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

TESTIMONY OF
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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 report[1] 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.

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[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.