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VA HEALTH CARE: STRUCTURAL PROBLEMS, SUPERFICIAL SOLUTIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS AND INTERNATIONAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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VA HEALTH CARE: STRUCTURAL PROBLEMS, SUPERFICIAL SOLUTIONS

TUESDAY, MAY 14, 2002

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS AND INTERNATIONAL RELATIONS,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:06 p.m., in room 2154, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Gilman, Weldon, Putnam, Otter, Sanders, Kucinich, Tierney, Allen and Watson.

Staff present: Lawrence J. Halloran, staff director and counsel; Kristine McElroy and Thomas Costa, professional staff member; Jason M. Chung, clerk; David Rapallo, minority counsel; and Earley Green, minority assistant clerk.

Mr. SHAYS. A quorum being present, the Subcommittee on National Security, Veterans Affairs and International Relations hearing entitled, "VA Health Care: Structural Problems, Superficial Solutions," is called to order.

Each time we examine the quality and quantity of health care delivered by the Department of Veterans Affairs, VA, we are told the veterans' equitable resource allocation or VERA system will evolve and improve in matching scarce resources to urgent needs. But as we heard in three previous sessions, since 1997—in Washington, New York and Massachusetts—VERA remains insensitive to significant regional differences in costs and patient demographics. As a result, access to care can be limited, delayed, or denied altogether as funding is spread inefficiently across the VA's 22 health care networks. A system designed to account for patient workload fails to account for fully one-fifth of those seeking care. So-called wealthier veterans in eligibility Priority 7 are largely excluded from VERA calculations on the dubious rationale ignoring them might limit their numbers.

Veterans' integrated service networks, VISNs, treating a growing number of Priority 7 patients, do not get paid for doing so. Other categories of care obviously suffer. VERA also fails to capture changes in the types of care provided by relying on old data to apportion funding allocations between basic and complex health services. Other regional cost variations go undetected as well because the current system uses only 3 of a possible 44 categories to characterize patient mix.

According to the General Accounting Office, GAO, these rigidities limit VERA's ability to allocate comparable resources for comparable workloads between regions with differing types of patients. Systematic problems produced by VERA's lack of sophistication are addressed only cosmetically through a process of supplemental funding which can appear to punish efficiencies while rewarding waste. In the delicate work of surgically dividing a finite VA health budget among the Nation's veterans, VERA is still just too blunt an instrument.

VA pleas for time, not months but years, to ponder corrective actions, long obvious to some, ignore the plight of veterans, particularly those in the Northeast who have already lingered too long in the health care gaps and voids created by VERA's inequities.

We asked our witnesses to describe in greater detail the impact of chronic VA health care funding shortfalls and what is being done to retool the VERA system into the sophisticated health care model envisioned by Congress in 1996. We look forward to their testimony.

At this time I would like to recognize Mr. Sanders.

Mr. SANDERS. Mr. Chairman, thank you very much for holding this extremely important hearing for those of us in the Northeast. Let me just say a few words because this is an issue I feel very strongly about and this is an issue I get extremely angry about, and I would like some comments later on from our panelists.

You know, men and women throughout this country put their lives on the line, they go to war, some of them come back wounded in body and some of them come back wounded in spirit. And this is the richest country in the history of the world. We are so rich, my friends, that we were able to give $500 billion in tax breaks to the wealthiest 1 percent of our population, people with a minimum income of $375,000 a year. We are so rich that we can increase military spending for all kinds of exotic weapons systems, but apparently we are not rich enough to make sure that the men and women who put their lives on the line, who were wounded, get the quality care that they were promised. This is an absolute disgrace.

Now I understand that the people on the panel are not the President of the United States. I do understand that. My eyes are good enough. But I think we have a right to demand of you, if you are serious about providing health care, quality health care, to the veterans of this country—and I know that Dr. Post is. We had a very good meeting on April 1st, and I thank you very much for the work that you did. We met her in White River Junction. You have got to tell us, and be very loud and vocal, about the needs of veterans so that this Congress can work to appropriate the adequate kinds of money that our veterans need. I consider that your job, and if you're not doing that job, if you're not coming forward to Congress and saying we don't have sufficient resources, I don't believe that you are doing your job.

So the first point that has to be made is that Federal funding for the VA is inadequate. Some will say, well, the President has put more money into funding. Yes, that's true, but the other half of the equation, as our panelists will speak to, is that the VA, from one end of the this country to the other, is seeing a huge increase in the number of people who use the services, and given that huge in-

crease, because of the health care crisis and the crisis in prescription drugs, more and more people coming into the system, clearly the funding is inadequate on a national level. And the reason that the chairman called this hearing is that we believe the VERA formula clearly is not adequate for the Northeast.

Let me just mention a few points, if I might. To the best of my knowledge, from 1996 to 2002, Network 1, our network, New England, has experienced a 22 percent decrease in VERA allocations from that period.

Furthermore, since full-time employees are the largest portion of the network's expenditure, we have seen in our region a loss of over 2,700 employees. So as I understand it, and I would appreciate later on if the panelists think that I'm wrong here, a huge increase in the number of people using the facility, cutbacks in funding, cutbacks in employing, and what are the results? Let me read you what the results are.

May 9, 2002 from the director of Veterans Affairs in White River Junction, and I quote from a letter sent to veterans in the State of Vermont. "Due to an overwhelming demand for services, we have reached a full patient capacity in our primary care clinics. New patients will be accepted; however, appointments will be provided on a space-available basis as patients leave the VA."

We have, I believe, in the State of Vermont and one bordering us in New Hampshire, five very good outpatient clinics. The only problem is they no longer have the capability of accepting new patients. This is absolutely unacceptable, and I look forward to working with the chairman and other members of this committee to change the formula and to demand, by the way, that the U.S. Congress adequately fund the VA so that all of our veterans from one end of this country to the other get the care they need, and we do not have to see horror stories as exist in some hospitals where, as I understand it, veterans are waiting years before they can get into that facility. This is unacceptable. We have got to address this issue.

Mr. Chairman, thank you very much.

Mr. SHAYS. I thank the gentleman. At this time the Chair recognizes Dr. Weldon.

Dr. WELDON. Thank you, Chairman, for calling this hearing, and I certainly am pleased to see Dr. Roswell here to testify. I had the pleasure of working with Dr. Roswell when he was the VISN director of VISN 8 in Florida. While Dr. Roswell presided over VISN 8, we saw the funding for VISN 8 increase by about 40 percent; however, we also saw the number of veterans seeking service in VISN 8 increase by 40 percent. This is a critical point because as we look at the impact of VERA, we must also consider the dramatic increases in utilization of the VA that we have seen all over the country, especially in Florida. While VERA has made funding a little more equitable, those of us representing growth States still see significant funding problems and believe that much more progress needs to be made.

While the chairman and I come from two different regions of the country and come at the VERA program from different perspectives, I believe that we share and all the members of the committee share the common goal of working toward the best service for our

veterans, those who have sacrificed, defending our liberties. Just yesterday I received the following message from one of those veterans in my congressional District, Mr. Ord, who wrote to me, saying, "Veterans' health care at Vierra"—by the way, the clinic in my district is in a town called Vierra, a little confusing there—"The veterans' health care in Vierra claims they can't accept any more veterans. I am a disabled veteran from World War II. The steel company I worked for went out of business. I lost my hospitalization and need protection from the high cost of medicines. I am 80 years of age, and back in 1943 and 1944, I flew 69 missions over Europe as a tail gunner and I have the Purple Heart. I was also promised health care."

Another constituent wrote to me, saying, "I have been enrolled with the VA clinic at Vierra for well over 1 year. I am a Category 5, nearly poverty level income. I am told that they are not making any more appointments and haven't for over 1 year. They do not know when the situation will change. What good is the VA clinic if they won't make any new appointments? My income in 2001 was $22,000. My medical bills were $9,000."

Just for the record, I wanted to read, and I actually have it on tape, the recorded message that veterans who have called the veterans' clinic in my district have been receiving for several months. "you have reached the Brevard County VA outpatient clinic enrollment eligibility office. We are either on the phone or assisting other veterans at this time. If you are calling about the status of your application, our clinic has reached full capacity and we cannot take any new appointments. If you have submitted an application after January 1, 2002, your name will automatically be placed on our waiting list and you will receive a letter when we can start taking new patients again. We do not anticipate that happening this year, so please do not call us to ask where you are on the list or how long it will be before we contact you. If you wish to be placed on the waiting list, please leave your name, full Social Security number."

Clearly we do not have enough resources in many regions. We have heard from the gentleman from Vermont. Obviously we have a problem in Florida. We need to meet the needs of the thousands of veterans like these who are waiting to enroll or simply waiting for an appointment to see a provider.

I also know about the shortage firsthand. I volunteer once a month at the veterans' clinic in my congressional district seeing patients, so I see it up close and personal.

I would like to point out that I was provided a very disturbing letter. The validity and the accuracy of this letter and the timeliness of it I do not know, but it was issued from the Bronx VA medical center. Evidently it was sent out sometime last year and it read, "On behalf of the VA, may we extend our best wishes to you on your birthday. As part our reorganization, the VA medical centers are expanding to make our facilities more friendly and accessible to all veterans. At present we have a program whereby all veterans may receive a yearly physical examination free, thereby offering one and all the opportunities to see for themselves at no expense the quality services offered by our team of expert medical clinicians. Also, veterans scheduling a free physical exam will re-

ceive a free eye exam and glasses," and it just goes on and on from there.

Meanwhile, I've got a 78-year-old veteran who wrote to me complaining that he has been told he has to wait a year to get his hearing checked. Clearly we have some problems within the system. Clearly VERA needs to be updated. I am very sensitive to the issues and the challenges that we are facing all over the country, but in Florida we now have 42,000 veterans on a waiting list. 42,000 veterans.

Mr. SHAYS. Amazing.

Dr. WELDON. VISN 8 has 400,000 veterans, trying to get access of VISN 8. I believe most Veterans are serving a population of about 100,000. So the timeliness of your hearing, Mr. Chairman, is incredible and I'm looking forward to the testimony from all of our witnesses, and thank you for providing me this opportunity.

Mr. SHAYS. I thank the gentleman. At this time the Chair will recognize Mr. Allen.

Mr. ALLEN. Thank you, Mr. Chairman, and I want to thank you especially for holding this hearing this afternoon. I am particularly pleased that John Bachman is here from Togus. He is a true New England patriot. Mr. Chairman, he has been awarded the Purple Heart and is one of Maine's staunchest and most knowledgeable veterans' advocates. I've enjoyed working with John and his committee, and I appreciate his willingness to be here.

I also want to welcome Dr. Post. I think Dr. Post has one of the most challenging jobs in the government, but she is truly committed to providing high quality health care to New England's veterans, and I have really enjoyed working with her.

I also want to thank the many veterans and VA staff who have helped me to understand the complex situation we have at Togus in Maine, particularly Helen Hanlon, Gary Larson, Linda Loriason, Admiral Rich Rybacki, and Ron Warner, who is probably Maine's most insistent veterans' advocate. And I want to say a word about Jack Simms and the staff at Togus. This is a very dedicated and hard working group of people. I think that they do everything they can. The veterans I talk to are very supportive of the staff at Togus, but they believe and they tell me that the facility is understaffed, overworked and sometimes micromanaged by the VISN headquarters.

In Maine for the last 2 years or so, the VA medical system has added over 500 veterans to its practice every single month. Under the current compensation formula, this should mean a commensurate increase in funding for those facilities, but unfortunately the VERA formula also contains a huge 2-year lead time in recognizing this increase. That is, although Maine facilities are caring for these additional veterans now, they won't see the increase in allotment for a very long time, and this is unacceptable. The increase is a reflection of the booming demand by veterans for medical care. This is not solely just a result of the aging of the veteran population. In fact, Vietnam era veterans have now surpassed World War II veterans as the largest group of patients seeking care at Federal hospitals.

Moreover, as the cost of private health care and health insurance continue to soar, we can expect that use of VA medical facilities to

increase further. In short, for many Americans, the health care system is breaking down and that is a large part of why you are seeing more and more people who are veterans turning to the Veterans Administration for servicing, particularly to deal with the cost of their prescription drugs.

The principal problems at the VA facilities in New England have been the lack of sufficient resources and regional recruiting difficulties, compounded by an uncompensated 23 percent of loss of purchasing power, and that's what I would argue sets us apart from other areas in the country. While other areas in the country have been getting more veterans and more funding, VISN 1 and VISN 3 have been getting more veterans and less funding. In my opinion, these issues have been exacerbated by the VA's reluctance to acknowledge that the VERA formula does not adequately factor in regional cost fluctuations or increased funds in a timely manner, and I have to add here that I want to associate myself with Congressman Sanders' remarks. The tax cut passed last year was, in my opinion, the single most reckless and irresponsible legislative act in the last 6 years and the problems it creates come to light in the way we deal with our veterans because we can't find enough money, it seems, to provide them with the care that they deserve.

I hope today to learn more about the impacts of the organizational and financial changes the VA is going through. I hope to find out how the VA, and VISN 1 in particular, and Togus will improve services to our Maine veterans and what more needs to be done, and I hope we can learn today how to work together more effectively to make sure that our veterans are treated with respect and dignity and that they receive the health care they need and have earned.

I believe that we can use this time of renewed appreciation for our veterans to build them a more secure future. They did not let our country down during our time of need. They are not doing it now. And we must not fail veterans by abandoning them in their time of need.

Mr. Chairman, thank you. I have a longer statement that I would like to submit for the record.

Mr. SHAYS. That will be done.

Thank you, Mr. Allen. At this time the Chair recognizes Butch Otter.

Mr. OTTER. Thank you very much, Mr. Chairman. And being from Idaho, after listening to all these other huge numbers, I'm a little bit sheepish about bringing up my group, but I guess to the individual it makes no difference. When you need the help, you need the help, but in this age of changing demographics, it is difficult to relocate a lot of the needs for the veterans, and so I'm pleased that you, Mr. Chairman, have demonstrated the leadership in recognizing the problem and bringing this, and we hope, I hope, that this panel and these panels that we will engage with today will come up with some opportunities and some ideas and some progress for us.

In addition to the regional economic difference in the maintenance cost, it is also important, I believe, for us to examine the additional financial factors such as the increase in administrative burdens at the veterans' health centers that are a result of the

sharp increase in Priority 7 veterans seeking to access the care. The GAO reported that the number of veterans who are being treated by the Veterans Administration who do not have a service-connected disability has increased since 1996, when they accounted for only 4 percent of the total veterans treated last year. They now account for 22 percent of the Veterans Administration patient workload, and my good colleague and friend from Florida here just explained to me why that is part of the problem, and I hope that is one of the things that we will engage in in this discussion is how many other medical resources do we have that are competing for attention and competing for the limited resources because, as Mr. Weldon just explained to me, one of his problems in Florida is that in order to access a pharmaceutical dimension, instead of being able to go to Medicare, a lot of folks now turn to the Veterans Administration in an effort to get into there. But given this increase in the nonservice-connected disability, it's easy to see why it's not uncommon for veterans in the State of Idaho to wait about a year and in some cases longer just to get in to see a doctor.

In fact, there are approximately 3,000 veterans waiting for care in Idaho and about two-thirds of those veterans are Priority 7 veterans. However, once in the system, I will tell you that Idaho veterans seem to be very pleased with the delivery of the care and the quality of service they receive. Now if that's compared to having received nothing at all prior to that, I can see why if they received any service it would be a tremendous improvement.

So, anyway, as we explore ways to make VERA more conducive to addressing the health care needs of veterans, I think it's an important factor for us to look into the resource allocation equation and a way to provide the Veterans Administration with necessary resources to address the increased administrative workload so as to the reduce the extreme waiting time that veterans face to receive health care from the Veterans Administration.

Again, Mr. Chairman, I appreciate your leadership and your focus on this problem, and I do hope that if not at this particular hearing but perhaps at a future one that we can interconnect with Medicare, Medicaid, and some of the other areas that would provide such resources and services to make sure that we are not just focusing on one avenue.

Thank you, Mr. Chairman.

Mr. SHAYS. Thank you very much, Mr. Otter. At this time the Chair recognizes John Tierney, from Massachusetts.

Mr. TIERNEY. Thank you, Mr. Chairman, and thank you once again for having hearings that matter to all of our districts, and I want to welcome the witnesses and thank them for being here.

Dr. Post, it's good to see you again. You were kind enough to come in fact to my district a couple of years ago where we dealt with many of these same issues. Unfortunately they remain with us.

My remarks are going to be very brief because I associate with just generally all of the observations and complaints that have been made by my colleagues here.

I do find it somewhat troubling that some of the officials at VA acknowledge that the Priority 7 veterans aren't counted under the current VERA system and then say that one of the reasons that

they may not argue with that too much is because they are afraid that people will use that as an incentive to seek out more veterans in that category to increase to the amount of money that they get reimbursed. That is as troubling as when originally we put out a notice in our district that the Veterans Administration provided prescription drug coverage for veterans, and in a day 500 people called up looking for those services and the Veterans Administration said they were distressed that we had put the news out so generally because they weren't equipped to handle that kind of an influx.

I mean the problem obviously here is that the entire system is not getting funded appropriately, and as Mr. Allen said very clearly, the idea that these people have served their country and they deserve to get what was promised to them and what we owe them so we need to have this whole formula reworked, we need to have the Priority 7s counted in and we need to have any other adjustments that need to be made occur. And I am just interested in hearing the testimony to make sure that we address these things, as well as the timeliness of those adjustments, so that people who are looking for the treatment now and people who are trying to provide the services are generally doing the best that they can under some very difficult situations are given the resources that they need to do that.

So I thank you for testifying. I thank the chairman and my colleagues for participating in this hearing and look forward to seeing if we can't work together to resolve some of the issues.

Mr. SHAYS. I thank the gentleman. At this time I recognize Mr. Putnam for any comments.

Mr. PUTNAM. Thank you, Mr. Chairman. I appreciate your leadership on this issue and a number of other issues relating to the quality of care that our veterans receive. As I'm sure my colleague from Florida has pointed out, there are some very serious deficiencies in the system and fast-growing States like Florida where you have a tremendous inflow of veterans from around the country and old data that doesn't take into account the current numbers of patients in need of care in these rapidly growing States. We have seen some facilities grow at a rate as high as 40 percent a year. And so using timely data, recognizing the changes of migration patterns, and everything else is critical. So as they relate to the VERA formula in ensuring that we are running the most efficient system possible, that acknowledges and prioritizes those veterans in the greatest need of care in those States that have the greatest number of veterans, rather than trying to do an equal distribution just to keep the facilities open, I think should be one of the key goals of our system.

So I look forward to hearing your testimony on this and I thank the chairman for his leadership on this.

Mr. SHAYS. I thank the committee members for all their comments. I think I also want to thank the panel for waiting to be sworn in and listening to our comments. We obviously have some very real concerns and I think I will say that I have some regret that this committee has not had more hearings, that we have let so much time elapse, because we have all heard from the field what a terrible problem our veterans are faced with.

I'd like to get two housekeeping things taken care of and then I will swear witnesses in and look forward to their testimony. I ask unanimous consent permit that all members of the subcommittee be permitted to place an opening statement in the record and that the record remain open for 3 days for that purpose, and without objection, so ordered.

I ask further unanimous consent that all witnesses be permitted to include their written statements in the record. Without objection, so ordered.

I ask further unanimous consent that written statements from the following organizations be inserted into the record after witness testimony: The American Legion, Veterans of Foreign Wars, Eastern Paralyzed Veterans Association, the Blind Veterans Association, AMVETS, and Disabled American Veterans.

At this time I would like to welcome our witnesses. First, Dr. Robert Roswell, Under Secretary for Health, Department of Veterans Affairs, who will have testimony, accompanied by Jeanette Chirico-Post, Director of Veterans Integrated Service Network, and that's VISN 1, the Department of Veterans Affairs; and Mr. James Farsetta, Director of Veterans Integrated Service Network 3, Department of Veterans Affairs. Network 3 is New Jersey and part of New York.

Mr. FARSETTA. That's correct.

Mr. SHAYS. And VISN 1 is New England. If you would rise, I will swear you in, and if there's anyone else that may be wanting to give testimony, just in case, it helps if I swear you in.

[Witnesses sworn.]

Mr. SHAYS. Note for the record all our of witnesses have responded in the affirmative. It is very nice to have you here. I would also want to say for the record that I know all of you care deeply about our veterans and are working very lard to serve them, so I'd like to think we are a partnership in this effort to figure out how we do a better job.

So, Dr. Roswell.

STATEMENTS OF DR. ROBERT ROSWELL, UNDER SECRETARY, HEALTH, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY DR. JEANETTE CHIRICO-POST, DIRECTOR, VETERANS INTEGRATED SERVICE NETWORK 1, DEPARTMENT OF VETERANS AFFAIRS; AND JAMES J. FARSETTA, DIRECTOR, VETERANS INTEGRATED SERVICE NETWORK, DEPARTMENT OF VETERANS AFFAIRS

Dr. ROSWELL. Thank you, Mr. Chairman. I'm pleased——

Mr. SHAYS. Your mic is not on, Doctor. I'm going to have you start over again.

Dr. ROSWELL. Thank you, Mr. Chairman. I'm pleased to testify before the committee on the status of the Veterans Equitable Resource Allocation or VERA model. Mr. Chairman, with your permission, I will briefly summarize my statement and then be prepared to respond to the committee's questions.

VERA was developed at the direction of Congress to replace an outdated historical-based allocation system. Since its inception, the VERA model has been developed to account for regional variances. For example, in 1997 a geographic price adjustment was introduced

to recognize the impact of regional variations in the cost of labor. This year in fiscal year 2002 the geographic price adjustment was extended to cover all contract costs, both labor and nonlabor and including the cost of utilities. The model also accounts for regional cost differences in accomplishing maintenance and repairs to facilities. Over the years the VERA model has been improved and enhanced to respond to changes in the practice of medicine and the delivery of health care services.

Both internal and external groups, such as PricewaterhouseCoopers, the Government Accounting Office and Rand Corp., have reviewed the model. These outside reviews have acknowledged that the VERA model is basically meeting its objective of allocating available resources in a fair and equitable manner. Currently the Rand Corp. is evaluating the VERA model and will have a final report later this fall. The Rand study is addressing a quantitative analysis of improved case mix adjustment, geographic differences in prices paid for nonlabor inputs in contract labor costs, the impact of teaching and research programs and the impact of physical plants. We expect to receive the final report from Rand in October.

We have also recently received recommendations from the GAO regarding improvements to the model. In its February report, GAO made 5 recommendations that are being evaluated as VA developed changes for the fiscal year 2003 VERA allocations. The Secretary of Veterans Affairs will make any final decisions.

Some of the issues currently under review are how the model accounts for nonservice-connected and noncomplex care provided to Priority 7 veterans, adjusting complex and basic care price split to more accurately reflect actual costs of the two groups, and providing an additional allocation for the very highest cost patients, those whose annual cost exceeds an established threshold.

My formal statements include discussion of all the GAO recommendations.

While we continue to review and change the model to more accurately allocate scarce resources, we recognize that there will be a continuing need for a process for making supplemental funding adjustments. Over the 6 years that the model has been in use, adjustments have been made to assist networks that were unable to operate within their initial VERA workload-based allocations. This allows networks to plan their operations with more certainty of available funding. We need to better understand what is causing certain networks to require adjustments year after year. While it is possible that part of the cause may be the allocation model itself, 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 may also be contributing factors.

Mr. Chairman, this concludes my opening remarks. I'd be pleased to answer any questions you or the committee may have.

[The prepared statement of Dr. Roswell follows:]

Statement of
The Honorable Robert H. Roswell, M.D.
Under Secretary for Health
Department of Veterans Affairs
Before the
Subcommittee on National Security, Veterans Affairs,
And International Relations
Committee on Government Reform
U.S. House of Representatives
on the
Veterans Equitable Resource Allocation System

May 14, 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.

Since its inception, the VERA model has been developed to account for regional variances. For example, in FY 1997 a geographic price adjustment was introduced to recognize the impact of regional variations in the cost of labor. In the FY 2002 VERA model, the two VISNs with the highest labor costs are VISNs

21 (San Francisco) and 3 (Bronx); the two VISNs with the lowest labor costs are VISNs 8 (Bay Pines) and 18 (Phoenix). VISNs 21 and 3 received positive funding adjustments of +$70 million and +$53 million, respectively, because of their higher labor costs. VISNs 8 and 18 received negative adjustments of -$57 million and -$20 million, respectively, because of their lower labor costs. In FY 2002, the geographic price adjustment was extended to cover all contract costs, both contract labor and non-labor. These contract costs include the cost of utilities.

Additionally, the RAND Corporation is currently evaluating the VERA model and will have a final report this fall. The RAND Study is addressing a quantitative analysis of the following issues: improved case-mix adjustment; geographic differences in prices paid for non-labor inputs and contract labor costs; the impact of teaching and research programs; and, the impact of the facilities' physical plants. The first interim briefing to Congress on the status of the ongoing RAND VERA study, as required by the Senate Appropriations Committee, was provided on March 1, 2002. The next interim briefing to Congress will be provided during July 2002, and a final report will be submitted to Congress in October 2002.

This brings me to GAO's most recent report issued in February this year. 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 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.

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, 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. In FY 2000, VISN 9 repaid their FY 1999 adjustment. In FY 2001, funds were withdrawn from eighteen VISNs to fund the adjustment for four VISNs and a Congressional rescission.

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%

* Advance on FY 2000 allocation paid back in FY 2000

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	VHA's FY 2002 Estimate for Complex Basic Split (GAO Rec. #3)	VHA's FY 2002 Estimate for 77 to 50% (GAO Rec # 1)	VHA's FY 2002 Estimate for 100 High Cost (GAO Rec #3)	VHA's FY 2002 Estimate for VERA 10 (GAO Rec # 2) See Note 1	Total of VHA's Estimate for FY 2002 All Changes	GAO's Estimate for FY 2001 Report Page No.29
1	Boston	$1	$4	$28	$70	$47	$41
2	Albany	($2)	$3	($1)	($1)	($8)	($9)
3	Bronx	($8)	$16	$72	$21	$105	$42
4	Pittsburgh	$1	$6	$6	$39	$43	$36
5	Baltimore	($2)	($1)	$2	($10)	($17)	($23)
6	Durham	($3)	($4)	$3	$2	($1)	$7
7	Atlanta	($4)	($1)	($14)	($7)	($37)	($14)
8	Bay Pines	$3	($2)	($4)	$1	($10)	$15
9	Nashville	$4	$7	($9)	($	($8)	$31
10	Cincinnati	($7)	($6)	($11)	$7	($15)	($8)
11	Ann Arbor	$0	$1	$13	$17	$33	$11
12	Chicago	($3)	$2	$12	$27	$32	($7)
13	Minneapolis	($3)	$3	($3)	$19	$11	$5
14	Lincoln	$2	$3	($2)	($4	($4)	$4
15	Kansas City	$2	$2	($11)	$6	($15)	($2)
16	Jackson	$11	($3)	($21)	($1	($32)	($3)
17	Dallas	($2)	($5)	($12)	($1	($35)	($12)
18	Phoenix	$6	($1)	($10)	($1	($31)	($20)
19	Denver	$3	$1	($2)	($1	($12)	$3
20	Portland	($3)	($4)	($17)	($	($46)	($40)
21	San Francisco	($2)	($4)	$16	($1	($5)	($23)
22	Long Beach	$1	($4)	$38	($	$26	($35)
		$0	$0	$0	$0	$0	($0)

Note: 1 - VERA with 10 case-mix categories is a better grouping of GAO's recommended 38 case-mix categories.

Mr. SHAYS. Thank you very much. I'm going to Dr. Weldon first, but is there a consensus right now that the system is broke?

Dr. ROSWELL. Mr. Chairman, when you say the system, are you referring to the VA health care system or to the VERA funding allocation system?

Mr. SHAYS. I'm referring to the fact that we have people who are literally waiting until someone else dies before they can be taken care of and I am just wondering—how would you define the system before we get to——

Dr. ROSWELL. I believe that since October 1998, when the VA health care system was opened in accordance with statutory entitlement to all veterans, we have had an unprecedented demand for VA health care, a demand that has far out—has far exceeded our expectations.

Mr. SHAYS. OK. And, rightfully so, you are putting a lot of the burden right back on our shoulders. We opened it up and you just couldn't, with the current resources, cope with it.

Dr. ROSWELL. Mr. Chairman, I think there are economic considerations that we didn't anticipate when the system was opened in October 1998. But it is clear that more veterans are seeking care through the VA now than ever before and it has created an unprecedented burden on the system to the point that we have reached or exceeded capacity in many of our over 1,300 locations nationwide.

Mr. SHAYS. Let me start the questioning. What I would ordinarily do would be to give 10 minutes, but we have so many Members, I'm going to do 5 minutes this first round and if—I'd like the ability of a Member to go beyond 5 minutes to pursue something, but let's this first time just do 5 minutes. Dr. Weldon.

Dr. WELDON. Thank you, Mr. Chairman.

Dr. Roswell, the letter that I mentioned from the Bronx VA, I was just told by my staff that they again verified that was an accurate letter. How can we—and it was sent out by the Bronx VA. How can the VERA system be working when we've got 42,000 veterans waiting to be seen in Florida and then we have another veterans' facility in another area of the country sending out letters encouraging people to come in?

Dr. ROSWELL. Dr. Weldon, I think you pose a valid question. The VERA model, by its very nature, is an incentive-based model. More workload generates a greater allocation of appropriated resources. Recognizing that the appropriated resources for veterans' health care are finite——

Dr. WELDON. Can I make a recommendation to you? I'm not the President. You can take my recommendation and throw it out the window. I know that. But I would recommend to all of your VISN directors to tell all of their hospital administrators don't send out letters like that because it absolutely drives people like me crazy. I mean I'm getting letter after letter after letter from veterans that just can't get in, and some of these guys are poor, some of these guys are really sick. You know this. You were the VISN 8 director. And then I have these veterans that moved from one location of the country down to Florida and they're furious. They were getting gold-plated treatment at their old VA center and now they can't even get their foot in the door and it's very, very bad policy.

And let me ask you another question. These 42,000 who can't get even get in, are they included in the calculations for the next year's adjustment and the adjustment after that, or are they totally considered outside the system?

Dr. ROSWELL. They are enrolled in the system, but unless they have received some form of health care, they would not be included in future year VERA allocations. However——

Dr. WELDON. So the future—I'm sorry to interrupt you. I only get 5 minutes. I just want to make sure I understand this correctly. So the 42,000 who can't get an appointment in Florida, we are going to get no extra funds to help accommodate them for next year under the VERA formula; is that correct?

Dr. ROSWELL. Not unless they received emergent care at one of our medical centers facilities where they are told they can go to receive such needed services.

Dr. WELDON. OK. So if they have an emergency and they show up at one of the facilities in Florida under emergency status, then they are included in the counting. OK.

I'm just curious. You have a VISN director from 1 and 3 here; is that right? Can you just share with the committee how many people are waiting to be seen in the VISN you represent?

Mr. FARSETTA. It really depends upon the clinic that they are in. There are some clinics that are essentially closed. They are referred to an assistant facility. I think the advantage we have in New Jersey is our proximity. So you could be denied access to care in a clinic which you conceivably, if you wanted that care in that clinic, could wait 6 or 7 months but then we could refer you to a hospital which is within commuting distance.

Dr. WELDON. Right. Or actually you could even just go across a river or a bridge and you could be in another VISN in some cases and get seen. But you don't keep track, in other words. My VISN 8 person told me we've got a backlog of 42,000, 16,000 in central Florida. You don't keep a record of that——

Mr. FARSETTA. We do not have tens of thousands of veterans waiting for care in our network.

Dr. WELDON. And you're in VISN 1?

Mr. FARSETTA. I'm in VISN 3.

Dr. WELDON. And you're in—you need to push the button. I'm sorry.

Ms. POST. In Network 1 right now we have a waiting list of over 8,000, and we have a capacity that's full at almost 85 percent at all of our clinics and CBOCs.

Dr. WELDON. Yes. That's what the gentleman from Vermont and the gentleman from Maine were referring to. Well, clearly we've got a problem. And thank you so much for your testimony. I appreciate it and I yield back, Mr. Chairman.

Mr. SHAYS. Thank you. I would want to say parenthetically that I did not realize that Florida, your VISN, had such a backlog. I am absolutely dumbfounded by it. I thought this was more of a regional concern——

Dr. WELDON. If the gentleman would just yield for a second.

Mr. SHAYS. Sure.

Dr. WELDON. And I say this for the benefit of all my colleagues on the committee. We did not accept all veterans in the State of Florida up until—Dr. Roswell?

Dr. ROSWELL. 1998.

Dr. WELDON. 1998. Whereas the rest of the country were taking all comers, we had refused and refused, but it was causing political problems within the veterans' system because these veterans were being eligible for care in the Northeast or Midwest and they were retiring to Florida and they being told we will not see you. So we were essentially told you've got to open it up to all comers, and in that 4-year period we've enrolled I think an additional 140,000 veterans in over a 4-year time period.

Dr. ROSWELL. 200,000.

Dr. WELDON. 200,000.

Dr. ROSWELL. The number has grown——

Dr. WELDON. I personally think we need to divide Florida into 2 VISNs or maybe into 4 VISNs, considering the average VISN has about 100,000. But thank you, Mr. Chairman. I appreciate that.

Mr. SHAYS. Thank you. Mr. Sanders, you have about 6 minutes, if you would like.

Mr. SANDERS. I apologize. I'm going to have to leave very shortly to another commitment, but I want to applaud all of my colleagues, regardless of political persuasion, because I think we all agree that we have an enormous problem, and I would hope that we work together. Ultimately what this is about is that we adequately fund the VA and that we get a fair formula. I don't think there's much disagreement, and let's do it. I don't think there is a person up here who thinks that you tell a veteran who is sick that they can't come into the system because the United States of America doesn't have enough money. We make their lives very difficult because we ask them to do what they can't do with inadequate funding.

I would just like to ask the panelists, I am looking at a chart and I just want to see—we're in VISN 1 here—if I have my numbers correct. My understanding is that between 1996 and 2001, there was in terms of funding for VISN 1 a 21,502,000 reduction in funding, which amounts to a 22.2 percent reduction in real inflation-accounted-for dollars. Is that consistent with your figures?

Dr. ROSWELL. I'm not familiar with your figures. My figures show that in fiscal year 1996, VISN 1 was funded at $854 million, that VISN 1 had a gradual increase, and this year received, including supplemental appropriations, $910 million for an aggregated percentage increase in unadjusted dollars of 6.6 percent——

Mr. SANDERS. But unadjusted dollars makes the whole discussion irrelevant, doesn't it, because medical inflation is going off the wall. So let's toss that out. It's irrelevant. In fiscal year 1996, VISN 1 received $821,805,000. So let me just stipulate something and you tell me if I'm missing something.

No. 1, in VISN 1, as I understand it, Dr. Post, we have seen in real inflation-accounted-for dollars, understanding that medical inflation is very high, a significant reduction in real dollars.

No. 2, that would be bad enough, and please correct me if I'm wrong, if we were looking at the same number of patients, but if you combine that with a substantial increase in caseload, you're

looking at substantially less money coming in trying to treat substantially more patients.

Am I missing something or is that correct, Dr. Post?

Dr. POST. I think that's correct, Congressman Sanders.

Mr. SANDERS. All right. Now, some people suggest that one of the problems may be that we have allowed Priority 7 people into the system. I am proud we have allowed Priority 7 people into the system, and I don't think anyone up here has to apologize for that.

Now, I understand you guys are not the President of the United States and are not responsible for the budget, but I want to ask you a question. As medical people, you cannot, it seems to me, do your job well if you don't have the resources to do that. Why are you not coming before Congress and telling us the kind of money that you need so that we can adequately treat our veterans? Dr. Roswell, why aren't you—how much do you need? The Members up here are responsive. How much money do you need so that we don't have these ridiculous situations in Florida or Vermont or Maine? How much do you need?

Dr. ROSWELL. I'm not sure I can associate a dollar figure with it. We clearly have a demand that has exceeded the current available resources and I think we need to seriously consider what the current demand for care, albeit unmet in some cases, means in a future year——

Mr. SANDERS. Dr. Roswell, that's not really a good answer. Why do you not have in your back pocket and say, look, to treat all veterans like the human beings they are, it's going to cost us "X" billions a year? I expect you would have that.

Dr. Post, do you have some estimates for VISN 1?

Dr. POST. I can only tell you what we've gone through in this last fiscal year. The shortfall that we faced in New England was over $80 million. We received a supplement early on or a VERA adjustment of over $40 million, and part of the issue for us as an organization is, as you said, the growth from, 1996 to 2002 has been over 50,000 veterans. This is the first year that we have people in a cue waiting to get seen, and part of that is accessibility of care in New England. VA New England is one of the few networks where over 95 percent of the veterans have access to care within 30 miles of their home. So once it is opened, as you know, in Vermont, the veterans will come there. The problem for us as an organization as we have faced these shortfalls over the last several years is what it is that we do to meet those shortfalls. We've closed over 60 percent of our beds, you've pointed out. We've decreased our work force by 25 percent. We have changed the delivery model in New England from an inpatient service to an outpatient model of care. We've done other consolidations and integrations that any additional ones will mean some closures within New England and that too then will be difficult for the veterans to deal with.

Mr. SANDERS. Mr. Chairman, let me just simply conclude by reiterating the point I made earlier. I would hope that under your leadership, this committee in a nonpartisan-type way can make a demand on the entire Congress and on the President to do the right thing. We are the richest country in the world. We can take care of veterans.

Yes, Dr. Weldon.

Dr. WELDON. If the gentleman would please yield.

Mr. SANDERS. Yes.

Dr. WELDON. I work in the system and I can just tell you that one of the things we can do in this Congress to help our veterans more than anything else is to pass a drug prescription benefit plan for Medicare beneficiaries. These people are flooding the system to get their prescriptions for free and if we can could ever overcome the challenges we face there as a body and pass and sign into law a drug prescription benefit, it would be a huge help——

Mr. SANDERS. As one of the leaders in the Congress on that issue, I would tend to agree with you. Thank you very much, Mr. Chairman.

Mr. SHAYS. Thank the gentleman.

Mr. Otter, you have the floor.

Mr. OTTER. Thank you, Mr. Chairman, and thank you for your testimony, Dr. Roswell. As I said during my testimony, we've got 3,000 folks that are on the waiting list in Idaho right now. My understanding is that they have just been notified that they are on the waiting list and that's it. There's no medical purgatory for them, so to speak. There's no VA purgatory for them, and as my colleague from Florida read where there was a phone message that said don't call us, don't ask us where you are on the list, wouldn't it be helpful, at least encouraging for those that are on that list, if we had some sort of—if not the treatment and if not the analysis and the diagnosis and everything else, at least somebody to say to them, yes, you're moving up on the list, this is how important it is that we get you in?

I'm just amazed that we can have that many people that are just sitting out there on the list. I don't think we'd tolerate that anywhere else. You know, I'm from Idaho and I would like to be put on the Environmental Protection Agency waiting list. I would love that. I would like to be put on the Army Corps of Engineers waiting list that they'll get to see me, but if we were to treat what we think are some problems on water and on land and on watershed in the West, if we were to treat that with the same urgency and the same alarm or if we were to treat our veterans in the same way, it seems to me like we'd make time, that we would make resources available.

Is there something that we can do, that we can plug into the system that at least gives them some attention while they're waiting in line?

Dr. ROSWELL. Well, it's an excellent question, Mr. Otter, and I agree with you. First of all, let me point out that to get on the waiting list they had to fill out an enrollment process form. It's an expedited form, but it does give us some demographic information. At that time everyone should be counseled on how they can obtain emergent care, should it be available, and as Mr. Farsetta spoke of, they're referred to a neighboring facility where capacity may exist. Certainly in Florida, even in Florida, with 42,000 people waiting, veterans are told if they have an urgent need for care, we'll provide the care. If something develops and if they need to be seen right away, we instruct them on where they can go. Most of the people are on the waiting list because they want to be enrolled in a primary care clinic at a location most convenient to their place

of residence. It's not because they have an urgent need for care or don't in fact have access to care, but rather what we have seen over the last several years is lower priority veterans who come into the system and have Medicare benefits but would like to receive primary care and prescription drug benefits from the VA. Those aren't routinely provided until they can be enrolled into a primary care provider's panel.

So I think there is a mechanism in place to identify an urgent need for care when—at the time they enroll and are placed on the waiting list.

We also are developing a process and working internally with our clinicians to develop a mechanism to screen people for medical need during the time they remain on a waiting list. Obviously our concern is that someone who doesn't have an urgent need for care might develop such a need and might not know how to get that.

Mr. OTTER. We've had very good experience with the outpatient clinic from Boise to Twin Falls. I would like to see that happen in my district. Twin Falls is not in my district. I would like to see that happen perhaps in a few other places. But before I run out of time, I'd like you to respond to—the general counsel from the Veterans Administration has held that when a health center reaches the point that they cannot immediately accommodate all their patients, they can no longer give preference to Priority 1s over Priority 7s. It seems to me that is backward, that if I'm coming in with a service-connected—which is a promise that I was made, that the gentleman from Vermont talked about several times and I am prior service, but if I come in with a rodeo injury and somebody else has got an Agent Orange problem, I would say that person should take priority over me.

Are we having lawyers make these decisions rather than doctors? Is that our problem?

Dr. ROSWELL. The general counsel only interpreted the law that was passed by this Congress in 1996, the Eligibility Reform Act of 1996, which essentially says that once enrolled, all veterans must be treated equally. The Secretary has the authority to determine eligibility for enrollment based on the availability of resources nationally, but once enrolled, all veterans, regardless, by law, by statute, must be treated equally. So it is the general counsel interpretation.

Mr. OTTER. Thank you. Thank you, Mr. Chairman.

Mr. PUTNAM [presiding]. The gentleman from Maine, Mr. Allen.

Mr. ALLEN. Thank you, Mr. Chairman.

Dr. Post, I understand that contract costs for just one specialty service in VISN 1, invasive cardiac procedures, came to over $2 million this year. That's the figure I've been given, and I gather that 1 reason may be that there is a lack of acute care beds in Boston, which is obviously a referral center for Maine. Can you talk a little bit about contract hospitalization costs in VISN 1 and what do you think has caused the increase, what plans are in place to address the problem? If you could give us some sense of that, I would appreciate it.

Dr. POST. It's a very significant problem for us, especially this past fiscal year. When we integrated the 2 inpatient hospital facilities in the Boston area into 1, we reduced our beds even more. I

used the figure before of coming down in our acute beds to about one-third of what we originally had. In 1996 we had something like 2,800 beds. Now we're down to about 900 beds. The issue is a domino effect, especially in the Boston health care system. We wound up moving all of the inpatient services to the West Roxbury campus in the last 18 months or so, and we wound up combining a number of intensive care units. We don't have enough ICU beds and enough telemetary beds in the Boston health care system. We are in the process of designing and constructing some more of those beds. If we don't have enough beds there, then the backup happens in Maine and in Vermont and in Rhode Island of the patients that might feed in there.

And another confounding problem for us in New England in the last year has been the new operating rooms in Connecticut where we also do open heart surgery. That had been delayed and finally opened up in the last several months. So they were behind as well in Connecticut where we can also do open heart procedures.

Mr. ALLEN. Does that mean you think the problem will be eased next year?

Dr. POST. It will be better next year once we get more telemetary and ICU beds in the Boston health care system and open up to full capacity the operating rooms in Connecticut. I'm not sure that it will resolve totally the issue because New England has a much older population. We have more veterans that are 75 and older, greater demand, and we have the largest open heart program in New England in all of the VA.

Mr. ALLEN. Let me go to another issue about recruitment, about retention of staff. I want to talk—have you talk about the Network Resource Board. The critics of the board would say that the process of reviewing staffing requests by the board makes the process convoluted and cumbersome and creates what they call a hiring lag, and I am going to obviously want you to respond to this, with respect to two categories of employees; first, with specialists, medical specialists of one kind or another; second, with ancillary or support staff.

We still hear in Togus that doctors are making appointments and nurses are washing beds, and they are doing things that lower-level employees would be more effective to have—cost-effective to have lower-level employees handle.

So the question is, how would you assess what the board is doing, and in terms how would—how would you talk about—how would you describe the general problems of recruiting specialists throughout New England VISN?

Dr. POST. I think there are several aspects of dealing with the work force in New England. One, in certain areas we have great difficulty of recruiting people, as you know, in Maine, trying to recruit a radiologist, which I think went on for over 2 years, trying to recruit. So that is one issue.

The second issue—and part of that first issue is the availability of the specialists, and our ability to pay a comparable salary to that individual working for the VA, if he or she were in the private sector, what he or she might be able to achieve in that area. So that is one issue.

And the second issue, and I—I actually have to address this as network director, the implementation of the network resource board to control, to better control our growth in numbers, and you know that I gave a commitment that anyone that needed to be hired would be hired with a phone call to me, and I have stood by that. Especially with the nursing shortage that we face in New England, you can't wait for the biweekly resource board to convene to have that. There has been a problem, I think, with the process itself, and we have pretty much ironed that out right now, so much so that within 24 hours of a meeting, I have those minutes and I approve them and it is done with.

The other issue you asked me about was ancillary support. You can't continue to face the budgetary shortfall that we have faced over the last 6 years as a network without redesigning the systems and the delivery of care. And in some of that, then you lose some of those support staff, and so the decision of hiring the cardiac surgeon versus the housekeeper is a very difficult decision to make, and I have asked an interdisciplinary group in the resource board to assist me in making those decisions. The proof, though, is in the outcome. And the outcome for Network 1 has been—and it may seem small to some other networks—we have reduced our FTEE so far this area by 120, that is another 120. We will save about $5 million just in doing that alone and by implementing the Network Resource Board.

It is a part of being an integrated delivery system, a part of addressing standardizing the care throughout New England, the same cardiac surgery program that exists in the support staff that we need in Boston and how it does exist then in Connecticut in support of the 195,000 veterans that we care for in New England.

Mr. ALLEN. Thank you.

Mr. PUTNAM. Thank you. It is illustrative to see the differences in perspective on this committee, and it gives us some insight into how difficult it is for you all to manage the system. It is not a—it is not a fight between the haves and the have-nots. It is a fight amongst the have-nots.

But on that point, as someone from a State that has a 42,000-case backlog, I would like to readdress Dr. Weldon's point as it relates to that backlog not counting toward the next year's enrollment or growth. Is that a change that must be congressionally motivated, or is that something that can be done from within the department?

Dr. ROSWELL. The VERA model is not department policy, is not congressionally driven or mandated. Well, there is a statutory requirement that requires a VERA model, but development of that model is departmental policy. The dilemma is that—and one may say this is a Catch–22 situation, but a veteran who is on a waiting list and not receiving health care consumes no health care resources, and, therefore, a model which attempts to identify the cost of providing care to a veteran and index the reimbursement to the VISN based upon the cost-providing care to that veteran, would look at that veteran and say this veteran received little or no care and therefore the VISN is entitled to little or no VERA allocation as a result of that.

I think the more important issue is how do we develop, expand the capacity to make sure that all veterans, regardless of service connection, regardless of priority, have access both to the care they were promised and the care they desire through the VA.

Mr. PUTNAM. Well, but clearly there is some—there is some—there is already in place a mechanism to set some priority. And you have a situation, I mean, you have got a lot of smart people in your department. Surely you could come up with some base allocation for these patients who are on the waiting list to make future funding decisions, to get something in there to acknowledge that they are there. But pretending that they don't exist because they didn't actually walk through the door because they were waiting a year to get an appointment is absurd.

We have, for example, also in place a policy that says that they must go to the hospital before they can qualify to go to an outpatient clinic that has been contracted with the VA.

So, again, we have a situation in my area where we have a capacity at an outpatient clinic that is contracted through the VA of a thousand veterans. They have 500 in there currently. But, because there is a year to 15-month wait to get into the hospital, to get pre-clearance to go to the outpatient clinic, you have people who live down the street from an outpatient clinic, under capacity, but they can't go see it because they are waiting a year to go get entered into the system at the hospital in Tampa before they can come back and go down the street for health care.

There has got to be a better way to do that. And in that particular case, it is not a matter of resources, it is a matter of bureaucratic hurdles that we can't find a way to input the person in the same in the outpatient clinic. They have to further bog down the waiting list at the hospital where people are in need of a higher level of care just to get in and get their paperwork processed.

Could you please comment on that.

Dr. ROSWELL. Well, it is a frustrating situation. I believe the clinic you are speaking of is what we call a contract clinic where we actually pay a capitation rate to the contractor who provides care to the veterans.

Given the current limitation of resources in VISN 8, my suspicion is—I would have to verify this—is that Tampa has felt obliged to restrain the growth even though there is a budgeted amount restraining the growth in the contract clinic as a cost-avoidance measure to be able to get through the current fiscal year, given the huge demand elsewhere.

To go back to your waiting list, we will certainly take it under advisement to look at a VERA process that would consider people on a waiting list. Let me point out that the VERA model currently has what we call unvested patients, who are patients who have been seen on 1 or 2 occasions but who haven't had a full and comprehensive physical examination, and there is a VERA allocation rate of $197 per year for those patients. My expectation is that a waiting list patient would be funded at something less than that, were we to move to that type of model.

Mr. PUTNAM. One final question before my time expires. We had talked about some of the staleness of data in high growth States where you have got 40 percent growth. Is there a way to change

the model that would include more recent statistics, for example, the last quarter of the previous year, and the first three quarters of the current year or some shift like that would be more timely? Is that a possibility?

Dr. ROSWELL. It is possible. It is something that we have looked at in looking at a trailing four quarters of workload. As you probably know, the VERA model is based on an entire fiscal year's worth of workload, and we use the most recent complete fiscal year. We have explored looking at a trailing two or four-quarters model. There are significant logistics associated with that because the data base has to be closed out. In other words, each medical center and now each location of care, over 1,300 nationwide, would have to make sure all of the data is entered into the data base on a date certain to be able to close that out even on a quarterly basis. Failure to get all of that data into the system would unfairly penalize any network that didn't get their data into the system. So it is something that we have looked at. There are some significant logistics. But if our current rate of growth continues with the unpredictability we have seen in the last couple of years, it may become a necessity.

Mr. PUTNAM. Thank you very much. At this time the Chair recognizes the gentlelady from California, Ms. Watson.

Ms. WATSON. Thank you, Mr. Chairman, for convening this hearing. America's war against terrorism requires us to once again call upon brave men and women of our armed services to risk their lives to protect America. They have taken a pledge to serve our country, to give their lives to protect our fellow citizens and our values.

Our troops deserve no less than to have their country fulfill its pledge to them. But on that count, our Federal Government continues to fall short. We are the most prosperous Nation on earth, and our veterans should not have to go begging for adequate health care from our Federal Government, especially when they have been given a pledge that in exchange for the great price they pay, they would pay the small price of providing for their health care.

Our veterans could be forgiven for thinking that they already fought enough. They shouldn't be forced to fight for the basic health services they were promised. The cruelest twist in this story is that our veterans are being forced by the Federal Government to fight their own brothers and sisters in arms; Connecticut vets pitted against their brethren in California; VA facilities in Newark pitted against those in Naples, Florida. And in the war to defend our veterans, this is the wrong battle. We should be talking about how to increase resources for the entire veterans affairs health care system rather than arguing over how the least few scraps are divided.

Mr. Chairman, I would like to see the members of this committee leave this hearing with an increased appreciation for the strains we place on our veterans and their families when we fail to provide the necessary resources to the VA system.

And one last observation. I can't help but believe that much of the increased demand for VA health services among Priority 7 veterans, those veterans without service-connected disabilities, is because of the increased cost of prescription drugs and the lack of an

affordable coverage for those drugs. I believe that if we here in Congress commit ourselves to creating and funding a comprehensive prescription drug benefit plan, as has been asked for, it might relieve much of the stress on the VA. And I understand that the GAO will soon be investigating this very issue.

In the meantime, I would hope that the VA does not look at Priority 7 veterans as a burden, but instead sees them for what they are, veterans who deserve the best care the VA can provide. And I would like to just suggest that we have VERA Priority 7. Have these different levels. And I really feel that we should strip the levels. Every one who has ever fought who is a veteran should be serviced, should be the benefit of the promises that we have made them.

If we want to build a strong military, we have to keep our promises. So thank you, Mr. Chairman. And no further comments or questions.

Mr. PUTNAM. Thank you, Ms. Watson. The chairman from Connecticut, Mr. Shays.

Mr. SHAYS [presiding]. Mr. Chairman, I would like to just be kind of clear as a basis before we pursue these hearings further, and I am pretty certain that we are going to try to go to some of the VISNs before the end of the year and get a better handle.

I am pretty certain, too, that Congress is as much a part of the problem, if not more, if we have required services to be provided and we haven't provided the resources, but then the VA system becomes culpable when they don't ask for exactly what they need, or it needs to do the job properly, because I mean it is self-evident.

I had been led to believe that part of the problem we encountered was that some VISNs were getting more than needed and some were getting less. I was led to believe that within a VISN—I certainly have this bias that Connecticut has done a better job of controlling costs than the Boston area, and so that some of our resources went to an area that hadn't dealt with the cost savings the way we needed to. And I am aware that we have expanded the—those who qualify so to include more people.

One of the things that I am wrestling with is, first off, so I would like you first, Dr. Roswell to tell me, where are the areas where we have the greatest problems and where are the areas where right now the resources seem to be adequate around the United States?

Dr. ROSWELL. Thank you, Mr. Chairman. I agree with your premise that it is not an issue of some networks having excess resources. In fact, when we began the allocation process for the fiscal year 2002 budget, based upon the fiscal year 2002 President's budget back early last summer, we had 18 of 22 VISNs then identify an operating shortfall based on a projected allocation. 18 of 22 VISNs felt that their allocation would be insufficient to meet the workload demands based on our projections at that time.

As it turns out, our projections at that time underestimated the actual number of veterans who would use the system this year. In fact, they underestimated the number of veterans using the system this year fairly significantly.

For example, we projected a 25 percent increase in Priority 7 veterans. The actual increase, fiscal year to date of Priority 7 veterans

who are using our system, is over 50 percent. So there is a huge demand. And yet our budget projections identified 18 of 22 VISNs with a shortfall. By applying management efficiencies, asking them to contain FTEE ceilings, employment ceilings, asking them to use collective purchasing agreements and other types of management efficiencies, all but five VISNs developed plans that would offset essentially all of their budget shortfalls. The remaining 5 VISNs did in fact receive supplemental fundings. Over $260 million in supplemental fundings was provided.

Mr. SHAYS. But the shortfalls—saying that they have met their shortfalls would imply that they are providing the services that are required for the area and yet, you know, in Connecticut, I have veterans who tell me that basically they can't use the facility until someone dies or moves away. Those are the two reasons why there would be—and yet you would, based on your terminology, say that the hospital has no shortfall. The reason they have no shortfall is they have decided not to take more.

Now nodding your head won't cover it for the record. So I need to know if that is—do you agree with that or not?

Dr. ROSWELL. I think you have made an accurate characterization of the demand for nonemergent care in many, many networks, including your own district.

Mr. SHAYS. So what you are really saying is that in some cases they were able to meet their shortfall, but then they were not able to take any new veterans. And so when you look at a budget, you might say they balanced their budget, but they basically didn't provide a service that was being demanded by a number of veterans. When I say demanded, that a number of veterans knocked on the door and they were told that they couldn't come in; correct?

Dr. ROSWELL. You are correct. I would point out that virtually all—not virtually, all VISNs have sustained a significant increase in the number of veterans they are providing care and services to this year. But many have exhausted their capacity to treat additional veterans.

Mr. SHAYS. Is that basically on the size of the facilities and the physical structure or the number of people and resources?

Dr. ROSWELL. It is based on all of the above. In some cases we have locations, community-based clinics, where we have limited space that would accommodate 1 or 2 primary care providers. Once they have reached a certain panel size, a primary care provider simply can't manage any additional patients.

So in some cases it is based on FTEE or employment. In some cases it is based on the physical capacity. In many cases it is based on the availability of resources. But I can assure you that there is no clinician that I have yet met, and I have met many of them in the VA health care system, who has time on their hands to be seeing patients who is not doing that.

Mr. SHAYS. Say that last point again.

Dr. ROSWELL. What I am saying is, we don't have clinicians who are able to treat any more patients than they are currently treating. Our staff are working harder, longer, more diligently than they ever had, in a Herculean effort to try to accommodate them.

Mr. SHAYS. I guess what I am trying to understand, if we appropriate more money, will we have the space to service them if we

hire more people, or are we at a capacity point? I mean, maybe our two VISN people could respond in their districts.

Dr. ROSWELL. We actually have excess space in our medical centers. Where we have a shortage is in our community clinics, what we call community-based outpatient clinics or CBOCs. Those are leased facilities, though. Those are short-term leases. With additional money we would expand the number of providers, and in a number of cases, lease additional square footage to accommodate the increase in clinical provider staff at those locations.

Mr. SHAYS. OK. Mr. Chairman, I understand you have to go. I am happy to have you just bring me the gavel. With your permission, I will give myself permission. I would like to—I would love to be able to do another round.

Mr. Allen, if you would like to go—if I could just do 5 more minutes, then I will just go directly to you. Is that all right?

I—I want to just be clear on both VISNs. Do you have space? Do you both agree—it is community-based—if you both can respond. Are your community-based clinics at capacity?

Mr. FARSETTA. I would agree with Dr. Roswell. There is clearly capacity in our main facilities. In our community-based facilities, most of them are in leased space. The limiting factor, if it is leased space, probability of relocation or expansion is there. But the real limiting factor are people needed to provide additional care to patients.

Dr. POST. I agree. I think that given additional resources, we would be able to hire more clinicians to see those patients in the space that we have.

Mr. SHAYS. What is interesting is we didn't have those clinics a few years ago. And both Republicans and Democrats alike, working together, I think we took a great deal of satisfaction in the fact that people didn't have to go to that big facility and they could come locally. And what it strikes me as, did we basically create a market that didn't exist before? In other words, was there kind of this way of deselecting—not deselecting, but not selecting because people simply didn't use the service because they had to travel 40 miles to get there and now the service is there it is great and they want it?

Dr. POST. We have not mentioned in any way today——

Mr. SHAYS. Is that a yes, first?

Dr. POST. It is a yes for sure. But we have not mentioned the quality of care. Because once the veteran comes in, he receives high quality care as measured by a whole host of performance measures that are there for us to point to. We are even better than the private sector.

Mr. SHAYS. Right. But the issue is, it strikes me in the past we had veterans who qualified who just didn't use the service. We made—we did what we should do. We said how can we better serve the customer, the veteran. In the process of doing that, we created veterans who said, hey, not a bad service, it is nearby, I am going to take advantage of this service. So that is one issue. Is that a yes?

Dr. ROSWELL. That is correct, Mr. Chairman. Today 87 percent of all veterans we serve live within 30 minutes of a VA clinic location. Part of the reason for establishing community-based out-

patient clinics was to make care more accessible. It was also intended and has proven to provide care at less cost, recognizing that care provided in a community setting is less costly than care in a metropolitan setting. What we didn't anticipate was the large number of veterans in lower priority groups who would opt to use VA for their health care benefits who previously had not done so.

Mr. SHAYS. Now how many different groups of veterans do we have?

Dr. ROSWELL. Currently 7 priorities.

Mr. SHAYS. The seventh one being so-called the lowest priority, but they now qualify the wealthy nonservice-related veterans, correct?

Dr. ROSWELL. Some would argue with wealthy. Living with an income for a single person about $25,000 a year, without compensable service-connected conditions. There are actually veterans in Priority 7 who have service-related disabilities.

Mr. SHAYS. So 7 isn't wealthy, necessarily.

Dr. ROSWELL. It is.

Mr. SHAYS. Mr. Allen, you have a question. You need to go?

Mr. ALLEN. I do have a question.

Mr. SHAYS. You can wait. OK. So what I want to ask is, is any veteran getting a letter who is service-related, service-connected, being told there is not a space available?

Dr. ROSWELL. That is probably occurring for a veteran in a higher priority who has chosen, for whatever reason, not to use the VA system in the past, but in the current fiscal year is now seeking care for the first time ever. That veteran would be told——

Mr. SHAYS. Why wouldn't that veteran jump ahead of all of the others, service-connected?

Dr. ROSWELL. Because of the eligibility reform legislation passed in 1996 that requires us to treat all veterans equally.

Mr. SHAYS. I can see you doing them based on income. I always thought that if it was service-connected, they would be first in the door. I always thought that. That is pretty surprising to me.

Dr. ROSWELL. That has changed. That changed in October 1998 when the legislation I referenced was implemented. That was the general counsel's opinion that the—the gentleman previously referred to which in essence says the law requires us to treat all veterans, regardless of priority, equal in assigning them to care once the Secretary has determined who can enroll in and receive the full health care benefits.

Mr. SHAYS. But now everybody can enroll?

Dr. ROSWELL. That is correct.

Mr. SHAYS. So the service-connected veteran is not given any disability—is not given any advantage over the veteran who has a concern not related to his service?

Dr. ROSWELL. That is correct.

Mr. SHAYS. Mr. Allen.

Mr. ALLEN. Thank you, Mr. Chairman. I will be brief.

Dr. Roswell, I am wondering why the VA doesn't seem to adequately take account of staff COLAs or other predictable annual increases in the cost of care? In Maine it is heat. It can be prescription drugs. But every year those costs go up. And every year you have to struggle with, you know, trying to—this situation caused

by those cost increases. Is there some way to do a better job of predicting those increases and dealing with them up front in your budget, or is this—is your current process the best of all possible worlds?

Dr. ROSWELL. I think there are ways to predict health care inflation which is, as you surmise, greater than the general inflationary rate. We have looked at actuaries to project workload. Changing economic projections have shown that our projections are less, our actuarial projections have underestimated the demand. Inflation and pharmaceutical costs particularly have risen substantially. But in the end I, of course, am obligated to support the President's budget request.

Mr. ALLEN. I understand. I understand that. Thank you, Mr. Chairman.

Mr. SHAYS. Thank you.

Ms. Watson, do you have questions that you want to ask?

Ms. WATSON. No.

Mr. SHAYS. Before we get to the next panel, I would like to just ask, have you—have the networks—I would like to ask both of our VISN folks, have your networks adjusted to the influx of Priority 7 veterans? How have you?

Mr. FARSETTA. I am not quite sure I understand the question. What we essentially do in our network is take care of all veterans who are seeking care as quickly as we possible can. Those that would experience long waits, we offer a referral to our main hospital. Those clearly who require emergent care, we recommend that they seek care in the local community or we move them to a, you know, to a VA hospital.

We have experienced about a 27 percent in Priority 7 level veterans. They comprise right now about 37 percent of my workload.

Mr. SHAYS. Is that based on their desire for prescription drugs?

Mr. FARSETTA. I think a percentage is. I think a percentage is related to the fact that the individuals who make I want to say 25 or $26,000 in the New York-New Jersey metropolitan area basically can't afford health care so they come to the VA; for whatever reason, whether they come for prescription medication, whether they come to see a podiatrist, whether they came to see an optometrist, or come to see a primary care doctor.

Mr. SHAYS. Describe to me the benefits of prescription services for a veteran.

Mr. FARSETTA. The benefit of prescription for veterans is a veteran has to see a VA provider in order to get prescription medication. So if a veteran comes——

Mr. SHAYS. Then the cost?

Mr. FARSETTA. The cost would be a $7 co-pay.

Mr. SHAYS. No matter what?

Mr. FARSETTA. No matter what.

Mr. SHAYS. No matter what the drug is?

Mr. FARSETTA. No matter what the drug is. If someone comes in for over-the-counter medication, it is 7 bucks. If someone comes in for a fairly expensive antiviral medication, it is $7.

Mr. SHAYS. I had a number of veterans come to my community meetings in the last 2 weekends and one of them said to me, he doesn't—he has the ability to pay for his own prescription drugs.

But he said he felt like he was not taking advantage of a service that was provided and so he said he then sought it, he said because it was so inexpensive compared to what he would have to pay in any other program.

He said, I wasn't asking for the service, but I began to think that I was crazy for not utilizing the service because I am entitled to it. And, you know, I am just—I am not sure if we even do what Dr. Weldon said and make sure we pass the prescription drug, whatever we pass won't even come close to touching the benefit for veterans.

Mr. FARSETTA. There is no question, I think, that—I am only speaking for my network, that we fill a very real need as it relates to prescription benefit that is available to veterans. As I said earlier, for many veterans it may be the difference between eating and not eating, between taking medication on a regular basis and not taking medication at all.

Mr. SHAYS. OK. Dr. Chirico-Post.

Dr. POST. Let me just add one comment about how we in Network 1 have tried to meet the demand of the influx of patients seeking care with us because in New England I think it is a factor of the economy, and certainly in several of the States, many of the HMOs have failed, and so many of those veterans have then come to us.

We in VA have been a proponent of something called the Institute of Health Care Quality Improvement to redesign the systems. And what has happened in New England is that, as Congressman Allen has said, in Maine they are coming in at a rate of 500 a month. The same is true in Rhode Island. The same is true in Vermont. So it requires a changing demand set to be—to change the delivery model and the CBOCs to meet the demand.

Mr. SHAYS. Could you say that again in words that I can understand? I want you to totally start over. I want to understand what you are addressing. It is not your fault; it is my fault. I missed the first part of the connection. I was always like trying to catch up to you.

Dr. POST. You asked how has the network met the increasing demand. You used Priority 7s only. I believe it is an increase in demand in—certainly in New England of all priorities. Granted, the greatest growth has been in Priority 7s. I added to that it may be a factor of the economy and the failure of the HMOs.

The change in the delivery model by using a technique to change how we address seeing patients in the clinics to become more efficient is one of the ways that we have addressed that increased demand.

Mr. SHAYS. Dr. Roswell, we have added billions of dollars each year to the Department of Veterans Affairs. How much of that—how many new dollars, though, have you gotten into the health care side? How much more do you have this year over last year and the year, and so on?

Dr. ROSWELL. Let me ask for some assistance here to give you a precise figure.

Mr. SHAYS. You were sworn in, correct, sir?

Mr. NORRIS. Yes, sir.

Mr. SHAYS. Bring a chair up.

Dr. ROSWELL. Jimmy Norris is our chief fiscal officer.

Mr. SHAYS. You just need to identify yourself and make sure you leave a card with the transcriber.

Mr. NORRIS. Yes, sir. I don't recall exactly what—how much more we got this year. We did get a substantial increase over last year for 2002 in the medical budget. It was insufficient to meet the increased demand that we have expected.

Mr. SHAYS. We are talking about $1 billion. And Everett Dirksen says, after a while $1 billion starts to add up to a lot of money. So we are putting billions of dollars of new money into health care, but we seem like we are really losing ground.

Mr. NORRIS. Yes, sir. In the 2003 budget that is now being considered by the Congress, we have a substantial increase over the 2002 level, coupled with a cost-sharing proposal that we understand probably is not going to be approved. But we had attempted to identify a need above our current fiscal year 2002 requirement of about $2.5, $2.6 billion.

Now there are some new things in there that don't provide health care, accounting transfers. But I am thinking about $1.4 to $1.5 billion of real increase in the 2003 budget request. Even at that, that was based on enrollment projections at the time that have been exceeded. So you are exactly right, we continue to be overwhelmed even in our best efforts to identify the requirements.

Mr. SHAYS. The reason why I am asking this question is, I don't think any of us up here have the full courage to do what a—what would probably have to be done, short of just bringing in vast sources of money. It would be to start to try to decide which veterans should be first in line, who should be second in line, who should be third in line, and do it that way, to make sure those in the greatest need get the services, and I am wrestling with the fact that I have no concept, for instance, if Priority 7, how much of that is your total workload? But I would be interested to know. What is it?

Dr. ROSWELL. Mr. Chairman, in fiscal year 2002 our medical care appropriation was increased by over $1 billion. However, on a $22 billion base, that billion dollar increase represented a 4.6 percent increase in the total available dollars. That 4.6 percent increase had to bear the cost of the annual pay raise, it had to bear the cost of medical inflation and pharmaceutical inflation. The pharmaceuticals, as costly as they are, comprise an ever increasing percent of our health care expense. So you can see that $1 billion is a substantial amount of money, but $1 billion on a $22 billion budget——

Mr. SHAYS. So what you are telling me—if they want to get on the next panel, if they want to jump in, feel free. I just want to establish this for the record. What you are basically telling me is that we need billions of new dollars each and every year into this system? I mean we are going to see more than a 4 percent increase. I mean that is fairly clear from your point.

Dr. ROSWELL. Yes. This year, under open enrollment with that 4.6 percent increase that covered all of the costs I have described, our actual increase in veterans receiving care, fiscal year to date, is up by 18 percent. So you can see, Mr. Chairman, that with an

18 percent increase in the growth of users, and 4.6 percent increase in available resources, we have a trend that is not good.

Mr. SHAYS. I am struck by the fact that if we gave you billions of dollars of new money, you would have to hire new people—I don't even think it is conceivable that you would be able to deal with that influx even with new money. It seems to me you are almost at a—you can only grow logically, there are only so many doctors you can hire, and you can only hire only so many nurses, only so many folks to do the services, it strikes me,I mean, and so it is—I am just leaving with this feeling that we have to do something on the other side of the equation. We are going to have to try to help decide who gets the service. I would think that if I were a veteran, which I am not, I would not want to be in front of anyone who had a service-connected disability. I would think that I would, you know, allow them to step in line in front of me. I would think most veterans would do that, wouldn't you?

Dr. ROSWELL. I am a Priority 7 veteran myself. And you are correct. I don't feel it is fair for me to use the system. As proud as I am of the system and the quality of care provided, I try to—I don't use the system routinely for my routine care. I pay for it myself. So, yes, I do agree with you.

I should point out that under the current eligibility reform legislation, Secretary Principi has the authority to determine if the system has insufficient resources to provide care to all priority veterans. In December of last year, he was prepared to close the system to new enrollment of Priority 7 veterans. However, he was asked to reconsider that with the promise that additional supplemental funds would be appropriated to cover the costs of Priority 7 veterans for the remainder of this fiscal year.

Mr. SHAYS. OK. Let me just ask you this question. We will close up. Do you want to jump in?

Mr. ALLEN. Yes. I have just two things. One, a more technical point. My understanding is that with respect to the VERA allocation formula itself, Priority 7 veterans are not included. Is that true?

Dr. ROSWELL. It is not entirely true. They are included for complex care, which is the most costly care, that pays an annual rate of $41,677. Also, if they are non-compensably service-connected, it is zero percent. They are included in the basic allocation. But the majority of Priority 7 workload, what we call the basic vested category, doesn't provide funds for Priority 7.

Mr. ALLEN. So those people coming in for prescription drugs, say, and not much else, they are not counted in the allocation formula?

Dr. ROSWELL. For the most part.

Mr. ALLEN. The second point is since we have—you have done a good job describing the stresses on the system. I just wanted to—to ask you to reflect on the place of the VA health care system in relation to what is going on in the rest of the country. I mean, I—I do have a point of view here. What I see happening in Maine is that in very fundamental ways our health care system is breaking down. There is no individual market left in Maine worth describing. And the small group market, particularly for the small business community is—the rates are going up so fast over the last 3

years that people are not being able to buy health insurance the way that they could in the past.

I just—can you talk a little bit about VA in relation to the—all of the stresses and strains in the rest of the health care system.

Dr. ROSWELL. I think several members have alluded to the crux of the problem, as I see it. There are 9 million veterans currently age 65 and over. 93 percent of those veterans age 65 and over are fully eligible for Medicare. However, as has been mentioned in this room today, Medicare does not provide a prescription drug benefit.

Since October 1998, virtually all of those 9 million veterans who rely upon Medicare for their health care have now been eligible to receive care, including prescription drugs, at $7 per prescription from the VA.

To date, almost 1 million of those 9 million are enrolled in and are currently receiving health care services through the VA. But until such time as a prescription drug benefit is available, we can expect continued growth from a million to something much closer to the total population of 9 million veterans who are Medicare beneficiaries.

Mr. ALLEN. Thank you very much. Thank you, Mr. Chairman.

Mr. SHAYS. You just said something that just heightens my concern. You said only 1 million of the potential 9 million are utilizing the very—almost nonexistent cost prescription service. I mean $7 is the cost. I have many, many constituents who spend thousands and thousands of dollars a year on prescription drugs. And if they happen to be veterans, they can go and it is a $7 co-pay; correct?

Dr. ROSWELL. If we can get them assigned to a primary care provider, yes.

Mr. SHAYS. If they get it.

Dr. ROSWELL. Yes.

Mr. SHAYS. As more and more people start to understand that they qualify for this extraordinarily inexpensive service, you are saying only 1 million of the 9 million have actually requested this service.

Dr. ROSWELL. As of the end of last year, that is correct.

Mr. SHAYS. So is there any estimate of what the cost would be if 7, 8, or 2 million did it, or 3 million did it? I mean the cost would just be mind-boggling. You are nodding your head.

Dr. ROSWELL. I do agree with you. I think were that number to increase significantly, as it clearly could, based on our market share——

Mr. SHAYS. It will.

Dr. ROSWELL. It could be astronomical.

Mr. SHAYS. I would just hope that we would develop a cost that would be a little more realistic. Obviously those who can't and don't have the resources, then I would want it to stay at this number. But it would just strike me that we got some real wrestling to do, don't we?

Dr. ROSWELL. Yes, sir.

Mr. SHAYS. Big time. I think this system is in a—is on the edge of cliff. And I think that we all know that it is.

Dr. ROSWELL. I do agree with you, sir. The Secretary proposed in the 2003 budget proposal sent forward by the President that some of the costs be borne by a $1,500 deductible. That has not

been well received by the veterans service organizations or oversight committees. I think we recognize that there are other options that could be considered. Medicare subvention would be a mechanism to deal with this extraordinarily expensive care we are providing. Another mechanism to limit access to care would be a third possibility. But I do agree with you, something has to change because we are on a trajectory that we cannot sustain.

Mr. SHAYS. You are not prepared for all of veterans to show up. That is the bottom line. And the way you are dealing with it is you are basically saying, until a veteran leaves or a veteran dies who is already in the system, we are not going to service you. And if that is the alternative, to—if—if that is what exists now, there is going to be a point in time where we are going to have to make some other very hard decisions, and I don't know if this Congress has the political will to do it. And I will include myself in that. But I do know I couldn't look a veteran in the eye and say this present system is serving veterans at all. And I know that we have to spend a lot more new dollars than we are. So I think you certainly know that, Tom. But, wow.

Do you have anything you want to say before we get to our next panel?

Do any of you want to answer a question that you thought we should have asked? I am being serious, I am not trying to be funny. Is there any question you were prepared to answer that you thought we really should have asked?

Mr. FARSETTA. The only point that I would like to make, I was just going to discuss what had gone on in our network——

Mr. SHAYS. Why don't you ask—what is the question you want to answer?

Mr. FARSETTA. The question is, what impact has the reduction had on the infrastructure of your network?

Mr. SHAYS. Good question.

Mr. FARSETTA. The answer is that in 1996, I started out with 176 buildings. I have reduced close to 4,000 employees, 51 percent of my beds, 69 percent of my average daily census, and I still have 176 buildings. I still have 8½ million gross square feet of space. I still have 218 elevators. The average age of my buildings is, instead of being 44 years of age, is now 50 years old. 30 percent of my buildings are more than 70 years old. If I don't shed my infrastructure, I can't possibly achieve——

Mr. SHAYS. You are under oath right now. All of this has to be true.

Mr. FARSETTA. It is true. It is right here. It is all here. This actually was a physical assessment of my—the structures in my network.

Mr. SHAYS. I am struck by the fact that we increased your workload, increased who qualified, but we also did something we all wanted to do, that was we had outreach so we created more potential customers. And I am struck by your community-based health care, your clinics are not—are turning people away. But I would like to think that if someone needed surgery, they wouldn't be told that they couldn't be serviced.

Mr. FARSETTA. The reality of the situation is that people who need acute care or urgent care, and I can speak for my network

treaters, if they need surgery, they get surgery. If someone comes in with an acute condition, you know they have an acute situation, if someone goes to our community-based clinics, and has to wait, we would say if you think it is an emergency, either go to your local emergency room or go to a VA hospital and they will be seen immediately. We do that. We aren't saying to someone who needs surgery, well, we will see you a year from now. That is not the case at all. I don't think that is the case in Florida, either.

Mr. SHAYS. Doctor, was there a question that you wanted to answer?

Dr. POST. No, there wasn't.

Mr. SHAYS. Dr. Roswell, just let me be clear on one more statistic and then we will be done here, unless you say something provocative.

When you give the 1 million, 9 million, that just relates to prescription drugs?

Dr. ROSWELL. Those are veterans aged 65 and older.

Mr. SHAYS. So you are saying the entire system, not just those who could qualify for prescriptions. You are saying that basically you serve one-ninth of the potential veterans right now?

Dr. ROSWELL. No. That is in the veterans aged 65 and older. Actually our total market penetration in the entire veteran population of about 24 million veterans is around 22 percent, 23 percent. We currently serve about 4.6 million. But we anticipate we will serve 4.6 million veterans this year. However, many veterans have been ineligible for VA health care until 1998.

Mr. SHAYS. Right.

Dr. ROSWELL. Therefore, veterans age 65 and older who have had access to the Medicare, the CMS health care system, have not sought care through the VA, now that they are eligible and receive a full prescription benefit, they are coming to us in huge numbers. And that is where I expect our relative market percentage will go up. It is currently one-ninth. But it can go substantially higher.

Mr. SHAYS. This takes my breath away.

Thank you all very much. I appreciate your service to our country and to our veterans. And we know we have, in this side have a role to play that we clearly aren't playing.

Thank you all very much.

Out next panel is Ms. Cynthia Bascetta, Director, Health Care, Veterans Health and Benefit Issues, General Accounting Office; accompanied by Dr. James Musselwhite, Jr., Ph.D., Assistant Director of Health Care, General Accounting Office; and also testifying, Mr. Gerald Donnellan, Director of Rockland County Veteran Service Agency; Mr. John C. Bachman, Captain, U.S. Air Force, Retired; and Mr. Edward Burke, Co-chair, VA Connecticut Community Mental Health Advisory Board.

I would welcome you all to stand.

[Witnesses sworn.]

Mr. SHAYS. OK. We will proceed as we called your names, we will do that. I guess, Mr. Burke, I am going to have GAO go first, because—just so you understand, GAO could request that they be testifying separately, but it is helpful to put the panel together. So we appreciate that. We understand, that is a request that we honor. Thank you for not making it.

Ms. BASCETTA. You are welcome.

Mr. SHAYS. Thank you.

STATEMENTS OF CYNTHIA BASCETTA, DIRECTOR, HEALTH CARE, VETERANS HEALTH AND BENEFITS ISSUES, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY DR. JAMES C. MUSSELWHITE, JR., ASSISTANT DIRECTOR, HEALTH CARE, GENERAL ACCOUNTING OFFICE; GERALD DONNELLAN, DIRECTOR, ROCKLAND COUNTY VETERAN SERVICE AGENCY; JOHN C. BACHMAN, U.S. AIR FORCE CAPTAIN (RETIRED); AND EDMUND BURKE, CO-CHAIR, VA CONNECTICUT MENTAL HEALTH ADVISORY BOARD

Ms. BASCETTA. Mr. Chairman, thank you for the opportunity to discuss VERA with you today. We have heard a lot about the important issue of VA's overall budget, but I would just like to underscore that we are now focusing back in on the allocation model.

Since 1997, this allocation system has done much to improve the equitable distribution of resources among VA's networks. This February, however, we recommended additional adjustments to better achieve the goal of providing comparable resources for comparable workloads. The problems we identified are not with VERA's design, but with its implementation. Its design is consistent with accepted payment principles, such as allocating resources on the basis of workload and adjusting allocations for factors beyond the control of management.

VERA also provides additional resources from its national reserve fund to ensure that needed care is not jeopardized in networks that may experience financial difficulties. Today, though, our focus is on how VA could better implement these principles.

First, as you have heard, except for those veterans in need of complex care, VERA does not account for most Priority 7 workload. This made a lot more sense when VERA was first implemented because then Priority 7s were only 4 percent of the workload, and VA's expected cost-sharing and third-party collections were expected to cover most of their costs.

But these veterans now make up 22 percent of the workload nationwide and, moreover, the proportion of Priority 7s by network varies from 14 percent to nearly 40 percent.

VA projects continued rapid growth in this population, at least through the year 2010. To the extent that they are not funded in VERA, networks will continue to pay for most of their costs with VERA allocations made for service-connected and low-income veterans.

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 uses just three categories.

Last year networks received about $120 for basic nonvested patients, about $3,100 for basic vested patients, and about $42,000 for complex patients. 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, almost $42,000. But the average cost to care for a

ventilator-dependent patient was about $163,000, while a home-based primary care patient cost only $25,000.

If VA used a better case mix adjustment and partially funded Priority 7 veterans, we estimated that $200 million could be more equitably allocated. More than 90 percent of the improvement resulted from better adjustment to case mix.

Specifically, Boston, the Bronx, Pittsburgh and Nashville would have each received $32 to $41 million more if VA had refined its case mix adjustment. Under the same adjustment, other networks, Baltimore, Phoenix, Portland, San Francisco and Long Beach, would have received about $22 to $36 million less.

Finally, VA has not used the supplemental process to improve VERA allocations in the management of VA's resources, even though the number of requests for supplemental funding and the amount provided through the national reserve fund has increased every year since 1999.

To better understand budget shortfalls, VA needs to identify the relative contributions of imperfections in VERA, lack of network efficiency, inability to close or consolidate programs or facilities, and other factors.

VA's inability to adequately explain its supplemental funding to stakeholders, particularly networks operating within their allocations, could erode their confidence in VERA.

Mr. Chairman, as you know, VA concurred with our recommendations for improving VERA's implementation, but has expressed concerns about implementing them. Delaying these improvements, however, will perpetuate the inequitable allocation of millions of dollars. We believe that VA can and should use more case mix categories for its fiscal 2003 allocation, as well as partially fund for all Priority 7 veterans.

As VA gains more experience, we would expect it to further refine VERA to incorporate more sophisticated ways to measure both case mix and workload.

This concludes my prepared remarks.

[The prepared statement of Ms. Bascetta follows:]

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on National Security, Veterans Affairs, and International Relations, Committee on Government Reform, House of Representatives

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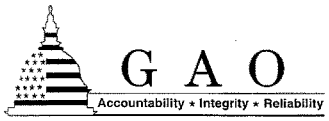
VA HEALTH CARE

Changes Needed to Improve Resource Allocation to Health Care Networks

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



GAO-02-744T

Mr. Chairman and Members of the Subcommittee:

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. Networks allocate the resources they receive from VERA 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

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

[2]See 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 does not fully address our recommendation 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 primarily to veterans without a service-connected disability, who have higher incomes.

VERA's Design Is a ReasonableApproach 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.

[3]Networks 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.

[4]We 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—who 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 comprehensive medical evaluations by VA practitioners. 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

[5]VERA 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 exceeded 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 that, if implemented, would better align approximately $200 million in resources with workloads in VA's health care networks.[6] 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

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

network control by incorporating more categories into VERA's case-mix 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 address factors, such as inefficiency, that may cause budget shortfalls.

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 disabilities.[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 service-connected disabilities 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

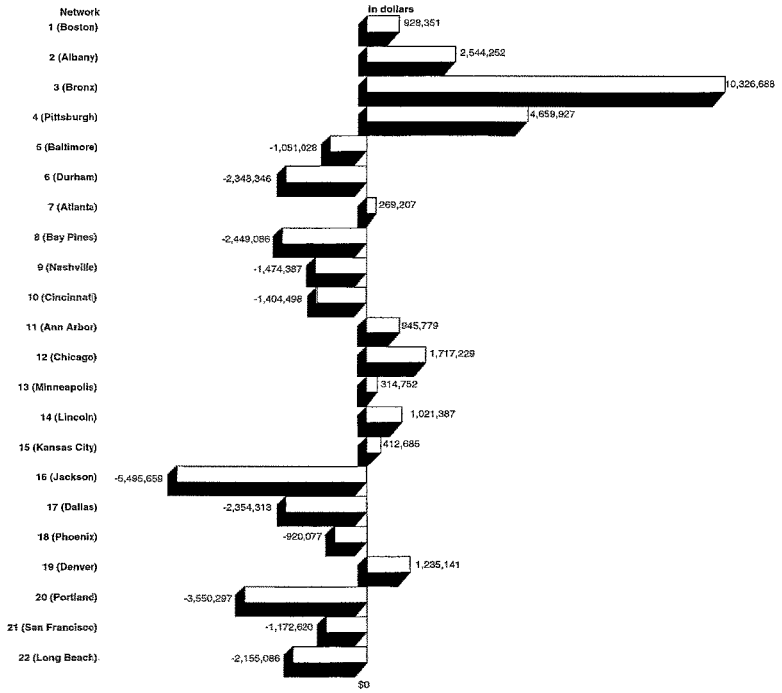
[7]VA's Office of Inspector General also recommended that VA include Priority 7 workload in the VERA model. See Office of Inspector General, Department of Veterans Affairs, *Audit of The Availability of Healthcare Services in the Florida/Puerto Rico Veterans Integrated Service Network (VISN) 8*, Report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

[8]VERA 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.

collections, VA collected only 24 percent of Priority 7 veterans' costs in 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 9 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.

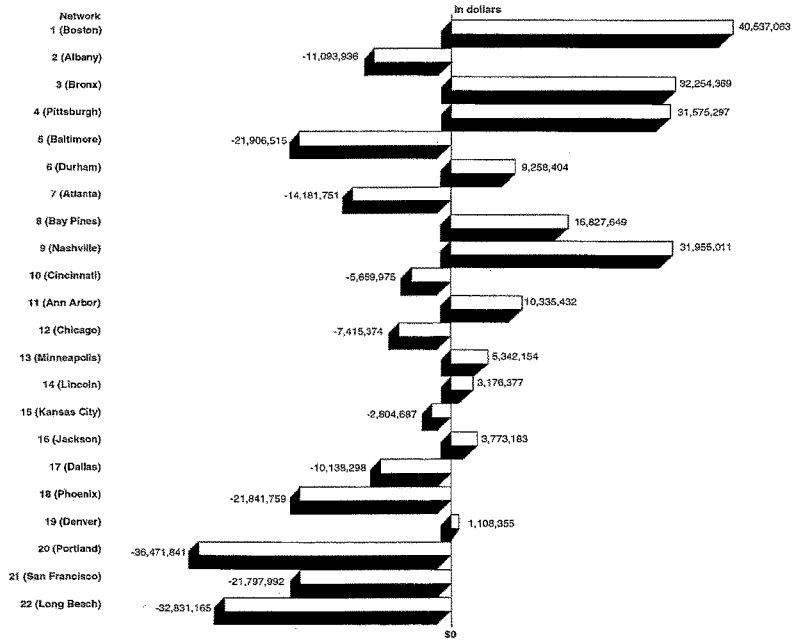
Source: GAO analysis of VA data.

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 home-based primary care and ventilator-dependent care—two of the patient classes in complex care—illustrates this point. The national average cost for home-based primary care in fiscal year 2000 was about $24,000, roughly $18,000 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 home-based primary 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]

[9]For our simulation we used the 44 patient classes VA uses to construct the three 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

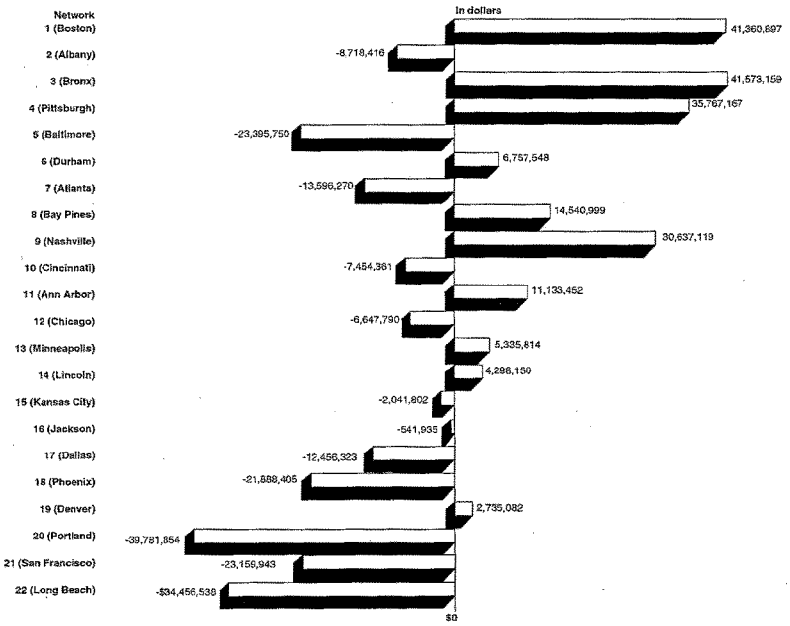


Note: We used fiscal year 1999 expenditure data for the calculations, the most recent data available for fiscal year 2001 VERA allocations.

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. The two networks with the largest percentage change are Network 1 (Boston) with an approximate 5 percent increase and Network 20 (Portland) with an approximate 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.[16] 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 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. From 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

[16]For example, RAND, *An Analysis of the Veterans Equitable Resource Allocation (VERA) System* (Santa Monica, Calif., 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

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 equitably.

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

Contacts and Acknowledgments

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

Related GAO Products

VA Health Care: Changes Needed to Improve Resource Allocation. GAO-02-685T. Washington, D.C.: April 30, 2002.

VA Health Care: Allocation Changes Would Better Align Resources with Workload. GAO-02-338. Washington, D.C.: February 28, 2002.

Medicare Managed Care: Better Risk Adjustment Expected to Reduce Excess Payments Overall While Making Them Fairer to Individual Plans. GAO/T-HEHS-99-72. Washington, D.C.: February 25, 1999.

Medicare Managed Care: Payment Rates, Local Fee-for-Service Spending, and Other Factors Affect Plans' Benefit Packages. GAO/HEHS-99-9R. Washington, D.C.: October 9, 1998.

VA Health Care: More Veterans Are Being Served, but Better Oversight Is Needed. GAO/HEHS-98-226. Washington, D.C.: August 28, 1998.

VA Health Care: Resource Allocation Has Improved, but Better Oversight Is Needed. GAO/HEHS-97-178. Washington, D.C.: September 17, 1997.

Veteran's Health Care: Facilities' Resource Allocations Could Be More Equitable. GAO/HEHS-96-48. Washington, D.C.: February 7, 1996.

VA Health Care: Resource Allocation Methodology Has Had Little Impact on Medical Centers' Budgets. GAO/HRD-89-93. Washington, D.C.: August 18, 1989.

VA Health Care: Resource Allocation Methodology Should Improve VA's Financial Management. GAO/HRD-87-123BR. Washington, D.C.: August 31, 1987.

Mr. SHAYS. Can I just ask you a quick question? If they are turning people away at the door and not letting them show up, are they part of the formula, or are all of those people shut and not considered part of the formula?

Ms. BASCETTA. That was discussed earlier. The fact that there is a backlog is not factored into the formula, because the formula starts counting people who have actually received care.

Mr. SHAYS. So how can we draw—I mean it seems almost irrelevant. That is why I went—this hearing—you are totally right. This hearing was about how we allocate it. The more I heard, the more I realized that is kind of like swallowing camels and straining out gnats. I mean I just am not—it is almost irrelevant in a way.

Ms. BASCETTA. Well, in a way I think that a lot of attention has been focused on VERA, perhaps inappropriately. VERA is the allocation model that is used once the budget is appropriated. We for a long time have looked at the overall budget, and we don't have a position on the adequacy one way or the other. But we do—we have seen over and over weaknesses in VA's budget formulation and execution.

We would like to see a better budget justification for exactly what they do need. They are now undergoing the CARES process, which I am sure you are aware of. This is a process to estimate what veterans need and where those veterans reside so as to better align VA's infrastructure with those needs so that service delivery can be improved. Part of the impetus for the CARES process was some work we did a number of years ago where we found that——

Mr. SHAYS. Let me just say, we will get into more of this issue. I just wanted to understand this one issue, though I mean it is kind of like—this is a very important issue, if it weren't for the fact that we don't have enough money appropriated, we don't have enough people, we aren't servicing a lot of the veterans who are basically told that they can't, you know, get the service. And some of those people may have real need to get it soon. And I am just struck by the fact that it would be really interesting, Congressman Allen, if we were able to have a frank assessment of what Congress, Republicans and Democrats alike, are going to appropriate, told the veterans organizations that obviously care and say, given—which should be a lot more than we are doing now, but given that, how do you want this system to work? Because it is still going to work with a system that probably won't get all of the resources that it needs, but a heck of a lot more than it is getting now, hopefully.

The issue will be, in my judgment, then, who should get that service. And who should at least be first.

Mr. ALLEN. If I can just make a quick comment here.

I do think that for—once you have a VA health care budget, the application of the VERA formula is a very big deal to certain districts, that—certain VISNs that feel that they are being shortchanged. Because that is the short-term problem. Every year people struggle with the actual budget that is in front of them and are trying to match expenditures and revenues.

I think what this hearing has revealed is that both for the long term, for the VA health care system, and for the long term for the rest of America's health care system, those problems are huge. And

they dwarf the problems of the—you know, the year-to-year VERA allocation issue. But somehow we can't neglect either one. We have to grow here with, you know, to some extent with the short-term issue. But the looming prescription drug issues are, in both the VA system and the health care system as a whole, are awesome.

Mr. SHAYS. Mr. Burke, we are going to do something that only a chairman can allow it to happen. This individual, a witness who happens to be from Connecticut, gets to jump in line here. It is one of those privileges that I have. You are a Priority 1 with me.

Mr. BURKE. I am a Priority 7 with the VA.

Mr. SHAYS. OK. Why don't you move the mic a little closer to you, and then we are going to let you leave when you have to. But we will get to the other witnesses.

Mr. BURKE. I would like to thank you for letting me do this.

I didn't realize that I was as long-winded as I was with my testimony here, so I would like to sort of go through it and take sections out.

Mr. SHAYS. That is the way to do it.

Mr. BURKE. Mr. Chairman and other distinguished members of the committee, I am grateful for this opportunity to present my views on the current state of VA health care delivery in Connecticut under the Veterans Equitable Resource Allocation Scheme.

In my home State I currently serve as the coordinator of Veterans Services for the Department of Mental Health and Addiction Services. I would like to clearly state, however, that I come before you today as a concerned veteran and as co-chair of the VA Connecticut Health Care Systems Community Mental Health Advisory Board and as one of two members of the VISN 1 Mental Health Community Advisory Board. I would appreciate your entering my prepared statement into the record.

Last Tuesday, I met a homeless veteran in a public operated substance abuse treatment center. He was in the center's locked detox unit. His treatment plan called for him to continue with substance abuse treatment and a rehabilitation program after he completed his detox. He, however, had several serious physical concerns which made placement in rehab impossible. He had received care through the VA for many years in the past.

I called the VA Connecticut ER, I spoke with the doctor on duty about the veteran's condition. As soon as it was clear that I was seeking admission for this veteran, I was told he couldn't be admitted because the hospital was on diversion and there was simply no beds.

What do I say to this veteran who is coughing up blood, has irregularities in recent EKG, needs treatment for depression and substance abuse, and the VA has no beds?

What do I say to the Korean War veteran who lives alone on an income that would entitle him to receive VA services at no cost? He goes to a VA hospital in Connecticut and is scheduled for surgery. His surgery is canceled or postponed 6 times—or 3 times within 6 months.

Finally, because his pain is so debilitating, he goes to his local non-VA hospital ER. Doctors find his condition grave and they perform the necessary surgery the next day.

What do I say to these 2 and others like them? Do I explain the VERA system? Do I tell them it is too bad that we don't live in another region where the allocation is more favorable? Would that cure their ills or ease their pain? All I can say to them is I am sorry we can't keep our promise to you. Stories like these are made possible because in Connecticut we simply don't have resources needed to get the job done. Seven years ago VA began a dramatic transformation from being a hospital-based health care system to a community-focused system. Promises were made back then.

VA leadership went to great lengths to allay the fears of veterans when acute care psychiatric capacity was slashed from over 200 beds to 30. Soon thereafter PTSD and residential substance treatment programs were closed.

Many of us were alarmed by what we saw. We spoke out about what we read as catastrophic hemorrhaging of resources, but VA reassured us. VA assured us that money being saved by reductions in patient beds and by curtailment of hospital-based services would be reinvested in community-based treatment and services.

Today, after 5 years of flat budgets that annually drive VA Connecticut deeper into the red, the sacrifices of 7 years ago mean nothing. The promises mean nothing. Four years ago I walked into the best mental health services operation I had seen in 20 years in the business. It has been an infuriating exercise to witness and to have repeatedly argued against the steady decline in service capacity since then, and it has been gut-wrenching to witness the winnowing away of dedicated staff by attrition.

Last year the community care center was awarded a compensated work therapy transitional residency grant. An exciting psychosocial rehabilitating initiative would provide transitional housing to veterans intent on improving their livelihood. Money will be turned back because no staff were available to run this program.

During the VA Connecticut Mental Health Advisory Board meeting this past Wednesday, it was announced that the acting director now intends to reduce the Errera Center's budget by 21 percent. That may force the center to close its doors for good. We are not going to stand for it. Do we have to do another Veterans March on Washington?

In closing, I would like to offer two observations. I want to tell you that in the face of all of the problems and frustration, there remains at VA Connecticut a cadre of dedicated and talented staff that keep the whole thing going through their sheer creativity, love, and sheer determination.

And the other point is this. In the decades of uncertainty in this world during our lifetimes, throughout the many seasons of ambiguous and often dangerous conduct of nations, we instill in our sons and daughters ownership of a patriotic notion that military service is a noble endeavor, indeed a personal responsibility.

We in turn place our faith and trust in them, our young men and women in uniform, that this fundamental relationship is mortised by our pledge to care for those we send in service in our name.

Members of the committee, I implore you to do all that you possibly can to restore fiscal health to the VA Connecticut health care system in New England, and quickly. America has broken its prom-

ise to its veterans and it is time to change that and ask more Americans to do their part to volunteer and enlist and become active duty.

We depend on you to keep the government's part of the bargain. Put the financial funding behind the words. Don't abandon our veterans. Don't abandon the American people. Thank you.

[The prepared statement of Mr. Burke follows:]

Testimony

Of

Edmund J. Burke

Before the

SUBCOMMITTEE ON NATIONAL SECURITY, VETERAN AFFAIRS AND INTERNATIONAL RELATIONS

May 14, 2002

Concerning

VA Health Care:
Structural Problems, Superficial Solutions

Mr. Chairman and other distinguished members of the committee, I am grateful for this opportunity to present my views on the current state of VA healthcare delivery in Connecticut under the Veterans Equitable Resource Allocation scheme. In my home state, I currently serve as the Coordinator of Veterans' Services for the Department of Mental Health and Addiction Services. I'd like to clearly state, however, that I come before you today as a concerned veteran, as Co-Chair of the VA Connecticut Healthcare System's Community Mental Health Advisory Board and as one of two Connecticut members of the VISN I Mental Health Community Advisory Board. I would appreciate your entering my prepared statement into the record.

Knowing that your Committee has had the opportunity to study the February 2002 GOA Report entitled *VA Health Care: Allocation Changes Would Better Align Resources with Workload*, I will not comment extensively on the report. I do agree with the report's more salient findings, and its suggested remedies to resolve the identified inequities in VERA distribution. In particular, I was impressed by GAO's depiction of what resource allocations would look like were VA to adopt the practice of using 44 case-mix categories in VERA allocations (GAO-02-338, Figure 7).

In preparing my testimony, I struggled with the question of how best to share with you the deep and pervasive apprehension and, yes, anger, that my fellow veterans are quick to exhibit when the subject of VA healthcare arises. I have vacillated between an approach that would laden the discussion with data, or one where I simply grab each of you by the collar, and state as clear and direct as I can: "Don't you people get it! America is walking away from its social contract regarding veterans!" Since I am neither an actuary nor an economist, my message will be plain and straight.

Last Tuesday, I met a homeless veteran in a public-operated substance abuse treatment center. He was in the center's locked detox unit. His treatment plan called for him to continue with substance abuse treatment in a rehabilitation program after he completed his detox. However, he had several serious physical concerns, which made placement in rehab impossible. He had received care through the VA for many years in the past.
I called the VA Connecticut ER. I spoke with the doctor on duty about this veteran's conditions. As soon as it was clear that I was seeking admission for this veteran, I was told he couldn't be admitted because the hospital was on diversion and there were simply no beds available for him. What do I say to this veteran who is coughing up blood, has irregularities in his recent EKG, needs treatment for depression and substance abuse and the VA has no bed for him.

What do I say to the Korean War veteran who lives alone on an income that would entitle him to receive VA services at no cost? He goes to a VA hospital in Connecticut and is scheduled for surgery. He has his surgery postponed three times within six months. Finally, because his pain is so debilitating, he goes to his local non-VA hospital ER. Doctors there find his condition grave and then perform the necessary surgery the next day.

What do I say to these two and others like them? Do I explain the VERA system to them? Do I tell them it's too bad that we don't live in some other region in this country where the allocation is more favorable? Would that cure their ills, or ease their pain?
All I can say to them is, "I'm sorry. We can't keep our promise to you".
These are not isolated incidents; I deal with cases like these almost every workday.

Stories like this are made possible because, in Connecticut, VA simply doesn't have resources needed to get the job done. Seven years ago, VA Connecticut began a dramatic transformation from being a hospital-based healthcare system to a community-focused system. Promises were made back then. VA leadership went to great lengths to allay the fears of veterans when Acute Care Psychiatric capacity was slashed from over 200 beds to 30. Soon thereafter the PTSD and residential substance abuse treatment programs were closed. Many of us were alarmed by what we saw. We spoke out about what we read as a catastrophic hemorrhaging of resources. But VA reassured us. VA assured us that the money that was being saved by reductions in patient beds, and by the curtailment of hospital-based services, would be re-invested in community-based treatment and services.

Today, after 5 years of flat budgets, that annually drives VA Connecticut deep into the red, the sacrifices of 7 years ago mean nothing. The promises mean nothing. Four years ago, I walked into the best mental health services operation I'd seen in my 20 years in the business. It has been an infuriating exercise to witness, and to have to repeatedly argue against, the steady decline in service capacity since then. And it has been gut wrenching to witness the winnowing away of dedicated staff by attrition.

Presently, the VA Errera Community Care Center, which in Connecticut represents the system's commitment to community health, is limping along at 49% staffing. The current hiring freeze has decimated several of the Center's core programs.

- The Mental Health Intensive Case Management Program provides services to seriously mentally ill veterans who are high users of inpatient services. This National Center of Excellence Program is VA Connecticut's frontline program in community treatment. Today it experiences a 43% shortage in staffing.
- The Community Reintegration Program, the Center's mental health day/mobile crisis program, now has a 51% staff shortage.
- The Vocational Services Program currently has a staff vacancy rate of 72%!
- Last month, the Center was forced to close the popular HUD-VA Supported Housing Program. Given the hiring freeze, there's no staff remaining to run it. And this is particularly upsetting, because every agency, every person, who is involved in the effort to end homelessness in America, agrees that two things are essential to success: one, is affordable housing, the other is supported housing. The VA-HUD Program accomplishes both. We just closed ours.

Across the spectrum of VA healthcare in Connecticut are troubling examples of what insufficient resources will guarantee. The 30-bed acute-care psychiatric unit is bursting at the seams, and the acuity of the patients is pronounced. The Psych ER is chronically full, and because admitting to the acute unit is not an option, it's not uncommon for veterans

to languish, alone, for days in the ER. Too often, these high acuity patients are diverted to the Community Care Center's Day Crisis Program, which presently averages a daily census of well over 100 acutely ill patients with only 6.6 FTEE. Last week Secretary Principi visited our state to quell complaints about our local leadership's plans to close services at the much-needed Newington campus. The list goes on.

Last year the Errera Center was awarded a Compensated Work Therapy/Transitional Residence grant, an exciting psychosocial rehabilitation initiative that would provide transitional housing to veterans intent on improving their livelihood. The money will be turned back because there's no staff available to run the program.

During the VA Connecticut Community Mental Health Advisory Board meeting this past Wednesday, it was announced that the Acting Director now intends to reduce the Errera Center's budget by 21%. That may force the Center to close its doors for good. Well, we just won't stand for it! What do we have to do, organize another Veterans' March on Washington?

In closing, I'd like to offer two observations. I want to tell you that in the face of all the problems and frustrations, there remains at VA Connecticut a cadre of dedicated and talented staff who keeps the whole thing going through their creativity, love and sheer determination.

The other point is this. In the decades of uncertainty in the world during our lifetimes – throughout the many seasons of ambiguous and often dangerous conduct of nations – we instilled in our sons and daughters ownership of a patriotic notion that military service is a noble endeavor, indeed, a personal responsibility. We, in turn, placed our faith and trust in them, our young men and women in uniform. This fundamental relationship is mortised by our pledge to care for those we send in service in our name. Members of the Committee, I implore you to do all that you possibly can to restore fiscal health to the VA's healthcare system in New England. And quickly. America has broken its promise to veterans, and it is time to change that. As we currently fight a new war, and ask ordinary Americans to do their part, to volunteer, to enlist, to become active duty, we depend on you to keep the government's part of the bargain. Put the financial funding behind the words. Do not abandon our veterans. Do not abandon the American people.

Mr. SHAYS. Thank you, Mr. Burke. I am tempted to try to let you get out of here soon so you don't race to the airport by just asking you this question. What you are saying, basically, strikes in—in the face of what we were told about how if it is surgically necessary, no one is turned away. I mean you have personal experience where it is surgically necessary, and they are turned away.

Mr. BURKE. Yes. I think care should be based on clinical need. I think that is an important consideration. I think anyone who comes into a hospital system, Priority 4 treatment has to be clinical need. Those who need the services the most should get them first.

However, what I have seen over the past 4 years is that because of the influx in veterans coming in, and the—the lack of resources, and the attrition rates, there is just not the staff available to provide services. And the numbers that I see are critical. They are really critical. I don't know really how VA can continue to do its job under the restrictions the way that they are.

Mr. SHAYS. Mr. Allen, do you have any questions?

Mr. ALLEN. I do.

Mr. SHAYS. Let me just say to you I think that it probably would make good sense for you to get on your way so you don't rush to the airport. But I would tell you, and I think it's self-evident, that there is a problem that both Congress and the administration need to resolve together, both Republicans and Democrats.

And my request would be veterans can demand certain things because of our respect for veterans and their service, but I hope that veterans are able to make an assessment of the conditions that exist to see how we can improve it in a way that brings some quick results.

And what I'm suggesting by that is, I'm not sure that Congress is going to appropriate all that we need, but I do think it's fair to say we would be inclined to do more than we were anticipating we should, and more than maybe even the administration feels we have the capability to do. So I think there will be some real interesting floor debates on the budget, but in the end, there's still going to be some rationing that probably is going to happen. It would be nice if the veterans could help us decide how we do that, with the hope that eventually we don't have to ration anyone. But right now what's happening is people are being shut out. And even if they're service connected and even if they are frankly in acute need, a very real need, they're being shut out. And some others may be in the system that would probably—if they knew, would be willing to let others step in.

And there may even be a need, frankly, to look at the prescription drug issue and saying should more be asked of the veteran, given that the benefit of that veteran's service is a heck of a lot better than the alternative. Even just a little bit of an increase or a copayment. It would seem to me the veterans would want to do that.

Mr. BURKE. I agree with you. In fact, the co-pay just went from $2 a prescription to $7 a prescription just recently. I also am a category 7 veteran. I am enrolled in the VA health care system. I have no intentions whatsoever of using the VA for prescription drugs or for services. I don't need it. I think there are a lot of category 7s that are like myself.

Mr. SHAYS. But it's hard to turn down if you think in one case I might have to pay $1,000, and in another I could do it for 50 or 25. That's a tough decision, because that's real money.

Anyway, you travel safe. We look forward to working with you.

Mr. BURKE. Thank you. Thank you very much.

Mr. SHAYS. Mr. Donnellan.

Mr. DONNELLAN. Thank you. My prepared statement——

Mr. SHAYS. Do you have your mic on, sir? I don't know if you have your mic on. You have such a nice voice you almost don't need it.

Mr. DONNELLAN. Is that better?

Mr. SHAYS. Yeah. That's good both ways.

Mr. DONNELLAN. As I understand it, the concept of VERA is to shift VA funding south and west, based on the fact that our veteran population from the Northeast is retiring and moving to warmer climes. On the face of this, it makes sense, however; looking further into the situation, there are important questions to be considered. For instance, should we be more concerned about the veteran who is well enough off to retire than his less fortunate comrade who can't? The retired veteran would seem to have more financial stability. Further, a move to Miami or Phoenix, their buying power would increase dramatically because of the decreased cost of living.

Based on the current Consumer Price Index, a veteran with a $30,000 income moving from New York would see a 54 percent drop in his cost of living. Conversely, a person moving from Phoenix to New York, based on the same 30,000, would need 130.9 times the income.

So you ask, why do any veterans stay in New York? There are many reasons. Some simply can't afford to move. Others are tied to the land. Others are afraid to change, reluctant to leave children, grandchildren. Some rely on family support. Some have moved and returned.

However, in order to survive in New York, many cannot afford to retire. Adding to this problem, earning an adequate living in New York, can put you over the means test of the VA. In simple terms, this means the veterans are hit doubly, considering they also have to have a copayment for VA medical care, which they may not have to if they live in Miami or Phoenix where the cost of living is less and they may not have to continue to work and could obtain free medical care. Cost of living also cuts into the operation of the VA hospitals in terms of attracting employees.

Based on the same statistical information, New York housing costs are four times greater than they are in Phoenix or Miami. Food and groceries are roughly 40 percent higher. Utilities, 70 percent higher than in the other two locations. It doesn't come anywhere near advantageous for health care professionals to relocate to New York.

One of the points I am trying to make is that a veteran—the veterans who are staying in New York are more likely to be in need of care and less likely to be able to obtain it.

Also, we need to look at the VA hospital system in the Northeast that serves as a backup. The reality is we will become involved in a war soon. Also the events of last September saw the VA system

serve as a backup for terrorist attack. Unfortunately, both the VA and the Department of Defense have reduced their bed space approximately 60 percent since 1993. At this point, VA estimates that in a mass casualty situation, within 24 hours they could have 3,200 beds available; 72 hours, 5,500; in 30 days, 7,500 beds. However, while the VA does have the excess beds and space, it does not have the staff to activate these beds. Therefore, we may be putting more than veterans in jeopardy.

Another point to underscore the need for medical care in the New York area: A few years ago, working with Rockland County, the Department of Veterans' Affairs hospital at Montrose opened a VA clinic in Rockland. At that time, there were 250 veterans using the outpatient services of the VA. Since that clinic opened only a few years ago, the number of veterans served has jumped from 250 to 6,000. I feel this works both—works to the advantage of both the Department of Veterans' Affairs in terms of cost savings and the veterans in terms of convenience. However, these clinics are becoming full. The veterans are being shifted back to VA hospitals which is more costly for the VA and less accessible for the veterans.

There is another plan that may help us leverage some funds not only for the veterans in the Northeast but veterans across the country. It is the Enhanced Use Leasing program, 38 U.S. Code, section 8161, which was first passed by Congress in 1991. At that time, the maximum time to lease VA property was 35 years to bring private funds into the VA and reduce the cost of operation. Larger projects could not be financed over that short period of time. However, in 2000, Congress wisely extended this authority to a possible 75-year lease. There are local projects under consideration whereby private corporations could lease VA land, develop housing that would go from retirement to supportive to nursing care for our veterans. In this way, underused VA property could be taken off the books of the VA and provide an income stream.

This project is now being discussed in relation to the FDR VA hospital in Montrose, New York, but I feel has a positive national implication.

In closing, I would like to say that I always knew living in New York was more expensive. However, until doing the research for this testimony, I didn't realize just how disproportionately high the cost of living in that area is compared to other very nice areas in this country.

I encourage the committee to consider restoring as much funding to the Northeast as possible. Even if funds were evenly distributed, New York is still so far behind the curve cost-wise that it isn't fair to the veterans in the area. Cutting back on VA services in the New York area jeopardizes the well-being of not only our veterans but our military in case of war, and our population at large in case of terror attacks. Thank you very much for your time.

Mr. SHAYS. Thank you very much for your time and your service to our country.

[The prepared statement of Mr. Donnellan follows:]

VETERANS EQUITABLE RESOURCE ALLOCATION (V.E.R.A.)

Congressional Hearing - May 14, 2002
"VA Health Care: Structural Problems, Superficial Solutions?"
Gerald Donnellan, Commissioner
Rockland County Veterans Office
(845) 638-5244

As I understand it, the concept of Veterans Equitable Resource Allocation (V.E.R.A.) is to shift more VA funding south and west, based on the fact that our veteran population from the northeast is retiring and moving to warmer climates. On the face of this it makes sense, however, by looking further into the situation, there are important questions to be considered.

For instance: should we be more concerned about veterans who are well enough off to retire or their less fortunate comrades who can't afford to retire? The retired veterans would seem to have financial stability. Further, if they move to Miami or Phoenix their buying power would increase dramatically because of the decreased cost of living. Based on the Consumer Price Index, a veteran with a $30,000 income moving from New York to Miami would see a 54% drop in their cost of living. Conversely, a person moving from Phoenix to New York, based on the same $30,000 income, would need to increase their income by 130.9% to live in New York.

So, you ask, why do any veterans stay in New York? There are many reasons. Some simply cannot afford the move, or are tied to the land; others are afraid to change or are reluctant to leave their children and grandchildren, and some rely on family for support.

However, in order to survive in New York, many cannot afford to retire. Adding to this problem, earning an adequate living wage in New York City can put you over the means test ceiling of the VA. In simple terms, this means these veterans are hit doubly considering that they also have a co-payment for VA medical care, which they may not have if they lived in Miami or Phoenix where the cost of living is less, where they would not have to continue working, and where they could obtain free medical care from the VA system.

The cost of living also cuts into the operation of the New York area VA hospitals in terms of attracting employees. Based on the same statistical information, New York housing costs are 4 times greater than they are in Phoenix or Miami. Food and groceries are roughly 40% higher in New York than in Phoenix or Miami. Utilities in New York are 70% higher than the other locations. Therefore, even with the VA's cost of living adjustment for different areas of the country, it doesn't come anywhere near making it advantageous for health professionals to relocate to the New York area.

One of the points I am trying to make is that the veterans who are staying in the New York area are more likely to be in need of care, and less likely to be able to obtain it.

We also need to look at our VA hospital system, particularly in the northeast, that serves as a back-up. The realities are getting closer that we will become involved in a war in the Middle East. Also, the events of last September saw the VA medical system serve as a back-up for the injured in the terrorist attacks, as well as in times of war. Unfortunately, both the VA and the Department of Defense have reduced their bed space by approximately 60% since 1993.

At this point, the VA estimates that in a mass casualty situation, within 24 hours they could have 3,272 beds available, within 72 hours 5,500 beds and within 30 days 7,574 beds. However, while the VA does have the excess beds and space, it does not have the staff to activate those beds. Therefore, we may put more than veterans in jeopardy.

Another point to underscore the need for medical care in the New York area is that a few years ago, working with the County of Rockland, the FDR VA Hospital at Montrose opened a VA clinic in Rockland County, New York. At that time, there were 250 veterans in Rockland County using the out-patient services of the VA. Since that clinic opened a few short years ago, the number of veterans served has jumped from 250 to 6,000. I feel this works both for the Department of Veterans Affairs, in terms of cost savings, and the veterans in terms of convenience. However, now these clinics are becoming full and veterans are being shifted back to VA hospitals which are more costly for the VA and less accessible for the veterans.

There is another plan that might help us leverage some funds to allow benefits, not only for veterans in the northeast, but veterans across the country. It is the enhanced-use leasing program (38 USC. SECTION 81, 61), which was first passed by Congress back in 1991. At the time, the maximum time to lease VA property was 35 years but the VA was still able to successfully use this authority 19 times to enhance private monies into VA assets and reduce the cost of operating VA systems and providing more services to its veterans. Larger projects could not be financed over this short period of time. However, in 2000 Congress wisely extended the authorization to a possible 75 year lease.

There are local projects under consideration whereby private corporations could lease VA land, and develop housing that would go from retirement-to-supportive-to-nursing care for our veterans. In this way, under-used VA property could be taken off the books of the VA and would provide an income stream. This project is now being discussed in relation to the FDR VA Hospital in Montrose, New York but I feel it has positive national implications.

In closing, I would like to say that I always knew that living and working in New York was a more expensive situation. However, until I had done the research for this testimony, I didn't realize just how disproportionately high the cost of living in this area is, compared to other very nice areas of the country.

I encourage the sub-committee to consider restoring as much funding to the northeast as possible. Even if funds were distributed evenly, New York is still so far behind the curve cost-wise, that it isn't fair to the veterans in this area. Cutting back on VA services in the New York area jeopardizes the well-being of not only our veterans but our military and the population at large.

Thank you very much for your time.

Mr. SHAYS. Mr. Bachman.

Mr. BACHMAN. Congressman Shays, members of the board——

Mr. SHAYS. Is that on?

Mr. BACHMAN. Is that on now?

Mr. SHAYS. It just was too high. Thank you.

Mr. BACHMAN. Chairman Shays and ranking members of this board, I'd like to thank you for your leadership in allowing me to come here this evening. I also want to express our heartfelt thanks for myself and the many million veterans to Congressman Tom Allen for his steadfast efforts he put forth for veterans over the years. Tom is Maine's point man on veterans' issues as the only member of the Maine's congressional delegation to ever meet with my committee. And we are fortunate for having Tom as a Congressman. We greatly appreciate your leadership, sir.

I would also to thank Congressman Allen's senior field advisor John McLaughlin for his effort and all his time he has spent with my committee, and John has gone well above the call of duty to help us.

Finally, I'd like to thank not least, but my wife Mary, for who next week she and I will celebrate our 30th wedding anniversary, I want to thank her for her love and support over these many years.

Now for the crux of the matter, sir. As you all know, my name is John Christopher Bachman. I'm a retired Air Force captain. I've served 2 years of combat duty in Vietnam with the U.S. Marine Corps. I'm a category 1 veteran. I'm a physician assistant. I've been in that position for 22 years. I am also the local line manager for the spinal cord injury clinic at the Togus VA. I want to tell you the VERA system, even though people do not like to hear it, has failed; and Togus has become a casualty of that failure. We have heard lots of people talk about different things today. I want you to know that the Veterans Administration probably takes great pride in the fact that they've cut 50 percent of our beds; 52 percent of our beds they have cut. And they stand there saying that's a great opportunity. They've cut staff.

As we go through all of this and we hear all of this, no one has come up with a solution to you or this committee. Hopefully I can provide that for you from the grass-roots opportunity of practicing medicine over the past 15 years with the Veterans Administration. As we deal with this each and every day, we see more and more veterans coming into Togus, and probably the rest of the country, and understand that Togus is just a small portion of what must be happening across the United States.

As we cut those beds and as we've heard people say there's more and more of our veterans becoming older and we're practicing medicine on an outpatient basis and in CBOCs—and Maine has quite a few CBOCs—those veterans still come to Togus, they still travel an enormous amount of time, as I related the last time I was here. But the thing that I think no one has addressed when we ask for money is that we never give Congress each and every year what it takes to supply the Veterans Administration with money. And I think VERA fails in that.

To give you an example of just a small thing that happens at Togus because of the lack of funding, the lack of personnel, and the

lack of beds that are in this small facility, we do a thallium stress test on people. We did between 150 and 200 of them last year. If we had the money to do the test and the personnel, which we do, and we have the equipment sitting there already at Togus, it would cost us $250 per test. But we farmed out between 150 and 200 tests last year at $2,800 a test. That means we could have saved Togus over $300,000 for a test. How many facilities across this country can do that?

You know, we talk about going to the community. I want someone to address to this grass-root provider how much money we can save by doing the tests within the Veterans Administration. You ask how much it would cost. Probably it would cost the Veterans Administration to function every single year, by what the GAO's report said, $4,729 per veteran regardless of their category, and 4 percent of them getting $42,000 being COMPLEX.

The other issue we heard today was in respect to category 7 people being wealthy, I think I heard the term. I'd like to know how that is wealthy. In Maine I think the Veterans Administration counts not so much their home but what their retirement was, what they're getting from retirement. We're talking about individuals who are 65 years old, who have worked very, very hard all their lives. And now they can't afford those medical costs anymore; not just prescriptions, just regular medical costs out there in the community. And somebody says to them, come to the VA. That's where they end up. That's what we're getting. It's not an abuse.

If you think about it, you heard somebody say there were 24 million veterans in this country who have served this Nation, and we serve 4 million only. Why aren't they in there? Somebody tells me, why aren't they in there? I'll tell you why. It's—for myself, I don't use the Veterans Administration, even though I'm a category 1. And why don't I use it, like most other veterans don't use it? The service-connected veterans get it right up front. They were injured. They deserve it. They got hurt defending this country. Everybody else served the country, but in the back of their mind we promised them that we would take care of them. And they worked, they had their own insurances, they went about—and for some reason they lost it. That's why we have 44-plus million Americans without health care insurance. And somewhere along the line somebody says, use the VA.

That's why we came. The VA is the safety net in this country for our veterans. We all need to remember that. It's not going to cost us billions and billions of dollars. And the cost needs to be delivered by what waste we're doing first. If we can provide this service within the facilities cheaper than the outside, we need to look at that.

The other thing that's very, very important to me at heart—and sometimes I get wrapped around this—is that up there in Togus, you know, we're far, far away. We never consider the geographic ability of how far it is when you say to somebody, go to Boston. Well, when you go to Boston, Congressman Shays, you and I have had this discussion, you live in Madawaska, you got a 12-hour drive to get to Boston. If you're sick, do you want to drive 12 hours?

And for another thing that happens that we do, that was addressed here today, someone talked about going to the emergency

room and needing hospitalization. Well, I work in an emergency room part time. I work almost a full-time second job. I work at Maine General Medical Center in the emergency room. I have had to tell veterans that they can't go to Togus. I've called my own facility and been told no beds, where that evening when I went to work, I walk through the ward and there was beds, but we filled them with veterans who are sometimes just there for an overnight procedure. We need another way of filling—those beds need to be filled by people we need.

And something that didn't get told to you people sitting up there is when that phone rings and they say go to an emergency room, if that veteran is not category 1, 2, or 3, he buys the cost of that emergency room visit himself. And the majority of category 7 veterans cannot afford that. That's what we need to do. That's a waste. Thank you.

Mr. SHAYS. Thank you very much.

[The prepared statement of Mr. Bachman follows:]

A Report to the Members of The House Committee On Government Reform Subcommittee on National Security, Veterans Affairs, & International Relations

VA Health Care: Structural Problems, Superficial Solutions?

May 14, 2002

John C. Bachman
Air Force Captain - Retired

Chairman Shays, Vice Chairman Putnam, Ranking Member Kucinich, Members of the House Committee on Government Reform Subcommittee on National Security, Veterans Affairs, & International Relations, thank you for your leadership on this issue and for inviting me to be here to share my thoughts. I also want to thank Kristine McElroy for all her help and patience.

I want to express heartfelt thanks from myself and Maine's many veterans to Congressman Tom Allen for the steadfast efforts he has put forth for veterans over the years. Tom Allen is Maine's Point Man on veterans issues and is the only member of Maine's Congressional Delegation to have met with my entire committee. We are fortunate to have him as our Congressman and we greatly appreciate his leadership.

I also want to thank Congressman Allen's Senior Field Representative, John McLaughlin, for all his efforts on behalf of Maine's veterans. John has consistently gone well above and beyond the call of duty for Maine's veterans and deserves to be commended for all his efforts.

I would also be remiss not to express my heartfelt thanks to Mike Clark, Maine's Representative for the Paralyzed Veterans of America and Gail Wright, the Social Worker for Togus' Spinal Cord Injury (SCI) Clinic. Mike and Gail are heroes in the truest sense of the word. Over the years, they have consistently provided ardent advocacy, encouragement, and comfort to innumerable Maine veterans and we are forever indebted to them.

Last, but certainly not least, I want to thank my wife, Mary. Next week is our 30th wedding anniversary and I want to thank her for all her love and support.

I am John C. Bachman, Chairman of the Committee to Save Togus. This committee was founded to provide active communication to the veterans of Maine, the congressional delegation, State officials and news media to ensure that the Veterans Administration Medical Center (VAMC) at Togus remains a fully staffed community hospital to serve the medical needs of the State of Maine Veterans.

I am a retiree from the US. Air Force, and a veteran of two tours in Vietnam in the United States Marine Corps. I am also a Physician Assistant, and have 22 years experience as a medical professional. I am the Local Line Manager for the SCI Clinic at Togus, but I am here as a private citizen on annual leave to report to you that the Veterans Equitable Resource Allocation (VERA) system has failed and that the Togus VAMC has become a casualty of that system.

The question that needs to be answered here is - why? Today, I will attempt to provide the answers to the why and, hopefully, some insight from a grass roots level as to what VERA actually does to the health care system of a community hospital supporting a veteran population. First, what is VERA and how does it affect the delivery of healthcare to the veterans of this nation?

VERA was established in 1995 under the direction of the Under Secretary of Health for the Veterans Administration. In 1996 the GAO and Congress acknowledged the need for changes in the allocation system and implemented by 1997 VA/HUD and Independent Agencies Act.

The Act required the VA to develop and submit to Congress a plan to allocate funds and personnel in a way that ensures that veterans with similar economic status and eligibility priority have similar access to VA care regardless of where they reside.

To the extent possible, the plan was required to reflect the new "network" management structure, account for workload forecasts, and ensure fairness to cost efficient facilities. Also, the plan was to include, to the extent possible:

(1) procedures to identify reasons for variations in operating costs among similar facilities;

(2) improve the allocations so as to promote efficiency and quality;

(3) adjustments to unit costs to reflect uncontrollable cost factors, and

(4) workload forecasts and consideration of VA healthcare demand that may not be reflected in current projections.

The Problem:

- The methodology used above did not ensure the equitable distribution of funds across the nation. The creation of networks or VISNs served only to compound the process of inequitable distribution. The VISNs fund themselves first and then whatever is left over is divided among the other medical facilities within the VISN.

- Increased the number of veterans needing healthcare in the nation by 47% since 1996 to 2001. In the period of time between 1996 to 2000 the VA closed 52% of the inpatient beds and during the same period increased outpatient visits by 36%.

- The number of veterans served at VA hospitals that are category 7 increased by 107,520 in 1996 to 827,722 by the end of FY2001 with the vast majority being non vested. The veterans deserve health care, but VERA doesn't provide funding for them currently unless they are admitted and coded complex. The GAO has made several suggestions to change this funding methodology, but when will these changes come and how many veterans will needlessly suffer or die due to this method of funding?

- Because of this inequity in acknowledging workload, supplies and use of facilities, the VERA system fails to allocate appropriate resources where they are needed. The GAO in its report GAO-02-338, February 2002, clearly identifies weaknesses in VERA implementation. These include exclusion of one fifth of the workload in determining allocation by excluding veterans with high incomes who do not have service connected disabilities, nor does it account for difference in cost differences among the networks from variations in patient's health care needs. Providing supplemental resources through the National Reserve Fund to supplement local allocations without identifying the need

for or the cause of these deficits, serves to further misrepresent the effectiveness of the VERA system

- The decrease of inpatient beds results in delay of medical care for veterans, increased cost to the VA when veterans are waiting in local community facilities.

- The decrease of Full-Time Employee Equivalents (FTEE) results in under staffing, longer waiting times, and increased costs to facilities due using community resources to provide these services.

- Transportation – The latest and greatest effort of the VISN to save money in this time of fiscal shortfalls is to deny transportation to Togus for patients not based on medical need, but based solely on service connection. There are many medically and financially needy veterans who come to Togus for their health care who have been denied transportation and, therefore, health care. At what point does this policy constitute medical malpractice?

- Increased micro management of medical facilities by the VISNs in an attempt to compensate for deficits.

- Decreases in sub-specialty availability results in increased costs to the facility for community provided services. For example, a nuclear stress test cost approximately $3000 in the community when Togus could do the same test for $250.

- Increased cost of pharmaceutical costs at Togus. In FY2000 costs were $16,689,000. In FY2002 the projected cost for just the first six months is $25,700.000.

The VA has made a great effort to recruit veterans into the VA health care system. They are to be congratulated for their effort and their great success. Unfortunately, for the veterans it means long delays in getting assigned a primary care provider and being evaluated by specialists. The VA misrepresents its data on how long it takes to get an appointment. The VA's goal of 30-30-20 does not now exist in fact and may not ever be achieved. Just as the VA "doesn't count" some of the workload the VA counts "next available appointment" as wait time. Never mind that an appointment may have been canceled the day before, after close of business, and that it was not possible to fill the cancellation either because of distance or preparation for the appointment (NPO for labs, or the availability of x-rays, etc.). At Togus, the actual "next available appointment for a neurology consult is February 2003." But if there is a cancellation, whether it can be reasonably filled or not, then that time frame is counted. This practice does a disservice to the veterans waiting for health care and for the VA providers who work hard to provide this health care.

The Solution:

First, one must understand and know what the mission statement of the Veterans Administration is: "To serve America's veterans and their families with dignity and

compassion and to be their principle advocate in ensuring that they receive the care, support and recognition earned in service to this nation."

1. The GAO should do a comparison study between the actual costs of medical procedures charged to the VA by community resources versus what the costs would be at VA facilities. Example: At Togus VA, the cost of doing a nuclear thallium stress test is $250 per procedure, but because of a lack of funding from VISN 1, Togus has sent approximately 150-200 of these procedures out to the community at an approximate cost of $2,800/per procedure. The community charges $420,000 for 150 procedures, which could have been done at Togus for $37,500, which would have saved Togus $382,000.

2. Currently facilities are funded by workload. This method doesn't reflect the true cost of medical care in the VA health care system. In order to correct this, the VERA system needs to increase the BASIC payment to the national GAO's suggested average of $4,729/veteran and allow 4% of the veterans served to be COMPLEX payment at $42,765/veteran. This increase would allow the VA to cover the cost of serving Category 7 veterans who are unfounded in the current system.

3. Even though VERA provides funds to the VISNs, there needs to be a provision for mandatory disbursements from the VISN to the local facilities in proportion to the number of basic and complex veterans served by the local facilities.

4. The staffing is based on designated categories. For example, medical patients are staffed at one level, while Spinal Cord Injury patients at a much higher level. The same is true for patients designated as lodgers and domicile. Without an accurate designation of patients, there is not enough staff to safely provide care.

5. VISN headquarters demands that staffing needs are reviewed at the local Resource Board, but often the Resource Board at headquarters overrides these recommendations under the guise of "cost saving." In actual fact, denying requests for staffing ends up costing the VA more because services then need to be sent out to community providers.

SUMMARY:

The Veterans Equitable Resource Allocation was created in a time that HMOs were at a peak. In good faith it appeared to the Veterans Administration and to Congress that this was the best way to provide the best care for veterans with some degree of cost control. Since its initiation, this system has proven to be inadequate in different portions of the country. It is not an equitable system to serve the health care needs of veterans.

The time has come for the Veterans Administration and Congress to come together to propose legislation to fix what's wrong with VERA and honestly provide the funds to grass root level providers so that they can provide the veterans of this nation health care that meets the VA standard and lofty mission statement. Health care should not be an issue exploited by entrepreneurs, elected officials, or individuals trying to make a spotlighted career for

themselves – changes at the expense of veteran's health care.

Quality health care should be provided to the millions of veterans who have served this nation honorably by ensuring that the VERA system provides at least one fully staffed community hospital in every state. This would decrease the cost of health care and provide the maximum care to our veterans. They deserve nothing less.

Thank you Chairman Shays. I look forward to answering any questions you or your committee members may have.

Mr. SHAYS. We've been joined by Mr. Gilman. But I want you to catch your breath a second. I'm going to let Mr. Allen just ask a question, too, so you can catch your breath. Mr. Allen.

Mr. ALLEN. Just quickly, Mr. Bachman, I want to, because I know you have opinions on this, I want to just ask your opinion about how you think Togus is being managed by the current administrator Jack Simms and his staff? I mean, because there is no question that for every one of these facilities, one of the things that needs to be done is to look at how each facility is being managed. I just would like your opinion on that.

Mr. BACHMAN. Mr. Simms and I have had our disagreements in the past. And Congressman Shays and you understand, him and I went to war a few times. Mr. Simms at the present time, I would say, has come around to the fact that he's pulling for the veterans as much as possible. The problem that Mr. Simms is having is that, as I look at it now as a line manager, he has been painted into a corner and been micromanaged by the VISN level. I think that's the problem that probably occurs throughout most of the VISNs in the United States. They were created initially to be giving advice, as I thought, and to be minimally staffed. And I think if you look at it, they've probably grown tremendously, and now they take for themselves and leave what's left over for the outlying facilities. That's why probably Maine is in one of the problems it is, sir.

Mr. ALLEN. Another question. You mentioned the thallium stress test as an example of how the facility could save money if you were using it to the fullest extent. Are there other ideas you have for ways to make the delivery of health care to our veterans more efficient?

Mr. BACHMAN. Yes, sir. Probably we spend at Togus, I don't know what everybody else spends, but we spend a little over half a million per year on MRIs that we ship out to the community. If the facility itself had an MRI, probably in 2 years you'd pay for that machine itself, and then you'd end up reaping the benefits from that.

Other things that we farm out, a lot of gastroenterology, cardiology. One of the laughs between the medical staff now is to get your waiting times over 1 year. That way, everybody who is over the 1-year period can be farmed out and at least get care on a quicker basis. In my own department, the chief of neurology, Dr. Salmon Malik, has a waiting time—if you called, sir, we would probably get you in in March 2003. So we're not meeting the 30/30/20. I don't think we've ever achieved that, in honesty.

Mr. ALLEN. Thank you.

Mr. SHAYS. Thank you.

Mr. Gilman is here. And I'm reminded seeing you, Mr. Donnellan and Mr. Gilman, that we did a hearing up in Mr. Gilman's district. And during the course of that hearing, the room was packed, one of the police officers came up to me and he said, Mr. Chairman, you may need to escape out the back door, and I just want to show you where it is. And I felt that it was a rowdy group, candidly, but when he made that comment, I thought I had to fear for my life. It was a very memorable hearing.

Mr. GILMAN. It sure was, Mr. Chairman.

Mr. SHAYS. You notice we've not had another.

Mr. GILMAN. Mr. Chairman, I want to thank you for holding——

Mr. SHAYS. I want you to turn on your mic.

Mr. GILMAN. We're on. I want to thank you for reviewing where we're at to examine the current state of veterans' health care, specifically how it's impacted over the last 6 years by the Veterans Equity Resource Allocation, the VERA formula.

Apologize for being late. I had to be up in the district, testifying in the court on a little matter called redistricting.

I also want to welcome our director of——

Mr. SHAYS. Do they know that you're a former veteran?

Mr. GILMAN. I hope that they recall that. I try to remind them that age shouldn't be a factor.

I also want to welcome our director of Rockland County Veteran Service Agency who's been doing an outstanding job in our 20th district, Jerry Donnellan, who also was present at that raucous hearing as well. This is an old and familiar subject for both of us, Mr. Chairman. And I'm certain that we all recall that raucous field hearing. And I can't thank you enough for coming up to our district at that time, and we felt so badly the way some of those folks had reacted, but they were hurting. That was the summer of 1997. And you did an outstanding job then of controlling that hearing and keeping things and moving along.

At that time, you and I were both concerned about the impact that VERA would have on the veterans in our part of the country. And at the same time, we were also assured by the VA that the best way to keep money in our respective States was to get veterans registered for VA services. And we all went to work on that. We did our part in that arrangement. But regrettably, the VA did not fulfill their responsibilities.

The VA's proposal that bringing in new patients would preserve VISN funds was questionable due to the fact that most of the new enrollees in New York would be category 7 veterans. Nevertheless, we stressed to our local veteran service coordinators that a greater registration for VA health services was required, and in fiscal year 2001 VA health services usage in our own area grew considerably. And despite this, VISN 3 continues to lose VA funding each and every year.

The veterans in the Sun Belt are receiving the exact same type of treatment as their northern counterparts, but in their case the costs are covered by the VA, whereas in New York they are not. Since VERA attracts noncategory 7 spending, that formula results in the shifting of funds south and west, solely because those areas have a lower cost of living and fewer specialty care patients.

This problem is not mitigated by increased overall funding. Congress has provided record increases in VA health funding since 1999. Yet, due to the existence of VERA, very little of the new money ever flows to the Northeast. Instead it goes to the Sun Belt to treat means-test eligible veterans in VERA-friendly regions, while the administrators of VISN 3 and other northeast networks have had to call on Washington for additional funding each and every year.

VISN 3's history since 1996 could be summed up as follows: From 1996 to 2001, VERA cut the network's budget by some 10

percent. At the same time, it saw an enormous increase in overall workload and priority 7 patients. So despite VA assurances to the contrary, getting new veterans into the system did nothing to guarantee additional funding in VISN 3. It has only further stretched the budget, led to long waits, up to a year in some cases, for new veterans to be able to receive medical services.

There are a number of possible solutions to correcting VERA's problems. The first and easiest is to incorporate category 7 veterans into the funding formula. And I understand the VA is opposed to that kind of a proposal, Mr. Chairman, because it would necessitate a greater health care budget. That's a separate issue entirely, the problems which lie with the Office of Management and Budget and not with the VA.

It's surprising that the VA is opposed to adopting meaningful changes to the VERA formula. I've long believed there seems to be some underlying hostility toward category 7 veterans among the VA hierarchy in Washington. That hostility was epitomized by the VA health care language accompanying the President's budget earlier this year. That language suggested the creation of an annual deductible for category 7 veterans.

It is gratifying that the General Accounting Office is now adopting the position that changes need to be made in the VERA formula. For years, GAO argued that too many facilities in the Northeast were underutilized and needed to be closed down, to be leased out, or sold off. I've long contended the reasons such facilities were underutilized was due to the historically high copayment costs that category 7 veterans have had to pay for using the system. Until the reduction in that copayment last year, it made no sense for the Medicare-eligible category 7 veterans to be able to use the VA. Now that the copayment has been reduced from $50 to $15, more category 7 veterans are going to be able to use this system for their health care needs.

So I look forward, Mr. Chairman, out of this hearing and all the testimony you've taken, that we can work with you and ensure that our veterans are going to be able in the future to receive the highest quality health care that they've earned through their service to our Nation.

Let me comment that Jerry Donnellan, who is before us, our regional director of veterans services, worked out a clinic program for our veterans. It's been outstanding. And it's been so outstanding that he's overwhelmed now with veterans, they're finding difficulty in keeping up with it. This prevents the veterans from having to travel long distances. They are able to get immediate care and, as a result of the outstanding job that Mr. Donnellan did in Rockland County, New York, our adjoining counties have copied his clinical approach and are also finding a tremendous increase in the need for services.

I have no questions at this time, Mr. Chairman. I can't thank you enough for your continued interest in making certain that our VA formulas meet the needs of our veterans.

Mr. SHAYS. I thank the gentleman.

Mr. Allen, I would be prepared to invite you to ask questions, or I can jump in. Which would you like?

Mr. ALLEN. I would just as soon have you go ahead and I'll jump in.

Mr. SHAYS. OK. I want to give credit to the GAO report and want to say that I realize we've kind of gotten sidetracked because I feel like—I'm trying to think of an analogy to describe it, but I see—I won't do it, but it's just like I feel almost overwhelmed by what I think the VA is telling us. I mean, whatever formula we have, we have an underfunded system that will not get the resources it needs. So we're kind of arguing about a formula. It's kind of like kind of an arranging the chairs on the deck of the Titanic. It's probably a poor example, but the best one I can come up with.

But having said that, I would like to understand the VERA system better. And I would like to ask you, Ms. Bascetta, a few questions. I'd like to know why does VERA need to increase the number of case mix categories? I'd like to understand why it needs to do that.

Ms. BASCETTA. Right. In both the complex and basic care categories, one capitated rate is set. And because of the variability in the actual costs of different diagnoses within those broad categories, the networks receiving those payments are either under- or overcompensated. For example, for the $42,000 payment that they would receive for complex care, patients who are ventilator-dependent, require kidney transplants, other kinds of transplants, have serious spinal cord injuries, or various forms of mental illness, would be way over that 42,000.

Similarly, in basic care you have a situation where there are many conditions that would be well in excess of the $3,100 payment. Alternatively, there are lots of conditions that are much less than that. So if they have a finer gradation of payment categories within those three—if they expand to have more case mix categories rather than the three, they can more closely approximate the actual payments that would be needed to cover the costs of the networks.

Mr. SHAYS. Now, the VA is looking at some other potential case mix approaches. I think there are three of them? Can you—but before that, tell me why we need to deal with this in the year 2003 instead of waiting for more studies.

Ms. BASCETTA. Part of the reason is the equity that exists now. As our report shows, the networks that have been discussed most today, networks 1 and 3, would be gainers largely because of the change in case mix. Network 3 would receive about $10 million more for the priority 7 payments and about $32 million more for case mix. Network 1 would receive a little less than a million for priority 7s, but close to $41 million for case mix.

So these are—we can discuss, you know, the relative impact of that as opposed to more money for the whole system, but these are changes that can be made right now with a change in the policy for 2003.

Mr. SHAYS. OK, would you take the three potential case mix approaches and tell me if any of them make sense? You want to basically put them all together, right?

Ms. BASCETTA. We think that the refinement of the current model is the best way to go for a few reasons. It's familiar to stakeholders. Part of what VA needs to do is ensure that the changes

that they make can be easily explained to the stakeholders. And the stakeholders, under the current model, they may not agree with it, but they could understand how this addition of the 7s and a more refined case mix would benefit some networks while it would disadvantage some others.

I shouldn't use the word "disadvantage." It would more appropriately reflect the payments that they need.

VA has talked—and one of their alternatives is what they call VERA 10, and it is this refined case mix.

The other alternative that they're talking about and that is giving them some concern in the sense that they would like to wait to go to this other system of diagnostic cost groups, this is a system that is partially used now by the Medicare program. It probably is more sophisticated. Certainly conceptually it's a better way to go, because it doesn't rely on utilization. But it has not been, by any stretch of the imagination, fully implemented in Medicare.

Only 10 percent of the payments are now made using this system. Only 30 percent will be made that way by 2004. It can't be used for long-term care payments because it would still rely on a utilization base for those payments. So you might as well stay with VERA which is utilization based now. It's also very reliant on much more precise data than we think VA is capable of developing right now for that use.

So our concern is that if the Department decides to use a DCG-based approach or to tailor DCGs to the VA, we are not talking about anything that's feasible, probably not even in 2004. So we think the cost of waiting and essentially tolerating the inequity that's in the current system is too high a price to pay.

Mr. SHAYS. OK. Let me ask you about the supplementary funding. What are the factors that the VA needs to identify as relates to a supplemental funding request?

Ms. BASCETTA. Well, they know what the—they probably know what the major factors are. They know that network inefficiency, for example, is one struggle that many networks deal with. What they don't know is the relative contribution of the different factors that affect shortfalls to the need for the supplemental funding, and we think that they need to get a much better handle on this so that they can hopefully prevent the need for a supplemental funding in the future or, if not prevent it, at least be very explicit about why they're giving certain networks additional funds.

The reason we think it's important is that not to have a handle on that could undermine the integrity of the process for all the other networks. In other words, if there's a perception that networks are not needing to justify their needs for supplemental funding, then there is really no disincentive for any other network raising their hand and saying they'd like additional funding as well.

Mr. SHAYS. How can we feel confident they're not going to reward inefficiencies in the supplemental request?

Ms. BASCETTA. We can't feel confident about that unless we better understand what proportion of the need of the budget shortfall is due to inefficiency. Then, if we understand why, that inefficiency could be effectively dealt with.

Mr. SHAYS. OK. So, bottom line, if they are inefficient, they still need the money.

Ms. BASCETTA. That's true.

Mr. SHAYS. So they're going to get it, but it's not a very comforting thing to think, that's ultimately who gets it.

You have the winners and losers—I thought it was on page 10 of your report, the bar chart. It's on page 29, I'm sorry. No, it's page 12. Let me make sure I'm looking at the right one—change in VERA allocations from incorporating the case mix categories and priority 7 basic vested veterans treatment. Would you walk me through that again? You described it earlier. But I see Boston. When I see Boston, I don't need to be concerned it's going to Boston instead of Hartford instead of West Haven? That's the whole network.

Ms. BASCETTA. That's correct. And another allocation would be made from the network to the facilities.

Mr. SHAYS. But walk me through. Are you saying that the district now—that Tom and I can link up in VISN 1 and link up against all our compatriots here, are we saying that VISN 1 is underfunded by $41 million?

Ms. BASCETTA. That's correct.

Mr. SHAYS. Which is the most anywhere.

Ms. BASCETTA. Yes.

Mr. SHAYS. And that is not—is that taking into consideration categories 7?

Ms. BASCETTA. No, that is just from case mix.

Mr. SHAYS. OK. Of those who are actually in——

Ms. BASCETTA. I'm sorry. That is including priority 7s.

Mr. SHAYS. So then we look at the Bronx, and that's another high one of $41.5 million. Then I look at Portland at $39 the other way and Long Beach, CA, $34. My sense is that you are—if we had the same dollar mix, you're basically saying to Long Beach you're going to have $34 million less.

Ms. BASCETTA. Correct.

Mr. SHAYS. Well, we know that's not going to happen. No, we do. So then I guess the way we would have to deal with it is to say any new dollars. In other words, we would hold them harmless, probably. And I'd be curious, I don't think you'd have the statistics, but if we held them harmless so that your formula worked, I wonder how much more dollars would have to be spent in the other areas? Do you understand the question?

Ms. BASCETTA. Yes, I do.

Mr. SHAYS. In other words, one way we can hold them harmless is to say you don't lose, but, Connecticut, you'd get 41.

But if we were really going to hold them harmless under a true formula where the formula would still be accurate and, Lord knows, they'd still need the money, we would—I'd be curious to know how much more—would that $41 million become $120 million or something like that? Is that possible to figure out under your formula? Not now, for your testimony now——

Ms. BASCETTA. I suppose it would be possible. But I don't have those.

Mr. SHAYS. See, I mean, because we're going—I'm going under the assumption that I don't think can be really refuted, is that all VISNs need more money. You're just saying, within that formula

of underfunded appropriations, the formula could be better directed.

Ms. BASCETTA. Correct.

Mr. SHAYS. We're all agreeing that even Portland can use that $39 million.

Ms. BASCETTA. I'm sure they've spent it.

Mr. SHAYS. Right. Yeah.

Mr. ALLEN. Could I—if you would yield, I'll wade into it.

I don't know what the numbers are either. But my guess is—and let me test this out. I would make two points.

First of all, when the VERA system was implemented over a period of time, VISN 1 took the hit. I mean, year to year to year we took a hit at least in purchasing power, if not in absolute dollar, an absolute dollar claim.

Mr. SHAYS. Would the gentleman yield?

But that first year we probably got what was fair under the formula in that very first year. Or no.

Mr. ALLEN. I know we've had an actual decline in dollars. I'm pretty sure about that. Let me——

Mr. MUSSELWHITE. That's correct.

Mr. ALLEN. So the question is whether——

Mr. SHAYS. Is everybody's mic on? You're kind of far away, Mr. Musselwhite. Sorry for the squeaks here.

Mr. ALLEN. The two points I have is—one is, so far as I know, VISN 1 and VISN 3 have had actual declines in dollars over the cost of this 5-year period. That's No. 1.

But, No. 2, I suspect—and I'm testing this, and I'm no math major—but if you actually were trying to implement this formula in a way that would do no harm to any of the VISNs like Portland and San Francisco and Long Beach, the cost would be huge, or it would be a lot more than simply adding up the positive numbers on the right-hand side.

Mr. SHAYS. It would be.

Mr. Donnellan, you're in VISN 2, is that correct?

Mr. DONNELLAN. Three.

Mr. SHAYS. You're in VISN 3. So it comes up. So you—OK. That's good. So we all can agree here. We don't have any arguments. I thought maybe you were in VISN 2.

Mr. DONNELLAN. No, 3.

Mr. SHAYS. What is your reaction, both of you, when you hear about the underfunded nature of the VA? What is your—you're both veterans, correct?

Mr. BURKE. Yes.

Mr. BACHMAN. Um-hmm.

Mr. SHAYS. The question I'm asking is—I mean, does your mind say, you know what? We're in a difficult situation. Let's find a good compromise here. Or do you basically say, gosh darn it, we're veterans. We're entitled to this service. No veteran left behind. Kind of like No Child Left Behind.

Mr. DONNELLAN. Well, yes, sir, I think no veteran should be left behind, but I personally am confused. Because several years ago when you were in our district and we had those hearings about VERA we were told go out and beat the bushes, enroll veterans in the system. Because one of the concerns was that the Northeast,

particularly VISN 3, the population was falling off. If the population fell off, the hospitals would be closed. So the more bodies we've got, the more head count—it goes back to Vietnam. It goes back to Vietnam. We've got to get the body count up.

So we beat the drums. It went from 250 to 6,000 people in about 4 years. If you give me another clinic, I could fill it by next year.

So I'm getting mixed signals from the people who are giving me signals.

The other point that I brought up in my testimony is the VA hospital near us at Montrose, New York, which I'm sure is similar to many others across the country, where it was opened in 1950 I believe is a 2,000 bed hospital now has less than 300 beds but still sits on 190 acres. Our local hospital in Nyack, New York, serves more inpatients than that on a city block.

So if we could do something with that surplus land that's sitting there, for all practical purposes, costing money, perhaps that might be a way to go. I realize it's not a complete solution but that many people could be serviced in a, you know, 6-story, small-footprint hospital building.

Mr. SHAYS. Mr. Bachman.

Mr. BACHMAN. I guess as a category 1 veteran in my time I look at it—again, we probably shouldn't leave anybody behind, but I think we have to look at it realistically. I think, as we look at this, you have to say to yourself, what did VERA do and can VERA, the way it is set up now, maintain the system? And what does Congress have to do, what does the Veterans Administration have to do to make it correct at this stage of the game without tearing the system apart?

I agree with the fact that our stakeholders do know the system. I look at it, I guess, as pretty basic math if you want to—sometimes simplistic is more than complex. I think if you look at what the GAO did, I think Congress's responsibility is to give up enough money and whatever it costs to even the playing field for everybody across the board.

I'm not saying that Long Beach needs extra money, but those that are already in the red, bring them to the playing field. Then look at the formula and say, is—because if you take the GAO's 50 percent at $849 of the basic rate for a category 7, you're still a loser. I think that if you look more to the GAO's national average of $4,729 of what it costs per veteran you're coming pretty darn close to what it's going to cost to even continue this.

And I think it—it comes down to this: If you do it that way and not work it on workload, if you base it upon the veterans that you take in, as we were all mandated back in 1998, open the doors up and bring all these people in, it gives Congress each year the ability to know how much the Veterans Administration increased their number.

It also, when you look at complex—I think what the Congressman needs to understand, I don't think he was told this at all, is complex, when you look at it, there's tons of categories in there, but there's only two that are permanent. That's spinal cord injury, HIV and AIDS. Everything else is based on an influx.

PTSD, you're in 5 years. If you don't get reevaluated, you're out. So now you're a basic. If you're a stroke patient, you're in 3 years.

If you don't get reevaluated, you're out. So you go back to basic. Then it takes—there's a 20-year lag time to get you there. So you're always behind the power curve. No matter what you're doing, you're not winning. If you're complex, you're complex. If you're basic, you're basic.

Raise the rates of what it takes. Report to Congress how much more veterans you took in. Have Congress bring up the money.

A lot of times what happens with the money that Congress appropriates is that it gets spent on other things. It doesn't get spent on medical costs. Small portion to medical. You raise the budget by $5 billion, how much of it is truly toward medical? A third, a quarter or one-tenth. That's the problem.

Mr. SHAYS. Thank you.

Ms. Bascetta, when—Dr. Roswell acknowledged there are a lot of factors that are contributing to this problem, but one of the things he did acknowledge was that within a VISN you have part of it that is making efficiencies and another part that isn't, but it becomes so within the VISN there's a disincentive for one part of it to become more efficient if the other part hasn't.

When I look at your chart, we would need about $175 million, which in the realm of things isn't a lot of money compared to the overall budget, to at least hold—if we held harmless those who have more than they should. But did you look at efficiencies within a VISN to understand who might be winners and losers within a VISN?

Ms. BASCETTA. No, we didn't.

Mr. SHAYS. You know what I mean by losers? I mean the losers are those who actually made cost savings, closed down a facility. I'm thinking, frankly, of our own VISN. We all know that Boston didn't eagerly jump in to making savings. So—and that's what I reacted to when I saw your chart saying "to Boston." But bottom line is you didn't look at that issue.

Ms. BASCETTA. No, we didn't.

Mr. SHAYS. I'm going to ask to you do something else. I'm almost tempted to say, like Connie Chung, just between you and me, one—frankly, there doesn't appear to be any reporter here, not that has prevented it from getting in the press. But if you were being very candid with us, having looked at this system, and you were to say to the administration, this is what you need to look at, administration, and these are some of the mistakes you all have made, and then you said to Congress, candidly, this is what you all did and this is what you need to look at, what would the answer be to that question? What are the mistakes Congress might have made?

We know we made mistakes. What are those and what are the mistakes you think the administrative side has made?

Ms. BASCETTA. Well, I don't know that I'd call it a mistake. I think it's pretty common to pass major legislation and not think enough about the unintended consequences.

When eligibility reform was passed, I know that there was attention focused on the situation that could occur, which is that more veterans could come in than the VA could pay for. So I think Dr. Roswell mentioned that the Secretary has the option every year to decide whether or not he needs to cutoff enrollment at their priority level, depending on what the appropriation is.

I think it's probably impossible to do that once priority 7 veterans, for example, are in the system. I think it's probably impossible to close the system to them. Moreover, without them, the liability of this system over the long run is questionable. Because these are the future veterans. The older veterans, the demographics are such that the older veterans are dying at a very fast rate.

Mr. SHAYS. Yeah, but when a veteran leaves or dies they're replaced by someone else.

Ms. BASCETTA. Um-hmm.

Mr. SHAYS. So I don't think that's the issue.

But your point about Congress is, though, we basically increased the eligibility, and when you say the unintended consequence we basically did it without providing any new funding. So that would be a clear question mark. And then our escape clause was, we said if we didn't provide you the funding, you, Mr. Administrator, have the ability to deal with it by then restricting who qualifies.

Ms. BASCETTA. Correct.

Mr. SHAYS. And the administrator, the Secretary, can do it without an approval from Congress. They can just do it. But a tough thing politically to do.

Ms. BASCETTA. Correct. That's right.

You know, you yourself mentioned the issue. With the CBOCs bringing in people, we did create a demand.

Mr. SHAYS. These are the Community——

Ms. BASCETTA. Community Based Outpatient Clinics. Sorry.

We did some work last year for Senator Bond. What we found was that, in fact, the CBOCs certainly make it more convenient for veterans to come in, but fully two-thirds of the veterans who used a CBOC also used a parent facility. So, although we don't do a quantitative analysis to nail this down, our belief is that those veterans would have come anyway because of eligibility reform, not because of the CBOC.

Mr. SHAYS. You know what? I just would intuitively tell you I don't think so in our district. I think if you can go in the greater Stamford area and you can get this service, you're not driving to West Hartford—West Haven. Excuse me West Haven. So, I mean, you have had the study. I'd love to see where that study was.

Ms. BASCETTA. I can share it with you. I'm from Connecticut, so I know what the driving distances are there; and they're certainly shorter than they are in other parts of the country.

Mr. SHAYS. When last have you been there? The distances aren't any longer, but the queuing time is. The queuing time. Big time.

Ms. BASCETTA. You're absolutely right. In fact, in VA's formula for geographic access, Dr. Roswell said that I think 87 percent are within 30, whatever. They've gone to a distance—to a time measure rather than a distance measure, because that's the reality.

Mr. SHAYS. That's a small point.

Ms. BASCETTA. But the point that I was making was that we have heard that it depends on what you're going for. You might be willing to make that drive or sit in that traffic if you're going for the prescription drug. As you point out, if you're paying hundreds or thousands as opposed to $7 for a 30-day supply you might make that drive.

Mr. SHAYS. Thank you.

Mr. ALLEN. A quick comment. In Maine, people get on buses to go to Canada to get their prescription drugs. So it depends on how much you're buying.

But my serious comment is—I have to leave, Mr. Chairman, but I thought I would ask Mr. Bachman to address your earlier question, that comment particularly on the kinds of proposals that are sometimes called the fee card proposal, just to be provocative.

Mr. BACHMAN. Since there's no news media here, I'll share with you.

As we talked about this in my committee, we said, what happens if you just—if Congress stood up, whether it's politically correct or suicidal or not, and just disbanded the Veterans Administration, just said, it's over, it's done with, we cannot afford it, we cannot provide you with care. Here is a fee card and go find your services in the community.

Just in the few things that I've seen, that the cost of what it costs from the VA to pay for it, you would have to probably fund 10 times more than the budget that you have right now to do that. Because the facilities are already there. I mean, if you can provide, as I quoted you earlier, $250 for a single test that costs almost $3,000 in the community and you are footing that entire bill, you know, would you—so, really, you can't do that.

You have a system that's there. I think you just need to look at the system. The mistake you made, Congress made was you created—you opened the doors up, but you didn't fund it. I think you didn't have the information to fund it.

As I look and as I read through the GAO, I do not think you were provided with the information, nor do I think that the VA itself knew what was going to happen when they opened that door up.

Mr. SHAYS. I think they probably knew more than you realized.

We're really closing up, so we'll have one recorder just finish up here.

So, bottom line, you're done. Would any of you like to make a closing comment?

Ms. BASCETTA. Just quickly. We don't know, but I'm not confident that the VA knows what budget they really need. We would really like to see them make a more concerted effort to develop a needs budget and to use the CARES process to develop that kind of information.

Mr. SHAYS. Thank you all very much.

I don't know if you're running out of paper or whether there's a system that I just destroyed that will never be straightened out.

Thank you all very much here. This hearing is closed.

[Whereupon, at 5:10 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

STATEMENT OF
JAMES R. FISCHL, DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

TO THE

SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS, AND
INTERNATIONAL RELATIONS
COMMITTEE ON GOVERNMENT REFORM
U.S. HOUSE OF REPRESENTATIVES

ON

"VA HEALTH CARE: STRUCTURAL PROBLEMS, SUPERFICAL SOLUTIONS"

MAY 14, 2002

STATEMENT OF
JAMES FISCHL, DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
TO THE
GOVERNMENT REFORM SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS, AND INTERNATIONAL RELATIONS
U.S. HOUSE OF REPRESENTATIVES
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"VA HEALTH CARE: STRUCTURAL PROBLEMS, SUPERFICIAL SOLUTIONS"

MAY 14, 2002

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 Networks (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 reasonable, 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

outside agencies as well have reviewed the VERA 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 allocates 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 concern was VERA's limited amount of categories used 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 been budgetarily limited for the last three fiscal years, but also the trend for the number of VISNs needing adjustments keeps increasing.

Whether the VA acknowledges this money as *bailout* 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 demand for service and VHA's ability to meet that demand. Normally, marginal annual increases barely cover the costs to maintain current services and rarely offer funding for expansion or improvement of 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.

BLINDED VETERANS ASSOCIATION
477 H STREET, NORTHWEST • WASHINGTON D.C. 20001-2694 • (202) 371-8880

Statement for the Record

Submitted to
Committee on Government Reform
Subcommittee on National Security, Veterans Affairs, and International Relations
Thomas H. Miller
Executive Director
Blinded Veterans Association

May 14, 2002

On behalf of the Blinded Veterans Association (BVA), thank you for this opportunity to share our views of the Veterans Equitable Resource Allocation (VERA) model and its effects on the VA Health Care system. BVA will focus specifically on how VERA is affecting VA's ability to provide quality blind rehabilitation services to our nation's veterans.

First, for the record, BVA would like to note it's displeasure with the "title" of this hearing – "VA Health Care: Structural Problems, Superficial Solutions?" Admittedly, there is room for improvement, but with limited financial resources it has available, VHA does very well in serving our nation's veterans. Over the years, VHA has constantly worked to change and improve allocation models to assure that veterans receive quality service in a timely manner. That said, BVA does have concerns about what happens to monies after they have been allocated to Veterans Integrated Service Networks (VISNs) and distributed to each facility.

The Blinded Veterans Association is proud of the VA's long and distinguished history of blind rehabilitation. VA is home to world-renowned Blind Rehabilitation Centers (BRCs). Beginning with one BRC, in 1948, located at the Hines VA Hospital, the now 10 centers serve an average of 2,000 blinded veterans each year. BVA strongly believes VA should hold it is special disabilities programs in the highest of regard and priority. Somehow, no matter what the allocation model, the VA struggles to maintain capacity in many of these unique and important programs, which serve some of our veterans in most need.

Special disability programs, including Blind Rehabilitation, are required under Title 38, USC, Section 1706, (as established in PL 104-262 and extended in PL 107-135) to maintain capacity of certain requirements outlined in the code as in the year 1996. For Blind Rehabilitation, each BRC is required to "count" current operating beds and staff (FTE). By law, these numbers are required to maintain the same "capacity" in 1996. Year after year, we hear from facilities: "We do not have enough funding to hire another FTE," or "The facility has our center under a hiring freeze." Excuse after excuse, always dealing with funding, as to why their Congressional mandate cannot be met.

In reviewing the recent GAO study, *VA Health Care: Allocation Changes Would Better Align Resources with Workload*, "Table 3: Complex Care Workload Allocations Compared With Complex Care Expenditures, Fiscal Year 2000[1]," caught the attention of BVA. Blind Rehabilitation Centers are hosted by eight VISNs. According to Table 3 in the aforementioned GAO Study, out of those eight VISNs, seven indicated an excess in allocation for complex care patients. About half of the Blind Centers (according to FY 2000 Capacity Report Data) claim they are not able to maintain staffing capacity because of funding issues. Suffice it to say, we agree with GAO's findings that perhaps the complex care allocations need to be examined. BVA would like an explanation as to how is there can be an excess in complex care funding, while facilities that serve complex care patients are not able to maintain CONGRESSIONALLY MANDATED capacity due to lack of funding. There is no tracking mechanism, of which BVA is aware, to follow dollars to a facility once they are allocated to a VISN.

BVA believes transferring from a three-category to 44-category payment system (referred to in aforementioned GAO report) may be a more equitable route for funding allocation. Nevertheless, we still have some reservations. Even with the subcategory "Blind Rehabilitation", there are several levels of funding needed. A stay at a Blind Rehabilitation Center can vary in price, depending on the length of stay and services provided.

BVA is concerned that the problem with the allocation of dollars may not be with the model itself. It seems very curious that the very VISNs whose facilities claim to have "hiring freezes" and not enough funding to maintain capacity, in the larger scope, end up with excess monies for complex care. How does this happen and where are the excess allocations being spent?

One may further ask why GAO did not explore this question. Perhaps it was easier to just focus on the requisition of supplemental funding. Going one step further and tracking the money from VISN to facility is a very tedious and lengthy, but necessary process.

BVA is extremely concerned about the discrepancy between dollars allocated for complex care and a facility's ability to provide quality care in a timely manner. An inability to adequately staff special disability programs leads to a reduction in amount and quality of care given to veterans who have sacrificed so much for our freedom.

Once again, thank you for this opportunity to provide comments regarding this important issue. Please do not hesitate to contact us if you have any questions regarding our comments.

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[1] U.S. General Accounting Office, *VA Health Care: Allocation Changes Would Better Align Resources with Workload,* GAO-02-338 (Washington, DC.: February 28, 2002) pp. 20-21

VETERANS OF FOREIGN WARS

OF THE UNITED STATES

STATEMENT OF

PAUL A. HAYDEN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS,
AND INTERNATIONAL RELATIONS
COMMITTEE ON GOVERNMENT REFORM
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

THE VETERANS EQUITABLE RESOURCE ALLOCATION SYSTEM

WASHINGTON, DC MAY 14, 2002

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.7 million members of the Veterans of Foreign Wars of the United States (VFW) and our Ladies Auxiliary, I would like to thank you for the opportunity to communicate our views on the Department of Veterans Affairs' (VA) health care resource allocation system.

The VA currently operates the nation's largest integrated health care network with over 200,000 health care professionals, 163 medical centers, 115 medical research centers, affiliations with over 100 schools of medicine, 800 community based outpatient clinics, 135 nursing homes, 43 domiciliary and 206 counseling centers. As the federal government's leading provider of direct medical services, the VA treated over 4.5 million patients last year with a health care budget of $22 billion.

VFW MEMORIAL BUILDING ● 200 MARYLAND AVENUE, N.E. ● WASHINGTON, D.C. 20002-5799
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Since 1997, the VA has utilized a capitated budget model known as the Veterans Equitable Resource Allocation (VERA) system to allocate its health care budget appropriated by Congress to its now 21 regional Veterans Integrated Service Networks (VISNs). This system "was designed to reflect changes in [veterans demographics such as] the geographic distribution of veterans over time and regional differences in health care needs and the costs of providing care, by periodically adjusting the allocations. At the same time, the system was designed to be simple and to be responsive to the health care needs of the highest priority veterans, that is, those with service connected disabilities. "[1]

Reviews of this system have generally concluded that it is more equitable than the previous practice of allocating funds to VA facilities based on their historical expenditures or bed levels. For example, the most recent testimony by the Government Accounting Office (GAO) before the House Committee on Veterans Affairs found that "VERA's design is a reasonable approach to resource allocation and has helped promote more comparable resource allocations for comparable workloads."[2] Further, a RAND study noted, "that VERA appears to be designed to meet its objectives of reallocating resources...more closely than did previous VA budget allocation systems."[3]

The VFW agrees with these assessments that VERA has improved access to health care for veterans given what it would have been without the ability to shift funds. We would, however, point out that even with the VERA process in place there continues to be areas where increased demand for VA health care exceeds VA's capacity to meet that need with existing

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[1] RAND, *An Analysis of the Veterans Equitable Resource Allocation (VERA) System* (Santa Monica, California, 2001), p. xiii.
[2] U.S. General Accounting Office, *VA Health Care: Changes Needed to Improve Resource Allocation*, GAO-02-685T (Trenton, NJ: Apr. 30, 2002) p. 3.
[3] RAND, *An Analysis of the Veterans Equitable Resource Allocation (VERA) System* (Santa Monica, California, 2001), p.xv.

resources or facilities. Case in point, a little over five years ago, on April 3, 1997, then VISN 8 (Florida and Puerto Rico) Director, Dr. Robert Roswell, testified before the House Veterans Affairs Committee in favor of the VERA process stating that "Florida and its veteran population typify the dynamic" of demand for care exceeding capacity for care and that the VERA process would "improve access to high quality healthcare for more Florida veterans." Last year, VERA shifted nearly $198 million of approximately $921million total funds shifted for fiscal year (FY) 2001 to VISN 8 to address medical appointment waiting times. As of last month, however, there are still roughly 40,000 veterans waiting for a medical appointment in Florida.

Further, the VERA process has had a negative impact on veterans residing in VISN 3 (New York and New Jersey). VERA shifted nearly $321 million from VISN 3 in FY 2001 leaving that network to request supplemental funding from the National Reserve Fund (NRF) for the third straight year. As the VFW Department of New Jersey recently testified before a field hearing of the House Committee on Veterans Affairs on April 30, 2002, "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." While this may have been an unintended consequence, it serves to underscore weaknesses in the VERA model and leads many veterans to conclude that the Veterans *Equitable* Resource Allocation system is not very *equitable*.

In fact, every evaluation of the VERA system has recommended some type of continual development and improvement to the system. The most recent GAO report, *VA Health Care: Allocation Changes Would Better Align Resources with Workload*, which we are here to discuss

today, is no different.[4] This report identified three major weaknesses in VERA's implementation.

First, GAO noted that VERA excludes Priority Category 7 veterans (non-service connected and non-compensable service connected veterans with incomes above established thresholds), or about one-fifth of VA's workload in determining each network's allocation. Once enrolled, however, all veterans, regardless of their priority category, share equal access to VA health care services and therefore, substantially impact the costs associated with that care. To exclude the fastest growing population of veterans (30 percent annual growth) seeking VA health care from a system designed to account for actual workloads is completely contradictory.

VISN 3 (New York and New Jersey), mentioned previously as the network that has had to request supplemental funding for the past three years under the VERA system, has the highest number of priority category 7 veterans. Moreover, the VA's Assistant Inspector General for Auditing testified before the same House Veterans Affairs field hearing on April 30, 2002, that "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 [VA] withdrawing funds from other networks in order to fund supplemental requests from those networks that have a higher than average priority group 7 enrollments and associated workload." VISN 3 is one of those networks.

Therefore, we agree with the Assistant Inspector General that the "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

[4] U.S. General Accounting Office, *VA Health Care: Allocation Changes Would Better Align Resources with Workload*, GAO-02-338 (February, 2002)

resource allocation decisions." Further, the VFW strongly supports the adoption of this practice for the FY 2003 allocation cycle.

Second, the GAO report identified problems in VERA's ability to account for cost differences among networks resulting from variation in their patients' health care needs. Currently, the VERA process allocates funds based on six model components: Basic Vested Care and Basic Non-Vested Care, Complex Care, Research Support, Education Support, Equipment and Non-Recurring Maintenance. According to VA's 2002 VERA report, they are considering potential changes to patient classification that would allow them to more accurately predict actual per-patient costs based on use of Diagnostic Cost Groups instead of utilization characteristics based on averages. The VFW fully supports expanding case mix components to better allocate limited resources.

Finally, GAO recommended that VA use the NRF process to better understand why networks need supplemental funding beyond their VERA allocations and to correct problems identified by this process. It is our contention that VISN 3 needed supplemental funding due to the exclusion of priority category 7 patients from the VERA process. Based on that information, GAO and the VA Inspector General's Office have concluded that priority category 7 veterans need to be included in the VERA process. The VFW fully supports the practice of analyzing why networks request supplemental funding.

As stated before, the VERA system was intended to be flexible and responsive to changing demographics. Moreover, the GAO recommendations mark an ongoing process of refining a fairly new allocation methodology. Any discussion of equitable allocations, however, would be incomplete without addressing an issue that is inextricably linked to the allocation process: VA Appropriations.

The Department of Veterans Affairs is already operating in deficit spending for FY 2002. This situation has only resulted in rationed health care and closed enrollment. Only Congress, through the power of the purse, can ensure that VA heath care has the proper amount of funding to begin with before the allocations process begins. The VFW, as member of the *Independent Budget*, recommends a $3.1 billion increase in VA health care for FY 2003. We believe all veterans, regardless of where they live, should have access to the level and quality of care that they have earned and deserve.

Mr. Chairman, this concludes my statement and I would be pleased to answer any questions you or the members of the subcommittee may have.

Paul A. Hayden
National Legislative Service
Veterans of Foreign Wars of the United States

Paul Hayden is a native of Mansfield, Ohio. Mr. Hayden joined the United States Army in 1990 and served with the 1st Infantry Division (Mechanized) as a dismounted infantryman during Desert Shield/Desert Storm where he received among others the Combat Infantryman Badge and a Valorous Unit Citation.

Upon receiving an Honorable discharge, Mr. Hayden utilized the G. I. Bill to pursue a Bachelor's in History and Political Science from the University of Arizona, which he received in 1998. While in Arizona, Mr. Hayden was employed as a Staff Assistant to Senator John McCain.

Paul joined the VFW National Veterans Service in 1999 as a Service Officer. He then served as Associate Director of VFW National Legislative Service from June 2000 until assuming his current position as Deputy Director of VFW National Legislative Service in March 2002.

He resides in Laurel, Maryland, and is a life member of VFW Post 9972, Sierra Vista, Arizona.

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TESTIMONY

of

Richard Jones
AMVETS National Legislative Director

before the

Committee on Government Reform,
Subcommittee on National Security, Veterans Affairs and International Relations,
U.S. House of Representatives

on

VA Health Care: Structural Problems, Superficial Solutions?

Tuesday, May 14, 2002
2:00 pm, Room 2154
Rayburn House Office Building

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of National Commander Joseph W. Lipowski, I am pleased to present the viewpoint of AMVETS on the Veterans Equitable Resource Allocation (VERA) system, the Department of Veterans Affairs (VA) health care resource allocation system used to proportion a $23 billion health care budget to 22 regional health care networks, called the Veterans Integrated Service Networks (VISNs).

Mr. Chairman, AMVETS has been a leader since 1944 in helping to preserve the freedoms secured by America's Armed Forces. Today, our organization continues its proud tradition, providing, not only support for veterans and the active military in procuring their earned entitlements, but also an array of community services that enhance the quality of life for this nation's citizens. Neither AMVETS nor I have been the recipient of any federal grants or contracts during the current fiscal year or the previous two years.

The Veterans Equitable Resource Allocation was begun in 1997 at the direction of Congress as a rational system to replace VA's Resource Planning and Management system, which had allocated funds according to historic trend lines. VERA is intended to reflect a changing veterans' demographic and allow the VA to shift funds to where patients currently live, as opposed to relying on historical patient data. Along with the VERA program, the VA also implemented the new enrollment system that classifies veterans through a series of eligibility rules and assigns them to priority groups based on military service records and income. Veterans with service connected conditions and those with low income form the core of VA's healthcare mission.

The changes brought on by VERA and the priority system have caused a shift in the historic pattern of healthcare funding among regions of the country. Resources have primarily moved from networks located in the Northeast and Midwest to networks located in the South and West. While this change would seem reasonable at first glance, that is, VA healthcare funds better directed to where veterans are, problems have arisen with the shifting of funds.

For example, VERA allocations do not address the relative ages of veterans being served by a particular VISN. This lapse in the calculation can sometimes leave a VISN with shortfalls in

funding due to higher costs of treatment for older veterans. In additional, the types of disease and treatment required by the veterans of a particular VISN can range widely.

Further compounding these burdens on individual VISNs is the influx of so-called Priority 7 veterans into the VA system. In recent years Priority 7s, veterans above a certain income level without service connected illness or injury, have been the largest group of new users of the VA system. However their impact on the system is excluded from calculation of a VISNs workload. Therefore, there is no accounting of these individuals in the allocation formula used in the VERA model. No additional funding is provided to treat these veterans. Congress and the administration have promised veterans, including those in Priority 7, health care within the system. If these veterans are to be served, they must be included in the determinations of healthcare resources needed by VA.

AMVETS believes that the VERA allocation can be improved along the following lines:

- Better integration in the VERA workload formula of actual workloads within a VISN, regardless of the veterans' priority groups served.
- Incorporation of additional categories of patient care into VERA's case-mix adjustment (VA presently only uses three of 44 possible categories) to increase the accuracy of allocations.
- Use of the supplemental appropriation process to address factors underlying VISN funding shortfalls and provision of additional resources as required.

Finally, Mr. Chairman, Congress must appropriate a realistic VA budget every year. The current challenges facing VA healthcare, such as long waiting lists and de facto rationing of care, all stem from inadequate funding. While I know this Committee does not appropriate funds, I would ask each member of this Committee to support a supplemental increase of $400 million for fiscal year 2002 and provide a $3.1 billion increase in fiscal year 2003 VA funding above current year funding. Only by providing adequate funding, this year and every year, will VA be able to fulfill its critical mission of caring for those who defended us.

AMVETS thanks you for the opportunity to present our views on this critical issue.

STATEMENT OF
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON GOVERNMENT REFORM
SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS, AND INTERNATIONAL RELATIONS
UNITED STATES HOUSE OF REPRESENTATIVES
MAY 14, 2002

Mr. Chairman and Members of the Subcommittee:

I am pleased to present the views of the Disabled American Veterans (DAV) regarding the impact of regional variances such as patient demographics and case mix on the Veterans Equitable Resource Allocation (VERA) model and ultimately on access and the delivery of health care to veterans. Many service-connected disabled veterans need and rely on the Department of Veterans Affairs (VA) health care system. Therefore, sufficient funding for veterans health care continues to be one of our foremost concerns and is of great importance to the DAV's more than one million members and their families.

The Veterans Health Administration (VHA) instituted the VERA system in 1997 to ensure that health care funds were equitably distributed to VA's 21 regional networks, known as Veterans Integrated Service Networks (VISNs). VERA was designed to correct regional inequities in resource allocation created by shifts in the veterans population from the northeast and Midwest to the southern and western portions of the United States. VERA was intended to equitably allocate health care resources based on actual workloads rather than on historic funding patterns. Each network receives an allocation based on predetermined dollar amount per veteran served. VA's 21 network directors are then in turn responsible for fairly distributing VERA resources to the facilities, clinics, and programs within their networks to ensure equity of access to health care services.

VERA adjusts for patient health care needs referred to as "case mix" through a classification system. VERA classifies patients into one of three categories based on the level of health care needs and associated costs. The first category is complex care, for patients with chronic conditions and special or complex medical needs who require significantly high-cost inpatient care; the second category is basic vested care, consisting of patients with routine health care needs but who rely on VA health care services; and the third category is basic non-vested care, for patients who are not reliant on the VA health care system and use only a limited amount of services. VERA also makes an adjustment for regional variances or certain uncontrollable factors that affect the cost of

patient care such as cost of labor, service agreements, and locally purchased energy-related products, and utilities.

The United States General Accounting Office (GAO) completed a report on the VERA system in February 2002 titled: *VA Health Care: Allocation Changes Would Better Align Resources with Workload.* Issues addressed in the report include: 1) the effect VERA has had on network resource allocations and workloads; 2) whether VERA's design is a reasonable approach to resource allocation, and 3) weaknesses in the VERA model that may limit the VA's ability to allocate comparable resources for comparable workloads.

GAO concluded that: VERA has had a substantial impact on network resource allocations and workload, and its overall design is a reasonable approach to allocate resources proportionate with each network's workload in relationship to the number of veterans served and their health care needs. However, maintaining only three case-mix categories in VERA does not adequately account for important variations in health care needs among networks. Additionally, GAO reported that weaknesses in the model such as the exclusion of about one fifth of VA's workload, by not accounting for higher income veterans without service-connected disabilities (Priority Group 7); not accounting for patient cost differences among networks; and failing to analyze the underlying cause of why some networks experience shortfalls and need supplemental resources compromise VERA's ability to allocate comparable resources for comparable workloads.

GAO suggested several improvements to the VERA model and recommended that the VA Secretary direct the Under Secretary for Health to:

- Better align VERA measures of workload with actual workload served regardless of veterans 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

VA agreed with conclusions from GAO's draft report, acknowledged the opportunities for improvement in VERA's implementation, and concurred with its recommendations. On April 30, 2002, the House Committee on Veterans Affairs held a field hearing concerning the status of the VERA model. Dr. Robert H. Roswell, VA Undersecretary for Health, testified that VA is currently evaluating the proposed improvements to the fiscal year (FY) 2003 VERA in response to GAO's recommendations; however, final decisions will be made by the Secretary.

Dr. Roswell further stated that VA is carefully weighing the best way to address the issue of VERA and non-service-connected/non-complex care Priority Group 7 veterans. VA admitted that including these veterans in the VERA formula would be a step toward better aligning the VERA allocation model with VA's actual enrollment experience. However, according to VA including them in the model would create financial incentives to seek out more of these veterans at the expense of veterans with service-connected disabilities, poor veterans, or those veterans who require specialized services, thus compromising VA's core health care mission. VA acknowledged "uncontrolled growth" in the Priority Group 7 veterans when they were not included in the VERA model and noted that it did not want to encourage further unmanageable growth by adding them to the VERA model.

VA also commented on GAO's recommendations for adding more case-mix categories in VERA and understanding the need for supplemental funding more fully. Dr. Roswell testified that while GAO may be correct in recommending additional case-mix categories, additional time is necessary for VA to evaluate which method would be most appropriate. He indicated VA is considering recommending that the Secretary delay a final decision on this issue until FY 2004. With respect to supplemental funding, Dr. Roswell commented that, although VA would like to keep supplemental adjustments to a minimum by identifying and correcting the causes as recommended by GAO, it is important to evaluate these adjustments in context of the system-wide impact of VERA. He believes there may be several contributing factors causing the need for supplemental funding and acknowledged that VA needs to better understand what is causing certain networks to require adjustments year after year.

The Office of the Inspector General (OIG) also provided testimony at the April 30, field hearing on the issue of inclusion of Priority Group 7 veterans in the VERA model. The OIG previously recommended the inclusion of the Priority Group 7 workload in the VERA model to improve the allocation of health care resources and integrity of the VERA model. OIG acknowledged VA's significant increase in the number of Priority Group 7 veterans enrolled and treated in the system and estimated that, for FY 2002, this group will represent 33 percent of all enrollees in VHA. OIG estimated the cost of care for Priority Group 7 veterans (an exception is Priority Group 7 veterans who meet the criteria for complex care) was $1.48 billion in FY 2001.

The OIG stated that, " The VERA model 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." However, based on changes in eligibility rules, there have been significant increases in the numbers of Priority Group 7 enrollments with the hope that third-party insurance billings and copayments would cover the cost of their care. Unfortunately, this has not been the case, and, in the past, it has resulted in VHA withdrawing funds from other networks to accommodate supplemental requests from networks that have a larger number of Priority Group 7 veterans and associated workload. Notably, OIG commented that providing these networks with the supplemental funding needed would further adversely impact the network's ability to reduce overcapacity of its clinics and thus veterans' waiting time for a clinic appointment.

DAV concurs with OIG's findings that the significantly increased number of Priority Group 7 veterans seeking care from VA has consumed an increasing share of VHA's appropriated budget resources and thus negatively impacted on service-connected disabled veterans, poor veterans, and veterans needing specialized services.

In March 2002, DAV wrote to VA Secretary Principi concerning the inability of our nation's service-connected disabled veterans to receive timely access to VA health care. We informed Secretary Principi that we had received a record number of calls from DAV members over the last several months, and feared this situation had reached a critical point with no sign of abatement.

We believe access to priority health care for our nation's disabled veterans has been seriously eroded over the years due to insufficient health care funding. Extreme stress has been placed on the system recently as a result of the unprecedented growth in Priority Group 7 veterans seeking health care, and VA is struggling to reduce waiting times while maintaining the highest standards for quality of care. Secretary Principi stated he intends to ensure that veterans with service-connected disabilities and poor veterans are afforded priority for care without sacrificing the excellent quality of care VA is now known for, or restricting health care for other deserving veterans. We appreciate VA's strong commitment to service-connected disabled and poor veterans; however; we know it will take more than good intentions to correct this serious problem.

It is difficult to understand why health care for veterans, especially those with combat or other service-connected disabilities, is not an entitlement. Veterans' health care is discretionary, and the level of VA health care funding is judged in light of competing priorities. It is disingenuous for our elected officials to promise health care to veterans and then make it unattainable because of inadequate funding. Unfortunately, the current stress on system has resulted in rationing of health care in some VHA facilities. For example, in Florida there are a record number of veterans waiting for access to the system, with more than 3,500 service-connected veterans waiting just to be scheduled for an appointment, which, in many cases, will not be scheduled for more than a year. Rationed health care is no way to honor America's obligation to the brave men and women who have and continue to unselfishly put our nation's priorities and defense in front of their own needs.

One way to address this growing problem is to make veterans' health care an entitlement. By making veterans' medical care funding mandatory, rather than subject to annual discretionary appropriations, will ensure VA's ability to care for all veterans who require care. Veterans should not have to beg year after year for adequate funding to receive timely and quality health care services they have earned through their honorable service to this country. Likewise, VISN directors should not be forced to make decisions based on repeated budget shortfalls that negatively impact sick and disabled veterans. It is unconscionable that VA would have to choose between accessibility to care or maintaining the quality care standards VA has worked very hard to improve over the last several years.

We appreciate the Subcommittee's consideration of our proposal to make veterans' health care an entitlement and giving service-connected disabled veterans priority access to health care once they are enrolled in the VA system. Given VA's own estimates of significantly increasing numbers of veterans seeking VA health care, mandatory funding is a reasonable solution to meeting the growing backlog for care.

Thus, we have to conclude that regional variances do have a significant impact on veterans' access to timely health care, and that GAO's recommended improvements to the VERA model would better align the health care allocation with actual workload. The issue of providing timely and quality health care to all veterans who seek care is a complex one, but one that should be immediately addressed by VA. Clearly, sufficient health care funding is essential for VA to meet the demand for medical services. Regardless of changes to the VERA model, without adequate resources VA will continue to delay medical services to many service-connected disabled veterans. We can ensure adequate funding for veterans health care by making this program mandatory.

We thank the Subcommittee for its strong commitment to America's sick and disabled veterans and its willingness to consider our initiatives to address this challenging situation.