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:

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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.

Comment: Do we have the % change in the # of cat 7 vets treated since FY97? Non cat 7 vets?

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 ye The growth rate for priority 7 medical

[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

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.

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*

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

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 clinics[6]).

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 <u>only half</u> 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 PL. 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*

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

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).

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

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

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