor given a clinic outpatient appointment. This review was to determine if the patient was eligible for and required further care. Between June 10 and July 14, 1985, VA staff reviewed a stratified random sample of 28 facilities to assess data reliability and to determine the reasons needed care was denied.

VA's survey results indicate that, systemwide, VA was unable to provide care to about 7.6 percent of the veterans seen in the admitting area and requiring further care. Table III.4 compares VA's survey results to our findings for the VA facilities in Miami, Tampa, and Boston.

**Appendix III
Denial of Timely Access to Needed
Medical Care**

**Table III.4: Denial of Needed Medical
Care: VA and GAO Results Compared**

Status of applicants	VA medical center		
	Miami	Tampa	Boston
VA week-long survey:			
Applicants needing care	437	549	573
Applicants denied further care	47	83	18
Percent denied	10.8	15.1	3.1
GAO sample:			
Applicants needing care	76	84	73
Applicants denied further care	9	5	2
Percent denied	11.8	6.0	2.7

Resource Allocation to VA Medical Centers

VA has implemented a new system to allocate its medical care funds among the 160 medical centers, Senators Hawkins and Chiles noted. They were concerned whether the new system took into account shifts in veteran population and corresponding shifts in demand for VA health care services. Our objective was to evaluate the extent to which VA's new resource allocation methodology considers veterans' demand for health care.

Scope and Methodology

To accomplish this objective, we reviewed the design and implementation of VA's new methodology for allocating medical care funds. We obtained relevant agency documents and interviewed key officials in VA's central office, medical district 12, and VA medical centers in Miami, Tampa, and Boston.

VA Resource Allocation Before 1985

Before fiscal year 1985, VA based each facility's funding on the prior year's budget adjusted for inflation and program changes. Such measures as the number of operating beds, average daily census, patients treated, and outpatient visits were used in determining workload. VA, the Office of Management and Budget, and other reviewers viewed this methodology as inadequate and obsolete partly because it did not respond to shifts in veteran demand for medical care.

Under the historical system, funding was not always consistent with veteran demand. For example, in fiscal year 1981, Sun Belt facilities processed about 36 percent of VA's total applications for medical care but received only 30 percent of obligated funds. This pattern continued through 1985 when Sun Belt facilities processed 37 percent of VA's applications for medical care and received 31 percent of obligated funds.

New Methodology for Allocating Resources Instituted

In fiscal year 1985, VA began using a new method of allocating resources to its medical facilities. The new methodology departed from the historical method by allowing VA central office to shift resources between medical centers based on their productivity in meeting workload requirements. VA shifted resources by creating a pool consisting of a part of each facility's budget for acute, ambulatory, and long-term care. VA central office then redistributed the pooled funds, allocating a greater

portion to the more productive facilities.¹ Thus, productive facilities obtained additional funds at the expense of less productive centers.

To measure productivity, VA central office uses standard measures of work called weighted work units (WWUs). VA uses different models to calculate WWUs in acute, ambulatory, and long-term care programs. The WWU values were originally based on a 1982 New Jersey statewide diagnosis related group (DRG) reimbursement schedule.

For acute care, VA assigns a number of WWUs to each of 470 DRGs based on groupings used in the Medicare program. VA places each discharged patient treated into 1 of the 470 DRGs, and the number of WWUs reflects VA's estimated cost of treating patients in the groups. A DRG that requires more resources than another DRG would have a correspondingly higher WWU assigned to it. VA took the reimbursement schedule, set the most expensive DRG to 1,000 WWUs, and then assigned each DRG of lesser value a proportionally lower WWU value. VA officials determined that VA hospitals would be reimbursed at the rate of the national average cost per WWU (\$29.91 for fiscal year 1985). Thus, if a DRG had a WWU value of 100, the dollar value of that DRG to a VA hospital would be \$2,991, or 100 x the national average cost per WWU of \$29.91. If a hospital's cost per WWU was greater than the national average, it would get a lower operating budget and therefore could treat fewer patients. If its costs were less, it would make a "profit" and could expand its programs. The incentive for each hospital, therefore, is to keep its average costs per WWU below the national average.

For ambulatory care, VA assigns WWUs for each outpatient visit within a particular age group. Certain resource-intensive outpatient visits, such as those for cancer chemotherapy and ambulatory surgery, are funded separately. For long-term care, VA bases WWUs on resource utilization groups reflecting the amount of nursing hours required to care for a patient.

VA's regional directors have discretion to make budget adjustments based on veteran demand for care at particular centers. About 2 percent of the basic recurring budget is set aside for regions to distribute among their facilities, the Southeastern Regional Director told us. In fiscal year 1985, for example, he provided an additional \$2.2 million to the Miami

¹In fiscal year 1985, VA redistributed acute care resources that comprised about 36 percent of the total recurring budget for VA's Department of Medicine and Surgery. In fiscal year 1986, VA redistributed acute care, ambulatory care, and long-term care resources that comprised about 55 percent of the recurring budget.

and Gainesville medical centers based on increased veteran demand for care at these facilities.

Although the directors of the VA medical centers in Miami and Tampa said that unmet or suppressed demand resulted from resource constraints, neither had ever appealed their budget allocations. In the past, we were told, such appeals were rare because of the manner in which VA allocated funds. Prior to the allocation, VA regional directors met with district and facility directors to review budget needs. These meetings included reviews of various factors that influence budget needs, such as new or deleted services, changes in population or demand, workload, and equipment. In this manner, facility directors and other key officials in VA's health delivery system had input into the budget process. Thus, they rarely formally appealed budget allocations.

Budget Effect of New Methodology

In fiscal year 1985, VA implemented its model for redistributing acute care funds. Approximately 36 percent of a facility's total funding was allocated using the DRG methodology; the remaining funding was allocated in the historical fashion (see table IV.1). In redistributing acute care funds, VA limited adjustments to minimize disruptions to facilities while phasing in the new methodology. In fiscal year 1985, the Southeastern Region received an increase of \$3.2 million, the largest adjustment to any region's budget.

Table IV.1: Fiscal Year 1985 Funding Adjustments Under VA's New Methodology

VA region	Funding adjustment ^a
Northeastern	\$-1,676,558
Mid-Atlantic	-1,694,998
Southeastern	+3,177,119
Great Lakes	-1,447,899
Mid-Western	+2,130,218
Western	-633,817

^aThe adjustments do not net to zero because, in fiscal year 1985, VA limited changes to facility budgets by the lesser of 1 percent of total measured dollars or 20 percent of the net change between actual and expected measured dollars. The limit was increased in fiscal year 1986 to 3 and 60 percent, respectively.

Using the acute care model, the Southeastern Region redistributed the \$3.2 million among facilities in its five districts. Within district 12, four of the five facilities received increases totaling \$939,812, as shown in table IV.2.

Table IV.2: Fiscal Year 1985 Funding Adjustments to Southeastern Region and Florida Facilities

	Funding adjustment
VA district no. (within Southeastern Region)	
9	\$+820,078
10	-8,060
11	+905,861
12	+675,857
19	+783,386
VA medical facility (within medical district 12)	
Bay Pines	-263,955
Gainesville	+228,552
Lake City	+103,949
Miami	+302,900
Tampa	+304,411

As a result of using the new methodology in fiscal year 1986, facilities in district 12 received a gross downward adjustment of about \$0.3 million before applying the limitation. The acute care model resulted in an upward adjustment of \$3.5 million. However, VA implemented the ambulatory care and long-term care models, which decreased the total budget. As with the DRG-based acute care model, a facility's budget was adjusted for the difference between its reported cost of providing ambulatory care and the average cost for all facilities. Overall, facilities in the Florida district received a downward adjustment of nearly \$2.3 million for ambulatory care.

Also, as with the acute and ambulatory care methodologies, a facility's reported cost of providing long-term care was compared to a national average and the difference produced the facility's budgetary adjustment. The process produced nearly \$1.5 million less in the long-term care budget for facilities in the Florida district. Collectively, the net loss of applying the new methodology was about \$334,000 for Florida facilities.

Observations

Because VA's new resource allocation methodology is based on the number of veterans treated by a facility, it is not sensitive to the demand for care that the facility was unable to meet and what VA calls suppressed demand. The regional director may, in distributing the discretionary funds, take into account the extent of unmet or suppressed demand. Therefore, to the extent that a facility is experiencing unmet or suppressed demand and is not receiving discretionary funds from the

region to meet that demand, it will not receive medical care funds for that demand under VA's new resource allocation methodology.

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