STATEMENT OF

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BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

ON

VA'S ACTIONS TO REVISE VERA, THE VETERANS EQUITABLE RESOURCE ALLOCATION

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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.