

**Questions for the Record
Subcommittee on Health
“FY 2019 Department of Veterans Affairs Budget Request for the Veterans Health
Administration”**

March 15, 2018

Questions for the Record from Dr. Wenstrup

Question 1: The budget request proposes hiring almost 6,000 additional full-time employees. Please provide the subcommittee with a break-down of the positions that these new employees would fill? What methodology was used to determine the number and composition of this increase?

VA Response: The proposed hiring of an estimated 5,792 full-time equivalent Employees (FTE) is similar to the actual hiring increase of 5,476 FTEs from fiscal year (FY) 2016 to FY 2017. The spread of the 5,792 FTEs in 2019 among the different types of FTEs is based upon the ratio found in 2017. A breakout of the estimated increase of 5,792 in 2019 is shown in the table below (see page VHA-56, Volume 2, FY 2019 President’s Submission). VA will take into consideration the effect of FY 2018 actual hires upon FTE projections for FY 2019 in the FY 2020 budget cycle.

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Question 2: We continue to hear different numbers quoted as to VHA’s existing vacancy rate. Could you provide the Committee with an accurate point in time, you determine the date, accounting of the VHA vacancy rate to include any data that supports that number such as job title, location, how long that position has been vacant, and if that position is funded.

VA Response: According to the March 8, 2018, VHA Official Vacancy report, attached, the vacancy rate is approximately 9 percent.

Question 3: We have veterans that have non-service connected conditions that want to get treated at the VA and they use their private insurance to do that. My

understanding is the collection rate based on billings is only about 36 percent. What is the VA doing to ensure that any reimbursements for care are accurately and thoroughly processed so that the maximum that revenue from other insurance is collected and reinvested in the VA care that is being provided?

VA Response: VA has historically reported collections performance/efficiency using the Collections to Billing (CtB) ratio, which compares claim level collections to gross billed amounts. The CtB ratio did not account for the limitations based on payer maximum allowable charges or patient cost sharing responsibilities which are uncollectible by the VA.

Going forward, VA will report collections performance using Net Collections Ratio. For ease of monitoring and reporting third-party collection performance, VA developed the Net Collection Ratio, which is a measurement that is comparable to industry standard reporting on collection performance. Net Collection Ratio measures collections as a percentage of Total Collectible Amount instead of billed charges. The Total Collectible Amount is billed charges minus uncollectible amounts like payer discounts and other health insurance (OHI) patient responsibility (VA does not collect OHI patient responsibility). The national Net Collections Ratio as of February 2018, is 95.9 percent, which is in line with industry standards.

Question 4: We know that there is a shortage of providers, there is a shortage of providers across the country, but in the VA particularly mental health, primary care, and certain specialties. The VA health profession scholarship program has not provided any scholarships for physicians or dentists in the past five years. Will this budget commit funds to achieve this purpose? Please share any proposals you may have in the works to that regard.

VA Response: Please see the attached Health Profession Scholarship Program physician response.

Question 5: As a legislative proposal, VA has asked that the Medical Services and the Community Care accounts be merged to allow for flexibility when unforeseen needs emerge. What is the role of the VISN's in supporting budget adjustments within the facilities under their purview? Do VISN's have enough authority to move funds between facilities to support emerging needs or unforeseen shortfalls?

VA Response: Veteran Integrated Service Network (VISN) Directors have the responsibility for balancing the financial resources allocated to their VISN among their subordinate VA Medical Centers. They do this using the Medical Center Allocation System (MCAS) model (information paper attached). As the fiscal year progresses, the VISN Director may move funds from accounts centralized at the VISN (such as equipment, non-recurring maintenance, or a VISN reserve) to VA Medical Centers based on emerging needs. They may also realign funds from one VA Medical Center to another if required. Any emerging funding needs that exceed a VISN's ability to

address are routed through the Deputy Under Secretary for Operations and Management and the Chief Financial Officer to the Under Secretary for Health to resolve.

Questions for the Record from Congresswoman Kuster

Question 6: I am very troubled to read that an additional \$4 billion of nonrecurring maintenance funding provided by Congress as part of the budget balance agreement is going to be taken back and used for other purposes, and yet we have dozens of Manchester projects as nonrecurring maintenance that were listed as future potential projects. Could you please give me an update on the Manchester SCIP ratings and were any possible additional funds may be allocated to that facility?

VA Response: While Manchester does have a list of future year projects, those projects are needs that the facility are not able to implement in FY18 or FY19. Accordingly, they were listed in the FY 2019 budget, to provide a forecast of potential future needs. Upon conclusion of the Vision 2025 Task Force, Manchester and VISN 1 will review and reconcile those projects against the recommendations from the Task Force, and refine the facility plan as appropriate, to address the backlog of facility infrastructure deficiencies at Manchester.

Questions for the Record from Congressman Brownley

Question 7: I know that in February the Secretary received three names from the commission that is tasked with finding viable candidates for the position of Under Secretary of VHA. Please provide me with the status of that search; has the Secretary submitted any of these candidates for review and potential nomination from the White House?

VA Response: Yes, a candidate for the Under Secretary for Health was submitted to White House.

Dr. Carolyn Clancy Submission for the Record Request

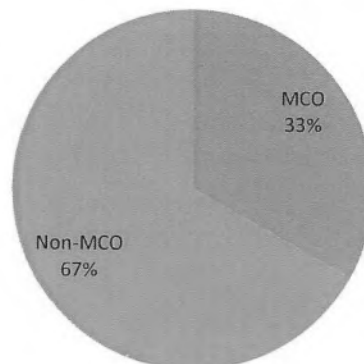
You may have seen a VA research study published just last week comparing one year use of opioids with nonsteroidal anti-inflammatory drugs, which you might know as Advil or Aleve. And actually at one year the people who were not on opioids had better outcomes. I might ask to submit that for the record. The referenced research study may be found at <https://jamanetwork.com/journals/jama/fullarticle/2673971>.

Department of Veterans Affairs
Report of Vacancies by State and Occupations
for Veterans Health Administration (VHA)

QUESTION 2 RESPONSE

State	Approved Vacancy (FTE's)
Alaska (AK)	125.5
Alabama (AL)	434.1
Arkansas (AR)	546.6
Arizona (AZ)	444.6
California (CA)	2,762.0
Colorado (CO)	662.7
Connecticut (CT)	198.1
Dist. Of Columbia (DC)	343.2
Delaware (DE)	86.0
Florida (FL)	2,644.2
Georgia (GA)	1,061.2
Hawaii (HI)	162.1
Iowa (IA)	275.9
Idaho (ID)	119.7
Illinois (IL)	967.0
Indiana (IN)	491.9
Kansas (KS)	553.8
Kentucky (KY)	298.7
Louisiana (LA)	589.6
Massachusetts (MA)	618.5
Maryland (MD)	379.7
Maine (ME)	187.9
Michigan (MI)	823.6
Minnesota (MN)	364.4
Missouri (MO)	906.5
Mississippi (MS)	474.2
Montana (MT)	131.0
North Carolina (NC)	855.2
North Dakota (ND)	73.1
Nebraska (NE)	210.3
New Hampshire (NH)	92.4
New Jersey (NJ)	243.8
New Mexico (NM)	94.7
Nevada (NV)	437.6
New York (NY)	1,226.2
Ohio (OH)	999.4
Oklahoma (OK)	448.9
Oregon (OR)	507.3
Pennsylvania (PA)	929.0
Rhode Island (RI)	127.2
South Carolina (SC)	506.8
South Dakota (SD)	200.8
Tennessee (TN)	898.2
Texas (TX)	1,998.8
Utah (UT)	242.2
Virginia (VA)	839.2
Vermont (VT)	117.2
Washington (WA)	942.3
Wisconsin (WI)	675.2
West Virginia (WV)	361.4
Wyoming (WY)	208.4

VA MCO vs Non-MCO Vacancy	
MCO	9,950.5
Non-MCO	20,142.9



MCO Vacancy Status	
MCO Series	FTEs
0180	566.9
0201	468.8
0602	1,670.7
0603	198.3
0610	5,433.6
0631	94.4
0633	131.6
0644	436.0
0647	249.1
0660	456.6
1102	243.6
2210	1.0
Grand Total	9,950.5

Department Of Veterans Affairs (VA)
Report to Congress On Health Professional Scholarship Program (HPSP)

Background

Pursuant to Public Law 46-330, HPSP gives priority to applicants pursuing a course of education leading to a career in one of the top five healthcare occupations with the largest staffing shortages throughout VHA. Currently, HPSP offers scholarship awards to the following occupations with the greatest workforce shortages: Physician Assistants, Nursing, and Physical Therapists.

Proposal

A proposal for Extension of HPSP Sunset Date was listed as one the 17 VA legislative proposals (see page 11 of 150 Volume I, Supplemental Information and Appendices Congressional Submission, 2019, available at <https://www.va.gov/budget/docs/summary/fy2019VAbudgetVolumelsupplementalInformationAndAppendices.pdf>). VHA plans to expand and offer scholarships to medical students in addition to the other top mission critical healthcare occupations.

FY 2019 Budget

Also, the fiscal year 2019 revised budget request for HPSP is 5.6 million (see page 146 of 595 in Volume II, Medical Programs and Information Technology Programs, Congressional Submission, FY 2019 Funding and FY 2020 Advance Appropriations, available at <https://www.va.gov/budget/docs/summary/fy2019VAbudgetVolumellmedicalProgramsAndInformationTechnology.pdf>).

Veterans Health Administration
March 2018

VA Medical Center Allocation System (MCAS 2018)

Background

Beginning in Fiscal Year 2011, VHA Chief Financial Officer (CFO) established a standardized methodology for distributing VISN-level VERA Model funds to medical centers within each VISN. Prior to FY2011, VISN-management had the authority to distribute VISN-specific VERA funding in a manner consistent with the following principles:

1. Be readily understandable and result in predictable allocations.
2. Support high quality health care delivery in the most appropriate setting.
3. Support integrated patient-centered operations.
4. Provide incentives to ensure continued delivery of appropriate Complex Care.
5. Support the goal of improving equitable access to care and ensure the appropriate allocation of resources to facilities to meet that goal.
6. Provide adequate support for the VA's research and education missions.
7. Be consistent with eligibility requirements and priorities.
8. Be consistent with the network's strategic plans and initiatives.
9. Promote managerial flexibility, (e.g., minimize "earmarking" funds) and innovation.
10. Encourage increases in alternative revenue collections.

The VISNs were required to document and substantiate their respective allocation methodology and outcomes each year. Consequently, this decentralized process resulted in 21 different resource allocation processes within VHA, thereby compounding the explanation and evaluation process for the varying methodologies for each VISN. The Under Secretary for Health subsequently directed the VHA CFO to develop a standard methodology to allocate VISN-level VERA allocations to VA Medical Centers (VAMCs). The result of this effort is the Medical Center Allocation System (MCAS) Model.

Methodology for MCAS

The process for developing the MCAS methodology began with a review of the different VISN-to-facility funding strategies to evaluate best practices in medical center funding processes. As part of the review, it was reaffirmed that the that the VERA business rules for allocating patient care funding were never intended to be used at the medical center level. However, the VERA business rules for allocating support funds for research and education are appropriate approaches at the medical center level. As a result, the VERA rules for allocating research and education support funds are identical MCAS; meaning that the respective support funds for research and education are distributed to the precise medical centers where the trainees and research grants are located.

Business rules for allocating patient care funds in VERA cannot be mirrored in MCAS primarily because a medical center does not have a sufficiently clinically diverse patient population to manage the risk associated with capitated funding concepts of a *Price per patient*. For this and other reasons, the VERA Model capitated Prices per patient were never intended as an allocation methodology below a VISN level. Consequently, the medical center allocation methodology incorporates a more robust patient workload measure known as Patient Weighted Work (PWW) for distributing VISN-level VERA patient care funds to medical centers within each VISN. By design, PWW more accurately accounts for the resource intensity of medical center patient workload.

Medical Center Allocation System (MCAS) Spreadsheets

The Medical Center Allocation System (MCAS) is based on the following guiding principles pertaining to the workload and budget used in the process.

1. MCAS consists of a uniform process for allocating VISN-level VERA General Purpose funds to VAMCs within each VISNs based on standardized data elements that are representative of each medical center's workload. The representative data elements used to distribute the VISN-level VERA budget to medical centers is documented on the ARC website.
2. The Initiatives section of the MCAS spreadsheet is designed to incorporate VISN-specific initiatives that are not accounted for in the standardized MCAS spreadsheet. The Under Secretary of Health (USH) authorizes VISN directors to identify and assign funds to VISN-specific issues within this section. Each initiative must comply with USH's criteria and documentation is required for each initiative. VISN Directors must explicitly state the reasons for adjustments and identify the precise category that has been approved by the USH.

"Off the Top" Adjustments Prior to Model Run:

- VISN headquarters (HQs) staff, supplies, leases, etc.
- Consolidated/integrated VISN functions (human resources, accounting, VISN-wide contracts, etc.)
- Centralized management (Non-Recurring Maintenance, Equipment, etc.)
- Contingency withhold to address emerging requirements (ORM payment's, etc.)
- VISN Initiatives
- Unfunded Activations

Reasons for Medical Center Specific VISN Initiatives:

- Recognition of significant revenue or workload or changes in advance of VERA
- Staffing realignments
- Tenant Support
- Special considerations (Artificial Limb Fabrication, Geriatric Research Education Clinical Center (GRECC) Operations, rural operations)
- New Community Based Outpatient Clinics (CBOCs)

Reasons to adjust the Medical Center Outcomes:

- Significant mission change
- Adjustment for model impact
- Recognition of structural impediments
- Identify specific clinical/financial conditions that the Model does not address

An Excel spreadsheet provides a standardized format for documenting the MCAS for each VISN. The spreadsheet includes color coded cells with a legend at the bottom, thereby allowing quick visuals of the business rules associated with each element. For example, yellow cells are variable and can be changed by VISN management, while blue cells indicate that the MCAS business rules mirror the VERA Model rules and funds are passed directly to the medical centers. Below is an example of the MCAS 2018 spreadsheet. Each VISN spreadsheet contains the name, station identification number, corresponding data and funding of all medical centers within the VISN. Beginning in FY2015, there are specific line items identifying the funds that will be transferred to the Chief Business Office (CBO) for the administration of purchased care (also known as Medical Community Care). These line items identify each medical center's anticipated non-VA expenses as well as the CBO staffing costs associated with performing these functions. The VISN-level Non-VA funds are accounted for on row 3 and the facility-specific reductions are documented in row 48.

Because they are removed from MCAS, they are considered Specific Purpose funds.

(A)	(B)	(C)	(D)	(E)	(F)
Line			4		
		FY17	FY18		
1	VISN VERA General Purpose Allocation	\$1,919,939,102	\$1,991,710,238		
2	VISN Carry-Forward				
3	VISN Contribution for Non-VA Care	\$209,938,234	\$209,079,838		
5	VISN Total General Purpose	\$2,129,877,336	\$2,200,784,076		
6				Wilmington	Altoona
7				460	503
8	VISN Reserves & Initiatives - Held				
9	VISN Operating Reserve		\$29,875,654		
10	VISN Office and Staff		\$8,032,939		
11	VISN Initiatives (Reserved)		\$49,679,581		
12	A1. Consolidated CITC BA Lebanon One Time		\$1,600,000		
13	A2. Consolidated COR Lebanon One Time		\$600,000		
14	A3. TELE PRIMARY CARE Butler One Time		\$1,071,008		
15	A4. Butler Nurse Call center One Time		\$2,465,893		
16	A5. VISN Wide Contracts Funded at VISN one time		\$13,942,680		
17	A6 Supplement NRM for Foundational Services - Realign		\$30,000,000		
18	VISN Initiatives (Facility Specific)		\$0	\$0	\$0
19	B1. Workload Growth		\$0		
20	B2. Rural FEE initiative		\$0		
21	B3. Other Initiative (specify)		\$0		
22	Total VISN Reserves & Initiatives	\$100,053,988	\$87,588,174		
23	VISN Capital Budget				
24	VISN Equipment	\$20,415,500	\$24,893,684		
25	Adjustment to Model with VERA Equipment		\$0		
26	VISN Equipment Balance after Model Adjustment	\$20,415,500	\$24,893,684		
27					
28	Total VISN, Reserves, and Capital	\$120,469,488	\$112,481,858		
29	Health Care System (facility) Distributions			Wilmington	Altoona
30				460	503
31					
32	FY17 Sub Network Distribution (SDM)	84.49%	\$1,799,469,614	\$148,367,259	\$86,152,713
33	FY16 Patient Weighted Work		289,449	24,082	15,501
34					
35	VERA to HCS Pass-Throughs				
36	High Cost Patient Allocation		\$123,863,003	\$10,231,912	\$2,022,502
37	Education Support		\$26,806,992	\$2,360,758	\$20,752
38	Research Support		\$21,543,593	\$0	\$0
39	Total of Pass-Throughs		\$172,213,588	\$12,592,670	2,043,254
40	VERA to HCS - Modeled				
41	General Purpose Model Allocation				
42	VERA to HCS Pass-Throughs		\$172,213,588	\$12,592,670	\$2,043,254
43	General Purpose HCS - Modeled Allocation		\$1,916,088,630	\$159,416,957	\$102,612,890
44	General Purpose to HCS Total	104.85%	\$2,088,302,218	\$172,009,627	\$104,656,144
45	Adjustment to Facility (\$ amount) Redistribute	1.0000	\$0	\$0	\$0
46	New General Purpose to HCS		\$2,088,302,218	\$172,009,627	\$104,656,144
47					
48	Reversion based on FY16 Adjusted CITC payments		(\$209,079,838)	(\$19,103,794)	(\$15,635,777)
49	Net General Purpose to HCS		\$1,879,228,380	\$152,900,833	\$88,960,367
50	Increase (Decrease) from prior year		\$79,758,767	\$4,533,574	\$2,807,655
51	% Increase/Decrease from prior year		4.4%	3.1%	3.3%
	Control Total		\$0		
	Price per PWW		\$7,215	\$7,143	\$6,752
	Input fields				
	Row Totals				
	Column Totals				
	Calculations				
	Fixed values				
47	Reasons for Adjustment for Line 44 or Line 20				

Legend	
Input fields	
Row Totals	
Column Totals	
Calculations	
Fixed values	

Overview of Patient Weighted Work

The VERA methodology of a national price per patient is not a viable allocation strategy to the medical centers, so an alternative workload variable known as Patient Weighted Work (PWW) is used

to accurately account for patient care practices at the medical center level. PWW is a risk-adjusted workload measure that accounts for facility-level factors such as patient volume, case-mix and specialized services. Patient Weighted Work is computed using FacWork, which is a variable that accounts for the national average *resource intensity* of patients within the VERA Patient Classification system. (See below for further description on FacWork.) However, because FacWork represents national average data, additional adjustments are required to normalize the data and account for precise medical center variations in salary costs, excessively costly treatments as well as the clinical variations at each medical center.

One of the major adjustments to FacWork includes the variable known as Resource Intensive Treatments (RITs), which provides additional workload *credit* for excessively costly services or procedures. The RIT credit provides additional workload credit for precise services or treatments that are not sufficiently accounted for in the FacWork for a given patient class. Examples of RITs include open heart surgery, neurosurgery and certain chemotherapies. The formulation of RIT credit is based on the residual cost as compared to the national average patient cost for a specific service.

For MCAS 2018, there were 707 RITs, which are itemized in the Allocation Resource Center's (ARC's) FacWork and PWW Cube. The RIT report identifies the name and the additional workload credit associated with each RIT. RITs are identified by a Diagnostic Related Group (DRG) for inpatient services and Common Procedure Terminology (CPT) code for outpatient services. When a patient receives a RIT, the additional workload credit is added to the FacWork for that patient. The process for awarding RIT credit is different for inpatient and outpatient services. For inpatient care, the patient receives RIT credit for the single highest RIT for the inpatient stay, even if more than one RIT is provided. For outpatient care, all patient workload is ordered by CMS RVU weight for each CPT/HCPCS code and if the highest weighted code is a RIT, the patient will receive the corresponding credit for that single RIT. The RIT values are reviewed and updated each year.

Two additional factors are multiplied against the medical center's PWW. First, the facility's labor index recognizes differences in cost of salaried labor between facilities. Second, the Complexity Group factor accounts for the variety of functions, missions and additional funding sources associated with each Complexity Group. The Complexity Group factor adjusts PWW and ensures each hospital group is treated fairly in the process.

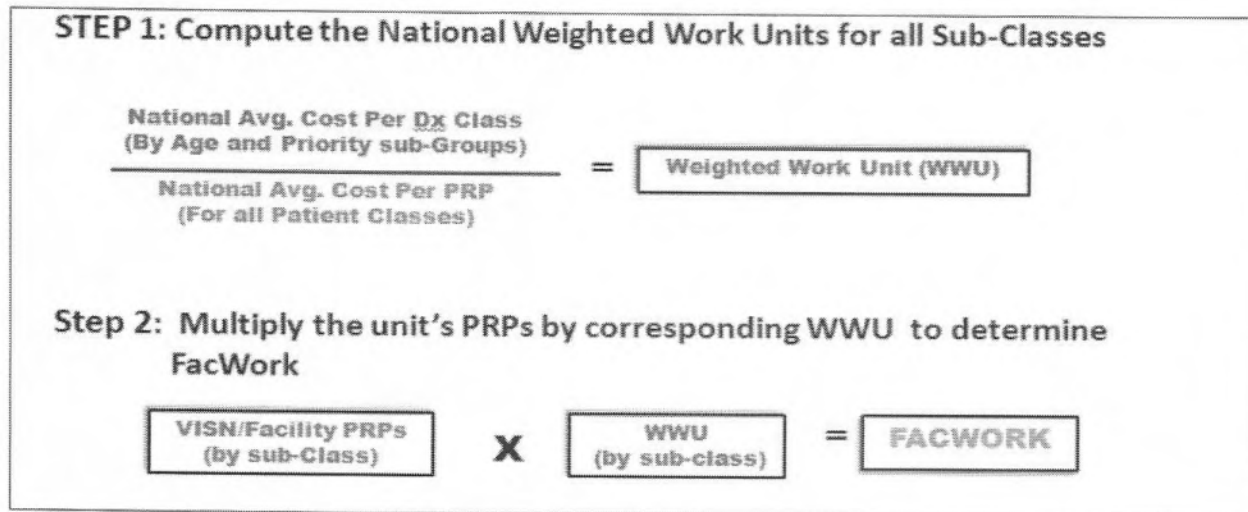
Origin of FacWork

The workload variable known as facility workload, or FacWork, is a longstanding workload measure in the Unit Cost Reports (UCRs) used by VHA's financial managers. The UCRs are designed to compare efficiency, effectiveness and other measures between facilities and VISNs. FacWork is a numeric representation of patient data that is intended to quantify the resource intensity of patient workload. The underpinnings of FacWork are formulated from patient workload and cost data that is organized within the VERA Patient Classification system based on specific diagnostic categories and utilization patterns. In brief, the VERA 2018 Patient Classification system is comprised of 64 patient classes that are subdivided into 141 diagnostic (Dx) classes that represent patient data in more refined sub-groupings based on diagnosis codes, treatment patterns and modalities of care.

Beginning with the VERA 2018 process, the FacWork calculation was modified to exclude approximately \$4.6 billion in patient costs (\$1.5 billion for Hepatitis C pharmaceuticals and \$3.1 billion in High Cost Payments). These costs were excluded from the FacWork formula because they are financed by separate funding streams in FY18. Excluding these costs from FacWork ensures that they are not doubly accounted for in the resource allocation process within MCAS. In addition, projected patient workload developed from the Enrollee Health Care Projection Model is also funded in MCAS beginning with FY17.

The formula for computing FacWork (illustrated in Step 1 below) uses the national average costs for each DX class (excluding the \$4.6 billion). The denominator in the formula remains constant representing the national average cost of a patient (which is also referred to as the national cost per FacWork). Because the denominator a constant variable, the outcomes, known as Weighted Work Units (WWU), are identified as *relative workload measures* and can be used for comparison purposes. (It should be noted that the actual calculation is done by DX class that is further stratified by eight distinct age groups and Enrollment Priority Groupings for Priority Groups 1-5; Priority Groups 6-8 and Non-Veterans.)

Graphic 1: Formula for FacWork



The FacWork for a VISN/medical center is determined in Step 2, when the unit's workload is multiplied by the corresponding Weighted Work Unit (WWU) for each respective DX class. The FacWork can be represented at the patient, facility or VISN-level making it a highly versatile workload measure that can be used for unit-level comparison purposes.

Computing Patient Weighted Work

Patient weighted work is a workload measure that begins with FacWork and includes additional facility-specific adjustments designed to more accurately account for patient workload intensity at the facility level. As indicated above, FacWork is computed at the Dx class level so it inherently accounts for patient-specific clinical differences at an individual facility, albeit at a national level. However, because FacWork reflects national values, additional adjustments are required to account for facility-level differences across the country. These additional adjustments are deemed to be outside the control of VISN management. Such factors include:

1. Geographic differences in pay as a result of salary structures that are mandated by the federal pay system;
2. Resource intensive treatments that are extremely costly to perform and are 70% higher than national cost per FacWork of a patient; and
3. Complexity Group differences that measure the complexity level of the services performed at the facility.

Each adjustment is addressed below.

Geographic Differences in Pay also known as the Labor Index: In the federal government, salaried employees are paid in accordance with GSA pay schedules which include local cost of living adjustments (COLA). Because the COLAs vary around the country and cannot be changed by VISN management, a labor index is computed to account for the differences for salaried staff. The labor index used to adjust the facility-level workload is a composite value that reflects the actual indices computed at the person class level. For each major person class, a facility specific index is computed and reported on the ARC website to document the relative costs of salaried staff for all VHA personnel. Note that the labor index does not include salary differences for contract or non-VA staff.

Resource Intensive Treatments (RIT): Resource Intensive Treatments are defined as specific treatments identified by either Diagnostic Related Group (DRG) for inpatient care or a Health Care Common Procedure Code (HCPCS) used during an outpatient encounter. These treatments are considered resource intensive because the cost of the specific procedure is 70% more costly than the national cost per FacWork, which was \$8,774 in fiscal year 2016. Since MCAS 2015, the credit of each RIT credit is computed at 170% of value. In prior years, RIT credit consisted of the 70% above the cost per FacWork.

The process for identifying RIT is different for inpatient and outpatient care. For inpatient care, the DRG is extracted from the PTF, Census PTF, non-VA PTF or the fee payment files. The additional weighted work (FacWork) associated with the RIT is attributed to the patient. For outpatient services the HCPCS codes for the encounter are ordered by "Fac RVU". If the code with the highest Fac RVU is an identified RIT, additional FacWork is attributed to the patient. There are quality controls applied to this process to account for atypical outpatient data. First, only one RIT per **clinic stop** is allowed in a calendar day. Additional quality controls include: HCPCS codes must have a "Fac RVU" greater than 2 and a national average cost of \$300 per treatment. These qualifying factors help remove extraneous data from files.

Other exclusions include codes for durable medical equipment, temporary codes and orthotic procedures. A list of the precise resource intensive treatments and their corresponding additional FacWork are available on the ARC Website in the FacWork Cube.

Complexity Group Adjustment

Every facility is assigned a Complexity Group by the Office of Productivity, Efficiency and Staffing (OPES) based on a comprehensive evaluation of the services provided by the facility. The FY2014 Complexity Group assignments were used in the MCAS process for this year. Using ARC patient costs, an additional FacWork adjustment was computed to reflect the variation in costs at the Complexity Group level. Specific adjustment variables that are assessed in the formulation of the Complexity Group Adjustment include patient case-mix, geographic costs and additional funding streams. The chart below contains the specific adjustments based on FY 2016 costs.

Complexity Group	FY18 MCAS Adjustment
1A, 1B, 1C High	.9966
2 Medium	1.0122
3 Low	1.0024
358 Manila	.2798
463 VA Alaska HCS, 629 New Orleans	1.1607