

RECOMMENDATIONS TO REVISE VA SYSTEM FOR
HEALTH CARE RESOURCE ALLOCATION

FIELD HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

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RECOMMENDATIONS TO REVISE VA SYSTEM FOR HEALTH CARE RESOURCE ALLOCATION

TUESDAY, APRIL 30, 2002

HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS AFFAIRS,
Washington, DC

The full committee met, pursuant to call, at 10 a.m., at the George Washington Ballroom, the War Memorial Building, Trenton, NJ, Honorable Christopher H. Smith, (chairman of the committee) presiding.

Present: Representatives Smith, Brown

Staff Present: Patrick Ryan, Peter Dickinson, Summer Larson, Stacy Zelenski

OPENING STATEMENT OF CHAIRMAN SMITH

The CHAIRMAN. Good morning, everyone. I want to welcome all of you to this Hearing of the full Veterans' Affairs Committee, and I welcome you for coming out this morning. The Hearing will come to order.

On behalf of the House Veterans' Affairs Committee, let me extend a warm welcome to all of you who have come to attend today's hearing here at the Trenton War Memorial Building. This historic building has recently undergone extensive renovation, and it stands, once again, as a proud tribute to our veterans.

I want to thank Ms. Molly McDonough and Bill Nutter. Molly is the War Memorial's executive director, and I want to thank her for making this beautiful room available to the House Veterans' Affairs Committee, and for all of the courtesies she has extended to the Committee, as well as to our staff.

Today's Congressional Hearing will examine the Veterans Equitable Resource Allocation, or VERA, the formula that apportions federal funding for veterans health care to each of the veterans integrated service networks around the country.

Our main focus this morning will be on a recent General Accounting Office, and VA Inspector General report, calling for significant reforms and changes to the VERA formula. First developed in 1996, the VERA formula was implemented in April of 1997, with the goal of better aligning the VA's limited health care resources with the changing workloads at VA facilities across the country, especially to account for population shifts.

However, recent independent reports by the GAO, and the VA Inspector General, have pointed out important weaknesses, significant weaknesses, with the current VERA formula that the VA

needs to address immediately, to ensure that the E, the equitable, continues to have any meaning.

As a member of the House Veterans' Affairs Committee for 22 years, and as Chairman for the last two, I have seen how year after year VA health care funding, particularly here in New Jersey's networks 3 and 4, seems to lag behind the demand for VA health care services.

And in recent years I have become increasingly concerned about the way the VA goes about not only dividing their funding among their regional networks, but also about the underlying manner in which they go about developing their annual budget.

Since 1985 the Department of Veterans Affairs has provided access to health care services to every former soldier, sailor, airman, and marine, who requested it. But skyrocketing health care costs, record enrollments and inadequate budgets have put the VA health care system at a crossroads on the question of universal access for veterans.

Although the VA opens its doors to all veterans, they have not yet fully opened their budgeting process to them. This has had serious consequences, not only here in New Jersey, but all across the country.

In the past 6 months the Department of Veterans Affairs has made two separate attempts to limit access to the VA health care system. Last December, Secretary Principi, faced with overwhelming demand and a budget shortfall, proposed preventing future enrollment of priority 7 veterans, that is to say those without service connected disabilities and whose incomes were above specified low income thresholds.

Before this had a chance to be announced I contacted the Speaker of the House, who contacted the White House, and fortunately the President reversed this decision.

This year the Administration proposed a new \$1,500 deductible to be imposed upon priority 7 veterans, which it estimated, would reduce health care costs by \$1.1 billion as a result of 470,000 veterans electing to reduce or totally eliminate their usage of VA health care services.

Their proposal would have primarily affected older veterans from World War II and the Korean War. I vigorously opposed this proposal and worked across party lines to defeat this proposal in the House. It will not be enacted this year.

But the dramatic increase in demand facing the VA is real, and it is substantial. Prescription drug costs have risen dramatically in the past several years, while seniors income levels have remained level. This has created a great demand for VA provided prescription drugs.

At the same time, millions of veterans continue to use the VA as their primary care provider because of the quality medical services they can now receive at increasingly convenient locations.

These trends have produced an enormous strain on the VA health care system. However, the solution to this problem should not be to curtail or limit access to veterans, but rather to provide sufficient resources to pay for their health care.

America, I believe, has a special obligation to care for former soldiers, sailors, airmen and marines who risked their lives to protect our freedoms, whether or not they were permanently injured.

After all, not all veterans were wounded in combat, but don't all of our soldiers, especially those who scaled the cliffs of Normandy, or fought in New Guinea, or stormed the beaches at Iwo Jima, or today are stationed in Afghanistan, deserve access to VA health care? I believe the answer is yes.

That is why this Committee has worked so hard to ensure that the budget resolution approved by the House of Representatives contained a record increase in the VA budget authority, \$56.9 billion, including a whopping 12 percent increase in VA health care.

That is a \$2.8 billion increase in the discretionary spending for the Veterans Health Administration, more than 1.4 billion above the Administration's proposed budget.

And in the House budget the \$1,500 deductible proposal was replaced, dollar for dollar, with new funds. I would also note that our budget resolution also included significant funding, at least 500 million next year, to resolve the problem of concurrent receipt, that glitch in the law that requires military retirees to have their retirement pay lowered by the amount of disability compensation payments that they also receive.

As many of you know, Congress approved, and the President signed this year, and last, five historic new laws that I sponsored, which boosted the GI Bill by 46 percent, authorized almost a billion dollars to end homelessness among veterans, provided a cost of living increase for disability compensation payments, improved life insurance policies for veterans' survivors, and strengthened the provision of VA health care nationwide.

These laws are fully funded in the budget this year, and they were the result of a tremendous amount of bipartisan effort, including that of my good friend and colleague, Lane Evans, the Ranking Member on the Committee.

Let me also point out that we did make progress on helping our Priority 7 veterans last year with the enactment of H.R.3447, again legislation that I sponsored, that contained among other provisions a reduced copayment for lower income veterans, requiring inpatient services.

Beginning October 1, Priority 7 veterans with incomes above the current limit but below the regional index, will receive a discount of 80 percent for inpatient copayments. That could translate into a \$640 per admission discount that goes directly back into the pockets of our veterans.

However, in my original house passed version we had used the HUD low income limits, in place of the VA's means test threshold, to fix this inequity. It would have done this by giving all veterans residing in the defined locality a means test threshold adjusted to reflect the cost of living for that particular region.

Use of the HUD low income rate to augment VA's means test standard would have created a more realistic, I believe a more equitable system, to reflect cost of living variations from one locality to another, and would have better affirmed Congressional intent that the VA provide care for poor veterans on a high priority basis.

To address any concerns about the potential effect of the HUD low income limits, on VA's internal allocation system, our measure would have placed a 5 percent limitation on resource changes allowed to occur any year, due to the application of this new approach.

But, sadly, the Senate rejected it, along with many other proposals. However, now I think our original proposal has been vindicated.

In all of these endeavors our committee has been successful because we, indeed, have worked together in a bipartisan fashion with members of both sides of the aisle in support of our veterans, all of our veterans, and that is how we will continue to operate.

Today's hearing will focus, again, on the VERA system, recommendations to modify and reform the VERA system, and the VA's plans to implement such changes. Since its development in 1996, the VERA system has increasingly raised almost as many questions as it has resolved.

It was designed with the objective of better aligning VA's limited health care resources with the actual workload at VA health care facilities across the country.

The results have been almost a billion dollars shifted every year from health care facilities from the northeast and midwest, to ones in the south and the west.

In the past 6 months reports by the VA's Inspector General, and the GAO, both came to the same conclusion. The VERA formula needs to be adjusted and it needs to be equitable to all regions of the country.

Reports issued by these two independent watchdog agencies, or groups, were on agreement on the most glaring problem in the present calculation of VERA, that it fails to count every veteran.

While VERA is supposed to allocate federal funding according to the relative workload of each of the regional VISNs, under the current formula most Priority 7 veterans are not counted, they are invisible to the VA.

Since 1996 the number of Priority 7 veterans has risen dramatically, from just over 100,000 to over a million. And the VA projects that this number will continue to rise sharply over the next 5 to 10 years.

When VERA was first developed, Priority 7 veterans accounted for less than 5 percent. I think 3.6 is the Inspector General's number, of all enrollees. But they now account for more than 25 percent of the total.

In fiscal year 2001, the last year in which we have detailed statistics, the national average of Priority 7 veterans as a percentage of overall enrollees was 22 percent. But this varied significantly depending on the region.

For example, in VISN 3, which includes most of New Jersey and New York City, 37 percent of all enrollees were Priority 7 veterans compared to several VISNs where the figure was less than 15 percent of their totals.

By failing to count Priority 7 veterans in the VERA calculation, networks with a higher percentage of Priority 7 veterans received less than their equitable share of the VA's health care funding.

Both the VA Inspector General, and the GAO, have recommended the obvious, count them all, including Priority 7 veterans. And according to a letter from Secretary Principi, in response to the GAO report, the VA concurs with the recommendation to count Priority 7 veterans, but with some very troubling reservations. Quoting from the letter.

“VHA is examining various VERA models/simulations for fiscal year 2003 network budget allocations, the VA says, that reflect VERA workload, and funding credit for patients in that Priority, both in whole, or in part.”

It goes on to say: “The VA is committed to thoroughly evaluating the appropriateness and the feasibility of including basic care Priority 7c workload in the funding methodology.”

It seems to me that there is no open question about the “appropriateness” of including these veterans, nor should there be any consideration of funding them only in part. Congress has made it clear, as has President Bush, that the VA health care system is open to all of America’s veterans. They should all be counted, and they should all be fully funded.

That is what we recommended to the budget committee, and that is what the House has approved with its increase this year.

The VA’s failure to fully embrace Priority 7 veterans, the fastest rising segment of veterans enrolling in the VA, also has consequences in terms of overall funding. By continuing to look for ways to limit or discourage Priority 7 veterans from signing up in the first place, the VA is undercutting their ability to argue for an increased health care budget.

VA can look to our budget resolution in the House to see that we can make, when we make the case that all veterans should count, we can be successful and are successful at increasing the overall budget.

The budget should be needs-based. What is the need and how do we fill it? And that is where we should engage, and that is where we should fight.

There are several other important recommendations contained in the GAO study that demand immediate action as well. In particular the part of the VERA formula that accounts for the different levels of care among patients, ranging from basic care to very complex care needs to better reflect current trends and the reality on the ground.

As GAO points out so well, this change can and should be made immediately, in order to ensure that the VERA allocations for fiscal year 2003 are decided in an equitable manner.

If VERA is to remain a credible system for allocating resources for veterans’ health care, it must remain above all else an equitable system that is fair to all veterans wherever they live.

When populations are discovered, and problems are discovered, they need to be corrected. This is the situation today. Independent auditors have identified the changes that need to be made. Congress gave the VA the authority and responsibility to make those changes, and now the VA must make them.

I look forward to hearing from our very distinguished witnesses today, and especially from Under Secretary Roswell about the specific plans of the VA health care system to address these problems.

At this time I would like to acknowledge some of our distinguished members of our audience, then I would like to introduce our panel.

I want to recognize Dick Bernard, a good friend from New Jersey, who has a distinguished record of military service from the Korean War. He is the former deputy commissioner of the New Jersey Department of Veteran's Affairs.

Peter Inverso, I believe, is here, or will be here very shortly. The state senator is the co-chairman of the New Jersey Senate Law and Public Safety and Veterans Affairs Committees.

Assemblyman Joseph Malone, a good friend for the last 20 years, will be here shortly. And let me also introduce a few people who are here from Governor McGreevey's staff, including Brigadier General Glenn Reef. General, thank you for being here, and I look forward to working with you.

Deputy Adjutant General Colonel Maria Morgan, is also here; Deputy Commissioner of Veterans Affairs, Colonel Emu Philibosian; Joint Chief of Staff Retired Colonel Michael B. Smith, who I would say parenthetically is my older brother, and it is always good to see my older brother.

Veterans program cemetery monuments and memorials, Retired Colonel Steven Able, who is also here; and Veterans Health Care Services, Colonel Cathleen Morrissey, who is also here. And you are all very, very welcome, and thank you for being here.

I also now would like to introduce members of our panel, Mr. Henry Brown, Congressman Brown, is a member of Congress from South Carolina. He has previously served in the South Carolina House of Representatives, where he served on the House Ways and Means Committee. Henry serves on four committees, which is amazing, that is really quite a workload, including the Veterans' Affairs Committee, the Armed Services Committee, where there is a great deal of overlap in what we do; Transportation and Infrastructure, and very importantly, on the Budget Committee, and was very helpful this year in pushing for the increased allocation as a member of our panel and the Budget Committee.

Henry, thank you for doing that, for doing that on behalf of all veterans.

Let me also say that we have Len Sitek, who is Counsel to Lane Evans, thank you for being here. We work very closely with the Minority, and we are glad to have him join us.

And Pat Ryan, who is Staff Director and Chief Counsel of the Full House Committee on Veterans' Affairs. And I would like to yield to my friend Congressman Brown for any opening comments.

[The prepared statement of Chairman Smith appears on p. 41.]

OPENING STATEMENT OF HON. HENRY E. BROWN, JR.

Mr. BROWN. Thank you very much, Mr. Chairman. It is a pleasure to be in your home State, it is a pleasure to serve on the Veterans' Affairs Committee with you. I'm a freshman from South Carolina, this is my first term.

And when I ran I wanted to be sure that I would go and try to restore the promise that was made to our veterans so many, many years ago, when they accepted the call of duty to defend this great Nation.

And so I tried to position myself in a place to do it. And you don't have any greater advocacy up in Washington than Chairman Smith. And by being on the Veterans' Affairs Committee, and also on the Budget Committee, we try to do some things on the Budget Committee to balance the budget and keep the budget resolution where the leadership wants it.

But with the encouragement of Chairman Smith we have been able to get some additional money, and raise the bar in the Budget Committee to help and support the health care delivery for veterans in this great Nation.

And Chairman Smith is absolutely the greatest advocate that I have ever seen. And so it is a pleasure, Mr. Chairman, to be here with you today, and to serve with you on such a great committee.

I have some opening remarks I want to include, but I just wanted to share those personal remarks up front. I think it is appropriate to hold a VA Full Committee Hearing in Trenton, NJ, at this War Memorial Building, and in this area where so many of our Nation's first veterans fought in the Revolutionary War.

I took a trip up here from the first district of South Carolina, which includes Charleston and Myrtle Beach, because the Veterans Equitable Resource Allocation Process is very important to me, and the veterans that I represent.

Within my district we have more than 70,000 veterans within our VA health care system, that falls under network 7, managed out of Atlanta. Many of our veterans relocated from New Jersey, and other States in the northeast, to enjoy our golf courses, and warmer climate.

We have one of the youngest veterans population in America, so they will be using the VA health care system for a long time. I believe that the VERA model has, generally, been very effective in meeting the objectives of allocating scarce resources in a fair and equitable manner. And most studies of this system have agreed.

From 1996, when VERA was introduced, through 2002 network 7 has seen 34.9 percent impact. This is reflected in other areas of the south as our veteran population migrates from the northeast and midwest.

Although this system is not perfect I think we can all agree it is a vast improvement over prior allocation systems. In fiscal year 2002, only 3 networks out of the 22 nationwide, saw decreases to prior year's VERA adjustments.

Overall only 1.5 percent of the funds needed to be reallocated between the networks in fiscal 2002, to make up VERA adjustments. This is a good record for such a diverse system.

I understand the impact that Priority 7 veterans will have upon the VERA system. I am very proud of the fact that we opened up the VA health care system to all of our veterans.

However, we must proceed carefully as we elevate the potential of including all Priority 7 veterans in future VERA allocation plans. I understand that New Jersey and other States in network 3 have had some problems with the current process, and I sympathize with these veterans.

Yet we need to be careful about moving too fast to change the VERA system. With supplement VERA adjustments in the VA national reserve funds, we can help New Jersey and other States

without severely impacting the VA health care system in the southeast and other regions.

We should also look at new areas to improve the system when it makes sense, such as Medicare reimbursement as a third party collection. And awarding those networks who allocate scarce resource in an efficient and cost-effective manner.

Mr. Chairman, thank you for inviting me to participate in the Hearing. I look forward to the testimony, I look forward to working with you as we improve the VERA system and the lives of all of our veterans. Thank you, Sir.

The CHAIRMAN. Mr. Brown, thank you very much for your statement, and I would like to ask Mr. Sistik if he has an opening statement.

Mr. SISTEK. Thank you very much, Mr. Chairman. On behalf of Congressman Lane Evans, the Ranking Democratic Member of the Full Committee, I too would like to welcome our panel members and guests.

Congressman Evans has provided a statement regarding VERA for this hearing. I would like to read that statement now.

The VERA model seeks to distribute VA health care funds to meet VA's patient-based needs. It outpaces the performance of the preceding system in this regard, but the preceding system mostly used the philosophy of just fund it like we funded it last year.

Over time the previous system did not adjust to changes in veteran population demographics, and soon became inequitable. VERA was designed to be more equitable. In a world where advertisers label products good, better, best, the current VERA system is somewhere between good and better. Its underpinnings are generally sound, but its calculus for determining distribution needs is evolving far too slowly. VERA is not keeping pace with the need.

Experts agree that VERA can be strengthened by the application of new methodologies for tracking patient workload. Fully counting Priority 7 veterans, and workload calculations under VERA, would assure that integrated networks with a high overall proportion of Priority 7 veterans, for example VISN 3, the Bronx region here, and the newly formed VISN 23 in the midwest, they would both receive more resources.

Additionally linking VERA to an area-based cost of living index would allow more equitable distribution of allocated funds. VERA is not broken, it merely needs a professional tuneup.

Not only must the equitabilities in the process be clarified, systemic efficiencies must also be uncovered to maximize the overall level of health care service VA provides our veterans.

To seek efficiencies in health care items procurement, and stretch the VA health care dollar, Mr. Evans recently introduced H.R. 3645, the Veterans Health Care Items Procurement Reform and Improvement Act, to centralize procurement contracting, and leverage the tremendous purchasing power of the VA.

Other efficiencies may be gained and further multiplied by enhancement of DOD/VA sharing initiatives. I join with the majority in support of reasonable DOD/VA sharing legislation, and I ask my majority colleagues to join me in the efficiencies of H.R. 3645.

More than just gaining efficiencies really needed, you can divide the VA health care pie in an unlimited number of ways. But some-

times you just need a bigger pie. Ultimately the Administration must properly prioritize the need for more VA health care funding, and Mr. Evans, as a veteran, would support that wholeheartedly. Thank you, Mr. Chairman.

STATEMENT OF HON. ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; MICHAEL SLACHTA, JR. ASSISTANT INSPECTOR GENERAL FOR AUDITING, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY STEPHEN L. GASKELL, DIRECTOR, OFFICE OF AUDIT CENTRAL OFFICE OPERATIONS DIVISION, DEPARTMENT OF VETERANS AFFAIRS; CYNTHIA A. BASCETTA, DIRECTOR, HEALTHCARE—VETERANS' HEALTH AND BENEFITS ISSUES, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY JAMES C. MUSSELWHITE, PH.D., ASSISTANT DIRECTOR, HEALTHCARE, U.S. GENERAL ACCOUNTING OFFICE

The CHAIRMAN. Mr. Sistek, thank you very much for your statement, and for working so cooperatively with us over the last year and a half, almost two years.

Let me now welcome our first panel today to this Hearing. The Honorable Robert Roswell, Dr. Roswell, the Under Secretary of Health, for the Veterans Health Administration; Mr. Michael Slachta, Jr., the Assistant Inspector General for Auditing, and Ms. Cynthia Bascetta, Director of Health care-Veterans' Health and Benefits Issues for the General Accounting Office.

Let me introduce and welcome Dr. Roswell, who heads the VA Health Administration, and is responsible for the operation of the Nation's largest integrated health care system, really the largest in the world.

With a medical care budget of more than \$22 billion, VHA employs approximately 180,000 health care professionals at 163 hospitals, more than 800 community and facility-based clinics, 135 nursing homes, 43 domiciliaries, 206 readjustment counseling centers, and various other facilities.

In addition to its medical care mission, the veterans health care system is the Nation's largest provider of graduate medical education, and a major contributor to medical and scientific research.

Prior to his nomination by President Bush, in February of this year, Dr. Roswell directed VA's health care network for Florida, and Puerto Rico, since 1995. He also served as Executive Director of the Federal Persian Gulf Veterans Coordinating Board, from 1994 to 1999, and held leadership positions in other VA facilities, and VA central office.

Dr. Roswell is a 1975 graduate of the University of Oklahoma School of Medicine, where he completed his residency in internal medicine, and a fellowship in endocrinology and metabolism.

Dr. Roswell served on active duty in the U.S. Army from 1978 through 1980, and is currently a colonel in the Army Reserve Medical Corps.

Dr. Roswell, please proceed.

STATEMENT OF ROBERT H. ROSWELL

Dr. ROSWELL. Thank you, Mr. Chairman. It is a pleasure to appear before the Committee today. I do have an opening statement that I would like to submit for the record, and would like to make brief remarks from that statement.

The CHAIRMAN. So ordered.

Dr. ROSWELL. First let me thank you for your pledged support in your opening comments to help us gain the additional resources that are necessary to keep the system open, as well as your actions over the last 2 years, to assure that the resources are available to allow the Veterans Health Administration to treat all veterans.

As you pointed out we have had a huge growth in new users. In fact this year alone we've had a 13 percent increase, already, in the number of patients using the VA, just this year.

As you pointed out, the number of Priority 7 veterans across the system has grown by almost 700 percent. And, unfortunately, the resources necessary to provide care to all of these veterans may not be available at the current rate of growth.

Also many of the new Priority 7 veterans are veterans which rely not entirely on the VA to meet their health care needs, but rather use the VA preferentially to meet their needs. Their consumption of resources threatens to divert resources from those veterans who are service connected, those with disabilities, those with special needs, who have no other health care system to rely upon.

So we do have some concerns, and I would like to discuss those this morning.

I would like to point out that VERA is a dynamic model, it changes over time, and it has changed. The changes are based, primarily, on internal recommendations from VA professionals, as well as external recommendations from such agencies as the Government Accounting Office, our own Inspector General, the Rand Corporation, and Price-Waterhouse, to name a few.

I want to publicly recognize the General Accounting Office for their professionalism in the way they have approached this task in providing the recommendations to us today.

One of the recommendations deals with the better alignment of the VERA workload resources, specifically providing the non-complex Priority 7 veterans in the VERA model, and I believe that this would be a step towards better aligning VERA with its current enrollment process. In other words, funding Priority 7 veterans through the VERA.

We have seen an uncontrolled growth, as I've said, in that group of veterans. And to encourage further growth in that group by funding Priority 7 veterans could potentially create an unmanageable growth in the VERA model.

Increased resources for Priority 7 would come at the expense of veterans who are service connected, poor, who require specialized services. Allocation of resources to areas with a disproportionate Priority 7 veterans would come at the expense of veterans who live in areas with disproportionately higher numbers of service connected, indigent, and special needs veterans.

The Government Accounting Office has also recommended that we adjust the case mix weights of VERA. GAO has proposed a change to adjust the price split between the complex care reim-

bursement category and the basic care to reflect the current cost experience between these groups.

However, the Secretary has said he will not approve a change that would create a disincentive for the enrollment and treatment of complex care patients, veterans who need treatment for services, such as blind rehabilitation, or spinal cord injury, and related special needs.

The Government Accounting Office has also recommended that we establish a mechanism, in the national reserve fund, to provide additional allocation to networks for the highest cost patients. Those networks would receive an additional allocation equal to the amount of their cost, exceeded by a threshold that the department would set, above the current reimbursement levels.

This is currently under study and we hope to be able to make a determination on this in the near future.

The Government Accounting Office has also recommended that we provide additional case mix categories within VERA. Three models have been examined, one is to expand VERA from its current three capitation levels, to a 44 case mix stratification.

A second model would look at a ten case mix stratification, and a third model would look at diagnostic cost groups, a method used by the Center for Medicare and Medicaid Studies to provide HMO type Medicare funding.

We believe that better stratification of cost is valuable. But the two models differ on how they apply to veterans. The VERA based models rely, primarily, or predominantly upon utilization.

And yet a model that relies upon utilization may reflect inefficient use of health care services. Conversely, the DCG group looks at diagnosis. And when veterans rely upon VA for only a portion of their care, a diagnosis may overly reimburse care.

So this is currently under study. We expect that the Rand Corporation will make final recommendations later this year, and we hope to be able to incorporate their recommendations before we make any final decisions.

GAO has also recommended an additional examination of the supplemental funding process to identify factors in the allocation model that require a need for additional adjustments.

Although we would like to minimize the adjustments by identifying and correcting the causes, as GAO recommends, it is also important to evaluate these adjustments in relation to the system wide impact of the VERA allocation model.

The VERA model was used to allocate funds to 22 networks this year, and required an adjustment of only 1½ percent. It would be unrealistic to expect any model to be 100 percent efficient.

However, we need to better understand what is causing networks to require adjustments year after year. It is certainly possible that part of the cause may be the allocation model itself.

However, the difficulty associated with eliminating excess capacity, adjusting the size of the workforce, and shifting costly inpatient programs to more efficient health care delivery models, may also be contributing factors.

Mr. Chairman, this concludes my remarks, I would be happy to answer any questions that you may have.

[The prepared statement of Dr. Roswell appears on p. 45.]

The CHAIRMAN. Dr. Roswell, thank you very much. And at the conclusion of all of the testimonies of the members of the panel, we will be posing some questions.

I'd like to now introduce Mr. Slachta, who as the Assistant Inspector General for Audit, Mr. Slachta directs a nationwide staff of 176 auditors, and support staff, located in Washington, and seven other cities. His office conducts audits and evaluations of VA facilities, programs, and functions.

In 1970, Mr. Slachta earned a bachelor's degree from the University of Pittsburgh, and completed graduate work in management audit at the New School of Social Research in 1982.

Mr. Slachta started his federal career in 1971 in Detroit as an adjudicator with the Veterans Benefits Administration. In 1974 he joined the internal audit service and worked on the development of the Inspector General Act.

He has been employed in various senior auditing capacities since the passage of the Inspector General Act of 1978. He is a member of the Association of Government Accountants, and is a Certified Government Financial Manager.

Mr. Slachta served in the U.S. Navy as a Hospital Corpsman during the Vietnam conflict. During his military service he was awarded the Bronze Star with Combat Purple Heart, Combat Action Ribbon, Meritorious Unit Citation, and the Vietnam Service Medal with Fleet Marine Force Insignia.

Mr. Slachta, welcome to the Committee. Without objection your full statement, and all of our distinguished witnesses, will be made a part of the record.

STATEMENT OF MICHAEL SLACHTA, JR.

Mr. SLACHTA. I am here today to report on the Office of the Inspector General's audit work related to the inclusion of Priority Group 7 veterans, and the Department of Veterans Affairs VERA system.

On August 13th an audit report was issued to the Under Secretary for Health, recommending inclusion of the Priority Group 7 veterans in the model. Inclusion of the Priority Group 7 workload would, in our opinion, more closely align the VERA model with the patient enrollment system, and help to ensure that all patient workload was considered in the resource allocation decisions.

This would provide the opportunity for a more equitable veteran access to care, since all patient demand for VHA care resources will be considered in the budget distribution decisions.

VHA has been experiencing significant increases in the number of Priority Group 7 veterans enrolled, and treated, at its health care facilities. In 1996 VHA reported that there were approximately 3 million unique veteran users of its health care services. This included about 108,000 that were Priority Group 7 veterans.

Since that time the growth rate for Priority Group 7 veterans has averaged 30 percent annually, and now comprises 33 percent of enrollees in the VHA health care system. By fiscal year 2010 the percentage of Priority Group 7 enrollees is expected to increase to 42 percent.

The cost of providing care to these veterans is significant. For fiscal year 2000 VHA estimated the total cost for Priority Group 7

veterans was 946 million nationwide. For 2001 these estimates increased to \$1.48.

Since VERA does not fund care for the majority of Priority Group 7 veterans workload, the financial impact of this workload in some VISNs has resulted in VHA withdrawing funds from other networks in order to fund supplemental requests from those networks that have higher than average Priority Group 7 enrollments, and associated workload.

This occurred in January 2001, when 18 of the 22 networks were required to return funds in order to provide supplemental funding of \$90.7 million to four networks, due primarily to high levels of Priority Group 7 workload that was not funded.

VHA's decision to fund Priority Group 7 veterans by taking back funding that was allocated through the VERA process, effectively acknowledges that limiting Priority Group 7 access to excess medical care capacity, and the ability to generate additional funds through insurance billings, has not worked well.

Since completion of our audit work in 2001 VHA continues to review the issue of including Priority Group 7 workload, and funding distributions in the system.

On January 24, 2002, a staff report provided to our office, by VHA's Chief Financial Officer stated: "It is estimated that fiscal year 2003 would be the earliest possible time frame to incorporate all Priority Group 7 veterans into the VERA distribution model."

In our opinion, considering the significantly increasing workload, and cost impact of providing health care services to Priority Group 7 veterans actions on this necessary change in the VERA system needs to be completed as soon as possible.

This concludes my testimony, and I would be pleased to answer your questions.

[The prepared statement of Mr. Slachta appears on p. 52.]

The CHAIRMAN. Thank you very much, Mr. Slachta.

I would like to just note, for the record, and I'm sure he is here ready to answer any questions that we might have, as well, is Mr. Steven Gaskell, who is the Director of the Office of Audit Central Office Operations Division, for the Department of Veterans Affairs.

I would like to now introduce our third panelist, Ms. Bascetta, who is the Director of Healthcare—Veterans' Health and Benefits Issues at the GAO, the Government Accounting Office.

For the past 4 years she has led reviews of VA's budget and planning process, and evaluations of specific programs in the Veterans Health Administration, and the Veterans Benefits Administration.

Before that she directed GAO's work on the Social Security Administration disability programs. Her work has resulted in billions of dollars in savings, and has supported bipartisan legislation to improve the disability insurance, and the supplemental security income programs.

She has also directed numerous reviews of health financing and public health issues, including federal efforts, through research and public education, to reduce the spread of HIV infection.

She joined the GAO in 1983 after beginning her career at the U.S. Department of Labor's Occupational Health and Safety Ad-

ministration, where she prepared regulatory impact analysis of major workplace health standards.

She is joined by Dr. James Musselwhite, Assistant Director, Health Care for the U.S. Government Accounting Office, as well.

Ms. Bascetta please proceed.

STATEMENT OF CYNTHIA BASCETTA

Ms. BASCETTA. Thank you, Mr. Chairman, Congressman Brown. Thank you for the opportunity to discuss VERA with you today.

Since 1997 this allocation system has done much to improve the equitable distribution of resources among VA's networks. However, as you know, our most recent review found that additional adjustments could improve the equitable allocation even more.

The problems we identified are not with VERA's design, but with its implementation. In fact I would like to underscore that VERA's design is reasonable and consistent with accepted payment principles.

Specifically VERA allocates resources on the basis of workload, and it adjusts network allocations for factors beyond the control of network management. In so doing VERA has moved VA toward its goal of comparable resources for comparable workloads.

VERA also provides annual supplemental resources to ensure that needed care is not jeopardized for patients and networks that may experience financial difficulties.

Today, though, our focus is on how VA could improve implementation in several important dimensions. First, except for those veterans in need of complex care, VERA does not account for most Priority 7s. This made more sense when VERA was first implemented because Priority 7 veterans were just 4 percent of the workload, and VA expected cost sharing, and third party collections, to cover most of their costs.

Currently, as we've heard, veterans make up 22 percent of VA's workload, nationwide, and collections cover only about 24 percent of their costs. Moreover, some networks have a disproportionate share of 7s.

As you know, the proportion of Priority 7 veterans here in network 3 is 37 percent, as of last year, more than two and a half times the proportion of Priority 7 veterans in network 20, Portland, which has the lowest percentage.

VA projects rapid growth in this population, at least through 2010. To the extent that they are not funded in VERA, their costs will continue to be covered with funds for service connected and low income veterans.

If Priority 7 veterans had been included in the allocation for fiscal year 2001, nine networks in the northeast and midwest would have received more funds.

The second problem is the small number of case mix categories VERA uses to determine capitation amounts. Although VA identifies 44 patient classes, which have widely varying costs, VERA places patients into just three categories, basic, non-vested at \$120, basic vested at about \$3,000, and complex care reimbursed at about \$42,000.

Consequently the cost range in each of VERA's three case mix categories is substantial. For example, both ventilator dependent

care, and home based primary care, are categorized as complex, and receive the same capitation amount of about \$42,000.

But the average cost of care for a ventilator dependent patient was about \$163,000, while a home care patient cost about \$25,000.

If VA used more patient classes to adjust for case mix, we estimated a significant resource shift would result, on average about 2 percent, per network.

The combined effect of including Priority 7 veterans in workload, and using more case mix categories, would better align about \$200 million. Overall some northeastern and midwestern networks would receive more resources, while some southern and western networks would receive less.

Finally, VA has not collected and analyzed information needed to identify the factors that have contributed to network budget shortfalls, even though the amount provided through the national reserve fund has increased every year since 1999.

Without understanding the root causes of financial need, VA can neither assure that the additional resources given to networks are appropriate, nor take action to correct problems that may exist in VERA network operations, or other areas that may adversely affect the network finances.

Moreover VA cannot adequately explain its supplemental funding to stakeholders and networks operating within their allocations.

Although VA concurred with our recommendations for improving VERA's implementation, the Department is hesitant to implement them. They have expressed concerns that these changes will provide incentives to treat more 7s, and to potentially reward inefficiency.

But delaying improvements to VERA's implementation will continue to result in inequitable allocation of millions of dollars.

Mr. Chairman, we believe that VA can and should partially fund Priority 7 veterans and use more case mix categories for the fiscal year 2003 allocation. As VA gains more experience it can further refine VERA to reflect new ways to improve both case mix and workload measures.

This concludes my statement, and we would be happy to answer any questions that you may have.

[The prepared statement of Ms. Bascetta appears on p. 55.]

The CHAIRMAN. Thank you very much for your testimony, as well.

And just to begin the questioning, before I do, I would like to recognize Ken Mizrach, who is here. Ken is the Director of the New Jersey Health Care System, and has been a very fine leader. And whenever we have worked with him, specially most recently with the anthrax problem, he has been very, very responsive. And I do thank him for his work.

And Jim Fassetta, who is the Network Director for VISN 3, who has also been a great champion of veteran's issues, and I'm very happy to have you here today, and we thank you.

I do have some questions and let me begin with you, Dr. Roswell. In looking at the GAO report that was issued in February, and then the testimony today, which parallels that, written by Ms. Bascetta, let me just ask a question with regards to the response from Secretary Principi.

In item after item raised by the GAO, he wrote how he concurred in those recommendations, as well as, apparently, the analysis of the problem. You know, he wrote on February 11th: "The VA acknowledges the opportunities to implement what GAO identifies, and concurs with the GAO's recommendations."

He goes on to write: "The VA is committed to thoroughly evaluating the appropriateness and feasibility of including basic care Priority 7c workload in the funding methodology."

And yet in looking at your testimony it would appear that that door is being slammed, or at least closed, rather significantly. You make the point that we do not want to encourage unmanageable growth, and growth can be a problem.

But, again, if resources are married up with the growth, I mean, somewhere these individuals, particularly the World War II and Korean War veterans are going to get health care. If they go into Medicare it is—Secretary Principi has told me, and members of the Committee, repeatedly, that Uncle Sam will actually have to pay far less when veterans use the VA system as opposed to using the public health care system.

But you make a point here that I think has a flaw to it. That allocation of fixed resources is a zero sum gain. These are not fixed resources. You know, if we get a needs-based budget, and we fail in the Congress, then shame on us, and the onus of responsibility falls squarely at our feet.

But, as you know, both last year and the year before, and again this year, we have significantly ratcheted up the amount of money that is available for veterans, it has been bipartisan.

As a matter of fact, Mr. Evans and I actually made a higher recommendation to the Budget Committee, and in an ongoing negotiation with Speaker Hastert, with our Chairman of our Budget Committee as well, we were able to get \$2.8 billion, 1.4 more billion than last year.

We did it using the documents submitted by you, which show need. And that is what I stressed, that is what we stressed over and over again. So I would beg to differ that it is not fixed resources. It is fluid if we want it to be.

And it is a matter of political will and priority, as opposed to just saying we are on a fixed income therefore we can't expand it.

And, frankly, when you say it would come at the expense of veterans who are service connected, poor, or require specialized services, again I beg to differ. And I would ask you to respond to that.

You know, we need to do a better job, as was pointed out by Ms. Bascetta, and others, in third party reimbursement, going after the insurance companies. If my numbers are right I think you said we are getting about 24, 25 percent.

So we are not getting 75 percent of that which we are really entitled to from the Blue Crosses of this world. But I don't think, we are not looking to take one dollar away from spinal cord injury patients, we want to increase it.

As a matter of fact, part of our legislation, the Health Care Bill, had a capacity issue contained within it, that we not lose any of that core capacity as we go through health care allotments. But I don't think it is a fixed income, or fixed resource, or zero sum gain, at all.

If you could respond to that?

Dr. ROSWELL. Well, thank you, Mr. Chairman.

If I may I would also like to acknowledge the presence of Larry Biro, the Director from VISN 4, who is with us in the room today.

I don't believe the door is shut on funding Priority 7 veterans, I think simply that it is a matter that we are still taking very seriously. Priority 7 veterans are growing at a truly astonishing rate.

And we don't fully understand their utilization of the VA health care system. I believe it is important that we better understand how they utilize the VA health care system in order to establish funding mechanisms that reflect the actual utilization and cost of their care.

Let me point out several observations. We've recently completed a study, in Florida, where we have a huge increase in the number of Priority 7 veterans, having grown from less than 4 percent a few years ago, to over 22 percent today.

We found that 58 percent of veterans enrolling in VA care for the first time in community based out patient clinics in Florida, are Priority 7 veterans; 73 percent of whom are Medicare eligible. Fully half of that number acknowledged that their only reason to come to the VA is to seek prescription benefits that aren't covered by their Medicare providers.

This causes me great concern. When we have compared HCFA data bases with VA data bases we find that dually eligible veterans, veterans who are entitled to access to both Medicare benefits and the VA system, tend to rely upon Medicare for more complex care, and VA for less complex care, and for prescription benefits.

Therefore using a funding mechanism that reflects funding based on their full cost of their care would be disproportionate, and potentially could, over time, shift resources away from the core of the VA health care system. It could even change the infrastructure of the VA health care system.

Ms. Bascetta indicated that only 24 percent of the cost of care is recovered through the MCCF program for Priority 7 veterans, and that number is approximately correct, I agree with that number.

But let me point out that the major insurer for that group of veterans is Medicare, as I've also pointed out. And as you know, Mr. Chairman, we are not allowed to bill Medicare for the cost of care provided without some legislation.

So in many cases our potential to collect from Priority 7 veterans is scarcely more than what the current collection levels are.

All of these are factors that must be examined as we look at this, and we have to look at the growth in Priority 7 veterans. Today there are over nine million veterans who are age 65 and older, and who are potentially eligible for Medicare.

Our system this year will treat 4.4 million veterans, the overwhelming majority of whom are service connected, or indigent, or have special needs. And yet if we examine the nine million veterans who are Priority 7 who might seek to use VA to augment their Medicare benefits with prescription benefits at low cost through the VA, the impact on our system is significant, and something I believe that we must better examine before making any final recommendations.

Thank you, Mr. Chairman.

The CHAIRMAN. When you say—let me just ask you on the price mix, or the case mix adjustment. Which, again, the Secretary agreed to in his submission to the GAO, in the back of the book.

The Secretary said: “The VHA expects to finalize preliminary decisions about modifications in the fiscal year 2003 methodology by the end of September of 2002.”

Your testimony suggests that we lose a year and recommend that the Secretary delay a final decision until 2004.

I’ve looked at that case mix very, very carefully, as I’m sure many of the members of the Committee have. The GAO has suggested that if we counted all Priority 7s, and use the 44 case mix categories, VISN 3, for example, would gain 41 million dollars, 500 thousand, if fiscal year 2001 numbers were used; VISN 4 would gain 35.7 million.

Yes, there would be some losers, but if we are getting a more accurate portrayal of the care that is provided, rather than a three-pronged case mix that, which frankly is profoundly inadequate, I mean, the 44 case mix gives you, why not have more clarity than less?

And the answer that was given by certain VA folks, that I found almost to be an insult, was that the stakeholders, a VA official told us that they have not introduced more than 3 case mix categories because the VA wants VERA to be easily understood by the stakeholders.

I mean, when you talk about where the money can best be utilized, to worry about whether or not the stakeholders understand or don’t understand, I think they will understand it completely.

I mean, the 44 listed by GAO that you used, or have used, couldn’t be more clear. I mean, I frankly don’t understand the delay. If it means that somebody is upset at the end of the day, but veterans are being more adequately treated, if my VISN gets hurt on certain things, then so be it.

But it seems to me, in this case we would stand to be winners and not losers, but a veteran is a veteran, is a veteran, wherever he or she may reside.

And let me just say, just because I think it might add a little credibility to what I’m saying, because we are net winners if this is changed, when I did the H.R. 811, the legislation that passed the House, but again died in the Senate, that piece of legislation would have provided for emergency hospital repair, \$550 million over 2 years.

We worked very closely with the Secretary, who walked the halls of the Senate, and it died over there. Not one dime of that was going to New Jersey, most of it was going to the west coast, especially for seismically challenged VA facilities that could be at great risk if we have earthquakes, and other problems.

To me, that is part of our national responsibility. I think using a more accurate number, maybe not 44, as GAO and the Inspector General points out, maybe there is a lesser number, but it is accuracy that we are looking for.

And I don’t understand why, you know, you say we are waiting for the Rand study when we’ve already had a Rand study that said that it is a problem; we’ve already had Price Waterhouse that said in 1998 it is a problem.

Delay is denial, when the VISNs are not getting the money that they need, that clearly marries up need and case load, and case mix, with the money.

Dr. ROSWELL. Mr. Chairman, I do understand your frustration, and I concur with many of the points you make. The problem we are finding is that the case mix adjustment models we are examining, either what we call a 10 step VERA, a 44 step VERA, or a DCG model, diagnostic cost group models, tend to move money in divergent directions.

And we don't fully understand the impact of the movement of funds. As I pointed out earlier a VERA model, whether it is a 10 step, or a 44 step model, looks more at utilization. Which, quite frankly, rewards inefficient models of health care delivery, and doesn't incentivize more efficient ways to deliver health care.

Conversely the DCG model looks at diagnostic categories and demographic groups, and looks at the projected cost of health care for those individuals. However, that is a model that may not be appropriate when veterans are using VA only preferentially and not—and receiving health care from other providers as well, including Medicare.

So it is important that we understand the divergent nature of those various case mix adjustment models. Clearly we want to make the model more accurate, but we want to move it in a direction that reflects the way dollars should be flowing to provide and meet the needs of our current veteran population.

I believe that a recommendation, or that a decision can be reached in fiscal year 2003 if the Rand study is provided on time. But we believe that the Rand study, in its original report, recommended further study.

We have concurred in that, and asked them to study further the case mix distribution methodologies, and we expect that before the end of this current fiscal year.

The question remains whether or not a decision this fiscal year might be implemented in time for the 2003 budget allocation. But I will certainly relate your urgency and your impatience to the Secretary.

The CHAIRMAN. I appreciate that. Ms. Bascetta, do you want to respond?

Ms. BASCETTA. I would like to make a couple of points. First of all, there is no perfect system, neither the current system, nor the DCG system would be able to perfectly allocate resources.

But as we've said today, the system that is in place now is working pretty well. And it could work better if it had more case mix categories. VERA 10 would be, we believe, an excellent choice.

The reason that we think that there is a compelling need to move to that system, next year, is that right now there are such glaring inequities in some of the categories. For example, in the complex category, the example that we used of the home based care, costing only \$25,000, compared to the ventilator care at \$163,000, is a perfect example of something that just doesn't make sense, and could be improved on right away.

Other examples that are undercompensated in complex care would be transplants, end-stage renal disease, some spinal cord injury, and mental illness.

I would also point out that the same problem exists in basic care, it is not just in the complex care. PTSD, hepatitis C, and different cancers are under reimbursed in the basic care model.

VA has the data, it is familiar to its stakeholders, and making these additional adjustments would be easy for them to do right away.

Waiting for DCGs is something that I can understand conceptually, but not in a practical sense. DCGs, I mean, talk about something that would be unclear to stakeholders. DCGs is much more difficult to explain, both technically and in terms of the way it would be operationalized.

I would also point out that the Medicare program is starting to use DCGs, but only now to reimburse about 10 percent of their payments. They are only planning to reimburse 30 percent of their payments by 2004, using DCGs.

DCGs cannot be used for extended care, for long term care, and DCGs are very reliant on accurate data. We are not confident that VA's data, largely because of problems with things like coding, would be in a position to implement DCGs, certainly not in 2003, probably not in 2004, either.

So we think that waiting for the perfect system imposes too high a cost on what the current misallocation is.

The CHAIRMAN. Mr. Slachta, before I go to you, I just want to make an announcement. There is an illegally parked car, a green Isuzu van, ARJ5383, and I hope whoever owns it would bring it over to the lot.

Mr. Slachta.

Mr. SLACHTA. I don't know that there is much that I can add to what has already been said, but I think a point that really needs to be made, once a veteran is enrolled he is, entitled; veteran is a veteran.

And when you have that proportion of the workload that is not being funded in the allocation system, something has to happen. VERA needs to include your Priority Group 7s.

The CHAIRMAN. Let me ask: network 3, according to the GAO, lost 322 million as a result of this VERA. Of course the national reserve fund probably did provide some tangible plus up or give back.

We had, as I said at the outset of my opening comments, in legislation that I introduced, that President Bush ended up signing, but without the provision, because of the Senate, numerous holds that were put on the bill, that would have killed the bill completely if we didn't take that provision out.

And that was to use the HUD index, which certainly seems fair and equitable when distributing HUD funds. We do it with federal employees, routinely, with a paid difference for those who live in higher income areas. Yet when it comes to veterans we have one straight line that goes across the entire country, when it costs a heck of a lot more to live in the northeast than it does in Biloxi, MS.

Mr. Slachta, you point out that the current number is 24,305, the threshold for a veteran. With one dependent it is 29,169, and for each additional dependent 1,630 dollars. But just take the 24,305.

Do any of the panelists, Dr. Roswell, do you believe that is a fair and accurate assessment of what it means to be poor, if you make 24,305 in New Jersey, in northern New Jersey, in New York City, the cost of apartments, food, you name it, even heating and cooling, air conditioning, is so much significantly higher as given to us by the HUD index, in terms of those differentials.

Yet that is the straight line that runs across the country. We wanted to do, in our bill, is to say use the HUD index for defining what constitutes a poor person, and who isn't. Well, we might even say near poor, really are poor in our State, and in New York City, and in Connecticut, and in the northeast.

And yet this arbitrary number of 24,305 seems to be unconscionably low, and gravely inaccurate. Dr. Roswell?

Dr. ROSWELL. Well, Mr. Chairman, I think you make an excellent point, and I find it very hard to disagree with the points you've made.

We have done what we can with the VERA model to try to adjust for regional variations in the cost of health care, and have continued to refine the way that we adjust, regionally, the cost of labor, the cost of contract services, the cost of contract non-labor cost, as well, to give some regional adjustment.

But your point concerning the actual income of the veteran is a valid one.

The CHAIRMAN. Would anyone else like to—

Ms. BASCETTA. Yes, certainly there is ample precedent in other federally means tested programs to have a variable means test, as you've pointed out, the HUD program does that, so does the Medicaid program, which recognizes in many states a category called medical indigence.

We would just like to point out that we don't have the details, and I don't know whether VA has information on this, as to how many Priority 7 veterans might be recategorized as Priority 5 veterans.

That, of course, would be important to know. And of course in the future, with the continuing growth in the 7s, it would probably still be necessary to include funding for them in the model, because not all of them would be redefined.

The CHAIRMAN. Let me just say, for the record, because it is very important to me, when we had this provision in the House passed bill, it passed the House overwhelmingly, unanimously, we got into the Senate, and all of a sudden a breakdown on who would be the winners and the losers showed up over on numerous Senator's desks.

And it became what I think was a very unseemly process. Rather than what constitutes a core veteran, you mentioned, you said the right word, Ms. Bascetta, there would be, I think, numerous category 7s reclassified as category 5s, or Priority 5s, indigent, if an accurate barometer of poorness, or of how do you measure if somebody is indigent were to be employed.

Again, we can't let this happen, I don't think, and we are going to take another try at it. But knowing how the Senate works, and maybe even some House members, the VA needs to get behind an honest assessment of what a poor person is.

You know, there was a *New York Times* piece on April the 14th, and after this, I'm going to my good friend, Mr. Brown for any questions he might have.

But it says: "Nursing home care poses an immense financial burden on many families, but the impact varied greatly by city, a new study shows. The average nationwide cost for a private room in a nursing home now stands at 160 dollars a day."

And then it points out that in Stamford, CT, nursing home operators charge an average of \$347 a day. The least expensive State was in Shreveport, LA, where the average was \$88 per day.

Also in talking about home health care the average is \$18 an hour, but in Anchorage it is \$27 an hour, in Montgomery, AL it is 12, in the New York, New Jersey area it is about 25.

And yet we have this straight line. We have a case mix that doesn't really adequately reflect reality. We have Priority 5s who are called Priority 7s. We need some real reform here.

And, again, without the VA getting behind this, specially—I mean, if we don't include all Priority 7s, which is obviously what my hope is, we should at least not classify 5s as 7s, as we do in the northeast, and in other higher cost areas.

There is another example. This is nursing home care. I mean, you couldn't get more dramatic of a differential between the two.

Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. We have a little different slant back in South Carolina. I represent the first congressional district, which is Myrtle Beach, and Charleston, along the coast there.

And we have a tremendous amount of folks that come in as part time residents. We are glad to have them. They come from New Jersey, and New York, and Pennsylvania, and we are glad to have them come down and spend their winter months with us.

And I'm just, you know, trying to make a point that maybe there should be some consideration as you change the formula, if you recalculate the formula, to take into consideration the part-time veterans that actually need services in my area, during this time of their part-time citizenship.

Dr. ROSWELL. Thank you for that suggestion, Mr. Brown. Actually there is a provision in the VERA model now, it is called a prorated patient adjustment, that looks at the capitated costs through either the complex or the basic vested model of, as Ms. Bascetta said, \$41,677 for the complex category, or \$3,121 for the basic vested patient.

It then looks at the utilization of health care resources across all 21 VISNs, and then prorates the capitation cost between the VISNs where the veteran received care during a fiscal year.

So there is a mechanism, it may not be a perfect mechanism, and we are working on ways to refine that. But there is, currently, a mechanism in the prorated patient, or PRP provision of the VERA, that does adjust for the seasonal migration that you spoke of, that impacts your district. Thank you.

The CHAIRMAN. Mr. Sistik.

Mr. SISTEK. Very quickly. Ms. Bascetta, you note in your testimony that no particular model of this type can be 100 percent ef-

fective. But, clearly, the management goal is to get as close as you reasonably can.

And in determining what is reasonable you have to know the factors that are coming to play in the model that give you particular specified results, allocations to various regions.

You state, in your testimony, network shortfalls, such as network inefficiency. Could you just elaborate on that? Because I also notice in Dr. Roswell's testimony, under supplemental funding, he states that there is some lack of clarity on why some networks encounter these difficulties.

I believe Mr. Evans would like to know some of the causal factors.

Ms. BASCETTA. I would be happy to. Inefficiency, of course, covers a broad range of issues, some as simple as staffing patterns, others as complicated as infrastructure costs, some of which are difficult for network managers or facility directors to deal with.

We believe that while it may be hard to eliminate all of the inefficiencies that may be in the system, there needs to be an explicit recognition of those inefficiencies, particularly if they are being compensated for in the supplemental process.

We understand that it is not easy to eliminate inefficiency in a health care system. But we, and Rand as well, called for a quantitative analysis, for example, of the infrastructure costs, and variation across the networks.

This would make it clear in the supplemental process that inefficiency is the cause of the budget shortfall.

Mr. SISTEK. Dr. Roswell, do you have any follow-ups to that?

Dr. ROSWELL. I generally concur with Ms. Bascetta. I would make one point, and that is that I'm not entirely sure, nor do I necessarily believe, that an allegation model should reflect the actual cost of care in all cases.

An allocation model is, in fact, an incentive to enhance the efficiency, and delivery of health care services to veterans. And in so doing there must be some gap between the capitated rate and the actual rate to begin to change clinical behaviors and management behaviors, to streamline our system to make it more efficient.

So I don't believe that a model should necessarily reimburse penny per penny, dollar for dollar, the actual cost of care. Otherwise we wouldn't have those management incentives to make our system more efficient.

And we clearly must make our system more efficient. Having said that, I think some examples of inefficiency are similar to those Ms. Bascetta has mentioned. Certainly staffing patterns is one, procurement prices for pharmaceuticals and medical supplies is another.

But some of the more difficult costs that are related to infrastructure, that are more difficult to deal with, include the actual infrastructure.

For example, where we have multiple special care programs in a single VISN, where we have excess long term care beds; where we have inpatient programs that could be better shifted to an outpatient program; where we have hospital beds that exceed the needs of veterans as the Government Accounting Office pointed out in a previous study.

That infrastructure requires substantial operating dollars to maintain, and yet it may not be the most efficient platform to deliver today's health care to today's veterans.

Mr. SISTEK. Thank you, Dr. Roswell.

The CHAIRMAN. Thank you very much. Let me just conclude, I don't think that there is any excess acute care beds, 24,000 have been taken out of the system. But, of course, that was part of a shift to outpatient care, and I think a very important shift that went over the course of two decades.

Let me just ask just a couple of final questions. The example that the GAO gives about the case mix, talking about domiciliary care costing 25,000, ventilator dependent aide 163,000; and that when you use a complex care and count those as equal, what is your read, Dr. Roswell, on why the VISN 3, especially, because we believe we have an over-abundance of maybe not just ventilator dependent care patients, but more expensive patients, older, sicker, more frail.

And while there is a net gain to the VISN when there is a domiciliary care capitation fee being a little over 42,000, whatever the current number is, there is a net loss of 121,000 when you have something like a ventilator dependent patient.

You add enough of those together and you get a major shortfall in the VISN. All the more reason why a case mix expansion is absolutely imperative. But in looking at VISN 3, hasn't there been any analysis done, as Ms. Bascetta points out, whether in the supplementals too much of it gets just written off as attributable to inflation, or some other nondescript category.

We need specifics. Do we have a higher number of sicker, more ventilator dependent type patients in the northeast than in other VISNs?

Dr. ROSWELL. Recently VA completed a study conducted by Dr. Lou Kazis that examined the disease burden of the entire veteran enrolled population, using a validated standard instrument called the SF36.

That instrument assesses the physical and mental illness disease burden across the 22 VISNs. And, in fact, based on that study VISN 3 does not have an older, nor a sicker population than the rest of the system.

In fact the highest disease burden, based on the work of Dr. Kazis, is in the southeast. And I believe the highest, greatest disease burden is in VISN 9.

Now, having said that, the infrastructure in VISN 3 does reflect a less efficient platform to deliver health care. There are more long-term care beds in VISN 3, there are more special care programs in VISN 3, and the utilization of that inefficient infrastructure creates for the provision of more costly care.

That is one of the factors we are dealing with, that is why VISN 3 has been provided over \$268 million over the last 3 years in supplemental funding, to adjust for that inefficient infrastructure.

But, ultimately, we believe that the process will allow us to examine that infrastructure and change the infrastructure to better reflect the way care is provided, both today and for the future, for America's veterans.

The CHAIRMAN. If we don't have a sicker population, do we have higher costs that no matter how inefficient you may or may not think the VISN is, nursing costs, and costs of just real estate being, you know, location, location, location.

It is more expensive to have a place here, an outpatient clinic here, I'm sure, than it is everywhere else. Doctor's pay and the like. How is that factored in?

Dr. ROSWELL. Well, the salary costs, both VA salary costs for physicians, nurse's pay, contract labor costs, and contract non-labor costs, are now all included in a VERA adjustment.

So that cost, that regional cost, which is higher in the northeast, would be adjusted in the VERA model. I think the question goes back to the infrastructure. And while that infrastructure may be inefficient, I believe that the model will never fully reflect the actual cost of care in VISN 3, unless we have a way to deal with changing and streamlining the infrastructure.

The CHAIRMAN. I would like to yield to the General Counsel, and Staff Director Pat Ryan.

Mr. RYAN. Dr. Roswell, you just talked about a report that showed that network 3 patients are no sicker than the rest of the patients in the country. But as an attachment to your testimony there is a chart that reflects what would occur if you reimbursed network 3 for the 1 percent of the highest cost patients.

That is if you implemented a stop loss policy. And according to this calculation, which is attached to your testimony, network 3's gain from this policy would be far in excess of that of any other network in the country.

How do you reconcile that fact with the study which found that the patients were no sicker?

Dr. ROSWELL. Well, again, your observations are correct, Mr. Ryan. Let me restate that the SF36V study done by Dr. Kazis looked at all enrollees. You are talking about costs associated with only a very small percentage of the total care we provide, in fact less than 1 percent.

Again, VISN 3's infrastructure is such that acute care beds over the last two decades have been converted to long-term care beds to inpatient programs that provide institutional care for 365 days a year.

So while that is a minority of the total care provided in VISN 3, the care provided in that kind of setting is extremely costly. It doesn't mean that the entire disease burden across the veteran population in VISN 3 is sicker, or necessarily older, but that component of care is more costly.

That is care that in other networks is not provided by the VA. Where VISNs don't have that infrastructure, don't have the long term care beds, it is not possible to provide that care. And that kind of care is either shifted to an outpatient setting, or to non-VA providers, such as State veterans homes.

The CHAIRMAN. But that is precisely our point. That is not inefficiency, maintaining a capacity of long-term health care is something, and again in our most recent legislation we tried to bolster that, on the budget we've tried to argue for increasing, rather than decreasing long-term capacity.

This VISN is doing it, and we think, doing it well, and yet they get penalized for it. I mean, that is not an inefficiency, that is a commitment.

Dr. ROSWELL. Mr. Chairman, no one probably feels more strongly about long term care to America's veterans than do I. I would simply point out that when we look at long term care delivery models, we go from a high of approximately \$340 a day for a VA staffed facility, to a low of just a few dollars a day when we use interactive technologies and provide care in the veteran's home.

Not all veterans are suitable for all levels of care, but we have found we can shift costs from \$380 a day, to approximately \$160 a day on average to contract for community nursing home care, or to \$50 a day, on average, to place veterans in State veteran's homes, and to just a few dollars a day to provide care in the home environment, or to contract for adult day health care centers.

My point is that we need to be examining more efficient models of long term care. That is not to say that we should walk away from our long term care commitment. I have a deep and abiding belief that we need to meet the long term care needs of our veterans.

But I don't believe one size fits all. And I believe that the infrastructure in VISN 3 may be too heavily skewed towards the more costly delivery models. And I would love to see efforts to try to streamline some of that infrastructure to provide home care programs, community based programs to meet the long term care needs of the veterans who are very deserving in this network.

The CHAIRMAN. Let me just ask a question. Dan Flynn, from the Disabled American Veterans will be testifying later on today. And he makes a very strong case for health care funding becoming mandatory.

As you know, as everyone knows, about probably more than half of our VA budget, whether it be the GI bill, or other kinds of funding, service connection disabled compensation payments. I mean, if someone presents, if they fit the criteria, it is mandatory. Which is why this Committee took the lead in ensuring, for instance, that the GI bill was increased. That is mandatory, and it will flow. It is not discretionary like the health care budget.

What is the view of our panelists on matriculating or changing this system into a mandatory one, as opposed to discretionary, which leaves open the possibility of adequate funding every single year?

Dr. ROSWELL. Mr. Chairman, I'm not in a position to state an opinion, or the position of the Department. But I would point out, with all due respect, that when we examine access to VA health care benefits over the last several years, it has become increasingly like an entitlement.

The discretion that was once available to provide care to only the highest priority veterans is no longer possible, once the Eligibility Reform Bill of 1996 was enacted in October of 1998.

Increasingly we are seeing benefits by statute placed into the uniform benefit package, as well as certain programs.

The CHAIRMAN. With all due respect, if I might interrupt, part of that came out of a lack of recognition for years. The first bill that

I offered, along with Tom Daschle, was on Agent Orange. And we lost, we lost in Committee.

And even though there were volumes of mutually reinforcing evidence that was highly suggestive of causation for chloracne, and some other anomalies, it took years. So the statutory position of service connection disability compensation has been borne out of acute frustration, over the years, of VA's lack of responsiveness.

And that has transcended Democrat and Republican administrations.

Anything else that our panelists would like to say? Again, I want to thank you so much for being here, and for your testimony. It really helps our Committee, hopefully helps the VA, and all of us, to do a better job to help our veterans. Appreciate it.

STATEMENT OF MICHAEL H. WYSONG, NEW JERSEY LEGISLATIVE DIRECTOR, VETERANS OF FOREIGN WARS; ACCOMPANIED BY DONALD E. MARSHALL, JR. STATE COMMANDER, VETERANS OF FOREIGN WARS; VINCENT S. BEVILACQUA, DEPARTMENT OF SERVICE OFFICER, DEPARTMENT OF NEW JERSEY, THE AMERICAN LEGION; PAUL J. TOBIN, ASSOCIATE EXECUTIVE DIRECTOR OF BENEFIT SERVICES, EASTERN PARALYZED VETERANS ASSOCIATION; DANIEL T. FLYNN, COMMANDER, DEPARTMENT OF NEW JERSEY, DISABLED AMERICAN VETERANS; ACCOMPANIED BY CHARLES A CARROLL, ADJUTANT, TREASURER, DEPARTMENT OF NEW JERSEY, DISABLED AMERICANS VETERANS; ROBERT MARAS, NATIONAL BOARD OF DIRECTORS, VIETNAM VETERANS OF AMERICA

The CHAIRMAN. I would like to introduce our next panel, which consists of Mr. Michael Wysong, New Jersey Legislative Director for the Veterans of Foreign Wars; Mr. Vincent Bevilacqua, the Department Service Officer for the Department of New Jersey, of the American Legion; Mr. Paul Tobin, Associate Executive Director of Benefit Services for the Eastern Paralyzed Veterans Association; Mr. Daniel T. Flynn, Commander, Department of New Jersey, Disabled American Veterans; and Mr. Robert Maras, of the National Board of Directors for the Vietnam Veterans of America.

Let me just introduce, first of all, because he will begin the testimony, Mr. Wysong. He is employed by the Department of the Air Force as an Air Reserve Technician at McGuire Air Force Base in New Jersey, a federal civil service position with duties that parallel his Air Force Reserve assignment.

A native of New Jersey, he enlisted in the Air Force in 1967, and served 7 years on active duty as an aircraft weapons technician, which included three tours of duty in Vietnam and southeast Asia.

As an air crew member he has amassed more than 8,000 flying hours, and has participated in such operations as the Vietnam Baby Lift, the evacuation of Vietnam, the Granada rescue mission, and the Operation Just Cause, the invasion and liberation of Panama.

He was recalled to active duty for 11 months in support of Operation Desert Shield, and Desert Storm, and is presently participating in Operation Enduring Freedom, the war on terrorism.

Mr. WYSONG has been a member of the Veterans of Foreign Wars since 1969, and has held many leadership positions and committee assignments on the local, county, state and national level.

He was also appointed by the Governor of New Jersey to the New Jersey Veterans' Service Council. He and his wife Patty, and their daughter, reside in New Egypt, NJ.

If you could begin?

STATEMENT OF MICHAEL H. WYSONG

Mr. WYSONG. Thank you, Mr. Chairman, Mr. Brown, Members of the Committee.

On behalf of the 80,000 plus members of the Veterans of Foreign Wars, Department of New Jersey, and our Ladies Auxiliary, Commander Don Marshall, and I, thank you for the opportunity to express our views on the Veteran's Equitable Resource Allocation Process.

The present model used by the VA for distributing funding to the 22 veterans integrated service networks has had a direct negative effect on New Jersey's veterans, especially those being cared for in VISN 3.

The funding shortfall in this network over the last 3 years alone, is enough to send a loud and clear signal that the formula is inadequate to meet the needs of our veterans.

Each year the New Jersey and New York Congressional Delegations, led by New Jersey Representative Rodney Frelinghusen, have had to request additional funding from the VA's national reserve account.

And each year that request was not met in its entirety, and therefore compounded the problem of providing quality service and care to veterans.

The result of inadequate funding for New Jersey veterans has been longer waiting times for appointments. The VFW state service officer has calculated that the average wait for a first time primary care appointment is 3 months, and 6 to 12 months for a specialty clinic appointment, depending on the specialty care needed.

The VA outpatient clinics in Brick, Hackensack and Elizabeth, are essentially turning away veterans by directing them to other clinics with slightly shorter waiting periods.

VERA provides comparable resources for comparable workloads in each network, which is an important step to ensure equitable access to care. However, this funding formula is flawed because it doesn't take into consideration New Jersey's unique circumstances of having one of the oldest veterans population in the Nation, and a high concentration of hepatitis C and HIV infected veterans.

As you well know these veterans require more care, and in most cases complex care. We are aware that the present formula adjusts for patient health care needs, but the allocation for the present fiscal year is based on prior years' work load.

Each year more and more of these veterans seek VA health care for the first time, and the proper resources weren't made available. The VA is more than a day late, and is more than a dollar short.

To further support this argument, in fiscal year 2000 the VA's complex care workload allocation for VISN 3 fell \$42.2 million short of the actual expenditures for complex care.

The problem is further exacerbated in the fact that overwhelming majority of Priority 7 veterans who seek VA health care are not counted in the workload computations and therefore not funded.

When I mention this to my 14 year old daughter she said to me, Dad, duh. That is like if I only bought \$10 worth of dog food a month, when I know my dog eats \$30 worth of food. The fix is fairly obvious to her.

The VA's and the Veterans service organizations outreach programs have been very successful in attracting veterans to the VA health care system, especially into the Priority 7 category. The Priority 7 workload now represents 22 percent of patients served nationwide, and is expected to increase in the future.

The highest numbers of Priority 7 veterans, as you've heard in prior testimony, are in VISN 3, followed by VISN 4, both of which serve New Jersey. Once enrolled all veterans, regardless of their priority group, share equal access to the health care services offered by the VA.

We applaud the VA's success, and encourage their continuing efforts. It is right to care for all veterans. We have reviewed the February 2002 Government Accounting Office report, and the report issued by the VA Inspector General in August 2001, both of which speak to the need for allocation changes.

We agree with the GAO report that recommends the VA improve the comparability of resource allocations with actual workloads served, regardless of the veteran priority group, including Priority 7s.

Incorporate more categories into various case mix adjustment. As we noted, presently VA uses only 3 out of 44 case mix studies available. Using more case mix studies will increase the accuracy of allocations.

Mr. Chairman, I now speak on behalf of the 2.7 million members of the Veterans of Foreign Wars of the United States, and our Ladies Auxiliary, when I say the VFW believes that if these steps are actively pursued, and positive change initiated, along with full VA funding, as outlined in the independent budget, a more equitable distribution of available funding will be realized, the requirement for supplemental funding through the national reserve account will be significantly reduced, and timely care will be provided for all categories of veterans.

Mr. Chairman, it is long overdue for the VA to move forward in implementing a formula that is truly equitable for all veterans, one that will provide them with the quality of care and service they so richly deserve.

I thank you, Mr. Chairman, for bringing this oversight hearing to New Jersey, and for elevating our concerns into action. This concludes my testimony, and Mr. Marshall and myself will be available to answer any questions.

[The prepared statement of Mr. Wysong appears on p. 72.]

The CHAIRMAN. Mr. Wysong, thank you very much for your testimony.

I would like to now ask Mr.——

Mr. WYSONG. Mr. Chairman, I would ask your excusal if Mr. Marshall could sit with the panel and answer questions. I have a

World War II navy veteran living in Florida who is gravely ill, my mother, and I have to leave for the airport.

The CHAIRMAN. Oh, absolutely.

Mr. WYSONG. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you for being here, and for your patience.

Mr. Bevilacqua has been the State Service Officer, Department of New Jersey, for the American Legion since June of 1989. Prior to this time he served in various positions, such as the assistant to the Department Service Officer, Post Vice Commander, Post Commander, and Post Adjutant.

He was born in Newark, NJ, and later moved to Hillside, NJ, and graduated from Hillside High. He enlisted in the U.S. Coast Guard in 1971, and served in the U.S. Coast Guard Reserve until 1977.

He currently resides in Lincoln Park, NJ, with his wife, the former Judith Snyder, who he married in 1995.

Mr. Bevilacqua, please proceed.

STATEMENT OF VINCENT BEVILACQUA

Mr. BEVILACQUA. Thank you, Mr. Chairman. My extended remarks are submitted for the record. I would like to just very briefly make this statement.

First of all, Mr. Chairman, thank you for the opportunity for the American Legion to comment on the Veterans Equitable Resource Allocation.

The American Legion believes VERA is a valid formula for the national distribution of annual discretionary federal appropriations. However, the American Legion sees four chokepoints in the current process, inadequate annual discretionary appropriations, subjective distribution of resources within the VISN, limited third party reimbursements, and no access to Medicare dollars.

Traditionally the annual increase in VA's medical care budget barely covers the cost of maintaining current services. Due to federal pay increases, inflation, and other physical factors, VA needs an annual increase of approximately \$900 million just to maintain current policies.

With enactment of Eligibility Reform in 1996, now more veterans have access to VA than ever before. Although VA's patient population has dramatically increased, the number of health care professionals has failed to increase proportionally.

Therefore demand for service far exceeds VA's ability to meet that growing demand. Without appropriate resources, no resource distribution formula is adequate. VERA is used to equitably distribute limited resources to VISNs.

However, once the funds arrive at the VISNs, the VERA formula does not apply for the distribution of resources to the individual medical facilities. Logic would dictate otherwise, but the VISN Director determines where the funding goes.

If VERA was used to distribute funds to a VISN it would seem logical to use the same formula to distribute funds to the actual health care delivery point.

Nationally VA is doing a terrible job in collecting third party reimbursements, about 24 percent of the actual billing rate. In con-

trast the VA's collection rate of first party, directly from the veteran's pocket collection rate, is about 90 percent of actual billing.

Many private health care insurance companies refuse to pay, especially health maintenance organizations. Others seek explanation of benefits, which VA historically fails to respond to in a timely manner.

The VA must improve its third party reimbursement process, or seriously consider outsourcing this task. Currently the VA is prohibited from billing and collecting third party reimbursements from the Center for Medicare and Medicaid Services.

Over half of Priority 7 veterans are Medicare eligible. When Priority 7 veterans enroll they agree to pay copayments, and to identify their third party insurers. Those Medicare eligible veterans were federally mandated to participate in Medicare.

Each Medicare eligible veteran has prepaid for this federal health care insurance. Thus the VA should be an authorized Medicare provider, and allowed to seek third party reimbursements from CMS.

Thank you, Mr. Chairman, for allowing the American Legion to voice its views on VERA.

[The prepared statement of Mr. Bevilacqua appears on p. 75.]

The CHAIRMAN. Mr. Bevilacqua, thank you very much for your testimony.

I now would ask Mr. Tobin if he would present his testimony. He is the Associate Executive Director of Benefit Services of the Eastern Paralyzed Veterans Association. In his current capacity Mr. Tobin supervises a number of highly specialized staff that has daily involvement advocating the delivery of all benefits offered by the Department of Veterans Affairs.

In his 6 years at EPVA, Mr. Tobin has been a Hospital Liaison and the Director of Special Projects. He is involved with numerous hospital and VISN level committees.

He coordinated EPVA's effort, in cooperation with the Bronx VA Medical Center, to bring the 21st National Veterans Wheelchair Games to New York City.

Mr. Tobin graduated from Manhattan College with a Bachelor of Science degree in Civil Engineering. He was commissioned in the U.S. Navy, and served 1990 to 1993 in the Navy's Civil Engineer Corps, sustaining a spinal cord injury in 1993, he underwent rehab at the Bronx and Castle Point VA Medical Centers in New York.

Let me just note, parenthetically, that in his testimony, and he will be talking about the Health Care Program Enhancement Act of 2001, the Public Law 107-135, our Health Care Bill.

What he doesn't take credit for is how he was so helpful, and his organization, in trying to come up with a way of classifying people who truly are poor, to get them out of the Category 7 and into Category 5, where they rightly belong. And I do appreciate the technical expertise that he provided.

Mr. Tobin.

STATEMENT OF PAUL J. TOBIN

Mr. TOBIN. Thank you Mr. Chairman. It has been a pleasure working with you and your Committee on that issue.

Good morning, Chairman Smith, Mr. Brown, and Staff of the House Veterans' Affairs Committee. On behalf of the Eastern Paralyzed Veterans Association, I want to thank you for this opportunity to represent the EPVA's views on recent reports that have recommended changes to VERA.

Over the past 12 months three independently issued reports have concluded that various changes to VERA were necessary to ensure adequate VA health care budgets for all regions of the country.

The Government Accounting Office, the VA's Office of the Inspector General, and the Rand Corporation, have all released studies calling for changes to VERA. EPVA has been studying VERA and its effects on local VISNs since its inception.

And we strongly believe that changes in accord with the spirit of these three reports must be made. A phenomenal number of Priority 7 veterans seeking VA health care in this region necessitates either a change of the VERA model, or the creation of other funding methodologies, specifically addressing the costs associated with treating these veterans.

The system can simply no longer absorb this population in the overly optimistic belief that third party collections will be able to offset expenses.

It is only through definitive action by the Secretary, and this Committee, that all veterans will receive the quality and range of health care services that they have earned.

Mr. Chairman, EPVA has submitted three possible courses of action in our written testimony, and I ask that our written testimony be included into the record.

In the interest of time I will present EPVA's preferred recommendation. However, all recommendations echo the sentiments of the three previously mentioned reports.

Six years ago VA created VERA at the command of Congress, in an attempt to address regional inequities of previous funding systems. In that time VERA has relentlessly shifted \$322 million from VISN 3 to other networks, making VISN 3 the only network in the Nation to have an overall decrease in its allocations since 1997.

Meanwhile the Secretary has stated that the number of Priority 7 veterans enrolled in the VA system increased 66 percent from September 1999 to March 2001, alone.

Priority 7 veterans now constitute 33 percent of enrollees in the VA system, and are expected to comprise 42 percent of enrollees by 2010. The migration of financial resources from the northeast to other regions, coupled with the explosion of newly enrolled veterans seeking care, has resulted in increased wait times for outpatients, decreased staffing levels and beds for inpatients, and the lockout of Priority 7 veterans from certain access points here in VISN 3.

VERA, which was intended to repair such disparities has, indeed, created and exacerbated new inequities. Each of the previously mentioned reports calls attention to these problems and calls for the Secretary to take remedial action.

Like you, Mr. Chairman, EPVA believes that every veteran has earned access to VA health care by virtue of their military service. And full reimbursement for all veterans, regardless of priority group, is the most equitable way of allocating resources.

If that is not feasible, to ensure that those veterans who need VA health care are able to access it in a timely fashion, EPVA calls upon the VA to utilize the regionally adjusted means test enacted earlier this year as a threshold to include these near poor veterans within the VERA model.

This would allow VA to continue collecting reduced copayments from these near poor veterans, and maximize MCCF collections from those higher income veterans who truly have the ability to defray the cost of their care.

Since the near poor veterans are unable to pay the VA for their anticipated costs, projected MCCF collections are over-inflated. Without VERA reimbursement, VISNs are left no option but to turn Priority 7 veterans away from care, or utilize funds intended for the treatment of other veterans.

Clearly something must be done and, fortunately, the Secretary agrees.

At the conclusion of the GAO report Secretary Principi wrote a letter affirming the report's findings and indicated that the VA was considering VERA changes. Today we call on you to demand that Secretary Principi use his authority to immediately authorize VA Central Office to reimburse VISNs for the services offered to these near poor veterans.

Without this, VISNs will continue to be unable to recover the cost of care provided to near poor veterans and will be forced to stretch their already inadequate budgets further.

The three previously mentioned reports, the Secretary's thwarted proposal of a 1,500 dollar deductible for all Priority 7 veterans, the 59th minute of the 11th hour decision by the Administration to continue to enroll all Priority 7 veterans, and the explosion of Priority 7 veterans enrolling in VA health care, all converge at this time, and beg for this committee's immediate intervention.

The time for study has passed and now is the time for action. EPVA commends this Committee for their actions and leadership on this and all veterans issues, and we appreciate the opportunity to work on these important issues with you.

Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Tobin appears on p. 78.]

The CHAIRMAN. Thank you very much, Mr. Tobin, for your testimony.

Mr. Flynn is a Vietnam veteran, and he is 100 percent disabled. He is a former insurance agent and is the State Commander of the 28,900 VVA members. If he could proceed?

STATEMENT OF DANIEL T. FLYNN

Mr. FLYNN. Chairman, Members of the Committee, on behalf of 27,400 members of the Disabled American Veterans, and the Department of New Jersey, I am pleased to provide the DAV's views on the VERA formula that apportions federal funding for the veterans health care, veterans integrated service networks, and the recent Government Accounting Office, and VA Inspector General reports calling for changes to this formula.

Year after year federal funding has failed to keep pace with medical care inflation and the mounting financial burdens of veterans. Health care, by rising costs and increasing demands for medical

services, this has severely hampered timely access to quality health care for our Nation's sick and disabled veterans.

Solving this problem will require a fundamental change in the way government funding is provided for the VA medical system. Federal legislation would be required to make VA medical care an entitlement, and shift it from a discretionary to a mandatory funding program.

Making veterans health care a mandatory program would eliminate the year to year uncertainty about funding levels that have prevented the VA from being able to adequately plan and meet the constantly growing needs of veterans seeking treatment.

An entitlement program guarantees a certain level of benefits to persons who meet requirements set by law. Such VA disability compensation, Social Security, or unemployment benefits.

Because funding of these programs is mandatory, it leaves no discretion with Congress about how much money to appropriate the entitlements, and carry permanent appropriations.

If veterans health care were a mandatory program, the government would have to provide sufficient funding for the VA to treat those veterans who meet the statutory requirements for care.

Veterans would not have to fight for adequate funding in the budget and appropriations process every year as we do now. It has been the DAV's firm conviction that veterans have earned the right to VA medical care by virtue of their extraordinary sacrifices and service to our Nation.

In fact our membership has adopted two national regulations regarding this issue. One calls for the VA to provide timely and adequate health care services for war time service connected disabled veterans. The other supports enactment of federal legislation, giving service connected disabled veterans priority for VA medical care, unless compelling medical reasons indicate otherwise.

The Veterans Health Care Reform Act of 1996, which the DAV strongly supported, greatly expanded access to VA health care system. This was an important step toward meeting veterans' medical needs.

But as long as veterans health care remains a discretionary program, funding levels will be continued to be decided each year, through an annual appropriations bill. Currently the law imposes limits, or caps, on annual discretionary spending.

Within the cap the President and the Congress can often, and do, change spending levels from year to year, for thousands of individual federal spending programs. And the competition for those discretionary funds is fierce.

The cumulative effects of years of unpredictable and inadequate funding, have had a devastating and irreversible impact on the VA system. Rationed health care is no way to honor America's obligation to the brave men and women who have honorably served our Nation.

Sufficient funding levels are required in order for the VA to treat veterans in need of care. And the VA must be held accountable for providing high quality care in a timely manner.

The DAV will continue to work with members of Congress, and others, to build support to ensure reliable adequate level of funding

for VA medical services, which is essential to fulfilling our Nation's moral obligation to care for America's sick and disabled veterans.

Should Congress fail to act upon our proposal to make funding VA health care mandatory, actions should be taken to make the VERA formula more equitable so that the sick and disabled veterans can receive timely quality health care when necessary.

However, regardless of how the VERA formula is readjusted, the total level of funding is inadequate in the care for all veterans who are currently enrolled in the system.

Mr. Chairman, thank you very much.

[The prepared statement of Mr. Flynn appears on p. 86.]

The CHAIRMAN. Mr. Flynn, thank you very much and for the good work that the DAV does.

Mr. FLYNN. Thank you, Sir.

The CHAIRMAN. We, like the other VSOs, this Committee has greatly benefitted from the counsel and insight that you provide, so thank you so much.

I would like to just introduce, briefly, Richard Manners, who is the National Director for the American Prisoners of War, who is here, as well as Zach Robbins, who is the former National Commander, and we thank them for being with us today.

And also Larry St. Laurant, Ocean County Veterans Director, who came up with the idea of the cold weather presumption, gave me and others a great deal of information from the Korean War on that, and I appreciate his work on that, and other issues.

And Ned Kelley, the former Burlington County clerk who is here, and who has been very active in veterans affairs issues for many, many years.

I now would like to introduce our final panelist, Mr. Bob Maras, who is with the Vietnam Veterans of America, resides in Lakehurst, born in Newark, joined the Marines in 1965, and served in Vietnam, and was wounded in combat.

He started with the VAA in 1991, he was State President from 1996 to 2000. In 1997 he became National Chairman of the Veterans Affairs Committee. He has been back to Vietnam three times now, and has been in my office many time with a lot of valuable insight, as well.

Bob, I look forward to your testimony.

STATEMENT OF ROBERT MARAS

Mr. MARAS. Thank you, Mr. Congressman. Good morning Congressman Chris Smith, members of the State Legislature, distinguished guests, and fellow veterans.

My name is Robert Maras, I'm the National Chairman of Veterans Affairs Committee for the Vietnam Veterans of America. On behalf of our National President, Tom Corey, I bring you warmest regards, and best wishes for a successful meeting.

I'm here today to speak about concerns of our veterans. Before you, you see a glass. This glass may appear to be empty, but it is not, for it is the glass of freedom, and the glass is full. It is full because of the sacrifices that the veterans of our great Nation, and this State have made for all of us.

Many drink from this glass, this glass of freedom. But there are veterans who cannot drink from it because of their hardships, and

illnesses that they face, brought on in part because of the sacrifices they made for their country.

We must never forget that the veterans should have the first drink from this glass. But in this troubled times of financial hardships, and budget cutbacks, it is the veteran that seemingly drinks last.

As the veteran population ages it is imperative that the state not turn its back on the promises made to all those who have sacrificed for our country. We must be creative in finding ways to improve the system so that these veterans are not deprived of the medical care that they need, and they deserve.

They gave up so much to keep our country safe and free, and we must take great pains to provide for them, as they gave of themselves. The number of homeless veterans in our country is shameful, 300,000.

There are many, in our own State, that have nowhere to turn, and do not know where to seek help. We, as leaders of our great State, must make this one of our top priorities. We must fulfill the promises that were made to our veterans.

Promises to provide the best possible medical care, and to reach out to those who need our assistance. It is my firm belief that if we do not show our veterans that they are not forgotten, if we do not attend to their needs, those considering military service will think twice.

We are all too painfully aware of the military personnel now serving around the world. Our Guard and Reserve are being stretched to their limit. We must ensure that these individuals, when they return, will not be forgotten.

For when one veteran is not worth saving then we, as a country, have failed.

Congressman Smith, I thank you for your hard work and dedication on behalf of the veterans, and hope that you will take my words to heart. I also ask that the Vietnam Veterans of America be allowed to add an additional report into the Congressional Record. Thank you.

The CHAIRMAN. Thank you very much, Mr. Maras.

As all of you heard earlier, the GAO, and the Inspector General, made it very clear that all veterans should be included, including category 7s. There needs to be improvements in the adjustment for cost differences beyond network control by incorporating more categories into VERA's case mix adjustment in order to more accurately account for the differences in veterans networks patients health care needs.

And you heard the extensive back and forth on that. I would like to ask you, you might want to comment on that, which you have already in part in your testimonies. But this geographic adjustment, you know, we talked about the Rand Study, and there will be another Rand study recommendation made, probably in the early fall.

Previously, they had said a geographic adjustment to the means test used to determine if veterans financial status should be considered with regard to eligibility for services, which is exactly what we tried to do in our legislation.

Again, Mr. Tobin, you worked with us on that, as did others. But you were very, very helpful. What is your sense on that, would any of you like to respond to that?

I mean, it seems to me that it should have been a no-brainer. If you are poor, you use an index that has been through the mill, that has been run through the traps. If it is okay to allocate money for the Housing Urban Development, and for Medicaid, and a host of other, and a myriad of other problems, why not the VA?

Mr. Tobin?

Mr. TOBIN. I can't answer why not the VA. It seems to be a no-brainer. When we look at MCCF collections and the Administration, Congress, has been looking to MCCF collections to offset appropriations for many years.

We are looking to, as a population, that we don't know exactly the number, but many of these people simply don't even have the ability to defray this cost of care. And we are counting upon those MCCF collections to make up the appropriation. It simply doesn't jive.

We are going to have to take a look at near-poor veterans. Congress wisely said that these veterans can only pay 80 percent of their MCCF collections. Well, the flip side is that that 80 percent has to be made up someplace.

I would hope that VA does, immediately, the Secretary has the authority, right now, to start reimbursing for category 7, or for near-poor veterans.

And I would hope that this Committee, and he, would hear that it is time.

The CHAIRMAN. Let me just add to that. Earlier, and I should have asked this of Dr. Roswell, he pointed out that third party collection really is Medicare, which would require Medicare subvention.

I support Medicare subvention, I think it can be done wisely and prudently without in any way harming the core mission of categories 1 through 6.

Do you see Medicare subvention as an answer, or at least part of the fix, the remedy?

Mr. MARSHALL. Yes, Congressman Smith, yes. Medicare subvention is a part of the answer. One of the reasons, and one of the things that the doctor was saying about the fact that many of the veterans are utilizing other sources, and then just coming to the VA, one of those reasons is because of the VERA funding.

If you need a podiatrist in Brick Town right now, you are going to be told that your appointment is 2003. I cannot tell and 80 year old World War II vet, in good faith, just hold on, help is on the way.

They are going out and utilizing more expensive sources, billing it to Medicare, if the funding was there through VERA, and through the Medicare subvention, they could see a podiatrist, using that as one example, within reasonable time.

So they would not just be coming back for their prescriptions. They come back for their prescriptions because they are being barred from the others. So Medicare subvention is one way to meet those needs.

The CHAIRMAN. Yes, Mr. Flynn?

Mr. FLYNN. Mr. Chairman, one of the major inequities is the, in the VERA program, is the fact that the time factor of a category 1 veteran, rated 100 percent, is just, or almost as bad as category 7, sir. And this is the problem.

And the only way that this can be fixed is for the formula to be that veterans are rated priority number 1. It is time to come off the back burner for the veteran in this day and age, with patriotism as high as what it is. And it is time.

Four years ago they shifted, I was at a meeting, where they shifted VERA allocations from the northeast here, to the midwest, and to the south. And when we questioned it, due to many senior citizens in Manmouth and Ocean counties, they said, their answer was, we have the whole State of Florida to contend with.

Well, it is time we bring the money back to the northeast here, and get what we've earned with our blood. Thank you very much, Mr. Chairman.

Mr. BEVILACQUA. With regard to Medicare, the American Legion several years ago introduced what was called the GI Bill of Health. One of the linchpins being Medicare subvention to pay for the care for those veterans who have this eligibility.

The region's position is that with Medicare subvention being granted we would look at a situation where we feel there would not be a need for funds to be shifted from one VISN to another, in order to meet the demands of the veterans in that particular area.

Congressman Brown before referenced the fact that a lot of veterans have relocated from the northeast to his area, to the south. This is true. A number of these individuals have families here in the northeast, however. Even though they've relocated down there, and some split their time between the two areas.

The Legion's feeling is that if Medicare subvention were enacted an individual in that situation, seeking care, who is Medicare eligible, going to a facility in, let's say, Congressman Brown's district, would be able to get the care. Medicare would pay that facility for the care that is provided.

And when that individual is back with his family in the northeast, as often occurs, seeks care from the VA, the facilities here would then be able to receive the payments for that particular veteran's care, improving services and funding throughout the entire Nation.

Thank you.

The CHAIRMAN. Thank you.

Mr. MARAS. Mr. Chairman, a number of people have addressed the issue about the snowbird effect. We are all too painfully aware of the fact that veterans will go to seek where they can get the help.

Sometimes it behooves them to go to the southwest, or to the sunbelt states to receive that care. That doesn't diminish the fact that the cost of living in the northeast is the highest in the United States, and that we must take that into effect, and allow for the VERA to adjust its monies to come back to the northeast, so that we are not suffering, the veterans are not suffering, as we have all this aged population in the Nation, here in the northeast.

The CHAIRMAN. Let me just ask you, the EPVA, and all of the organizations, what percentage you think would be the ideal amount to fund Priority 7 veterans?

As we know, about 25 percent of the money we can glean from the Medicare, not the Medicare, the medical care reimbursement from third party insurers. No one is talking about 100 percent, that probably wouldn't be justified because of that. But anywhere from 50 to 75, but 50 is often the number that is put out.

Yet my understanding is that some might even say that it should be as low as 25 percent. Obviously it would be more than we are getting now. What is your sense on that, what should the number be?

Mr. TOBIN. I believe that looking at, once we determine the number of near-poor veterans, those Priority 7 veterans that will be reclassified when the VA finally implements, puts forth regulations on that legislation, I think that money in total ought to be added, to make up that differential.

These are not veterans who have the ability to defray the cost of their care. Expecting anything above the 20 percent of the copayment that they will pay is simply, it is just not rational. They should be in total, they should be reimbursed, sir, and included within the VERA model.

The CHAIRMAN. Mr. Marshall.

Mr. MARSHALL. I might just point out, as Mr. Tobin was saying, the near-poor veterans in category 5, if we go back and take a look what was done previously with the World War I veterans, in toto, were moved into category 6, to move them into a funding area.

Our World War II veterans, again, are now at that age level, where it was done prior for the World War I veterans, to move them up a category. Again with the funding level, and taking a look at the near-poor, they would be moved into category 5. But at least they are being treated.

Because we have so, so many of them that are sitting there, that have a retirement plan from 10, 15 years ago, that is not meeting up with inflation, and they just cannot afford the continued health care.

The CHAIRMAN. Before yielding to Mr. Brown I just want to recognize Gordon Mansfield is here. Gordon is the former Executive Director of the Paralyzed Veterans of America, and now serves as the Assistant Secretary for Congressional Affairs, and a great leader, and a very concerned veteran who speaks out very boldly.

Sometimes as we all know, the OMB, and not the VA, has the final say on what happens, but we know he is a true advocate.

And we also have Jimmy Norris who is the CFO for the Veterans Health Administration, who is also here. So if anybody wants to talk to the money man, there he is.

Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. I don't know that I have a question, but certainly I want to thank you all for coming and being part of this dialogue. And I think that you have raised some good questions. And I'm telling you, you have the greatest advocate in the United States, in the Chairman.

And I think we created a good dialogue this morning, Mr. Chairman, and particularly as we looked at, maybe there should be some

cost adjustments between the different regions. And I certainly support that, certainly the point was well made.

And, Mr. Chairman, I look forward to continue working with you and this Committee to resolve some of the concerns, and particularly to build a level of confidence in our veterans population that we are up in Washington trying to make a difference for them. And I'm just grateful to be with you this morning.

The CHAIRMAN. Mr. Brown, thank you very much, and thank you for undertaking this journey to come up to Trenton today, I appreciate it.

Mr. Sisteck.

Mr. SISTEK. Yes, thank you Mr. Chairman. Mr. Evans would like to join you in welcoming the members of this panel, and in recognizing their current service to the veterans community, and thanking them for their continuing service to America.

Mr. Evans has enjoyed working with you on this Committee, and is very supportive of many of the goals that we have together.

The CHAIRMAN. Thank you so much. And everyone should know we do really work very closely together, both member to member, member to staff, and staff to staff. If you look at the bills that we've produced, they have been hybrids, they have been works of consensus, always trying to push the envelope to the greatest extent possible, whether it be on the homeless, the GI Bill, or any of the other issues, or health care.

And I think that is why we have been successful. We vet, and we are looking for answers, not for blame. So again I want to thank the witnesses, and our previous witnesses, for their testimony.

Hopefully we can build a better system, and make the improvements where they are necessary, and they certainly are.

This Hearing is adjourned, thank you.

[Whereupon, at 12:08 p.m., the above-entitled matter was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF CHAIRMAN SMITH

Veterans Health Care Funding Formula

Good Morning, and on behalf of the House Veterans' Affairs Committee, let me extend a warm welcome to all of you who have come to attend today's hearing here at the Trenton War Memorial Building. This historic building has recently undergone extensive renovation and it stands once again as a proud tribute to our veterans. I want to thank Ms. Molly McDonough, the War Memorial's Executive Director, for making this beautiful room available to the House Veterans' Affairs Committee and for all of the courtesies extended to the Committee and its staff.

Today's congressional hearing will examine the Veterans Equitable Resource Allocation (VERA) formula that apportions federal funding for veterans' health care to each of the 21 Veterans Integrated Service Networks (VISNs) around the country. Our main focus this morning will be on recent General Accounting Office (GAO) and VA Inspector General reports calling for significant changes to the VERA formula.

First developed in 1996, the VERA formula was implemented in April 1997 with the goal of better aligning VA's limited health care resources with the changing workloads at VA facilities across the country, especially to account for population shifts. However, recent independent reports by the GAO and the VA Inspector General have pointed out important weaknesses with the current VERA formula that the VA needs to address immediately in order to ensure that the "E" in VERA continues to stand for "equitable."

As a member of the Veterans' Affairs Committee for 22 years, and as Chairman for the last two, I have seen how year after year VA health care funding—particularly here in New Jersey's networks 3 and 4—seems to lag behind the demand for VA health care services. And in recent years, I have become increasingly concerned about the way the VA goes about not only dividing their funding among their regional networks, but also about the underlying manner in which they go about developing their annual budget request.

Since 1985, the Department of Veterans Affairs (VA) has provided access to health care services to every former soldier, sailor, airman and marine who requested it. But skyrocketing health care costs, record enrollments, and inadequate budgets have put the VA health care system at a crossroads on the question of universal access for veterans. Although the VA opens its doors to all veterans, they have not yet fully opened their budgeting process to them. This has had serious consequences not only here in New Jersey, but all across the country.

In the past six months, the Department of Veterans Affairs has made two separate attempts to limit access to the VA health care system. Last December, Veterans Secretary Principi, faced with overwhelmingly demand and a budget shortfall, proposed preventing future enrollment of Priority 7 veterans, those without service-connected disabilities and whose incomes were above specified low-income thresholds. Before this had a chance to be announced, I contacted the Speaker of the House who contacted the White House, and fortunately the President reversed this decision.

This year, the Administration proposed a new \$1,500 deductible to be imposed upon Priority 7 veterans, which it estimated would reduce health care costs by \$1.1 billion as a result of 470,000 veterans electing to reduce or eliminate their usage of VA health care services. Their proposal would have primarily affected older veterans from World War II and the Korean War. I also vigorously opposed this proposal and worked across party lines to defeat this proposal in the House. It will not be enacted this year.

But the dramatic increase in demand facing the VA is real and substantial. Prescription drug costs have risen dramatically in the past several years, while seniors' incomes levels have remained level. This has created a great demand for VA-provided prescription drugs. At the same time, millions of veterans continue to use the

VA as their primary care provider because of the quality medical services they can now receive at increasingly convenient locations. These trends have produced an enormous strain on the VA health care system.

However, the solution to this problem should not be to curtail services or limit access for veterans, but rather to provide sufficient resources to pay for their health care. America has a special obligation to care for former soldiers, sailors, airmen and marines who risked their lives to protect our freedoms, whether or not they were permanently injured.

After all, not all veterans were wounded in combat, but don't all the soldiers who scaled the cliffs of Normandy, or stormed the beaches at Iwo Jima, or are stationed in Afghanistan today, deserve access to VA health care?

That's why this Committee worked so hard to ensure that the budget resolution approved by the House of Representatives contained a record increase in the VA's budget authority—\$56.9 billion—including a whopping 12 percent increase in VA health care. That's a \$2.8 billion increase in discretionary spending for the Veterans Health Administration—more than \$1.4 billion above the Administration's proposed budget. And in the House budget, the \$1,500 deductible proposal was replaced dollar-for-dollar with new funds.

I would note that our budget resolution also included significant funding, at least \$500 million next year, to resolve the problem of concurrent receipt, that glitch in the law that requires military retirees to have their retirement pay lowered by the amount of disability compensation payments they also receive.

As many of you may know, Congress approved, and the President signed, five historic new laws last year which boosted the GI Bill by 46 percent, authorized almost a billion dollars to end homelessness among veterans, provided a cost-of-living increase for disability compensation payments, improved life insurance policies for veterans' survivors, and strengthened the provision of VA health care nationwide. These laws are fully funded in the budget this year.

Let me also point out we did make progress on helping our Priority 7 veterans last year with enactment of H.R. 3447, legislation I sponsored that contained, among other provisions, a reduced co-payment for lower income veterans requiring inpatient services. Beginning October 1st, Priority 7 veterans with incomes above the current limit but below a regional index will receive a discount of 80 percent for inpatient co-payments. This could translate into a \$640 per admission discount that goes directly back into veterans' pockets.

In all of these endeavors, our Committee has been successful because we have worked together in a bipartisan fashion, with members from both sides of the aisle, in support of our veterans—all of our veterans. And that is how we will continue to operate.

Today's hearing will focus on the VERA system, recommendations to modify the VERA system, and VA's plans to implement such changes. Since its development in 1996, the VERA system has seemingly raised almost as many questions as it has resolved. It was designed with the objective of better aligning VA's limited health care resources with the actual workload at VA health care facilities across the country. The result has been that almost a billion dollars was shifted from VA health care facilities from the Northeast and Midwest to ones in the South and West.

In the past six months, reports by VA's Inspector General and the GAO both came to the same conclusion: the VERA formula needs to be adjusted if it is to be "equitable" to all regions of the country. Reports issued by these two independent watchdogs were in agreement on the most glaring problem in the present calculation of VERA: that it fails to count every veteran. While VERA is supposed to allocate federal funding according to the relative workload of each of the regional VISNs, under the current formula most Priority 7 veterans are not counted—they are invisible to the VA.

Since 1996, the number of Priority 7 veterans has risen dramatically from just over 100,000 to over a million, and VA projects that this number will continue to rise sharply over the next 5 to 10 years. When VERA was first developed, Priority 7 veterans accounted for less than 5 percent of all enrollees, but they now account for more than 25 percent of the total.

In fiscal year 2001, the last year in which we have detailed statistics, the national average of Priority 7 veterans as a percentage of overall enrollees was 22 percent, but this varied significantly depending upon the region. For example, in VISN 3, which includes most of New Jersey and New York City, 37 percent of all enrollees were Priority 7 veterans, compared to several VISNs where the figure was less than 15 percent of their totals. By failing to count Priority 7 veterans in the VERA calculation, networks with higher percentages of Priority 7 veterans received less than their equitable share of the VA's health care funding.

Both the VA's Inspector General and the GAD have recommended the obvious: count all veterans, including Priority 7 veterans. And according to a letter from Secretary Principi in response to the GAD report, VA "concur[s]" with the recommendation to count Priority 7 veterans, but with very troubling reservations. Quoting from the letter:

VHA is examining various VERA models/simulations for FY 2003 network budget allocations that reflect VERA workload and funding credit for patients in that Priority, both in whole or in part.

And quoting further from the letter:

VA is committed to thoroughly evaluating the appropriateness and feasibility of including basic care priority 7 c workload in the funding methodology.

It seems obvious to me that there is no open question about the "appropriateness" of including these veterans, nor should there be any consideration of funding them only "in part". Congress has made it clear, as has President Bush, that the VA health care system is open to all of America's veterans. They should all be counted and they should all be fully funded. That is what we recommended to the Budget Committee and that is what the House approved.

The VA's failure to fully embrace Priority 7 veterans, the fastest rising segment of veterans enrolling in the VA health care system, also has consequences in terms of overall funding. By continuing to look for ways to limit or discourage Priority 7 veterans from signing up in the first place, VA is undercutting their ability to argue for an increased health care budget. VA can look to our budget resolution in the House to see that when we make the case that all veterans should count, we are successful at increasing the overall budget.

There are several other important recommendations contained in the GAD study that demand immediate action. In particular, the part of the VERA formula that accounts for the different levels of care among patients, ranging from basic care to very complex care, needs to better reflect current trends. As GAD points out so well, this change can and should be made immediately, in order to ensure that the VERA allocations for FY 2003 are decided in an equitable manner.

If VERA is to remain a credible system for allocating resources for veterans' health care, it must remain above all else an "equitable" system that is fair to all veterans wherever they live. When problems are discovered, they must be corrected. That is the situation today. Independent auditors have identified the changes that need to be made. Congress gave VA the authority and responsibility to make these changes, now VA must make them.

I look forward to hearing from all of our witnesses, and especially from Under Secretary Roswell about the specific plans of the VA health care system.

PREPARED STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, HOUSE COMMITTEE ON VETERANS' AFFAIRS, FIELD HEARING—TRENTON NJ, APRIL 30, 2002

The VERA model seeks to distribute VA healthcare funds to meet VA's patient based needs. It out paces the performance of the preceding system in this regard, but the preceding system mostly used a philosophy of: "Just fund it like we funded it last year." Over time, the previous system did not adjust to changes in veteran population demographics and soon became inequitable. VERA was designed to be more equitable.

In a world where advertisers label products, "Good, Better, Best," the current VERA system is somewhere between "Good" and "Better." Its underpinnings are generally sound, but its calculus for determining distribution needs is evolving far too slowly—VERA is not keeping pace with the need.

Experts agree that VERA can be strengthened by the application of new methodologies for tracking patient workload. Fully counting Priority 7 Veterans in workload calculations under VERA would assure that Integrated Networks with a high overall proportion of Priority 7 veterans, for example VISN 3 [Bronx-region] and the newly formed VISN 23 in the mid-west, would receive more resources. Additionally, linking VERA to an area-based cost of living index would allow more equitable distribution of allocated funds.

VERA is not broken; it merely needs a professional tune-up. Not only must the equitabilities in the process be clarified, systemic efficiencies must also be uncovered to maximize the overall level of healthcare service VA provides to our veterans.

To seek efficiencies in healthcare items procurement—and stretch the VA healthcare dollar—I recently introduced HR 3645, the Veterans Health-Care Items Procurement Reform and Improvement Act of 2002, to centralize procurement con-

tracting and leverage the tremendous purchasing power of the VA. Other efficiencies may be gained and further multiplied by the enhancement of DOD and VA sharing initiatives. I join with the Majority in support of reasonable DOD/VA sharing legislation; I ask my majority colleagues to join me in the more certain efficiencies of H.R. 3645.

More than just gaining efficiency is really needed. You can divide the VA healthcare pie in an unlimited number of ways, but sometimes you just need a bigger pie. Ultimately, the Administration must properly prioritize the need for more VA healthcare funding. As a veteran, I would support that wholeheartedly.

**Statement of
The Honorable Robert H. Roswell, M.D.
Under Secretary for Health
Department of Veterans Affairs
Before the
Committee on Veterans Affairs
U.S. House of Representatives
on the
Veterans Equitable Resource Allocation (VERA) Model**

April 30, 2002

Mr. Chairman, it is my pleasure to testify before the Committee on the status of the Veterans Equitable Resource Allocation (VERA) model.

As you know, VERA was developed at the direction of Congress to replace an outdated historical based allocation system. Over the years, the VERA model has been improved and enhanced to respond in a fair and equitable manner to changes in the practice of medicine and in the delivery of health care services. Proposed changes to the VERA model have been generated from two main sources, internal teams of senior VA health care practitioners, managers, and executives; and external consultants such as the General Accounting Office (GAO), the RAND Corporation, and PriceWaterhouseCoopers. GAO has been particularly helpful in highlighting areas and challenges that need to be addressed to improve the VERA model. The recommended changes and improvements from outside experts are an excellent endorsement of the effectiveness of the VERA model, because none of them has ever recommended replacing the VERA model. The external experts have all acknowledged that the VERA model is basically meeting its objective of allocating scarce resources in a fair and equitable manner.

This brings me to GAO's most recent report issued in February this year, which is the subject of this hearing. Before I comment on GAO's specific recommendations, I would like to commend GAO for the professionalism and thoughtful analyses that characterize this, their third evaluation of the VERA model. GAO's five recommendations were as follows:

1. better align VERA measures of workload with actual workload served regardless of veteran priority group;
2. incorporate more categories into VERA's case-mix adjustment;
3. update VERA's case-mix weights using the best available data on clinical appropriateness and efficiency;
4. determine in the supplemental funding process the extent to which different factors cause networks to need supplemental resources and take action to address limitations in VERA or other factors that may cause budget shortfalls; and
5. establish a mechanism in the National Reserve Fund to partially offset the cost of networks' complex care patients

VHA is currently evaluating proposed changes to the FY 2003 VERA to be responsive to GAO's recommendations. Final decisions will be made by the Secretary. We hope to have final decisions in time to implement for the FY03 allocation. Some of the issues being addressed are:

- how to address non-service-connected/non-complex care Priority 7 veterans in VERA Basic Vested Care (responds to recommendation 1);
- adjusting the Complex Care and Basic Care price split to reflect actual costs of the two groups (responds to recommendation 3); and
- providing an additional allocation for the very highest cost patients, those whose annual cost exceeds an established threshold (responds to recommendation 5).

I would like to discuss GAO's recommendations.

GAO Recommendation 1 – Better Align VERA Workload Measures

Although inclusion of non-service-connected/non-complex care Priority 7 veterans in the VERA Basic Vested Care category would be a step toward better aligning the VERA allocation model with VA's actual enrollment experience, including these veterans in the VERA model would create financial incentives to seek out more of these veterans instead of veterans with service connected disabilities or those with incomes below the current income threshold or special

needs patients (e.g., the homeless), veterans who comprise VA's core health care mission. We experienced uncontrolled growth in the Priority 7 veterans when they were not included in the VERA model, and we do not want to encourage unmanageable growth by including them in the VERA model. Allocation of fixed resources is a zero sum game. Increased resources for Priority 7 veterans would come at the expense of veterans who are service-connected, poor, or who require specialized services. Allocation of resources to areas with a disproportionate percentage of Priority 7 veterans would come at the expense of veterans who live in areas with disproportionately higher numbers of service-connected and lower income veterans. Therefore, we are very carefully weighing how best to address this issue.

GAO Recommendation 3 - Update VERA's Case-mix Weights

GAO has also proposed a change to adjust the price split between Complex Care and Basic Care to reflect the current cost experience between these two groups rather than using a fixed ratio that reflects their FY 1995 relative costs. The Secretary will not approve a change which would create a disincentive for the enrollment and treatment of complex care patients, veterans who need treatment for services such as blind rehabilitation or spinal cord injury.

GAO Recommendation 5 – Establish a Mechanism in the National Reserve Fund

The proposal to provide an additional allocation to networks for the highest cost patients recognizes the impact on those networks with patients whose annual costs exceed an established threshold. These networks would receive an additional allocation equal to the amount that their costs exceeded the threshold. This addresses not only the highest cost Complex Care patients, but also those in the Basic Care group.

GAO Recommendation 2 – More Categories in the VERA Case-mix Adjustment

With regard to recommendation 2, we currently have identified three potential case-mix approaches; however, they affect various networks very differently and we do not yet fully understand these effects. The three potential approaches are:

1. VERA with 44 case-mix categories, as described in the GAO report;
2. VERA with 10 case-mix categories, which is a higher grouping of the 44 case-mix categories; and
3. the Diagnostic Cost Groups (DCGs) with 24 case-mix categories.

Both the first and second approaches contain the foundation building blocks of the current VERA 3 case-mix model. The DCG model is similar to the one used by the Centers for Medicare and Medicaid Services (CMS) for its Medicare + Choice program and is a case-mix model that is based mainly on the diagnosis and demographics of the patient, except in the case of special needs patients, where case-mix is based on utilization factors similar to the VERA model.

While GAO may be correct in recommending more case-mix categories, additional time is needed to evaluate the appropriate method because of the significant differences in allocation results under the three approaches. Therefore, we are considering recommending that the Secretary delay a final decision until FY 2004. Additionally, the RAND Corporation is currently evaluating VERA and will report its conclusions and recommendations this fall. We hope that RAND's analysis will provide information on which a more informed decision can be made on model case-mix adjustment.

The attached table shows the estimated impact on all networks of GAO's recommendations in FY 2002 compared to GAO's report estimates for FY 2001.

GAO Recommendation 4 – Supplemental Funding Process

GAO's fourth recommendation indicates a need to determine why some networks need a VERA adjustment or supplemental allocation, identify factors in the allocation model that create a need for these adjustments, or identify the other factors that may contribute to this situation in some networks. Over the six years that the VERA model has been operational, it has been necessary to make supplemental VERA funding adjustments in four of those years. The supplemental adjustments are intended to assist networks that were unable to operate within their initial VERA workload-based allocations and their locally generated revenues from first- and third-party collections and reimbursements.

Prior to FY 2002, requests for supplemental adjustments would be evaluated in various ways before the Under Secretary for Health made a final decision. The process was not complete until about mid way into the fiscal year. In FY 2002, VHA reengineered the supplemental request process to make the determination part of the initial VERA allocation. This was accomplished by developing updated estimates of each network's projected FY 2002 financial status, to include estimates of all resources that would be available to each network and their estimated expenses for the year. The estimate of available resources included funds carried over from the prior year, estimated collections, estimated reimbursements, and the estimated VERA allocation of the medical care appropriation. The estimated expenses were based on the actual expenses of FY 2001, plus approved budget increases for inflation and pay raises, minus a two-percent efficiency target. Based on this analysis, it was determined that five networks should receive an adjustment to their initial VERA allocation. This adjustment was included as part of the initial VERA allocations on December 7, 2001. The table below provides a summary of VERA adjustments from FY 1999 through FY 2002.

VISN	Name	FY 1999	FY 2000	FY 2001	FY 2002
8	Bay Pines, FL	\$4.0M			
9	Nashville, TN	\$5.0M			
3	Bronx, NY		\$66.2M	\$73.8M	\$128.5M
13	Minneapolis, MN		\$14.7M	\$44.7M	\$43.9M
14	Lincoln, NE		\$ 9.8M	\$48.3M	\$32.9M
1	Boston, MA			\$53.2M	\$41.3M
12	Chicago, IL				\$20.8M
	Total	\$9.0M	\$90.7M	\$220.0M	\$267.4M
	Percent of Total System-Wide Allocation	0.1%	0.5%	1.2%	1.5%

Although we would like to minimize these adjustments by identifying and correcting the causes as GAO recommends, it is also important to evaluate these adjustments in relation to the system-wide impact of the VERA allocation model. The VERA model was used to allocate funds to 22 networks in FY 2002 and required an adjustment of 1.5 percent. It would be unrealistic to expect any model to be 100 percent perfect. However, we need to better understand what is

causing certain networks to require adjustments year after year. It is certainly possible that part of the cause may be in the allocation model. However, the difficulty associated with eliminating excess capacity, adjusting the size of the work force, and shifting costly inpatient programs to more efficient health care delivery models in a Federal system may also be contributing factors.

Mr. Chairman, this concludes my statement. I greatly appreciate the opportunity to discuss VHA's progress in improving and refining the VERA methodology. I will be happy to answer any questions the Committee may have.

Estimated Impact of GAO's Recommended Changes

(GAO's Estimates Based on FY 2001 & VERA 44 Groups and VHA's Estimates Based on FY 2002 & VERA 10 Groups)

Network	Complex Basic Split (GAO Rec #3)	P7 at 50% (GAO Rec # 1)	1% High Cost (GAO Rec # 5)	VERA 10 (GAO Rec # 2) See Note 1	VHA's Estimate for FY 2002 All Changes	GAO's Estimate for FY 2001 Report Page No 29
1 Boston	\$1	\$4	\$22	\$20	\$47	\$41
2 Albany	(\$1)	\$3	(\$1)	(\$10)	(\$9)	(\$9)
3 Bronx	(\$6)	\$16	\$73	\$21	\$105	\$42
4 Pittsburgh	\$1	\$6	\$6	\$30	\$43	\$36
5 Baltimore	(\$5)	(\$3)	\$2	(\$10)	(\$17)	(\$23)
6 Durham	(\$1)	(\$4)	\$3	\$2	(\$1)	\$7
7 Atlanta	(\$0)	(\$1)	(\$14)	(\$21)	(\$37)	(\$14)
8 Bay Pines	\$3	(\$0)	(\$34)	\$1	(\$30)	\$15
9 Nashville	\$4	(\$3)	(\$9)	(\$2)	(\$9)	\$31
10 Cincinnati	(\$5)	(\$3)	(\$11)	\$3	(\$15)	(\$2)
11 Ann Arbor	\$0	\$1	\$15	\$17	\$33	\$11
12 Chicago	(\$8)	\$2	\$12	\$27	\$32	(\$7)
13 Minneapolis	(\$3)	\$3	(\$3)	\$19	\$11	\$5
14 Lincoln	\$2	\$3	(\$5)	(\$4)	(\$4)	\$4
15 Kansas City	\$2	\$2	(\$21)	\$4	(\$13)	(\$2)
16 Jackson	\$11	(\$8)	(\$27)	(\$11)	(\$35)	(\$1)
17 Dallas	(\$1)	(\$5)	(\$15)	(\$12)	(\$32)	(\$13)
18 Phoenix	\$6	\$1	(\$18)	(\$19)	(\$31)	(\$22)
19 Denver	\$3	\$1	(\$2)	(\$14)	(\$12)	\$3
20 Portland	(\$1)	(\$6)	(\$17)	(\$22)	(\$46)	(\$47)
21 San Francisco	(\$3)	(\$4)	\$16	(\$14)	(\$5)	(\$23)
22 Long Beach	\$1	(\$4)	\$33	(\$4)	\$26	(\$35)
	\$0	\$0	\$0	\$0	\$0	(\$0)

Note: 1 -- VERA with 10 case-mix categories is a higher grouping of GAO's recommended 44 case-mix categories.

**DEPARTMENT OF VETERANS AFFAIRS
VETERANS EQUITABLE RESOURCE ALLOCATION (VERA) SYSTEM**

**TESTIMONY OF
MICHAEL SLACHTA JR**

**ASSISTANT INSPECTOR GENERAL FOR AUDITING
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS**

**COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES**

April 30, 2002

Mr. Chairman and Members of the committee, I am here today to report on the Office of Inspector General's (OIG) audit work related to inclusion of priority group 7 veterans in the Department of Veterans Affairs (VA) Veterans Equitable Resource Allocation (VERA) system.

The VERA system was instituted in April 1997 to allocate funds to networks based on the veterans who use the VA health care system. VERA allocates resources based primarily on patient workloads. Each network receives a funding allocation based on a predetermined dollar amount per veteran served. Since VERA allocates resources based upon veterans served, those networks that have more patients generally receive more funds than those networks with fewer patients.

The "Veterans Health Care Eligibility Reform Act of 1996" required VA to enroll veterans annually according to seven priority groups. Once enrolled, all veterans, regardless of their priority grouping, have access to all of the health services described in VA's basic Medical Benefits Package. Priority groups 1-6 include veterans with service-connected disabilities, low-income veterans, and veterans in special categories (e.g., former prisoners of war). Priority group 7 is comprised of veterans without compensable service-connected disabilities and with incomes above the statutory threshold for free care and who agree to pay specified co-payments. During Fiscal Year (FY) 2002, the income levels at which point a veteran is classified as Priority 7 are \$24,305 (veteran with no dependents) and \$29,169 (veteran with 1 dependent plus \$1,630 for each additional dependent).

Since passage of the Act, the number of priority group 7 veterans seeking healthcare services has increased significantly along with the associated cost of care provided. This increasing utilization of medical resources by non-service connected, higher income veterans has required an increasing share of VHA's appropriated budget resources.

On August 13, 2001 we issued an audit report¹ to the Under Secretary for Health recommending inclusion of priority group 7 veterans in the VERA model to improve the allocation of healthcare resources in the Veterans Health Administration (VHA). Inclusion of priority group 7 workload would increase the integrity of VERA by more closely aligning the VERA model with the patient enrollment system and ensuring that all patient workload is considered in resource allocation decisions. This would provide the opportunity for more equitable veteran access to care since all patient demand for VHA healthcare resources would be considered in budget distribution decisions.

Full implementation of our recommended action would provide for better distribution of the \$1.48 billion annually in estimated expenditures related to treatment of priority group 7 veterans. Currently, our recommended action has not been implemented, pending completion of further study and analysis by the Department.

Priority Group 7 Veteran Workload Has Increased Significantly

VHA has been experiencing significant increases in the number of priority group 7 veterans enrolled and treated at its healthcare facilities. In 1996, VHA reported that there were 3,012,366 unique veteran users of its healthcare services. This included 107,889 (3.6 percent) that were priority group 7 veterans. Since that time, the growth rates for priority group 7 veterans has averaged 30 percent annually and for FY 2002 is estimated to comprise 33 percent of enrollees (estimated for FY 2002 at 4.3 million unique patients) in the VHA healthcare system. By FY 2010, this percentage is expected to increase to 42 percent. One of the contributing factors to these increases has been VHA's policy of increasing the number of veterans served in order to reduce the average cost per patient. Although this policy was changed in FY 2001 as part of the Under Secretary's annual performance goals for network directors, and replaced by a greater emphasis on reducing waiting times, the incentives to increase the number of patients treated will likely continue since the VERA system continues to emphasize and reward lower "unit costs."

The Costs Of Priority Group 7 Veteran Healthcare Services Is Significant

Once enrolled, all veterans, regardless of their priority group, share equal access to the healthcare services offered in VA's Medical Benefits Package. However, the current resource allocation strategy, as implemented under the VERA system, does not provide funding for the majority of priority group 7 veterans (an exception is priority group 7 veterans who meet the criteria for "complex care"). The cost impact of providing care to these veterans is significant. For FY 2000, VHA estimated that total costs for priority group 7 veterans were \$946 million nationwide, while for FY 2001, these estimates increased to \$1.48 billion.

¹ Audit of the Availability of Healthcare Services in the Florida/Puerto Rico Veterans Integrated Service Network (VISN) 8, Report No.: 99-00057-55, dated August 13, 2001. The report is available on the VA Office of audit web site at <http://www.va.gov/oig/52/reports/mainlist.htm>: "List of Available Reports".

VERA System Excludes Priority Group 7 Veterans

The VERA system was developed to encourage facilities to enroll and treat higher priority veterans, with “excess capacity” used to enroll a limited number of priority group 7 veterans. During FY 2002, the VERA reimbursement rates for these patients are \$41,667 for complex care, \$3,121 for basic vested care, and \$197 for basic non-vested care (outpatient visits). However, subsequent to the development of the VERA based incentives, revised eligibility rules and VHA’s concurrent policy requiring significant overall increases in the number of veterans enrolled has resulted in many networks enrolling large numbers of priority group 7 veterans with the hope that third party insurance billings and veteran co-payments would pay for the cost of their care. This has not been the case, and much of the timeliness problems and overcrowding of clinics we identified in our audit work in the Veterans Integrated Service Network (VISN) 8 can be traced directly to the enrollment of “unfunded” priority group 7 veterans.

While the overall VHA funding level will not be directly affected by including priority group 7 veterans in VERA (since VHA’s budget and spending authority is developed through a separate process), strategic planning will benefit by considering the total workload, costs, and capacities of VA’s healthcare system. We estimate that this will result in at least \$1.48 billion annually (the FY 2001 estimated cost of providing care to priority group 7 veterans) in more effective funding distributions to VHA’s 22 VISNs.

Since VERA does not fund care for the majority of priority group 7 veterans workload, the financial impact of this workload in some VISNs has resulted in VHA withdrawing funds from other networks in order to fund supplemental requests from those networks that have higher than average priority group 7 enrollments and associated workload. This occurred in January 2001 when 18 of the 22 networks were required to return funds to provide supplemental funding of \$90.7 million to 4 networks, due primarily to high levels of priority group 7 workload that was not funded by VERA.

VHA’s decision to fund priority group 7 veterans by taking back funding that was allocated through the VERA process effectively acknowledges that limiting priority group 7 access to excess medical care capacity and the ability to generate additional funds through insurance billings has not worked well. VISN 8’s share of this funding redistribution was about \$11 million, which our audit work disclosed would further adversely impact the network’s ability to reduce the number of its overcapacity clinics and thus the veterans waiting time for a clinic appointment.

Since completion of our audit work in 2001, VHA continues to review the issue of including priority 7 workload and funding distribution in the VERA system. In a January 24, 2002 status report to the OIG, VHA’s Chief Financial Officer stated, “it is estimated that FY 2003 would be the earliest possible timeframe to incorporate all priority group 7 veterans into the VERA distribution model.” In our opinion, considering the significantly increasing workload and cost impact of providing healthcare services to priority group 7 veterans, action on this necessary change in the VERA system needs to be completed as soon as possible.

This concludes my testimony. I would be pleased to answer any questions that you and the members of the committee may have.

United States General Accounting Office

GAO

Testimony

Before the Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 10:00 a.m.
in Trenton, New Jersey
Tuesday, April 30, 2002

VA HEALTH CARE
Changes Needed to
Improve Resource
Allocation

Statement of Cynthia A. Bascetta
Director, Health Care—Veterans'
Health and Benefits Issues



Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss the Department of Veterans Affairs' (VA) health care resource allocation system and how it could be improved. In fiscal year 2001, VA used the Veterans Equitable Resource Allocation (VERA) system to allocate \$17.8 billion of its \$20.3 billion health care budget to 22 regional health care networks. These networks then allocate resources to their respective facilities. VERA was intended to equitably allocate resources by providing comparable resources to networks with comparable workloads. Before VERA was implemented, resources were allocated to facilities primarily on the basis of their historical expenditures. By aligning resources with workloads, VERA shifted approximately \$921 million among VA's networks in fiscal year 2001 compared to what the allocations would have been under the previous allocation system.

In my remarks today, I will briefly discuss our conclusion that VERA's design is reasonable and highlight our recommendations for improving its implementation to better align resources with workload. My comments are based on a report we issued on February 28, 2002.¹ To examine these issues, we reviewed VA documents and consultants' reports on VERA's original design, proposed VERA changes, and actual VERA changes. We also interviewed VA management officials in headquarters and eight networks, conducted site visits in five VA health care networks, interviewed VA and other public and private sector health care resource allocation experts and analyzed current literature on health care resource allocation. We also relied on our more than 10 years of work reviewing VA's resource allocation process in addition to other health care financing work.² In addition, we analyzed changes that have been made in resources allocated among the networks since VERA was implemented and the effect of making adjustments to VERA.

In summary, VERA's design is reasonable for equitably allocating resources, but certain improvements to VERA's implementation could result in a better allocation of comparable resources for comparable workloads. VERA's design is reasonable because allocations are based primarily on

¹U.S. General Accounting Office, *VA Health Care: Allocation Changes Would Better Align Resources with Workload*, GAO-02-338 (Washington, D.C.: Feb. 28, 2002).

²See the Related GAO Products page at the end of this testimony.

network workload and adjustments are made for factors beyond the control of network management. These include the health care needs of veterans and certain local cost differences. In addition, VERA's design protects patients from the effects of network budget shortfalls. But implementation weaknesses we identified result in approximately \$200 million annually that could be reallocated to better align network resources with workloads. First, VERA's measurement of network workload is not as accurate as it could be to determine each network's allocation because VERA excludes most veterans with higher incomes who do not have service-connected disabilities—about one-fifth of VA's workload. Second, VERA does not adjust as accurately as it could for cost differences among networks that result from differences in patients' health care needs or case mix across networks. We also found that VA has not analyzed whether the networks' need for supplemental resources—provided through the National Reserve Fund—is the result of potential problems in VERA, network inefficiency, or other factors. Without such information, VA can neither ensure the appropriateness of supplemental funding nor take corrective action.

We made recommendations to correct weaknesses in VERA's workload and case-mix measures. Although VA concurred with all our recommendations, in commenting on a draft of our report, VA stated that it planned to wait for further study before determining how and whether to change VERA for fiscal year 2003. Given the already extensive study by VA and others of VERA's workload and case-mix measures, we believe VA should implement these changes for fiscal year 2003. In addition, VA's response to our recommendation regarding the supplemental funding process is not fully responsive because it does not provide information on the relative contributions of specific factors to network shortfalls such as network inefficiency, imperfections in VERA, and other factors.

Background

Before VERA was implemented during fiscal year 1997, VA based its allocation of resources primarily on facilities' historical expenditures. By the 1990s, the share of the veteran population in the Northeast and Midwest declined while the share of the veteran population in the South and West increased. However, resources continued to be allocated based on historical expenditures, resulting in inequitable resource allocations to some VA networks. VERA was intended to correct these regional inequities.

VERA allocates nearly 90 percent of VA's medical care appropriation. These allocations are for six categories of expenses: complex patient care, basic patient care, equipment, nonrecurring maintenance, education support, and research support.³ Resources for the first four categories are allocated on the basis of patient workload and account for approximately 96 percent of the resources VERA allocates.⁴ Allocations for education support and research support are based on workload measures specific to those activities within the VA health care system.

As VERA was being implemented, two major changes in VA health care occurred as a result of the Veterans' Health Care Eligibility Reform Act of 1996. First, by eliminating certain restrictions preventing VA from treating some veterans in outpatient care settings, the act allowed VA to begin delivering care, where appropriate, in outpatient rather than inpatient settings—a practice consistent with care delivery throughout the health care industry. Second, VA introduced an enrollment system to manage access to VA health care in relation to available resources. As required by the act, VA established seven priority categories for enrollment. Higher priority for enrollment is given to veterans with service-connected disabilities, lower incomes, or other statuses such as former prisoners of war. Priority 7, the lowest priority level, is given to veterans who are primarily nonservice-connected with higher incomes.

VERA's Design Is a Reasonable Approach to Resource Allocation

VERA's design is a reasonable approach to resource allocation and has helped promote more comparable resource allocations for comparable workloads in VA. Consistent with the literature and expert views on resource allocation, VERA allocates resources primarily on the basis of network patient workload, attempts to adjust network resources for factors beyond the control of network management, and provides protection to patients against network budget shortfalls. As a result, VERA has shifted substantial resources among regions to better reflect workload.

³Networks and their facilities also receive resources from the medical care appropriation not allocated through VERA for such things as prosthetics, homeless programs, and readjustment counseling. In addition, VA facilities' budgets include collections for insurance reimbursements, copayments and deductibles for the care of some veterans.

⁴We examined these four categories in our analysis. We did not examine the education support and research support categories which constitute approximately 4 percent of VERA's allocation.

VERA is a reasonable approach because it allocates resources to networks primarily based on workload. Each network receives an allocation based on a predetermined dollar amount per veteran served. This is consistent with how other federal health care payers, such as the Medicare and Medicaid programs, allocate resources to managed care plans for their patient workload. Because VERA uses workload to allocate resources, networks that have more patients generally receive more resources than networks that have fewer patients. By receiving funding based on workload, VA's health care networks have an incentive to focus on aligning facilities and programs to attract patients rather than focusing on maintaining existing operations and infrastructure regardless of the number of patients served.

In addition, VERA adjusts network allocations for cost differences beyond the networks' control. VERA does this through adjustments for networks' case mix by classifying patients into one of three categories—complex care, basic vested care, and basic "non-vested" care—which are based on the level of patient health care need and the costs associated with that care. Complex care comprises about 4 percent of VA's workload and includes patients who generally require significant high-cost inpatient care as an integral part of their rehabilitation or functional maintenance. Basic vested care and basic non-vested care patients—which compose 84 percent and 12 percent of VA's workload, respectively—include patients whose health care needs are more routine and can be met in an outpatient setting. These patients typically require significantly fewer resources than complex care patients. However, basic vested care patients rely primarily or completely on VA for meeting their health care needs, while basic non-vested care patients receive only part of their care through VA and have not undergone a comprehensive medical evaluation by a VA practitioner. In fiscal year 2001, the capitation amount—or dollar amount per patient served—was \$42,765 for complex care, \$3,126 for basic vested care, and \$121 for basic non-vested care.⁵ In addition, VERA adjusts for cost differences beyond networks' control by applying a price adjustment factor to each network's allocation to account for uncontrollable geographic price differences. The adjustment lowers the VERA allocation for networks located in lower cost

⁵VERA allocated about \$16.2 billion in fiscal year 2001 for basic and complex care and \$878 million for equipment and nonrecurring maintenance based on patient workload. In addition, VERA allocated about \$688 million for research support and education support based on other workload measures.

areas and increases the allocation for networks located in higher cost areas.

Also contributing to the reasonableness of VERA's approach is that it provides protection to patients against network budget shortfalls. VERA does this by providing supplemental resources through the National Reserve Fund to networks that have difficulty operating within their available resources. These supplemental allocations protect patients from the risk that a health care network would be unable to provide services if its expenditures exceed available resources. Since fiscal year 1999, resources distributed through the National Reserve Fund have supplemented VERA allocations in six networks and averaged approximately 1 percent of total VERA allocations. As a result of VERA's approach, resources have shifted among regions to better reflect workload.

Consequently, resources moved primarily from networks located in the Northeast and Midwest to networks located in the South and West. In fiscal year 2001, VERA shifted approximately \$921 million among networks compared to what the allocations would have been if networks received the same proportion of funding they received in fiscal year 1996, the year before VERA was implemented. VERA shifted the most resources in fiscal year 2001 to Network 8 (Bay Pines)—approximately \$198 million—and the most resources from Network 3 (Bronx)—approximately \$322 million—compared to what allocations would have been if both networks had received the same proportion of funding they received in fiscal year 1996.

Implementation Specifics Weaken VERA

Although VERA's overall design is a reasonable approach to equitably allocate resources, we identified weaknesses in its implementation that compromise the achievement of its goal of allocating comparable resources for comparable workloads. To correct these weaknesses we made several recommendations which if implemented would better align approximately \$200 million in resources with workloads in VA's health care networks.⁵ Specifically, we recommended that VERA improve its workload calculations to include all veterans served—including Priority 7 veterans, the most rapidly growing proportion of VA's workload. We also recommended that VA improve its adjustment for cost differences beyond network control by incorporating more categories into VERA's case-mix

⁵We also made several other recommendations to improve VERA's implementation. For a complete discussion of our recommendations, see GAO-02-338.

adjustment to more accurately account for the differences in networks' patient health care needs. Finally, we recommended that VA improve its process to protect patients from network budget shortfalls by determining the extent to which different factors cause networks to need supplemental resources in order to take actions to address factors that may cause budget shortfalls such as inefficiency.

VA Could Better Align Resources With Workload and Network Cost Differences

To improve its network workload calculation, VERA should account for all veteran workload served—including Priority 7 veterans, who have higher incomes and no service-connected disability.⁷ By excluding most Priority 7 veterans from VERA's workload calculation, networks with a higher proportion of Priority 7 veterans have fewer resources per patient to treat veterans than networks with a lower proportion of Priority 7 veterans. For example, in fiscal year 2001, Network 3 (Bronx) had the highest proportion of Priority 7 veterans, 37 percent, and Network 20 (Portland) had the lowest proportion, 14 percent. Nationally, VA's proportion of Priority 7 veterans was 22 percent of total workload in fiscal year 2001.

When VERA was established, the number of higher income veterans without a service-connected disability that VA treated was about 4 percent of the total number of veterans treated in fiscal year 1996. VA decided not to include most of these Priority 7 veterans in VERA's basic care workload calculations because of their small numbers and the expectation that collections from copayments, deductibles, and third-party insurance would cover most of their costs. However, Priority 7 veterans accounted for 22 percent of VA's workload in fiscal year 2001—a substantial increase from 107,520 patients in fiscal year 1996 to an estimated 827,722 patients in fiscal year 2001.⁸ In addition, VA projects that the growth in Priority 7 patients will continue at least through fiscal year 2010. Although VA initially expected to cover the majority of Priority 7 patient costs through collections, VA collected only 24 percent of Priority 7 veterans' costs in

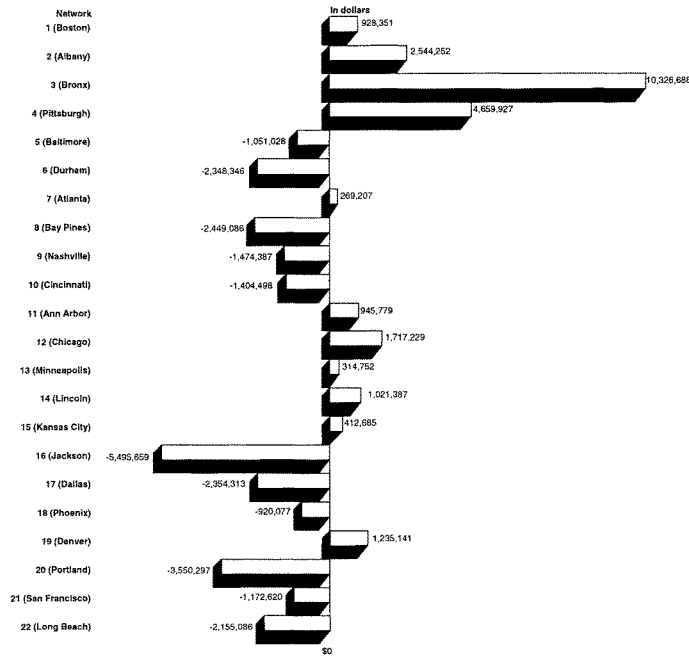
⁷VA's Office of Inspector General also recommended that VA include Priority 7 workload in the VERA model. See Office of Inspector General, Department of Veterans Affairs, *Audit of The Availability of Healthcare Services in the Florida/Puerto Rico Veterans Integrated Service Network (VISN)* 8, Report Number 99-00057-55 (Washington, D.C.: Aug. 13, 2001).

⁸VERA does include some Priority 7 veterans in its workload measure. In fiscal year 2000, about 8 percent of Priority 7 veterans treated were included in VERA's workload measure because they were complex care patients or basic care patients with service-connected conditions.

fiscal year 2000. As a result, networks pay for most of the costs of Priority 7 services through VERA allocations made for the service-connected and low-income veteran workloads.

Inclusion of Priority 7 veterans in VERA's basic vested care workload would increase the comparability of resources among networks' per patient treated. If VERA were to have funded Priority 7 basic vested veterans at 50 percent of their costs, as VA had considered, resources would have moved from networks with smaller proportions of Priority 7 veterans to networks with larger proportions of Priority 7 veterans based on our simulation (see fig. 1). VERA allocations would have increased to nine networks in the Northeast and Midwest and decreased to 10 networks in the South and West in the fiscal year 2001 VERA allocation.

Figure 1: Estimated Change in VERA Allocations from Adding Priority 7 Basic Vested Veterans to VERA Workload at Half Their National Cost, Fiscal Year 2001



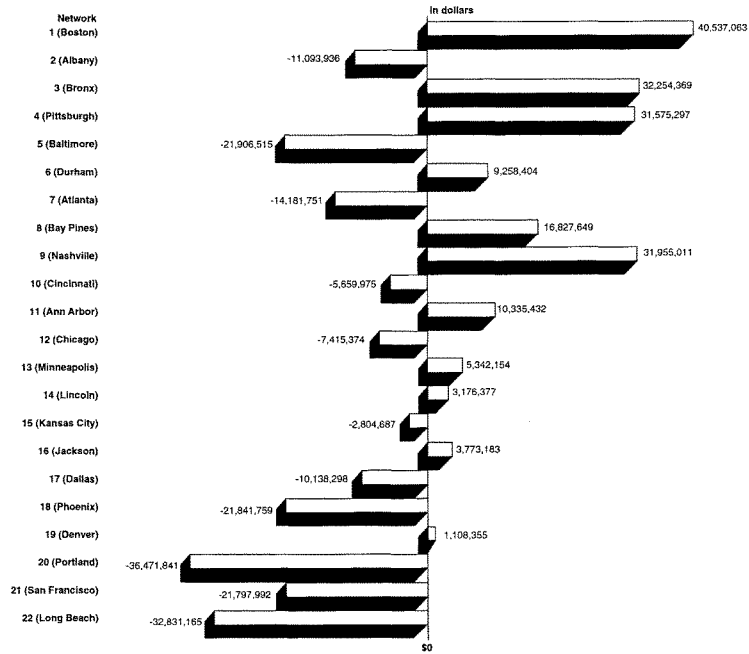
Note: For this simulation we used VERA fiscal year 2001 workload numbers for basic vested care, which are the total unduplicated numbers of veterans served for fiscal years 1997, 1998, and 1999.
 Source: GAO analysis of VA data.

To improve its adjustment for cost differences beyond networks' control, we also recommended that VERA use more case-mix categories to adequately adjust for differences in patients' health care needs across networks. Based on the results of our simulation, this change to VERA would have the largest effect on resource allocation. VERA's three case-mix categories—complex, basic vested, and basic non-vested—are based on 44 patient classes. Because average costs of patients in the classes within the VERA categories vary significantly and can be dramatically higher or lower than their capitation amounts for the three case-mix categories, VERA's ability to allocate comparable resources for comparable workloads is limited. The wide variation in cost between domiciliary care and ventilator-dependent care—two of the patient classes in complex care—illustrates this point. The national average cost for domiciliary care in fiscal year 2000 was about \$25,000, roughly \$17,000 less than the \$42,153 capitation amount for complex care. In contrast, the average patient cost for ventilator-dependent care in that year was about \$163,000, roughly \$121,000 more than the complex care capitation amount. As a result of VERA's having only three case-mix categories, networks with proportionately more workload in less expensive patient classes, such as domiciliary care, receive more resources relative to their costs than other networks. Similarly, networks with more workload in more expensive patient classes, such as ventilator-dependent care, receive fewer resources relative to their costs.

If VERA were to use VA's current 44 patient classes rather than the three case-mix categories, resources would move from networks having proportionately fewer patients in expensive patient classes to networks having proportionately more patients in expensive patient classes. As figure 2 shows, based on our simulation, there would be a significant movement of resources—an average of 2 percent per network.⁹

⁹For our simulation we used the 44 patient classes VA uses to construct the 3 VERA case-mix categories.

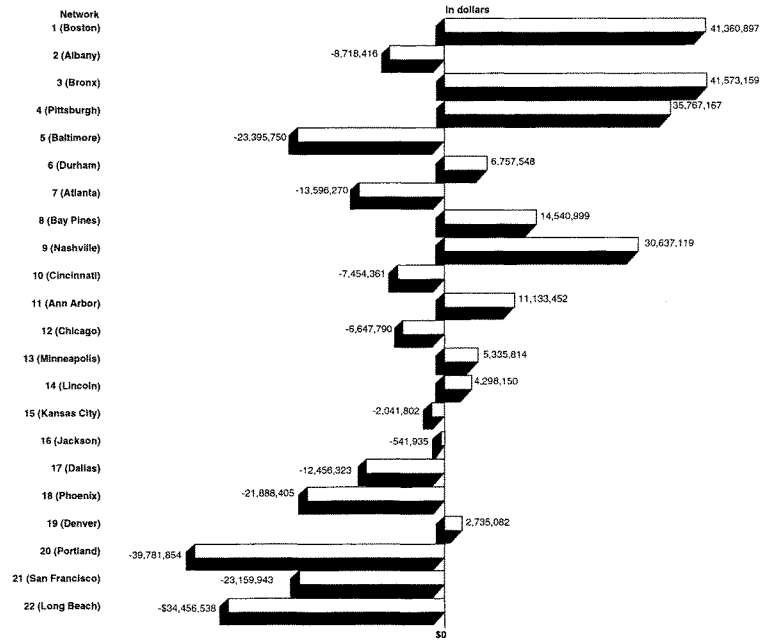
Figure 2: Estimated Change in VERA Allocations among Networks as a Result of Using 44 Case-Mix Categories, by Network, Fiscal Year 2001



Note: We used fiscal year 1999 expenditure data for the calculations, the most recent data available for fiscal year 2001 VERA allocations.
 Source: GAO analysis of VA data.

The combined effect of including basic vested Priority 7 veterans in VERA's workload and using all 44 VA patient classes in VERA's case-mix adjustment would provide additional resources to some northeastern and midwestern networks and reduce resources for some southern and western networks (see fig. 3). The allocation change would represent about 2 percent of networks' budgets but would be more substantial for some networks. Network 1 (Boston) would get approximately a 5 percent increase and Network 20 (Portland) approximately a 5 percent decrease.

Figure 3: Estimated Change in VERA Allocations from Incorporating 44 Case-Mix Categories and Priority 7 Basic Vested Veterans Treated, Fiscal Year 2001



Note: We allocated resources for Priority 7 basic vested care veterans at 50 percent (\$849) of the national average cost based on a policy VA had considered implementing to minimize possible incentives for networks to serve more Priority 7 veterans. We used fiscal year 1999 expenditure data for these calculations.

Source: GAO analysis of VA data.

While VA concurred with our recommendations to better align VERA's measure of workload with actual workload served and to incorporate more (not necessarily 44) categories into VERA's case-mix adjustment, it plans to wait for further study before making a decision about modifications to VERA for the fiscal year 2003 allocation. VA and others have conducted various studies on including all Priority 7 workload in VERA and increasing the number of VERA case mix categories.¹⁰ Given the extensive studies by VA and others of VERA's workload and case-mix measures, we believe that VA should make needed improvements to VERA for the fiscal year 2003 allocation and further refine VERA as needed in subsequent years.

Identifying Reasons for Budget Shortfalls Would Help VA Take More Appropriate Corrective Actions

To improve its process to protect patients from network budget shortfalls, we also recommend that VA's supplemental funding process determine to what extent networks need supplemental resources due to such factors as imperfections in VERA, lack of network efficiency, or lack of managerial flexibility to close or consolidate programs or facilities. VA's supplemental funding processes have not collected the information necessary to make these determinations. As a result, VA cannot provide adequate assurance that supplemental allocations are appropriate or take needed action to correct problems that cause networks to have budget shortfalls.

VA has focused its process for providing supplemental funding from the National Reserve Fund almost solely on providing supplemental resources to networks to get through a fiscal year, but it has not included in this process an examination of the root causes of networks' needs for additional resources. Between fiscal years 1999 through 2001, VA used different approaches for evaluating networks' supplemental funding requests and distributing a total of approximately \$323 million in supplemental resources to six networks. However, in none of these approaches has VA collected adequate information for determining the extent to which certain factors cause budget shortfalls. For example, in fiscal year 2001, about half of the supplemental resources provided to networks was for "inflation and miscellaneous program adjustments." All networks experienced inflation, however, and VA did not distinguish

¹⁰For example, RAND, *An Analysis of the Veterans Equitable Resource Allocation (VERA) System* (Santa Monica, California, 2001), pp. 21-22 discusses the need for additional case-mix adjustment in VERA as does Price Waterhouse LLP and The Lewin Group, Inc., *Veterans Equitable Resource Allocation Assessment—Final Report*, March 27, 1998.

between the level of inflation in networks that requested supplemental resources and those that did not.

VA concurred with our recommendation to improve the supplemental funding process. For fiscal year 2002, VA developed a different approach to providing supplemental resources to networks, one that it indicates will better identify factors, such as inefficiency, VERA imperfections, or other factors, that cause networks to require supplemental resources. However, the actions VA discussed to improve the process do not address our recommendation to identify the relative contributions of such factors to network budget shortfalls. Until VA implements our recommendation, it cannot provide assurance that supplemental resources are appropriate or take needed actions to reduce the likelihood of network shortfalls in the future.

Concluding Observations

VERA's design is a reasonable approach to resource allocation and has had a significant effect on promoting more comparable resource allocations for comparable workloads in VA. Yet VA needs to correct weaknesses in VERA's implementation to better align resources with workload and to adequately account for important variations in health care needs among networks. Our analysis shows that doing so would better allocate about \$200 million annually. Although most of the reallocation at this time would result from better case-mix adjustments in VERA to reflect differences in health care needs among networks, the importance of including all Priority 7 veterans in VERA workload could increase in the future because the number of Priority 7 veterans is projected to continue to increase at least through fiscal year 2010. Making changes to address these weaknesses in VERA will add some complexity to how VA allocates resources, but delaying these needed improvements to VERA will perpetuate inequities that currently exist.

In addition, VA has not used the supplemental funding process to improve VERA allocations and management of VA's resources. The amount of resources provided to networks through the supplemental funding process for the National Reserve Fund has continued to increase, yet VA has not been able to determine the relative contribution of factors such as imperfections in VERA, network inefficiency, or lack of managerial flexibility to close or consolidate programs or facilities to the need for supplemental resources. Because VA has not identified the relative contribution of factors that could cause network budget shortfalls, it is unable to ensure that the supplemental funds provided are appropriate or

take needed action to correct problems that cause networks to have budget shortfalls. Without knowing the extent to which VERA imperfections or other factors are responsible for budget shortfalls, stakeholders may lose confidence in VERA's ability to allocate resources in an equitable manner.

Mr. Chairman, this concludes my prepared remarks. I will be pleased to answer any questions you or other members of the committee may have.

**Contacts and
Acknowledgments**

For further information regarding this testimony, please contact me at (202) 512-7101 or James Musselwhite, Assistant Director, at (202) 512-7259. Marcia Mann and Thomas Walke also contributed to this statement.

Related GAO Products

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STATEMENT OF

**MICHAEL H. WYSONG
NEW JERSEY LEGISLATIVE DIRECTOR
MEMBER, NATIONAL LEGISLATIVE COMMITTEE
VETERANS OF FOREIGN WARS OF THE UNITED STATES**

BEFORE THE

**COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES**

WITH RESPECT TO

VETERANS EQUITABLE RESOURCE ALLOCATION PROCESS

TRENTON, NJ

APRIL 30, 2002

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the 80,000 plus members of the Veterans of Foreign Wars of the United States (VFW) Department of New Jersey and our Ladies Auxiliary, I thank you for the opportunity to express our views on the Veterans Equitable Resource Allocation (VERA) process.

The present model (VERA) used by the VA for distributing funding to the 22 Veterans Integrated Service Networks (VISN) has had a direct negative affect on New Jersey's veterans, especially those being cared for in VISN 3. The funding shortfall in this network, over the last three years alone, is enough to send a loud and clear signal that the formula is inadequate to meet the needs of our veterans. Each year the New Jersey and New York Congressional delegations, led by NJ Rep. Rodney Frelinghuysen, have had to request additional funding from the VA's National Reserve Account. And each year that request was not met in its entirety and therefore compounded the problem of providing quality service and care to veterans.

The result of inadequate funding for New Jersey veterans has been longer waiting times for appointments. The VFW State Service Officer has calculated that the average wait for a first time primary care appointment is three months and six to twelve months for a specialty clinic appointment depending on the specialty care needed. The VA Outpatient Clinics in Brick, Hackensack and Elizabeth are essentially turning away veterans by directing them to other clinics with slightly shorter waiting periods.

VERA provides comparable resources for comparable workloads in each network, which is an important step to ensure equitable access to care. However, this funding formula is flawed because it doesn't take into consideration New

Jersey's unique circumstances of having one of the oldest veterans populations in the nation and a high concentration of Hepatitis C and HIV infected veterans. As you well know, these veterans require more care and in most cases complex care. We are aware that the present formula adjusts for patient health care needs. But the allocation for the present fiscal year is based on the prior years workload. Each year more and more of these veterans seek VA health care for the first time and the proper resources weren't made available. The VA is more than a day late and more than a dollar short.

To further support this argument; in FY 2000 the VA's complex care workload allocation for VISN 3 fell \$42.2 million short of the actual expenditures for complex care.

The problem is further exacerbated in the fact that the overwhelming majority of Priority 7 veterans who seek VA health care are not counted in the workload computations and therefore not funded. When I mentioned this to my 14-year-old daughter, Jennifer, she said, "DUH! That's like if I only bought 10 dollars worth of food a month for my dog when I know Toby eats 30 dollars worth of food." The fix is fairly obvious to her. Increase the funding and distribute it fairly.

The VA's and Veterans Service Organization's outreach programs have been very successful in attracting veterans into the VA health care system, especially into the Priority 7 category. The Priority 7 workload now represents 20 percent of patients served nationwide and is expected to increase in the future. The highest numbers of Priority 7 veterans are in VISN 3 followed by VISN 4, both of which serve New Jersey. Once enrolled, all veterans, regardless of their priority group, share equal access to the healthcare services offered by the VA. We applaud the VA's success and encourage their continuing efforts. It's right to care for all veterans.

We have reviewed the February 2002 General Accounting Office Report (GAO-02-338) and a report issued by the VA Inspector General in August 2001 (Report No.: 99-00057-55). Both of which speak to the need for allocation changes. We agree with the GAO Report that recommends:

- VA improve the comparability of resource allocations with actual workload served regardless of veteran priority group (include Priority 7)
- Incorporate more categories into VERA's case-mix adjustment (presently VA uses only three out of 44 case-mix categories available). Using more case-mix categories will increase the accuracy of allocations
- Update VERA's case-mix weights using the best available data

I now speak on behalf of the 2.7 million members of the Veterans of Foreign Wars of the United States and our Ladies Auxiliary when I say; the VFW believes that if these steps are actively pursued and positive change initiated, along with full VA funding as outlined in the Independent Budget, a more equitable distribution of available funding will be realized, the requirement for supplemental funding through the National Reserve Account will be significantly reduced, and timely care will be provided for all categories of veterans.

Mr. Chairman, it is long overdue for the VA to move forward in implementing a formula that is truly equitable for all veterans. One that will provide them with the quality of care and service they so richly deserve. I thank you for bringing this oversight hearing to New Jersey and for elevating our concerns into action.

This concludes my testimony. I would be happy to answer any questions you may have.

THE VETERANS OF FOREIGN WARS OF THE UNITED STATES IS NOT IN
RECEIPT OF ANY FEDERAL FUNDING OR FEDERAL GRANTS

**STATEMENT OF
VINCENT BEVILACQUA
DEPARTMENT SERVICE OFFICER
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
VA'S ACTIONS TO REVISE VERA,
THE VETERANS EQUITABLE RESOURCE ALLOCATION**

APRIL 30, 2002

Mr. Chairman and Members of the Committee:

The American Legion is grateful for the opportunity to share with the distinguished members of this committee its perspective on the status of the Department of Veterans Affairs (VA) response to recent recommendations to revise the system it uses to make resource allocations to its health care facilities.

Historically, VA medical centers operated independently and provided as much care as possible within their allotted budgets. The Resource Allocation Model (RAM) of the late 1980s was based on the number of episodes of care a facility provided. However, the growth in the volume of workload and in the medical complexity of patients (which equates to higher costs), quickly outpaced the growth in VA's Fiscal Year (FY) medical care appropriations. By the early 1990s it was apparent that a methodology based on episodes of care was ineffective at controlling costs and at assuring equity of access to care across the country. In response to that, VHA developed, in part, Resource Planning Management (RPM), in an attempt to introduce equity into the funding process. However, RPM was not effective in directing resources or assuring equity of access to care. It was determined that even though there was justification to begin redirecting resources, VA failed to do so.

Finally, in response to a mandate from Congress in Public Law 104-204, Section 429, which was to improve the allocations of resources across the entire VA health care system, the VERA model was developed by the Veterans Health Administration (VHA). This mandate stemmed from years of documented, widespread disparity among regions of the country with regard to the consumption of resources per veteran treated.

Since April 1997, VERA has been the model used to allocate the medical care budget appropriated by Congress each fiscal year, to the now 21 Veterans Integrated Services Network (VISNs) that comprise the VHA. VERA was created to address the problems and shortfalls of the other resource allocation systems that VA had implemented but had ultimately failed. VERA supports VA's goals:

- Treating the greatest number of veterans having the highest priority for health care,
- Allocating funds fairly according to the number of veterans having the highest priority for health care,
- Recognizing the special health care needs of veterans,
- Creating an understandable funding allocation system that results in having a reasonably, predictable budget,
- Aligning resource allocation policies to the best practices in health care,
- Improving the accountability in expenditures for research and education support, and
- Complying with the congressional mandate.

The VERA model is a work in progress that is constantly being refined by several internal workgroups within VA. Each year these workgroups submit recommendations to the Undersecretary for Health for approval and implementation of improvements to the various components of VERA. Not only is VERA under intense scrutiny by the VA, other agencies as well have looked at the model and how it operates. The first was PricewaterhouseCoopers LLP, the second was conducted by AMA Systems, Inc., the third and fourth were completed by the U.S. General Accounting Office (GAO), followed by the fifth and sixth assessments being conducted by the RAND Corporation and GAO for a follow-up audit.

The general consensus of these outside agencies has been that VERA is a well-grounded and sound budgeting system that is ahead of other health care budgeting systems. Additionally, GAO, in the 1997 report, *VA Health Care: Resource Allocation Has Improved, But Better Oversight Needed*, concluded VERA improves resource allocation to networks and shows promise for correcting long-standing regional funding imbalances that have impeded veterans' equitable access to services. In February 2002, GAO released, *VA Health Care: Allocation Change Would Better Align Resources With Workload*, and stated, "VERA's overall design is a reasonable approach to allocate resources commensurate with workloads."

Over the past decade, The American Legion witnessed a significant reorganization and realignment of VHA resources and programs. Many dramatic changes were initiated to improve VA's ability to meet the healthcare needs of the veterans' community. VA health care continues to shift from primarily inpatient care to outpatient care. Commensurate with that, the advent of eligibility reform saw the veteran population seeking care at VA swell until it reached an all time high of over six million veterans enrolled while four million of these veterans use the VA as a primary health care provider.

VERA has also been a part of this evolution. Since its implementation, VERA continues to shift a significant amount of resources between VISNs. In FY 2001, VISNs that saw the biggest increases were nearly all located in the south and southwest. Approximately \$921 million were shifted among VISNs in FY 2001 compared to what funding would have been if networks received the same proportion of funding they received in FY 1996, the year before VERA was implemented. VERA shifted \$198 million to VISN 8 (Bay Pines), the most in VHA, and shifted the most resources out of VISN 3, (Bronx), which amounted to nearly \$322 million. Moreover, 10 VISNs saw a smaller piece of VA's medical care appropriation in FY 2001 than in FY 1996.

The VERA model remains under heavy scrutiny throughout its short life span. As mentioned, no less than six assessments have produced many conclusions and recommendations. The most recent GAO report, issued in February 2002, identified weaknesses in VERA that may limit VA's ability to allocate comparable resources for comparable workloads. GAO focused on VERA's allocation of resources from headquarters to VISNs, but did not examine the extent to which each VISN in turn allocate comparable resources for comparable workloads to their medical facilities and programs. There is variance across VISNs in how resources are distributed locally and a review of this may prove beneficial.

Among the weaknesses reported by GAO was the exclusion of the Priority Group 7 veteran workload in ascertaining each VISN's allocation. Priority Group 7 veterans are nonservice-connected veterans and noncompensable, service-connected veterans with income and net worth above the established dollar thresholds. Priority Group 7 veterans also agree to pay specified co-payments. They represent the largest segment of growth of new enrollees. In FY 00-FY 01, there was a 53 percent increase in the number of Priority Group 7 veterans. Additionally, VERA does not use enough categories to adjust for patient health care needs in order to account for patient cost differences among networks.

Another area of concern is the process for providing supplemental resources to VISNs through VA's National Reserve Fund (NRF). The American Legion is unaware of any study to analyze the effectiveness of the NRF or its impact on VERA's allocation, VISN inefficiency, or other factors. Currently, VA uses NRF as a financial *safety net* to bail out VISNs that cannot operate within their allocated budget – clearly, a subliminal message.

Although VERA is acknowledged as a reasonably well-balanced system of revenue distribution, improving its weaknesses could further improve the methodology; however, the problem of inadequate funding remains a pervasive underlying issue. Annually, VHA is repeatedly under funded. To correct this situation, the President and Congress must focus on the annual discretionary appropriations allocation that is based on both demands for service and VHA's ability to meet those demands. Normally, marginal annual increases barely cover the costs to maintain current services and rarely offers funding for expansion or improvement of excellent, much-needed programs.

Furthermore, The American Legion continues to advocate major change in VHA's ability to generate new revenue streams for third-party reimbursements (Medical Care Collection Fund), to

include the Center of Medicare and Medicaid Service for the treatment of nonservice-connected medical conditions of Medicare-eligible veterans. The American Legion urges Congress to authorize VA as a Medicare provider. Medicare is a pre-paid, Federally mandated, health insurance program. Over half of the Priority Group 7 veterans enrolled in VA are Medicare-eligible, yet their third-party insurer is exempt for MCCF billing and collection. In essence, VHA continues to subsidize Medicare – the nation’s largest Federal health care insurance program.

The American Legion is deeply concerned with the overall performance of VA’s MCCF. Significant internal reforms must be taken to improve and increase collection of accounts receivable within MCCF. Currently, VHA has a good track record in first party billing, where the collection rate is about ninety percent; however, its third-party collection rate is totally unacceptable. The American Legion recommends VA either focus efforts to improve MCCF or seriously consider outsourcing this program.

Conclusion

Thank you again Mr. Chairman for your capable leadership on behalf of veterans and their families. Clearly, VERA is an impersonal, nonpolitical effort to distribute scarce discretionary funds throughout VA’s integrated health care system. The American Legion does not see the core problem with VERA, but rather:

- Distribution of resources within a VISN,
- An inadequate annual discretionary appropriations for VA medical care,
- An inept MCCF process, and
- VA’s inability to bill, collect, then reinvest third-party reimbursements from CMS.

Correct these four fundamental flaws and VERA will prove to be an extremely equitable means of distributing resources throughout the system.

Mr. Chairman that concludes my statement, I am prepared to answer your questions.

STATEMENT OF
THE EASTERN PARALYZED VETERANS ASSOCIATION (EPVA)
BEFORE THE HOUSE OF REPRESENTATIVES VETERANS
AFFAIRS COMMITTEE
CONCERNING RECENT RECOMMENDATIONS TO REVISE
THE VETERANS EQUITABLE RESOURCE ALLOCATION (VERA)
SYSTEM

Submitted by:

Paul Tobin
Associate Executive Director, Benefits Services

April 30, 2002

The Eastern Paralyzed Veterans Association (EPVA) appreciates this opportunity to present our views on recent reports that have recommended changes to the Department of Veterans Affairs funding distribution formula known as the Veterans Equitable Resource Allocation system or VERA. EPVA has been studying VERA for a long time and we strongly believe that changes must be made to the method in which the VA distributes its funds, be it through changes to the VERA model or by creating other funding methodologies through which all veterans will receive the quality and range of care that they deserve. Today, EPVA calls upon the Committee to demand that the Secretary implement at least one of the following three courses of action.

EPVA believes that one way for the VA to rectify the disparities created through VERA implementation is for the VA to reimburse the Veterans Integrated Service Networks (VISNs) for the care they provide to all priority group 7 veterans. If VA resists authorizing reimbursement to the VISNs for all priority 7 veterans, they should, at least, reimburse the VISNs for the care offered to the newly established category of “near poor” veterans. This category of veterans was created by the Department of Veterans Affairs Health Care Programs Enhancements Act (P.L. 107-135) enacted last year. Through this new law, Congress and the President acknowledged that these “near poor” patients cannot afford third party insurance from which the VA can recoup the cost of providing care. The third option would be the creation of a new reimbursement methodology exclusively addressing the costs incurred by VISNs for the treatment of priority 7 veterans.

Background

On April 1, 1997, the VA implemented the VERA system to distribute its health care funds among the 22 VISNs. The VA created VERA in an attempt to address the problems of the previous funding systems. VERA shifted dollars away from the areas where veterans had historically been clustered to those areas where veterans were migrating. As a result, the funding formula brought about sharp shifts in funds from the Northeast to the South and West. In an attempt to correct the regional inequities resulting from the population shift, VERA reallocated \$921 million among the networks in FY

2001.¹ Since the beginning of VERA implementation, VISN 3, which covers the New York/New Jersey metropolitan area, was the hardest hit losing \$322 million to networks in the south and west. Furthermore, VISN 3 is the only network out of the 22 networks to experience an overall decrease in its allocation (down 11.1% since 1996). Every other network has received an increase (Bay Pines up 50%, Phoenix up 47%).² Paradoxically, this has occurred despite a universal increase in the number of veterans served by the VA system, especially in priority group 7.

The number of priority 7 veterans enrolled in the VA system increased by 66% from September 1999 to March 2001. In a recent appearance before the House Veterans Affairs Committee, the Secretary explained that, "VA has experienced unprecedented growth in the medical system workload over the past few years. The total number of patients treated increased by over 11 percent from 2000 to 2001 – more than twice the prior year's rate of growth. For the first quarter of 2002, we experienced a similar growth rate when compared to the same period last year. The growth rate for priority 7 medical care users has averaged more than 30 percent annually for the last 6 years, and they now comprise 33 percent of enrollees in the VA health care system. Based on current law, this percentage is expected to increase to 42 percent by 2010."³

The shift in fiscal resources from the Northeast states to other regions, coupled with the explosion in veterans seeking care, has resulted in unprecedented cuts in EPVA's service area. This 6-year old formula, which was intended to repair such inequities, has created and exacerbated new disparities.

Over the past 12 months, no less than three independently issued reports concluded that various changes to VERA were necessary to ensure adequate budgets for all regions of the country. The General Accounting Office (GAO), the VA's Office of the Inspector General (VAOIG), and the RAND Corporation have all released studies calling for various changes to VERA, changes that EPVA strongly endorses.

¹ GAO Report 02-338: Allocation Changes Would Better Align Resources with Workload: Feb 28, 2002

² Department of Veteran Affairs VERA Book, March 2002

³ Statement Of The Honorable Anthony J. Principi Secretary Of Veterans Affairs For Presentation Before The House Committee On Veterans Affairs; Feb 13, 2002

Full VERA Reimbursements for all Priority 7 Veterans

On March 1st, 2002, the General Accounting Office issued a report entitled "VA Health Care: Allocation Changes Would Better Align Resources with Workload". This report concluded that since VERA excludes priority 7 veterans within the workload tabulations that determine the distribution of funding throughout the nation, VA has significantly hurt VISN 3 by not distributing enough funding to adequately care for all veterans seeking care in the New York/New Jersey metropolitan area. The report stated that, "*VERA's calculation of networks' workloads excludes most higher income veterans without a service-connected disability, which is a growing proportion of VA's users*".⁴ (It should be noted that many of these "higher income veterans" have now been recognized as "near-poor" after the enactment of P.L. 107-135 - legislation not considered by the GAO report.) Omitting this category of veterans from VERA's workload calculation generates an inequitable allocation of resources across all networks.

The failure to include any priority 7 veterans in the calculation of VERA reimbursements has resulted in VISNs with high numbers of priority 7 veterans, like VISN 3, being unfairly punished for being situated in high cost of living areas and for providing quality health care to those veterans most in need. Last year VISN 3 spent \$22 million for the care provided to priority 7 veterans in New Jersey alone but was only able to collect \$3 million.⁵ This inequitable distribution of funds has already led to increased wait times for out-patients, decreased staffing levels and beds for inpatients, and the lockout of priority 7 veterans from certain access-points (Hackensack and Brick clinics⁶).

GAO recognized this issue and reported that: "*if priority 7... veterans... were capitated at half the average national cost of their care this would have increased the allocation to 9 networks in the northeast in FY 2001 VERA allocations*".⁷ GAO estimates that the change in VERA allocations by adding priority 7 veterans to VERA workload in VISN 3 at only half of the average national cost would result in an astonishing increase of \$10.3 million (FY 2001 dollars). While any influx of funding would be greatly beneficial, the

⁴ GAO Report 02-338: Allocation Changes Would Better Align Resources with Workload: Feb 28, 2002

⁵ Ken Mizrach, Director of the VA New Jersey Health Care System to Stakeholders, Apr 16, 2002

⁶ Ken Mizrach, Director of the VA New Jersey Health Care System to Stakeholders, Apr 16, 2002

⁷ GAO Report 02-338: Allocation Changes Would Better Align Resources with Workload: Feb 28, 2002

GAO scenario provides for less than half of the necessary funds to treat priority 7 veterans in New Jersey alone.

Clearly the simplest way of ensuring equitable allocations with regard to VISN workloads would be to simply include all priority 7 veterans in future VERA tabulations. In fact, this was the recommendation the VA's own Office of the Inspector General who wrote, "*We recommend that the Under Secretary for Health incorporate all enrolled priority group 7 veterans in the VERA resource allocation model so that funding decisions consider the total number of veterans enrolled and treated.*"⁸ While EPVA endorses this idea, provided that adequate funding is appropriated, we are cognizant of the political, logistical and financial difficulties that would arise by adding all priority 7's into the VERA mix.

Partial Funding through VERA Reimbursements for "Near-poor" Veterans

Another feasible option, one that EPVA prefers, would be to regionally adjust VA's means test to better reflect the cost of living associated with a particular locale (as provided by P.L. 107-135). EPVA has long argued that VA could effectively reimburse the VISNs for the care offered to some, but not all, of their priority 7 veterans by re-categorizing them. This idea was echoed by the recent study conducted by the Rand Corporation entitled "An Analysis of the VERA System". This study, contracted by the Secretary, recommended that, "*A geographic adjustment to the means test used to determine a veteran's financial status should be considered with regard to eligibility for services.*"⁹

At EPVA's urging, P.L. 107-135 included a provision that modifies the VA's system of determining nonservice-connected veterans' "ability to pay" for VA health care services. In essence, this recently enacted law, which the VA has yet to issue regulations on, created a new category of "near poor" veterans (EPVA urges the VA to issue these regulations as soon as possible so as not to delay this new laws implementation).

⁸ VAOIG Report 99-00057-55: Audit of the Availability of Healthcare Services in the Florida/Puerto Rico VISN 8; Aug. 13, 2001

⁹ RAND: An Analysis of the Veterans Equitable Resource Allocation (VERA) System, Sept 18, 2001

By passing and signing this legislation Congress and the President acknowledged that veterans located in high cost of living areas, like VISN 3, could not really afford to “defray the cost” of their care and appropriately lowered their required co-payments by 80%. However, this legislation did not address the fiscal realities of its implementation.

“Near-poor” veterans are unable to pay the VA for their care beyond the applicable co-payments, thus anticipated Medical Care Collections Fund (MCCF) collections are over-inflated. The cost of their care has either remained the same or increased, so the treating VISN is left no option but to turn priority 7 veterans away or utilize funds intended for the treatment of other veterans. Clearly something must be done. Thankfully, the Secretary agrees.

At the conclusion of the GAO report Secretary Principi wrote a letter affirming the report’s findings and indicated that VA was considering VERA changes. Today, we ask the committee to insist that the Secretary take immediate action to implement the GAO recommendations. We call on you to demand that Secretary Principi authorize the VA central office to reimburse VISNs for the services offered to these “near poor” veterans. This is absolutely necessary to offset the damage done by not initially tabulating all priority 7 veterans into the formula in the first place. Without this, VISNs will continue to be unable to recover the cost of care provided to “near-poor” veterans and will be forced to stretch their already inadequate budgets even further.

Creation of New Priority 7 Funding Account

Finally, an alternate method would be the establishment of a new sub-account within the VA’s fiscal year 2003 medical care budget exclusively addressing the costs incurred by VISNs for the treatment of priority 7 veterans. EPVA believes that the distribution of any additional dollars over the baseline \$1.4 billion requested by the administration, should be distributed to the VISNs through this newly created sub account. VISNs would receive a reverse-capitated reimbursement based upon the proportion of priority 7 veterans treated in a VISN in relation to all priority 7 veterans treated nationally. This will ensure that the VISNs providing the care will benefit from funding intended to deal with this growing issue.

In his recent testimony before this committee, Secretary Principi detailed a proposal by the Administration that would charge priority 7 veterans a \$1500 deductible. This proposal would have generated an additional \$1.1 billion dollars to offset the costs of priority 7 veterans' care. When questioned on his testimony, the Secretary admitted that this \$1.1 billion is the minimum amount absolutely necessary to cover the cost of care to priority 7 veterans. Applying these funds to the VERA account will not distribute the dollars to the VISNs most inundated with priority 7 veterans, as VERA does not factor these veterans into its capitation model or reimbursement scheme. As such we propose the creation of this new sub-account.

Conclusion

Clearly the time is now for any VERA or priority 7 related initiatives. Secretary Principi's recent deductible proposal, in conjunction with the aforementioned reports, lends impetus to dealing with these issues now.

EPVA commends the committee for their actions and leadership on this, and all veterans' issues and we appreciate the opportunity to discuss these important concerns. We look forward to working collaboratively on finding a solution that would ensure quality health care for all our nation's veterans.

Paul J. Tobin

Paul J. Tobin is the Associate Executive Director of Benefits Services of the Eastern Paralyzed Veterans Association, a nonprofit veterans service organization dedicated to enhancing the lives of veterans with spinal cord injury or disease by ensuring quality health care, promoting research and advocating for civil rights and independence. In his current capacity, Mr. Tobin supervises a number of highly specialized staff that has daily involvement advocating for the delivery of all benefits offered by the Department of Veterans Affairs.

In his six years at EPVA, Mr. Tobin has been a Hospital Liaison and the Director of Special Projects. He is involved with numerous hospital and VISN level committees. He has held a position on PVA's Field Advisory Committee, giving him insight to VA SCI Centers outside of EPVA's immediate service area. He coordinated EPVA's efforts, in cooperation with the Bronx VA Medical Center, to bring the 21st National Veterans Wheelchair Games to New York City. These positions, as well as his time as a VA patient, give Mr. Tobin varied perspectives of the evolving state of VA health care.

Mr. Tobin graduated from Manhattan College with a Bachelor of Science degree in Civil Engineering. He was commissioned in the United States Navy and served from 1990 through 1993 in the Navy's Civil Engineer Corps. Sustaining a spinal cord injury in 1993, he underwent rehabilitation at the Bronx and Castle Point VA Medical Centers in New York. He has also attended Columbia University and taken coursework towards a Master's of Public Health degree.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts. EPVA received no relevant federal grants or contracts relevant to the subject matter of this testimony over the past two fiscal years

**STATEMENT OF
DANIEL T. FLYNN
COMMANDER
OF THE
DISABLED AMERICAN VETERANS
DEPARTMENT OF NEW JERSEY
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
FIELD HEARING
APRIL 30, 2002**

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than 27,400 members of the Disabled American Veterans (DAV) Department of New Jersey, I am pleased to provide DAV's views on the Veterans Equitable Resource Allocation (VERA) formula that apportions federal funding for veterans' health care to Veterans Integrated Service Networks, and the recent General Accounting Office and VA Inspector General reports calling for changes to that formula.

Year after year, federal funding has failed to keep pace with medical care inflation and the mounting financial burden for veterans' health care caused by rising costs and increasing demand for medical services. This has severely hampered timely access to quality health care for our nation's sick and disabled veterans.

Solving this problem will require a fundamental change in the way government funding is provided for the VA medical care system. Federal legislation would be required to make VA medical care an entitlement and shift it from a discretionary to a mandatory funding program.

Making veterans' health care funding mandatory would eliminate the year-to-year uncertainty about funding levels that has prevented the VA from being able to adequately plan for and meet the constantly growing needs of veterans seeking treatment.

An entitlement program guarantees a certain level of benefits to persons who meet requirements set by law, such as VA disability compensation, Social Security, or unemployment benefits. Because funding for these programs is mandatory, it leaves no discretion with Congress on how much money to appropriate, and some entitlements carry permanent appropriations.

If veterans' health care were a mandatory program, the government would have to provide sufficient funding for the VA to treat those veterans who meet the statutory requirements for care. Veterans would not have to fight for adequate funding in the budget and appropriations process every year as they do now.

It has been the DAV's firm conviction that veterans have earned the right to VA medical care by virtue of their extraordinary sacrifices and service to our nation. In fact our membership

has adopted two national resolutions regarding this issue. One calls for the VA to provide timely and adequate health care services to wartime service-connected disabled veterans. The other supports enactment of federal legislation giving service-connected disabled veterans priority for VA medical care unless compelling medical reasons indicate otherwise.

The Veterans' Health Care Eligibility Reform Act of 1996, which the DAV supported, greatly expanded access to VA health care. This was an important step toward meeting veterans' medical needs.

But as long as veterans' health care remains a discretionary program, funding levels will continue to be decided each year through an annual appropriations bill. Currently, the law imposes limits, or "caps," on annual discretionary spending. Within the cap, however, the President and Congress can, and often do, change the spending levels from year to year for the thousands of individual federal spending programs. And the competition for those discretionary funds is fierce.

The cumulative effects of years of unpredictable and inadequate funding have had a devastating and irreversible impact on the VA medical system. Rationed health care is no way to honor America's obligation to the brave men and women who have so honorably served our nation. Sufficient funding levels are required in order for the VA to treat veterans in need of care. And the VA must be held accountable for providing high quality care in a timely manner.

The DAV will continue working with members of Congress and others to build support for our efforts to ensure a reliable, adequate level of funding for VA medical services which is essential to fulfilling our nation's moral obligation to care for America's sick and disabled veterans.

Should Congress fail to act upon our proposal to make funding for VA health a mandatory program, action should be taken to make the VERA formula more equitable so that sick and disabled veterans can receive timely, quality health care when necessary. However, regardless of how the VERA formula is readjusted, the total level of funding is inadequate to care for all veterans who are currently enrolled in the system.