Statement of

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To the

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U.S. House of Representatives

On

"VA Health Care: Structural Problems, Superficial Solutions."

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Mr. Chairman and Members of the Subcommittee:

The American Legion is grateful for the opportunity to share it views with the distinguished members of this subcommittee on ***"VA Health Care: Structural Problems, Superficial Solutions?"*** With the scarce resources in veterans' health care, it is imperative that the most efficient and effective approach be used to allocate those funds.

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 Veterans Equitable Resource Allocation (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 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 constantly under a microscope 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."

As mentioned, no less than six assessments have produced many conclusions and recommendations. The most recent GAO report, and the subject of this hearing, was issued in February 2002 and 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.

The five recommendations given to the VA by GAO to improve the allocation of discretionary funding to the VISNs:

- Better align VERA measures of workload with actual workload served regardless of veteran priority group,
- Incorporate more categories into VERA's case-mix adjustment,
- Update VERA's case-mix weights using the best available data on clinical appropriateness and efficiency,
- 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
- Establish a mechanism in the National Reserve Fund to partially offset the cost of networks' highest cost complex care patients.

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.

Another area of concern was that VERA does not use enough categories to adjust for patient health care needs in order to account for patient cost differences among networks. Currently, patients are classified into one of three categories:

- Complex care.
- Basic vested care.
- Basic "non-vested" care.

These case mixes are based on the level of patient health care need and the costs that are associated with providing that care. VA is currently studying the effects of increasing the patient case mix, to include a model based on the Diagnostic Cost Groups (DCGs), which is a model that resembles the one used by the Centers for Medicare and Medicaid Services (CMS) for its Medicare+Choice program. This change in patient case mix would have a significant effect on current funding practices.

One more major 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. It is interesting to note that in FY 1999 two VISNs needed an adjustment, in FY 2000, three different VISNs needed additional funding but in FY 2001 and again in 2002 the same three VISNs requested substantial increases. Of those three VISNs, 13 and 14 no longer exist. They have been consolidated into VISN 23. Two failed VISNs, consolidated into one. While this was just an administrative move, clearly there are some adjustments to be made with respect to allocations. The American Legion also notes that not only have the same three VISNs for the last three fiscal years found themselves in dire straits concerning their budgets but the trend for the number of VISNs needing adjustments keeps increasing.

Whether the VA acknowledges this money as *bail-out* money for the VISNs or an adjustment is a matter of semantics. The fact remains that an increasing number of VISNs are not able to operate within their allotted budget.

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 offer 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 CMS 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 from 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.

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 believes the core problem is not 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 current inability to bill, collect, and 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.

This concludes my testimony.