

Veterans Equitable Resource Allocation System

Sixth Edition

March 2002



DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

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Foreword

The Veterans Health Administration (VHA) instituted the Veterans Equitable Resource Allocation (VERA) system in April 1997 to allocate funds to networks. VERA ensures that the distribution of funds is equitably distributed based on veterans who use the VA health care system rather than simply being based on historic funding patterns. VERA has been, and will continue to be a critical component of VA's success in implementing the mission and vision of the VHA.

The VERA system pays each network a "tailored" price that reflects the unique characteristics (e.g., the number of high and low cost patients and the cost of labor) of each network. In 1997, the allocations under VERA showed that resources had to be shifted among the networks to achieve equitable resource distribution within VHA. These funding shifts took place over a four-year period to ensure they were effectively managed. The need for these shifts in funds was identified previously by the General Accounting Office (GAO). A more recent GAO study concluded that the VERA model is making resource allocation in VHA more equitable than previous allocation systems.

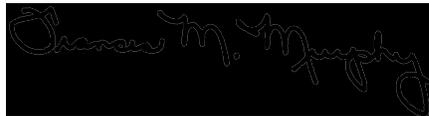
While VERA has significantly improved the allocation of the \$21 billion of the veterans' health care budget, VHA will continue to review and examine the model to assure its continued relevance and to identify needed improvement.

Toward that end, PricewaterhouseCoopers LLP (Limited Liability Partnership) was awarded a contract in October, 1997 to evaluate VERA's methodology to see if it was a sound basis for allocating funds and to see if it was meeting its stated objectives. PricewaterhouseCoopers LLP reported that VERA's conceptual underpinnings are sound, its methodologies are fundamentally sound, and it is meeting its overall objectives. They found that VERA, which allocates resources based on objective measures of need such as patient volume, is ahead of other global budgeting systems that, typically, depend on historical allocations with periodic adjustments. PricewaterhouseCoopers LLP also recommended several changes to strengthen and improve VERA. These recommendations have been reviewed by VHA workgroups and a number of them were implemented in Fiscal Year (FY) 1999 and FY 2000.

This VERA Book is the sixth edition and updates the March 2001 fifth edition. It contains the VERA allocations for FY 2002, as well as a discussion of changes to the methodology in FY 2002 and those anticipated for future years. This book was prepared before the consolidation of Networks 13 and 14 and this edition does not reflect the consolidation.

For FY 2002, some resource allocation policy changes have been made to the VERA methodology. The requirement for having twice as many days in a long term care setting as in an acute care setting to qualify for the Complex Care pricing group was eliminated. Revisions have been made to Complex Care designations in long-term residential and psychiatric care and a new Complex Care patient class entitled Mental Health Intensive Case Management has been created. A new geographic price adjustment has also been made to correct funding inequities caused by local procurement practices for contracted labor and non-labor contracted goods. Also, in FY 2002, VHA will continue to pass through research support funds directly to VA medical centers.

With the changes for FY 2002 and the ongoing evaluation of the VERA model for FY 2003 and beyond, VA will ensure that the allocation of taxpayer dollars for veterans' health care will remain equitable.

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Frances M. Murphy, M.D., M.P.H.
Acting Under Secretary for Health

EXECUTIVE SUMMARY

Background

In 1995, VA's Under Secretary for Health defined the need for a fundamental change in VA's funding allocation methodology. Since that time, the General Accounting Office (GAO) (February 1996) and the U.S. Congress (Public Law 104-204) also acknowledged the need for changes in the allocation system.

In 1997, the Department of Veterans Affairs (VA) developed and in April 1997, it implemented a new system (i.e., Veterans Equitable Resource Allocation -VERA) to allocate its then \$17 billion congressionally appropriated Medical Care budget to 22 Veterans Integrated Service Networks (VISNs). Because implementation took place after the beginning of the fiscal year, two methods were used to allocate resources in FY 1997. For the first half of the year, the networks were funded at approximately one half of the FY 1996 level, plus a 2.75% increase that was equal to the increase in the total systemwide Medical Care budget from FY 1996 to FY 1997. For the months that VERA was used in FY 1997, the maximum amount that any network was reduced was limited to 5% on an annualized basis. When both of these limitations were applied to the VERA methodology, the largest full year reduction (including equipment and non-recurring maintenance) for any network was 1.1% below FY 1996. The largest gain was 6.8% above FY 1996. In FY 1997, 17 networks received more funding than in FY 1996. Twelve (55%) of the networks had funding increases greater than the total rate of increase in the system's funding from FY 1996 to FY 1997 (i.e., 2.9%).

For FY 1998, VERA was used for the first time to allocate funds at the beginning of the fiscal year. Thirteen networks received increases over funding levels for FY 1997; nine networks received less funding.

In FY 1999, 15 networks received increases over FY 1998 funding levels; seven networks received less funding. As with the previous year, a 5% limitation was imposed on the amount that any network could be reduced below FY 1998 levels. Comparing FY 1999 funding with FY 1996 (the baseline year for VERA), seven networks had increases of 10% or more, with the greatest increase at 16.8%. In addition, the Medical Care Collections Fund (MCCF) collections of \$571 million in FY 1999 along with \$98 million for other reimbursements from sources such as TRICARE and sharing agreements, added to the funds available to provide health care to veterans.

For FY 2000, the Medical Care appropriated budget increased \$1.62 billion (after a reduction in capital accounts) or 9.4% above the amount in FY 1999. As a result, the 5% cap applied in previous years was no longer necessary because no network was reduced more than 5% from its FY 1999 level. Based on the model's results and VERA adjustments, all networks received increases over FY 1999 funding levels. Comparing FY 2000 funding with FY 1996 (the baseline year), eight networks had increases of 20% or more, with the greatest increase at +40.6%. MCCF collections of \$573 million and reimbursements of \$104 million were added to the FY 2000 VERA allocations.

The Medical Care appropriated budget for FY 2001 increased \$1.36 billion or 7.2% above the amount in FY 2000. Based on the model's results and including the rescission and VERA adjustments, all networks received increases over FY 2000 funding levels. Comparing FY 2001 funding with FY 1996 (the baseline year), six networks had increases of 30% or more, with the greatest increase at 46.9%. This only pertains to the allocation of the Medical Care appropriated dollars and adjusts the FY 2000 VERA funding base to reflect the centralized funding of prosthetics for FY 2001. MCCF collections of \$771 million and reimbursements of \$120 million were added to the FY 2001 VERA allocations.

VA continues to stress the expectation that networks must continue to become as efficient as possible – while maintaining or improving the quality of care and services to all veterans who seek care. Experience has shown that networks have continued to provide quality care and expand services to veterans, while VERA has improved the fairness of the allocation system. In 1997 the General Accounting Office (GAO) reported that VERA makes resource allocation more equitable than previous allocation systems. In March 1998, PricewaterhouseCoopers LLP cited VERA as not only sound in its concepts and methods, but also ahead of other global budgeting systems that are based on historical allocations with periodic adjustments.

The continued evolution of VERA involves dynamic processes. Further refinements to the methodology have been made for the FY 2002 allocations, and they are described in the sections that follow.

VERA Changes

Several internal workgroups have continued to refine VERA components, as well as incorporate recommendations of PricewaterhouseCoopers LLP, the contractor that evaluated aspects of the methodology. Based on this work, the Under Secretary for Health approved the following improvements in VERA for FY 2002.

Decision Support System (DSS) - The DSS system has been designated as VHA's new cost accounting system. For this reason, DSS cost data is used as the basis for VERA allocations beginning in FY 2002.

FY 2002 National Average Prices Per Patient - Basic Non-Vested Care is funded at the rate of \$197. Basic Vested Care has a price of \$3,121. The FY 2002 price for Complex Care is \$41,667.

Patient Classification Changes - The following three patient classification workload refinements were approved for implementation in the FY 2002 allocation process.

In FY 2002, the requirement for having twice as many days in a long term care setting as in an acute care setting to qualify for the Complex Care pricing group was eliminated. Patients requiring both acute and long term care inpatient stays can now qualify for Complex Care provided that they meet the criteria for at least one Complex Care patient group.

For FY 2002, the annual bed days of care criteria to qualify for the Complex Care pricing group in long term residential care patient classes was changed as follows:

- The number of care days needed for residential care programs including Domiciliary, is set at 91 days. Previously Domiciliary was 31 days. Compensated Work Therapy (CWT), Psychiatric Residential and Rehabilitation Treatment Program (PRRTP) will also be set at 91 days.
- The number of care days needed for long-term psychiatry is set at 41 days, (previously the bed days of care requirement ranged from 60 to 90 days a year).
- The Complex Care patient class length of stay criteria for substance abuse will remain unchanged at 180 days.
- The number of care days needed to meet Complex Care criteria for VHA nursing home and intermediate care is fixed at 31 bed days of care, regardless of all other acute hospitalization.

In FY 2002, a new Complex Care class has been established for patients actively participating in the Mental Health Intensive Case Management Program (MHICM), with a minimum of 41 visits recorded. Such patients would be considered as Chronically Mentally Ill (CMI) patients for future recording and reporting.

Geographic Price Adjustment – Two geographic price adjustments were approved for the FY 2002 allocation process to account for local cost of living factors associated with procuring contracted labor and non-labor contracted goods

such as energy-related products, utilities and provisions. The existing VERA labor adjustment methodology is now applied to the cost of contracted labor and non-labor goods. These adjustments will account for expenses caused by geographic cost factors that are beyond a network's immediate control.

Research Support – In FY 2002, networks will again pass research support funds through to each medical center and the medical centers will obligate funds to support the salaries of clinician-researchers and other research related expenses. Prior to FY 2000, this element simply allocated the national funding level for research support to the networks. The actual level of support expenditures was determined by network management in the context of network-wide operations. During FY 2001, VA Beta Tested a new research support accounting system at selected facilities. As a result of this Beta Test, the new research support accounting system is being instituted at all VA facilities and applied to FY 2000 and FY 2001 data. VA is also taking action to integrate this new accounting system into DSS during FY 2002.

VERA Changes Not Approved

There were two additional changes recommended for FY 2002 implementation but which were not approved by the Under Secretary for Health. The first change was to include Priority 7C veterans in the VERA allocation patient workload. The second change was to modify the funding allocation split between Basic Care and Complex Care by two percent per year until the fund allocation split equaled the actual cost split which was the situation when VERA was first implemented.

FY 2002 VERA Results

The Medical Care appropriated budget for FY 2002 increased \$1.095 billion or 5.4% above the amount in FY 2001. Based on the model's results and VERA adjustments, 19 networks received increases over funding levels for FY 2001. Three networks received less funding. The largest percentage loss was 0.93% and the largest gain was 6.13%. Comparing FY 2002 funding with FY 1996 (the baseline year), six networks had increases of 35% or more, with the greatest increase at 49.8%. This only pertains to the allocation of the Medical Care appropriated dollars and adjusts the FY 2001 VERA funding base for the rescission and VERA adjustments that occurred during FY 2001.

When estimated MCCF (Medical Care Collections Fund) collections and estimated reimbursements (including TRICARE, sharing and Health Services Improvement Fund) are added to the FY 2002 VERA allocations, the largest percentage increase from FY 2001 in funds available for any network is 7.59%,

while the smallest percentage increase in total funding for any network is 1.39%, as shown in the following table.

FY 1996 - FY 2002 VERA Allocations with Adjustments and Estimated Receipts (\$in thousands)														
Network	FY 1996 Allocations and Receipts	FY 1997 VERA and Receipts	FY 1998 VERA and Receipts	FY 1999 VERA and Receipts	FY 2000 VERA and Receipts	FY 2001 VERA and Receipts	FY 2002 VERA and Receipts	%Change						
								FY 1996- 1997	FY 1997- 1998	FY 1998- 1999	FY 1999- 2000	FY 2000- 2001	FY 2001- 2002	FY 1996- 2002
1 Boston	\$856	\$848	\$854	\$821	\$853	\$936	\$965	-1.02	0.78	-3.89	3.91	9.72	3.09	12.68
2 Albany	\$438	\$435	\$441	\$431	\$478	\$516	\$527	-0.68	1.32	-2.12	10.81	7.94	2.18	20.38
3 Bronx	\$1,024	\$1,019	\$1,021	\$994	\$1,010	\$1,038	\$1,094	-0.48	0.16	-2.61	1.57	2.84	5.38	6.87
4 Pittsburgh	\$776	\$781	\$819	\$828	\$901	\$988	\$1,004	0.53	4.85	1.21	8.72	9.71	1.61	29.31
5 Baltimore	\$426	\$444	\$484	\$489	\$527	\$575	\$590	4.21	9.00	1.15	7.74	9.17	2.48	38.48
6 Durham	\$687	\$713	\$749	\$754	\$828	\$893	\$924	3.68	5.12	0.67	9.77	7.88	3.50	34.49
7 Atlanta	\$781	\$816	\$896	\$922	\$983	\$1,057	\$1,113	4.54	9.83	2.88	6.62	7.49	5.27	42.52
8 Bay Pines	\$962	\$1,021	\$1,113	\$1,161	\$1,339	\$1,427	\$1,535	6.06	9.03	4.34	15.34	6.56	7.59	59.54
9 Nashville	\$691	\$703	\$741	\$746	\$811	\$857	\$897	1.76	5.37	0.69	8.74	5.58	4.76	29.86
10 Cincinnati	\$513	\$533	\$558	\$574	\$639	\$682	\$717	3.86	4.78	2.95	11.32	6.66	5.14	39.87
11 Ann Arbor	\$656	\$659	\$665	\$687	\$726	\$794	\$805	0.39	0.97	3.36	5.58	9.38	1.43	22.72
12 Chicago	\$839	\$832	\$840	\$820	\$868	\$928	\$948	-0.78	0.91	-2.38	5.87	6.95	2.13	13.02
13 Minneapolis	\$420	\$428	\$443	\$455	\$474	\$536	\$557	1.96	3.43	2.69	4.17	13.28	3.91	32.78
14 Lincoln	\$293	\$290	\$294	\$301	\$324	\$374	\$380	-1.18	1.35	2.59	7.64	15.50	1.39	29.52
15 Kansas City	\$587	\$618	\$645	\$635	\$669	\$717	\$760	5.25	4.41	-1.56	5.36	7.23	6.00	29.54
16 Jackson	\$1,077	\$1,139	\$1,245	\$1,283	\$1,434	\$1,497	\$1,555	5.76	9.30	3.08	11.73	4.39	3.90	44.40
17 Dallas	\$592	\$630	\$688	\$687	\$774	\$831	\$883	6.32	9.17	-0.13	12.72	7.39	6.21	49.04
18 Phoenix	\$495	\$528	\$579	\$597	\$715	\$752	\$766	6.58	9.67	3.16	19.64	5.25	1.84	54.62
19 Denver	\$368	\$386	\$412	\$407	\$449	\$488	\$512	4.82	6.79	-1.27	10.28	8.70	4.95	39.05
20 Portland	\$589	\$626	\$681	\$704	\$789	\$834	\$870	6.38	8.64	3.51	11.95	5.73	4.36	47.77
21 San Francisco	\$690	\$724	\$755	\$773	\$850	\$929	\$977	4.93	4.29	2.29	10.00	9.35	5.13	41.54
22 Long Beach	\$903	\$921	\$966	\$957	\$1,000	\$1,076	\$1,106	2.00	4.88	-0.95	4.51	7.60	2.84	22.54
VHA Totals	\$14,664	\$15,092	\$15,886	\$16,028	\$17,439	\$18,726	\$19,487	2.92	5.27	0.89	8.81	7.38	4.06	32.89

Note: The FY 1998 MCF totals include FY 1997 4th quarter collections. The FY 2002 MCF and Reimbursement figures represent projected collections. The numbers may not add due to rounding.
 FY 1999 includes VERA plus \$20M earmarked by the Congressional Appropriations Conference Committee for Network 3. FY 1999 includes VERA plus adjustments for newly decentralized programs for networks which exceeded the 5% limitation. FY 1998, FY 1999, FY 2000 and FY 2001 include supplemental funding adjustments. FY 2000 figures have been adjusted to reflect the centralized funding of Prosthetics for FY 2001. FY 2002 includes the VERA adjustments for 5 networks. FY 2001 figures have also been adjusted to reflect the rescission (\$43M).

Assessments of VERA

VERA has been in operation for four and a half years and has been subjected to six assessments. Of these, one was conducted by PricewaterhouseCoopers LLP, the second was conducted by AMA Systems, Inc., the third and fourth were completed by the U.S. General Accounting Office (GAO), and the fifth and sixth reviews are being conducted by the RAND Corporation and the GAO for a follow-up audit.

PricewaterhouseCoopers LLP Study Findings and Recommendations

In October 1997, VA retained a private contractor, PricewaterhouseCoopers LLP, to evaluate whether the VERA methodology was sound and was meeting its stated objectives. The primary purpose of this contract was to get a review of VERA by private-sector health care experts. PricewaterhouseCoopers LLP made four general findings and seven recommendations. The findings were:

- VERA is ahead of other health care global budgeting systems.
- VERA's conceptual underpinnings are sound.

- VERA's methodological underpinnings are fundamentally sound.
- Overall, VERA is meeting its specified objectives.

The seven recommendations were developed as “immediate” and “long-term.” VA has completed the implementation of much of the immediate recommendations, which are:

- Simplify data inputs.
- Revise patient classifications and budget split.
- Strengthen data accuracy and accountability.
- Clarify and improve process.

VA is in the process of evaluating the long-term recommendations of PricewaterhouseCoopers LLP in anticipation that some changes will be made to VERA in the future. These recommendations are:

- Implement a strategic enrollment system.
- Revise patient classes.
- Tie performance measures to budget.

AMA Systems, Inc. – Evaluation of Patient Health Status by VISN (July 25, 2000)

VERA adjusts for the differences across networks for high cost patients and patients in need of specialized services by providing a higher price for Complex Care patients as compared to the prices for Basic Vested Care and Basic Non-Vested Care patients. Nevertheless, there has been feedback from internal and external stakeholders that they believe VERA may not distinguish adequately the differences across networks for variances in patient health status.

VHA retained AMA Systems, Inc. and its subcontractor, The Center for Naval Analyses Corporation (CNAC) to conduct a study entitled “Evaluation of Patient Health Status by VISN.” The scope of the analysis was later expanded to include research into costs associated with providing VHA health care in rural areas to satisfy Section 108 of Public Law 106-74, the “Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 2000.” The report, “Evaluation of Rural Healthcare in the 22 Veterans Integrated Service Networks” was provided to Congress on April 25, 2000.

The contractor reviewed VERA and developed a quantitative model to assess the cost contribution of various factors (e.g., case mix, age, practice patterns). In addition, the contractor examined the issue of whether developing additional price

categories for the Complex and Basic patient groups would provide a “better fit” in terms of matching patient group prices with actual VHA cost profiles.

The report concluded the following with regard to patient health status:

- Systematic influences affect the deviation of VISN-level average costs from the overall national average; these costs are not completely captured by VERA formulation.
- Five separate and statistically significant patient characteristics influence the deviation in average cost for each VISN compared to the national average: age, case mix index, proportion of patients in the Community Nursing Home category, proportion of patients in the fee for service category, and the proportion of patients that are female.
- Age of patients is considered in the current rates in VERA, but in a linear fashion. The impact of age is non-linear, and becomes increasingly important at the upper end of the age distribution (i.e., above age 75).
- Two infrastructure characteristics influence the deviation in average cost: total VA beds and the ratio of direct VA staff to indirect VA staff.
- The contractor’s model explains 70 percent of the deviation in cost. Other influences on the deviation may exist.
- There is no statistically significant difference due to practice patterns.
- At the VISN level, the additions to and subtractions from average cost may cancel each other out. As a result, without additional study, it is impossible to identify specific modifications that would be appropriate to make to the current VERA formulation. However, the contractor’s model can be used to evaluate the relative predicted funding across VISNs, and verify if VERA gives results similar to the predictions. Such comparisons must be done with care, as VERA funding does not map in an exact fashion to patient-level costs used to build the model.
- Expanding the number of VERA patient groups and reimbursing at the national price levels does not yield sufficient additional precision to merit serious consideration by VHA.

The report’s four recommendations for further study include:

- A study to determine the precise way to implement funding modifications because it is not immediately clear how the contractor’s model information can or should translate into VERA modifications.
- A comparison of predicted costs for each VISN to actual funding allocations that can identify VISNs with funding misallocations.
- A study to determine if rural patients receive the same level of care and are their outcomes similar to what is observed for urban patients.

- The report suggested more knowledge about veterans who are enrolled and those eligible to use the system but not enrolled is needed. In addition, it suggested a survey of veterans' income, availability and preferences for health care, and access to alternate insurance coverage.

VA has continued to review this report to determine whether information from the report can be useful to make recommendations for modification to the VERA methodology.

AMA Systems, Inc. – Evaluation of Rural Health Care in the 22 Veterans Integrated Service Networks (March 1, 2000)

As a result of increasing concerns from a number of stakeholders, VA amended its evaluation of patient health status contract study to include an analysis of the efficiency of resource allocation to rural areas within the VERA process. The contractor reviewed the differences in costs for care across the VHA's 22 networks due to provision of care in rural settings. The contractor visited various sites identified as rural areas throughout the country to attain the findings. The report concluded the following with regard to rural health care:

- Rural veteran patient distribution by VISN varies across the country.
- Simple cost comparisons indicate providing care in rural areas is less costly than care in urban areas; however, the difference is not statistically significant.
- Statistically significant factors that influenced the report's regression model were patient characteristics and infrastructure.
- It was not possible to detect the independent impact of the variables for rural health care and practice patterns due to limited amount of historical data for analysis.
- None of the sites maintained systematic records of distance that veterans travel to receive health care.
- None of the sites maintained systematic records of waiting times for appointments. It should be noted that VA recently implemented a new methodology to measure waiting times as part of the service and access initiative. GAO indicated satisfaction with the new methodology.

Because of time constraints, only FY 1997 through FY 1998 data was used in the "Evaluation of Rural Healthcare in the 22 Veterans Integrated Service Networks" report. When an additional year of data (FY 1999) was included, the contractor was able to conclude that:

- The rural variable decomposed into two variables, rural and very rural.
- Providing care in rural areas is less costly than providing care in urban areas.

- Providing care in very rural areas is more costly than providing care in urban areas.

General Accounting Office Findings and Recommendations

In September 1997, the General Accounting Office (GAO) released its report, *VA Health Care: Resource Allocation Has Improved, But Better Oversight Needed*. (GAO/HEHS-97-178). In its report, GAO concluded that VERA improves resource allocation to networks and shows promise for correcting long-standing regional funding imbalances that have impeded veterans' equitable access to services. GAO also made the following two recommendations:

- Develop more timely and detailed indicators of changes in key VERA workload measures and medical care practices.
- Improve oversight of VISN's allocations of resources to their facilities.

VA accomplished several activities to implement these GAO recommendations. These were:

- Developed a tracking system to monitor Complex Care workload.
- Reviewed 3-year Basic patient single-encounter workload by network for three successive 3-year periods.
- Completed a review of 3-year Basic single-encounter workload with 3-year Basic Non-Vested care for FY 1996-FY 1998.
- Had a contractor evaluate the following components of VERA:
 - The accuracy and integrity of secondary data.
 - Methods of data collection and analysis.
 - Models and methodologies underlying the models.
 - Documentation of the models.
 - Timeliness of work processes.
- Issued a VHA Directive establishing that the allocation of resources at all levels within the VA be guided by ten principles that move the organization toward accomplishing its systemwide goals and objectives. Network allocation systems must:
 - Be readily understandable and result in predictable allocations.
 - Support high quality health care delivery in the most appropriate setting.
 - Support integrated patient-centered operations.
 - Provide incentives to ensure continued delivery of appropriate special care.
 - Support the goal of improving equitable access to care and ensure appropriate allocation of resources to facilities to meet that goal.
 - Provide adequate support for the VA's research and education missions.

- Be consistent with eligibility requirements and priorities.
- Be consistent with the network's strategic plans and initiatives.
- Promote managerial flexibility, (e.g., minimize "earmarking" funds) and innovation.
- Encourage increases in alternative revenue collections.

In August 1998, the GAO issued a report, *VA Health Care: More Veterans Are Being Served, but Better Oversight Is Needed*. The report was developed based on a request of the Congressional Committees on Appropriations to analyze changes in access to care in two networks, Network 3 (Bronx) and Network 4 (Pittsburgh). This was directed based on concerns that: 1) some networks would be required to implement significant cost-saving steps to manage within the diminished resources they would receive under VERA; and 2) these networks would reduce veterans' access to care as a result. GAO concluded that VA has increased access to care for veterans in Networks 3, 4, and VA nationally. VA has increased access mainly by expanding outpatient services through redirecting resources no longer needed for inpatient services. In its August 1998 report, GAO made the following two recommendations:

- Develop uniform definitions and institute timely reporting of changes in access to care.
- Develop criteria for equitably allocating resources to facilities and monitor any improvements in equity of access among and within networks.

Several actions have addressed this recommendation:

- VA has held "data summits" that specifically addressed the development of uniform definitions.
- The implementation of enrollment has allowed reporting service utilization by eligibility category, type of provider and geographic distribution as well as other demographic variables.
- Numerous improvements in timely reporting in areas such as performance and quality are now available on a real time basis.
- A criterion was added in the VHA network allocation principles policy document concerning the equity of resource allocations to facilities. This does not prescribe how this should be done; VA continues to allow networks the flexibility to meet local needs.
- VA established a workgroup to evaluate the allocation principles and the network's allocation processes. Its purpose was to determine if the principles are sufficient as well as to ensure that network allocations to facilities are fair and equitable.

The RAND Corporation – An Analysis of the Veterans Equitable Resource Allocation (VERA) System (dated September 18, 2001)

Congress directed by language in the Senate Appropriations Report and the enactment of Public Law 106-337 that VHA enter into a contract with a federally-funded research and development center to conduct an analysis of VERA. VHA retained the RAND Corporation to conduct this study. The following three tasks were included in the legislative language and subsequent scope of work developed by VHA:

- An assessment of the impact of the allocation of funds under the VERA methodology on VISNs and sub-regions with older-than-average medical facilities; those with older or more disabled enrolled veterans; those undergoing major consolidation; and those in both rural and urban sub-regions with appointment backlogs and waiting periods.
- An assessment of issues associated with the maintenance of direct affiliations between the VA medical centers and university teaching and research hospitals.
- An assessment of whether the VERA methodology accounts for differences in weather conditions when calculating costs of construction and maintenance of health care facilities, and whether VISNs that experience harsh weather require more resources.

Overall, the study concluded the following:

- VERA is only one piece of the veterans' health care puzzle, albeit an important one. In evaluating the impact of VERA, it was noted that a broad range of factors influence the cost and manner in which health care is provided to the veteran population. Other critical factors include, but are not limited to, financial considerations, such as the size of the annual VA Medical Care appropriation and the ways in which VISN directors allocate resources to individual facilities; the demographic characteristics and health care needs of the veteran population; VA's mission of providing health care of the highest possible quality; the availability of non-VA sources of care; and a myriad of local, state, and Federal political demands that often create significant barriers to cost efficiency and occasionally mandate services that are in excess of what is needed.
- VERA has been largely successful in meeting its objectives of reallocating resources to better match the geographic distribution of the veteran population. The overwhelming majority of interviewees indicated that VERA was preferable to previous resource allocation systems in terms of its incentive structure, degree of fairness, and simplicity.

- It was recognized that VERA is continuously being refined. This study represents one in a series of about a half dozen that have been performed by external organizations since VERA was introduced in 1997. In addition, nine internal workgroups, composed of representatives from the 22 VISNs are constantly monitoring aspects of the VERA methodology and recommending refinements they deem appropriate. It was noted that VHA has implemented many of the recommendations in both the external evaluators' reports as well as the workgroups' executive decision memoranda.

With regard to the three critical issues identified by the Congress, the study concluded the following:

- Evidence suggests that health care delivery costs may be affected by the age and physical condition of a VISN's capital infrastructure, and VERA does not account for these factors in VISN allocations. A quantitative analysis of this issue to determine the impact at the VISN level is recommended.
- VA is currently evaluating the use of a DCG (Diagnostic Cost Groups) – based case mix methodology in the future. Refining the current case mix adjustment in this manner would represent a significant improvement to VERA.
- Political pressure from key stakeholders presents a formidable barrier to efforts to consolidate facilities and services.
- To the extent that the size of the teaching program or level of teaching intensity might affect per resident education support costs raises a potential issue for further analysis.
- VERA equipment allocations to VISNs are based on patient workload without case mix adjustments. Facilities with major affiliations generally benefit as referral centers in these equipment allocations from the VISNs. The costs of both purchasing and operating needed equipment should be considered in an overall evaluation of the effects of academic affiliations.
- The effect of teaching and research on patient care costs and facility financial performance are closely related to issues involving case mix measurement and raise the following questions:
 - Are there systematic differences in case mix between teaching-intensive facilities and other facilities that are not currently recognized in VERA?
 - Are there systematic differences in costs between teaching intensive facilities and other facilities that are not accounted for by case mix?
 - To what extent are the effects of academic affiliations offset by other factors that are not accounted for under VERA?
- From the review of the literature and the case studies, there is no clear reason for adjusting VISN allocations under VERA for weather-related cost

differences. Rather it was stated that VA should investigate the extent to which prices of all non-labor inputs vary geographically to determine if appropriate allocation adjustments should be made if the amount of variation is significant.

- Any case mix adjustment linked to weather should be accounted for through a comprehensive case mix adjustment, in lieu of one that is simply targeted to weather-related conditions and procedures.
- It was noted that any potential adjustment should not be considered in isolation, rather, adjustments should be examined as part of a broader context of a comprehensive health care delivery cost model.

The study provided the following other conclusions:

- There is a lack of geographic adjustment to the means test used to determine a veteran's financial status concerning eligibility for services. Because the means test threshold is the same for all regions of the country, the study found that there are inequities in access to covered services for veterans in high cost of living areas. VHA is well aware of this inequity. However, a change in the eligibility measures is not within its purview and would require Congressional action.
- The workload forecasting process can be improved by using a more sophisticated approach to obtain workload estimates. For instance, a model that incorporates demographic characteristics and historical use patterns would provide a set of allocations that matches the needs of the VISNs more closely.
- Another area that needs additional data collection concerns contract services. VISN and facility directors frequently reported difficulty in managing the cost of these services, particularly in rural areas where the choice of providers is relatively limited. The contractors recognized that the cost data on contract services are typically presented as an aggregate number in facility cost reports making it difficult to analyze the impact of various kinds of contract services on total facility costs or cost per case.

The report, "An Analysis of the Veterans Equitable Resource Allocation (VERA) System", was provided to the Senate and House Appropriations Committees on September 18, 2001.

The various VERA workgroups will review this report in their continuing assessment of VERA for possible future refinements in the areas related to case mix, geographic differences in the prices paid for non-labor inputs (including energy prices and contract labor costs), teaching and research hospital affiliations, and the condition of facilities' physical plants. In fact, with regard to case mix and geographic adjustments, VERA workgroups are making good progress in completing ongoing developmental work. The Patient Classification Workgroup

is expected to complete its work evaluating the potential benefit of Diagnostic Cost Groups (DCG) potential application in the FY 2003 VERA methodology. The Geographic Price Adjustment Workgroup recommended geographic adjustments for contract labor and non-labor goods and services and they have been incorporated in the FY 2002 VERA allocation methodology.

The FY 2002 Senate Appropriations Committee report language indicated that the Committee was pleased with the initial results of the ongoing VERA study and directed VHA to continue this federally-funded research and development center study through the end of FY 2002.

General Accounting Office

Early in FY 2001, Congress asked GAO to study the VERA methodology and answer the following questions:

- Has implementation of the VERA methodology resulted in a more equitable allocation of VA health care resources?
- What specific problems are VISNs and medical facilities experiencing with the VERA methodology?

The GAO evaluation of the VERA methodology was completed in early FY 2002. VA received GAO's Draft Report, *VA HEALTH CARE: Allocation Changes Would Better Align Resources with Workload*, Report No. GAO-02-338 on January 23, 2002. A discussion of the report's findings, conclusions, recommendations and VA's action plan on the recommendations will be provided in the next edition of the VERA book.

Potential Future Changes to VERA

In the interest of continuous improvement, studies are ongoing to ensure that the VERA methodology includes timely and accurate information and processes.

Patient Classifications – During 2002, the VERA Patient Classification Workgroup will complete a review of the feasibility of classifying patients on the basis of diagnostic and functional data instead of utilization characteristics. The use of Diagnostic Cost Groups (DCGs) and risk adjusters are being studied by the Houston Health Services Research and Development Office and the Management Science Group in Bedford, Massachusetts for the workgroup. The Centers for Medicare and Medicaid Services (CMS) uses a modified version of DCGs in a portion of the Medicare+Choice program. The Medicare+Choice program is used by a very small percentage of Medicare beneficiaries who must enroll to participate in this HMO-like program. In brief, the DCG software package uses

diagnostic information (ICD-9 codes) to group patients into similar cost categories. The workgroup is developing modifications to the current DCG system using actual VA cost data. The Patient Classification Workgroup continues to evaluate DCGs for potential inclusion in the FY 2003 VERA allocation process.

Specific Purpose Funding – The VERA Specific Purpose Workgroup is reviewing all Specific Purpose accounts to ensure compliance with account criteria. The workgroup will report its recommendations for FY 2003 before the end of FY 2002.

Geographic Price Adjustment – The Geographic Price Adjustment Workgroup continues to review indexing methodologies to ensure that VHA is using the most accurate and reliable processes and data in the VERA geographic price adjustment methodology. This ongoing process includes continuous monitoring of VHA data and external (non-VA) practices for geographically adjusting costs.

Summary of Major Changes from the 2001 VERA Book

The FY 2002 VERA book is the sixth edition of this annual publication. Because many are familiar with the FY 2001 edition, it may be helpful to highlight the changes from that edition that have been incorporated in the FY 2002 version.

The following figures and tables have been added:

- Figure 2 – Percent of FY 2002 VERA Patient Workload
- Figure 10 – FY 2002 VERA Geographic Price Adjustment
- Figure 14 – Percent Change in Allocation by VERA Component, FY 1997 to FY 2002
- Table 4 – VERA Three Price Case Mix
- Table 5 – Energy As a Percent of Total Obligations FY 1996 to FY 2001
- Table 12 –VERA Adjustments FY 1999 – FY 2002
- Table 14 – Change in Network Allocations over Prior Year Including VERA Adjustments
- Table 15 – Network Allocations Compared to System-Wide Increases over Prior Year Including VERA Adjustments
- Table 18 – Percent Change in Allocation in Each VERA Component, FY 1997 to FY 2002

Where appropriate, the data used in the report, figures, tables, map and appendices have been updated to reflect the data used in the FY 2002 VERA calculations. Additionally, the following narratives have been added to the sections as noted below:

- Section I – VERA Components:
 - description of FY 2002 patient classification workload changes;
 - discussion of changing the FY 2002 geographic price adjustment to account for local cost of living factors associated with procuring contracted labor and non-contracted goods.
- Section II – VERA Results:
 - description of the VERA adjustment process from FY 1999 through FY 2002
- Section III – Assessments of VERA:
 - the analysis by the RAND Corporation, “An Analysis of the Veterans Equitable Resource Allocation (VERA) System.”

- Section IV – The Future of VERA:
 - VERA Patient Classification Workgroup will review the feasibility of classifying patients on the basis of Diagnostic Cost Groups instead of utilization characteristics.
 - VERA Geographic Price Adjustment Workgroup will evaluate the VHA Management Science Group’s review of potential indices available for geographically adjusting contract labor and non-labor costs and determine if an adjustment should be made in the VERA 2003 model.

TABLE OF CONTENTS

	Page
Executive Summary	i
Summary of Major Changes from the 2001 VERA Book	xvi
Sections	
I. VERA Components.....	1
II. VERA Results.....	30
III. Assessments of VERA	48
IV. The Future of VERA	67
Appendices:	
Appendix 1: Key formulas and data in the FY 2002 VERA.....	70
Appendix 2: The Veterans Integrated Service Networks.....	88
Appendix 3: History: Previous Allocation Models and Funding Inequities.....	91
Listing of Figures and Tables	
Figure 1: General Purpose and Specific Purpose components of VERA	3
Figure 2: Percent of FY 2002 VERA patient workload	9
Figure 3: Establishing VERA national prices, FY 2002	10
Figure 4: Average and median age of patients treated FY 1995	13
Figure 5: Energy as a percent of total obligations FY 1995.....	14
Figure 6: Energy as a percent of total obligations – FY 1996 to FY 2001	14
Figure 7: Basic single outpatient visits as percent of 3-year Basic workload, by network, FY 1995 – FY 1997	17
Figure 8: Basic single outpatient visits and non-vested workload as percent of 3-year Basic workload, by network, FY 1996 – FY 1998	18
Figure 9: Non-vested workload as a percent of 3-year Basic workload, by network	19
Figure 10: FY 2002 VERA geographic price adjustment	22
Figure 11: Components of Specific Purpose VERA funding	28
Figure 12: Projected VERA average price by network FY 2002.....	34
Figure 13: Full impact of VERA model.....	38
Figure 14: Percent change in allocation by VERA component, FY 1997 to FY 2002 (no caps, supplementals)	41
Figure 15: FY 1996 – FY 2000 dollars spent per patient	44
Figure 16: Historic resource consumption per patient	94
Table 1: Complex Care component – Patient classifications.....	7
Table 2: Basic and Complex Care workload, FY 2002	8

Table 3:	Network Basic Vested Care, Basic Non-Vested Care, and Complex Care allocations.....	11
Table 4:	VERA three price case mix	12
Table 5:	Energy as a percent of total obligations FY 1996 to FY 2001.....	15
Table 6:	Geographic price adjustment	21
Table 7:	Research support allocation	24
Table 8:	Education support allocation.....	25
Table 9:	Equipment allocation	26
Table 10:	Non-Recurring Maintenance allocation.....	27
Table 11:	Results of VERA model – FY 2002	30
Table 12:	VERA adjustments FY 1999 – FY 2002	31
Table 13:	Changes in network budgets FY 2001 – FY 2002	32
Table 14:	Change in network allocations over prior year including VERA adjustments.....	36
Table 15:	Network allocations compared to system-wide increases over prior year including VERA adjustment	36
Table 16:	Impact of VERA model FY 1996 – FY 2002 (uncapped and without VERA adjustment)	37
Table 17:	FY 1996 – FY 2002 resource allocations by network (capped and with VERA adjustment)	39
Table 18:	Percent change in allocation in each VERA component, FY 1997 to FY 2002	40
Table 19:	MCCF and other collections – FY 2002	45
Table 20:	FY 1996 – FY 2002 VERA allocations with adjustments and estimated receipts.....	47

Section I

VERA Components

To simplify VA's funding allocation system and to make it understandable and credible, the easiest approach would have been to implement a system that simply measured the number of veterans who use VA health care, and then give to each network a single dollar amount for each veteran in that network. This was believed to be unworkable, however, because of the varying health care needs of VA's patients and the complexity of the VA health care system. These complexities must be recognized and balanced with the need for an equitable and understandable funding allocation system.

VERA addresses the complexities of veterans' health care by recognizing several factors, including:

- ***VA treats three general types of patients*** – those who use some health care services but are less reliant on the VA system, those with “routine” health care needs who rely on VA health care, and those with “special” or “complex,” and generally chronic, health care needs that are relatively expensive;
- ***The costs of providing care across the country varies*** because of factors that are beyond the control of VA management (e.g., the cost of labor in New York is higher than in Mississippi);
- ***Not all veterans receive all of their VA health care in the same network.*** Many veterans receive “care across networks.” For example, veterans commonly referred to as “snowbirds” live in the northeast part of the year and in the south or southwest the remainder of the year;
- ***Costs for Research and Education vary*** because of differences across the country in VA's academic affiliations and research programs;
- ***Equipment and Non-Recurring Maintenance investments vary*** because of cost-of-living differences across networks, prior year investments, and differences in the size and square footage of buildings that must be maintained; and
- ***Not all funding should be included in the funding model*** because special legal or programmatic requirements, national support functions, and projects

where economies of scale can be achieved at a national level support the continuation of some allocations through non-model mechanisms.

Each of these complexities is addressed in the VERA system and is explained in detail in the following sections.

VERA has two major components: (1) General Purpose funding and (2) Specific Purpose funding. For FY 2002, General Purpose funds will constitute 86% (\$18.31 billion) of VA's Medical Care budget distributed to the networks. The Specific Purpose portion will constitute the remaining 14% (\$3.02 billion). VERA is used to allocate the General Purpose funds.

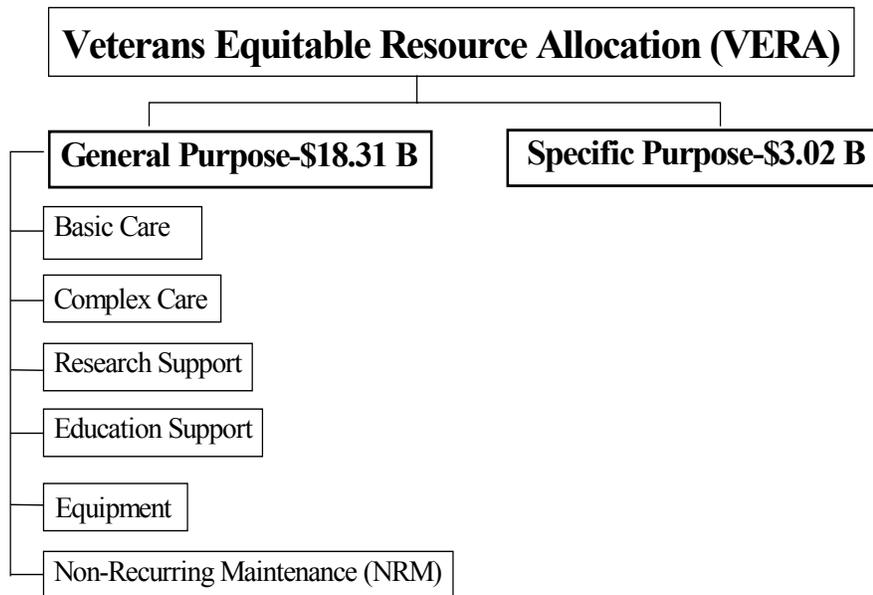
General Purpose Funds

To recognize the complexities discussed above, VERA consists of six elements used to allocate General Purpose funds. These are:

1. Basic Care (with two sub-components)
2. Complex Care
3. Research Support
4. Education Support
5. Equipment
6. Non Recurring Maintenance (NRM)

Figure 1 (in billions of dollars) depicts the VERA system and the dollar amounts in General Purpose and Specific Purpose funds.

Figure 1: General Purpose and Specific Purpose Components of VERA



The six General Purpose elements were developed to balance recognition of the complexities of the VA health care system with the need to make the funding allocation process more understandable and fair. Each of the six factors is discussed in the following sections.

Workload Elements: Basic and Complex Care

Funding the Basic and Complex Care elements accounts for the overwhelming majority of the Medical Care appropriation -- \$16.6 billion (78%). These two elements allocate funding based on the patient workload that the networks are expected to provide in FY 2002.

There are three fundamental components underlying each of the Basic and Complex Care elements:

1. Patient Groups (types of patients)
2. Workload (volume of patients within patient groups)
3. Price Setting (dollar value of workload volume within patient groups)

Each of these three components is discussed below.

Patient Groups

Basic Care patients are those who have relatively “routine” health care needs. They are principally cared for in an ambulatory care setting with short-term inpatient admissions, as needed. They generally do not require the services of the special emphasis programs such as spinal cord injury, blind rehabilitation, and chronic mental illness. They have a range of health care needs from simple to complex, including conditions such as acute and chronic cardiovascular disease, cancer, diabetes, acute substance abuse disorders, acute mental disorders and a broad range of primary care needs. Ninety-six percent of VA’s patients receive Basic Care. These patients represent 62% of the dollars allocated through the Basic and Complex Care elements of VERA. In FY 1999, Basic Care was further divided, and a separate price established, to address those patients who had only one outpatient encounter during the 3-year workload period. These veterans had very little reliance on the VA health care system.

Differences between the fully vested (Basic Vested) patient and the occasional user (Basic Non-Vested) was further refined for the FY 2000 network budget allocations. VA's goal was to determine what constitutes a fully vested patient, even with one visit, and fund those patients at the full Basic Care price. VA decided that clinical measurement criteria would be established as the basis for all patient classes and to move away from basing classifications on counting visits and hospital stays. A description was needed for the limited user that was not based on the number of care encounters (clinic visits or hospital stays). As a result, beginning in FY 2000, Basic Care patients consist of two groups; fully vested, those who rely on VA for their care, and non-vested, those who use some VA health care services but are less reliant on the VA system. A patient is considered fully vested in the veterans’ health care system if he or she has used inpatient services or if he or she received an appropriate, detailed medical evaluation during the past three years. This medical evaluation is determined through the presence of an appropriate Current Procedural Terminology (CPT) code. By applying relevant CPT codes to outpatients seen in Fiscal Years 1998, 1999, and 2000, and counting the inpatients for those same years, vested patients have been identified for the FY 2002 VERA. Separate prices for both vested and non-vested workload have been established.

Complex Care patients are those that generally require the services of VA’s special emphasis programs. These patients have had, or will require, significant high-cost inpatient care as an integral part of their rehabilitation or functional maintenance. These patients include those with hepatitis C with anti-viral therapy, spinal cord injury, chronic mental illness, stroke, traumatic brain injury, post-traumatic stress disorder (PTSD), ventilator dependency and those who need extended care, blind rehabilitation, organ transplants, dialysis, as well as

HIV/AIDS veterans with infection or malignancy and who are on specific HIV medications. The Complex Care group accounts for only 4% of the users, but 38% of the dollars available for the Basic and Complex Care groups. The list of Complex Care patient classes is included in Table 1 on page 7: “Complex Care Component – Patient Classifications”.

FY 2002 Patient Classification Workload Changes: The following three patient classification workload refinements were implemented in the FY 2002 allocation process.

1. The requirement for having twice as many days in a long term care setting as in an acute care setting to meet the Complex Care pricing group was eliminated. This requirement was designed to encourage minimum acute care days, but now is eliminating otherwise qualifying patients from the Complex Care designation because of their acute stays. Patients requiring both acute and long term care inpatient stays can now qualify for Complex Care without this limiting factor provided that they meet the criteria for at least one Complex Care patient group.
2. The annual bed days of care criteria to qualify for the Complex Care pricing group in long term residential care patient classes changed as follows:
 - The number of care days needed for residential care programs, including Domiciliary, is set at 91 days. Programs such as Compensated Work Therapy (CWT), Psychiatric Residential and Rehabilitation Treatment Program (PRRTP) will require 91 days as well.
 - The number of care days needed for long-term psychiatry is set at 41 days for all major mental health classes. Previously the bed days of care requirement ranged from 60 to 90 bed days of care.
 - The Complex Care patient class length of stay criteria for substance abuse will remain unchanged at 180 days.
 - The number of care days needed to meet Complex Care criteria for VHA nursing home and intermediate care is fixed at 31 days, regardless of all other acute hospitalization.
3. A new Complex Care class has been established for patients actively participating in the Mental Health Intensive Case Management Program (MHICM), with a minimum of 41 visits recorded. Such patients would be considered as Chronically Mentally Ill (CMI) patients for future recording and reporting.

Decision Support System (DSS): The DSS has been designated as VHA’s new cost assignment system. For this reason, VA will use DSS cost data as the basis

for VERA allocations. To transition from the current Cost Distribution Report to DSS, the VHA Chief Financial Officer established a workgroup to analyze DSS outputs and VERA inputs to ensure that the transition could be made to use DSS to develop future VERA allocations. DSS cost data are used as the basis for VERA allocations beginning in FY 2002.

VERA Changes Not Approved: There were two additional changes recommended for FY 2002 implementation but which were not approved by the Under Secretary for Health. The first change was to include Priority 7C veterans in the VERA allocation patient workload. The second change was to modify the funding allocation split between Basic Care and Complex Care by two percent per year until the fund allocation split equaled the actual cost split which was the situation when VERA was first implemented.

Workload

For each patient group, a workload (i.e., the number of veterans upon which allocations will be made) must be established.

Basic Care: In anticipating the need to move toward a stable, capitation-based allocation methodology, VA chose to allocate the Basic Care resources using a workload measure representative of a population of potentially “enrolled” eligible veterans (i.e., a “proxy” enrollment). This population would be larger than just the forecasted count of veterans that would be cared for in a single year, because not all VA patients use health care services every year. Further, one-year forecasts can vary from year to year depending on annual changes in capacity and economic factors. This annual variation was thought to be counter to the concept of a stable subscriber base. Furthermore, the ideal database of current eligible veterans (users and nonusers) by network for the years covered by the VERA workload volume is not robust enough for resource allocation purposes.

After considerable analysis, VA chose to use the count of eligible veterans who had used VA services during three prior years, i.e., in any of the years FY 1998, FY 1999 and FY 2000. “Eligible veterans” was further defined to include only Priority 1 – 7a veterans (formally “Category A”). This group included veterans with service-connected disabilities; veterans with income below the established dollar threshold; veterans who receive compensation and pension exams; World War I veterans; ex-Prisoners of War; veterans with special statutory eligibilities based on exposures to Agent Orange in Vietnam, radiation from a nuclear detonation, or an environmental hazard or toxic substance in the Persian Gulf; and domiciliary patients. The use of Priority 1 – 7a veterans as the basis of the allocation provides an equity of access dimension to VA health care resource management because it links funding to veterans who have the highest priority for

care under authorizing legislation. As a “proxy” enrollment this does not preclude the treatment of Priority 7c patients (formally Category C). As previously stated, Basic Care now consists of two groups, fully vested and non-vested.

Complex Care: The nature and treatment needs of the Complex Care user population is considerably different than that of the Basic Care users. Complex Care patients are high-intensity users. Their price is nearly 15 times greater than that of Basic Care patients, are cared for by the VA throughout each year (with multiple visits over 12 months), and receive care over the course of many years (i.e., they use VA year after year). Almost all of these patients will use VA special emphasis program services at some time during each year. The annual turnover rate (the percent of veterans seen each year who are not seen the following year) for Complex Care patients is usually less than 5% (as opposed to 20% for Basic Care).

As in the past, the Complex Care workload is forecasted based on the number of Complex Care patients who used VA services during the past five years. The FY 2002 Complex Care workload is a forecasted trend of workload based on veterans who used the VA health care system from FY 1996-FY 2000.

While determining the workload for each of the two patient groups, VA had to ensure that VERA recognizes and accounts for veterans who receive their health care in more than one network – i.e., veterans who receive their “care

Table 1: Complex Care Component-Patient Classifications

- Blind Rehabilitation Center patients
- Community Nursing Home
- Domiciliary
- End Stage Renal Disease
- Hepatitis C with anti-viral Therapy
- HIV+ with antiretroviral Therapy
- Home Based Primary Care
- Long term care: Low Activities of Daily Living
- Long term care: Behavioral
- Long term care: Clinically Complex Care
- Long term care: Physical Care
- Long term care: Rehabilitation
- Long term care: Specialized Care
- Mental Health Intensive Case Management
- Other Psychoses
- Post-Traumatic Stress Disorder (PTSD) Chronic
- Schizophrenia & Dementia
- Spinal Cord Injury (SCI) Quad-new Injury
- SCI Paraplegic-new Injury
- SCI Paraplegic-old Injury
- SCI Quadriplegic-old Injury
- Stroke
- Substance Abuse
- Transplant
- Traumatic Brain Injury
- Ventilator Dependent

Note: Detailed information on the patient classifications can be found in the VERA Handbook. The chapter is located on the Allocation Resource Center Website (<http://vaww.arc.med.va.gov>).

across networks.” A typical example is the veteran who lives in New York, but spends a significant part of the year in Florida. To account for these veterans, VERA provides each network with a proportion of the price for each veteran who has historically received care in different locations. For example the New York City Network may get 60% of the workload for a Basic Care veteran, and the Florida Network may get 40% if the veteran received 60% of his care at New York facilities and 40% at Florida facilities. The proportions are based on the actual past costs of the care for these veterans in each network.

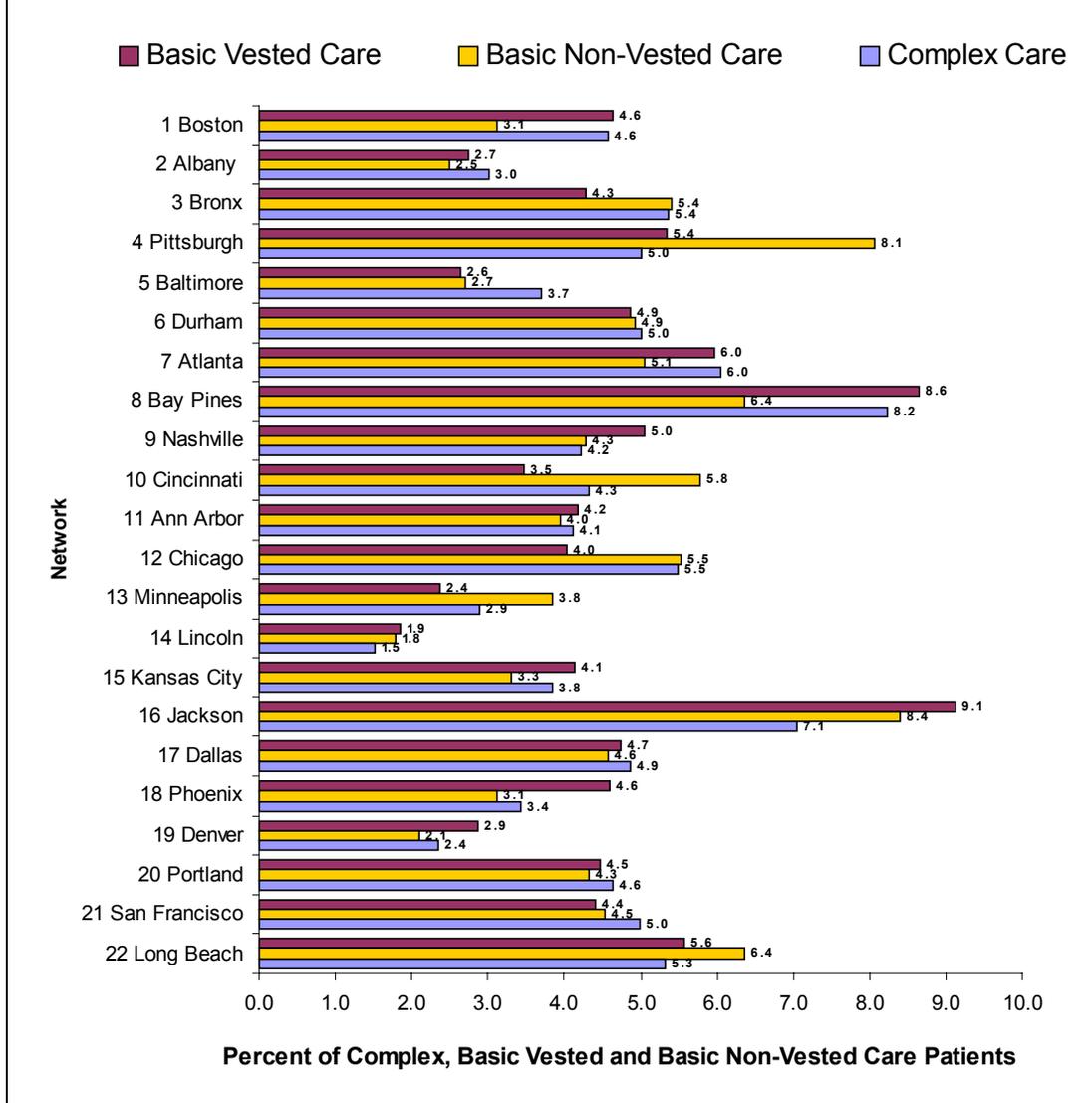
Table 2 shows the expected network-specific workload (in numbers of veterans) for the Basic Vested Care, Basic Non-Vested Care, and Complex Care patient groups for the FY 2002 VERA allocation. Specific formulas and back-up data used to create this table are included in Appendix 1.

This three-group allocation method ensures that the VHA’s Complex Care patients are appropriately resourced. VERA provides each VISN an allocation that recognizes its individual characteristics and its share of the three patient groups. For example in FY 2002, VISN 8 (Bay Pines, FL) had the highest percentage of Complex Care patients, VISN 16 (Jackson, MS) had the largest percentage of Basic Vested and Basic Non-Vested Care patients, and VISN 14 (Lincoln, NE) had the smallest percentage of Complex, Basic Vested and Basic Non-Vested Care patients. Figure 2 on page 9 shows the distribution of patient workload across the 22 VISNs.

Table 2: Basic and Complex Care Workload FY 2002			
Network	Basic Vested Care	Basic Non- Vested Care	Complex Care
1 Boston	150,422	12,315	7,002
2 Albany	89,109	9,874	4,607
3 Bronx	139,182	21,404	8,210
4 Pittsburgh	174,025	31,958	7,682
5 Baltimore	85,970	10,724	5,675
6 Durham	158,110	19,488	7,688
7 Atlanta	193,670	20,028	9,252
8 Bay Pines	280,937	25,192	12,598
9 Nashville	164,015	16,941	6,462
10 Cincinnati	113,122	22,877	6,618
11 Ann Arbor	136,167	15,657	6,315
12 Chicago	131,391	21,904	8,418
13 Minneapolis	77,065	15,249	4,427
14 Lincoln	60,348	7,069	2,321
15 Kansas City	134,637	13,062	5,893
16 Jackson	296,532	33,264	10,806
17 Dallas	154,180	18,161	7,450
18 Phoenix	149,301	12,377	5,240
19 Denver	92,954	8,350	3,602
20 Portland	145,592	17,124	7,112
21 San Francisco	143,053	17,966	7,627
22 Long Beach	181,322	25,205	8,150
VHA totals	3,251,103	396,188	153,155

Note: The numbers may not add due to rounding.

Figure 2: Percent of FY 2002 VERA Patient Workload

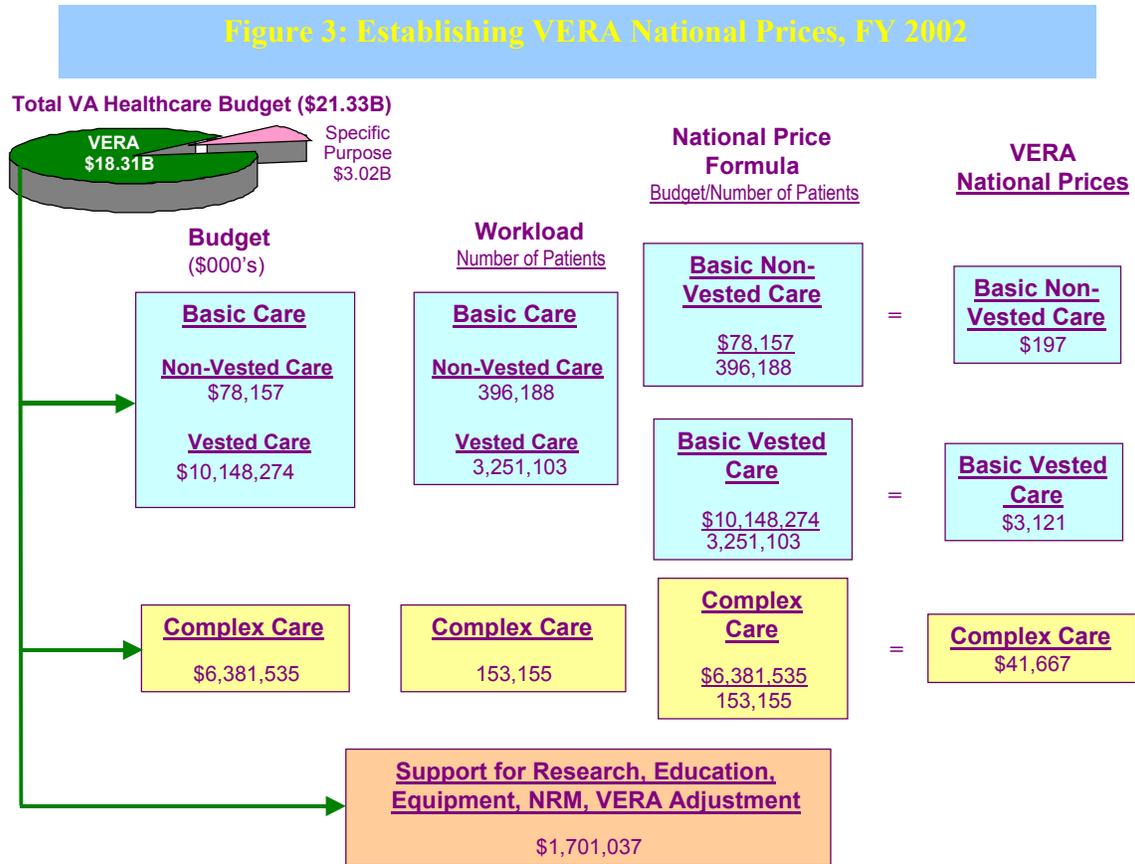


Setting the Price

The VERA methodology establishes a national price for each of the patient groups (Basic Vested Care, Basic Non-Vested Care, and Complex Care) by dividing the total dollars available in each of the groups by the workload in each group. The total dollars available in the patient groups was determined by taking the FY 2002 Medical Care budget and allocating to each group the same percentage it had in FY 2001. The total dollars available for the Basic and Complex Care groups in FY 2002 is \$16.6 billion – 38.4% (as in the past) is available for Complex Care (\$6.4 billion) and 61.3% is available for Basic Vested Care (\$10.1 billion), and 0.3% is available for Basic Non-Vested Care (\$0.08 billion). The percent of the Basic Care provided to the Basic Vested Care and Basic Non-Vested Care is based

on the proportion of FY 2000 Basic Care actual costs experienced in these two sub-groups of patients.

Figure 3 shows the total VA health care budget; total funding for the Basic Vested Care, Basic Non-Vested Care and Complex Care groups; the VERA workload; and the resultant national prices for each unit of Basic Vested Care, Basic Non-Vested Care and Complex Care workload.



These national prices for the Basic Vested Care, Basic Non-Vested Care and Complex Care groups are multiplied by the level of Basic Vested Care, Basic Non-Vested Care and Complex Care workload in each network to calculate the Basic Vested Care, Basic Non-Vested Care and Complex Care group allocations.

Network allocations for Basic Vested Care, Basic Non-Vested Care and Complex Care are presented in Table 3. Formulas and back-up data used to create these allocations are included in Appendix 1.

Table 3: Network Basic Vested Care, Basic Non-Vested Care, and Complex Care Allocations						
<i>(\$ in millions)</i>						
Network	Basic Vested Care Workload	Basic Vested Care Allocation	Basic Non-Vested Care Workload	Basic Non-Vested Care Allocation	Complex Care Workload	Complex Care Allocation
1 Boston	150,422	\$470	12,315	\$2.4	7,002	\$292
2 Albany	89,109	\$278	9,874	\$1.9	4,607	\$192
3 Bronx	139,182	\$434	21,404	\$4.2	8,210	\$342
4 Pittsburgh	174,025	\$543	31,958	\$6.3	7,682	\$320
5 Baltimore	85,970	\$268	10,724	\$2.1	5,675	\$236
6 Durham	158,110	\$494	19,488	\$3.8	7,688	\$320
7 Atlanta	193,670	\$605	20,028	\$4.0	9,252	\$386
8 Bay Pines	280,937	\$877	25,192	\$5.0	12,598	\$525
9 Nashville	164,015	\$512	16,941	\$3.3	6,462	\$269
10 Cincinnati	113,122	\$353	22,877	\$4.5	6,618	\$276
11 Ann Arbor	136,167	\$425	15,657	\$3.1	6,315	\$263
12 Chicago	131,391	\$410	21,904	\$4.3	8,418	\$351
13 Minneapolis	77,065	\$241	15,249	\$3.0	4,427	\$184
14 Lincoln	60,348	\$188	7,069	\$1.4	2,321	\$97
15 Kansas City	134,637	\$420	13,062	\$2.6	5,893	\$246
16 Jackson	296,532	\$926	33,264	\$6.6	10,806	\$450
17 Dallas	154,180	\$481	18,161	\$3.6	7,450	\$310
18 Phoenix	149,301	\$466	12,377	\$2.4	5,240	\$218
19 Denver	92,954	\$290	8,350	\$1.6	3,602	\$150
20 Portland	145,592	\$454	17,124	\$3.4	7,112	\$296
21 San Francisco	143,053	\$447	17,966	\$3.5	7,627	\$318
22 Long Beach	181,322	\$566	25,205	\$5.0	8,150	\$340
VHA totals	3,251,103	\$10,148	396,188	\$78.2	153,155	\$6,382

Note: The numbers may not add due to rounding.

VERA Three Price Case Mix

VERA three price case mix is established in VERA with the three price groups. Case mix can be measured by the ratio between the network’s current Basic Care and Complex Care allocations and a single price. This measurement depicts the case mix that is already built into the VERA allocations due to the network difference in workload and separate prices for Basic Vested, Basic Non-Vested and Complex Care patients. The case mix at the VHA national level is 1.0 and each network’s case mix is shown in Table 4. The table displays that there are variances in case mix among networks. For example, Network 5, Baltimore, has a VERA case mix of 1.13 which is 13% above the national average, and Network 16, Jackson, has a VERA case mix of .93, which is 7% below the national average. Network total workload can be multiplied by its case mix index and a single

national price to calculate the network’s total allocations for the Basic Care and Complex Care workload components of VERA. VHA is currently studying other case mix measures, such as Diagnostic Cost Groups, that may improve the risk-adjustment of the VERA methodology. Formulas and back-up data used to create case mix are included in Appendix 1.

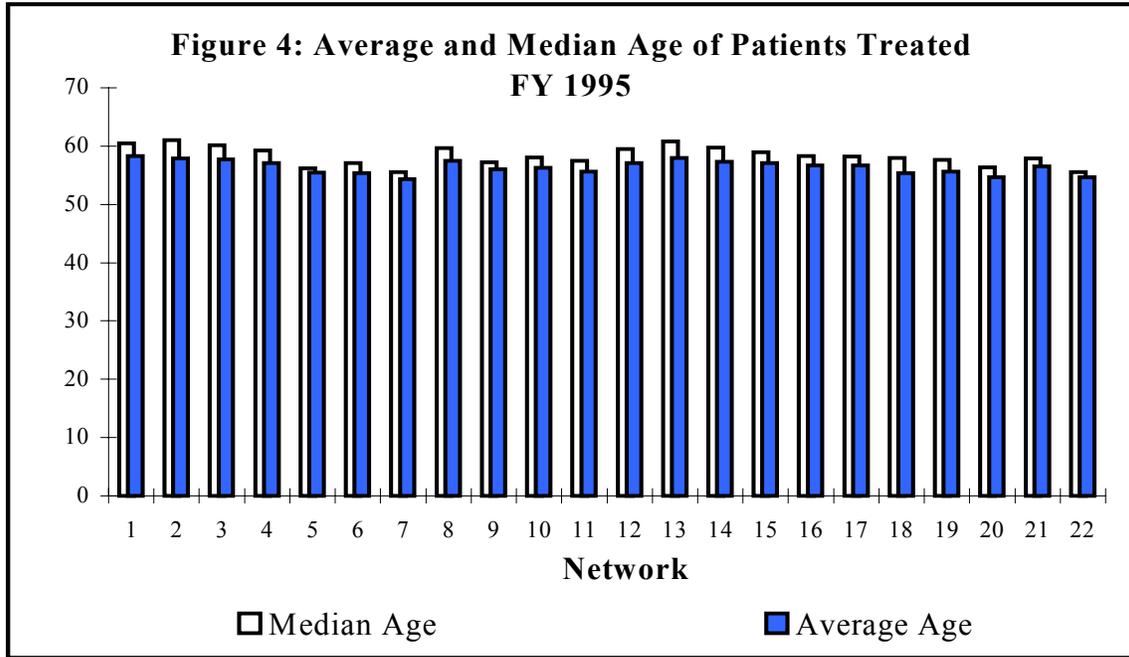
Adjustment of the National Prices

It is recognized that some factors affecting the cost of a patient’s care vary by geographic region of the country and cannot be controlled by VA management. VA considered a number of adjustments to the national price as a way to allocate resources that were outside the network’s ability to manage. These included: age of patients, cost of labor, fuel and utilities costs, grounds management, fire departments and beneficiary travel. The criteria for evaluating whether an adjustment should be added to the model were:

1. Were these costs outside of network management’s ability to control and manage?
2. If there are uncontrollable variations at the medical facility level, would the allocation of funds to the network allow sufficient flexibility for shifting of resources among network facilities to meet specific needs?
3. If an adjustment were added to the model, would it perpetuate or create inefficiencies at the network level?

Table 4: VERA Three Price Case Mix	
Network	Case Mix
1 Boston	1.03
2 Albany	1.04
3 Bronx	1.06
4 Pittsburgh	0.93
5 Baltimore	1.13
6 Durham	1.01
7 Atlanta	1.02
8 Bay Pines	1.01
9 Nashville	0.96
10 Cincinnati	1.02
11 Ann Arbor	1.00
12 Chicago	1.08
13 Minneapolis	1.01
14 Lincoln	0.94
15 Kansas City	1.00
16 Jackson	0.93
17 Dallas	1.01
18 Phoenix	0.94
19 Denver	0.96
20 Portland	1.02
21 San Francisco	1.04
22 Long Beach	0.97
VHA totals	1.00

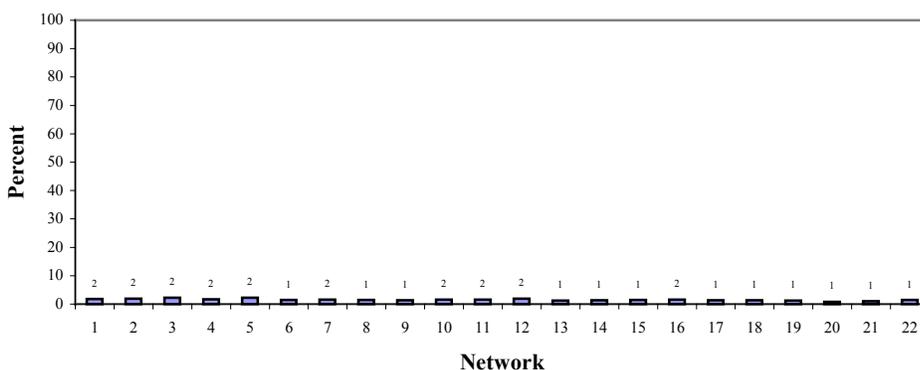
Some examples of VA's findings on these adjustments to the National Price are discussed in the following section.



Age of patients was considered as a basis for an adjustment, but there was relatively little variation among networks in the average and median age of patients treated, as is shown in Figure 4. The systemwide average age for VA patients in FY 1995 was 56.4 years, which ranged from 54.3 years in Network 7 to 58.3 years in Network 1. The systemwide median age of patients for the same year was 58.2 years, which ranged from 55.5 years in Networks 7 and 22 to 61.1 years in Network 2.

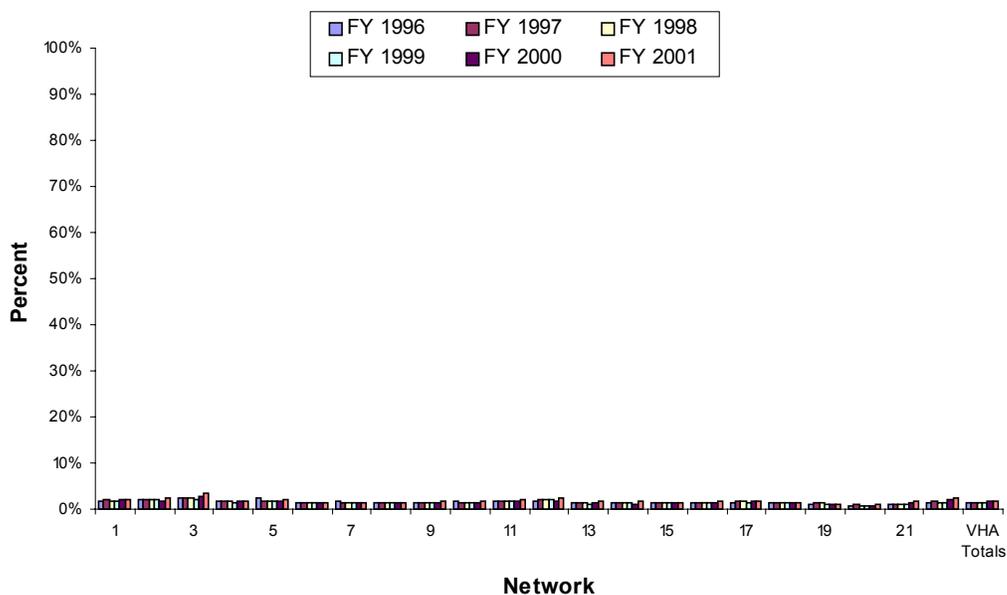
Fuel and utilities costs were also considered as a potential adjustment factor, but they were not included because they constitute a very small proportion of the networks' budgets (1-2%) and the variance across the system is less than 1%. Figure 5 shows energy obligations as a percent of total operating budget in FY 1995.

Figure 5: Energy as a Percent of Total Obligations - FY 1995



Similar findings for fuel and utilities costs are demonstrated in Figure 6 and Table 5 that show energy obligations as a percent of total operating budget in FY 1996 through FY 2001. Energy costs still constitute a very small proportion of

Figure 6: Energy as a Percent of Total Obligations - FY 1996 to FY 2001



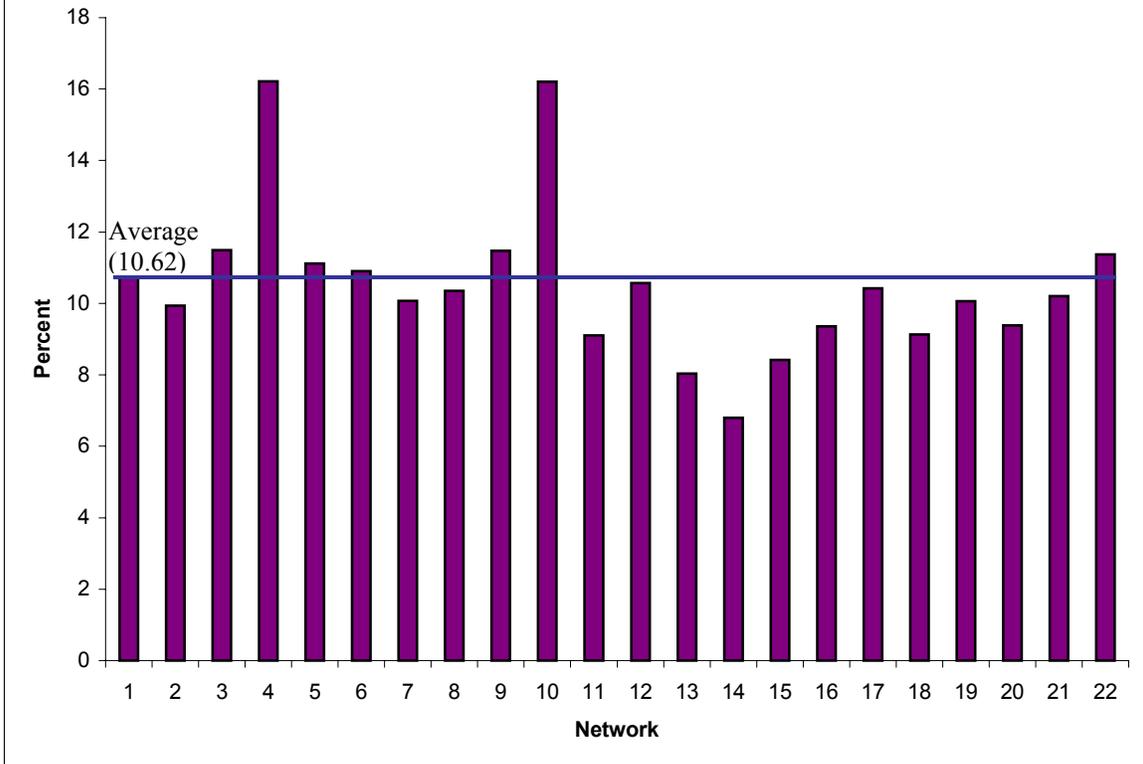
the network budgets (1.1% to about 3.4%), and the variance across the system, though still small has increased slightly from less than 1% to about 2.3%. During FY 2001 energy costs rose on the average slightly more than 23% at the national level, with one network (Network 21) increasing by 47%, though still constituting a small portion of each network's operating budget (1.8% for the national average). The VHA Office of Finance is monitoring energy data on a monthly basis and has provided its analyses to the Geographic Price Adjustment Workgroup for review. Based on the Geographic Price Adjustment Workgroup's review, it was determined that there would not be a separate stand-alone energy adjustment in VERA. However, because of the continuing uncertainties with rising fuel and utility costs, those networks experiencing financial difficulties can request supplemental funding. In addition, for the FY 2002 VERA methodology, the Geographic Price Adjustment Workgroup recommended and it was approved that VERA be modified to include a new adjustment for funding inequities caused by local procurement practices for contracted goods and services including: labor; service agreements; and locally purchased energy-related products, utilities and provisions. The adjustment is computed using VERA's labor adjustment methodology.

Table 5: Energy As a Percent of Total Obligations FY 1996 to FY 2001						
Network	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001
1 Boston	1.82%	1.92%	1.86%	1.81%	2.00%	2.23%
2 Albany	1.92%	1.99%	2.05%	1.91%	1.89%	2.36%
3 Bronx	2.31%	2.28%	2.34%	2.22%	2.72%	3.40%
4 Pittsburgh	1.70%	1.71%	1.65%	1.52%	1.57%	1.81%
5 Baltimore	2.26%	1.86%	1.83%	1.69%	1.64%	1.92%
6 Durham	1.42%	1.30%	1.32%	1.29%	1.42%	1.27%
7 Atlanta	1.56%	1.42%	1.41%	1.42%	1.36%	1.43%
8 Bay Pines	1.47%	1.44%	1.37%	1.33%	1.38%	1.46%
9 Nashville	1.37%	1.34%	1.35%	1.43%	1.47%	1.77%
10 Cincinnati	1.57%	1.45%	1.29%	1.39%	1.40%	1.71%
11 Ann Arbor	1.59%	1.62%	1.62%	1.62%	1.56%	1.92%
12 Chicago	1.87%	1.91%	1.96%	1.93%	1.86%	2.27%
13 Minneapolis	1.23%	1.35%	1.24%	1.19%	1.24%	1.59%
14 Lincoln	1.36%	1.36%	1.38%	1.29%	1.20%	1.61%
15 Kansas City	1.45%	1.36%	1.38%	1.37%	1.36%	1.47%
16 Jackson	1.52%	1.44%	1.45%	1.35%	1.35%	1.59%
17 Dallas	1.40%	1.58%	1.57%	1.54%	1.86%	1.67%
18 Phoenix	1.37%	1.34%	1.29%	1.29%	1.32%	1.24%
19 Denver	1.19%	1.23%	1.23%	1.19%	1.08%	1.19%
20 Portland	0.83%	0.89%	0.81%	0.83%	0.85%	1.07%
21 San Francisco	0.97%	1.10%	1.18%	1.20%	1.27%	1.72%
22 Long Beach	1.42%	1.60%	1.48%	1.55%	2.03%	2.42%
VHA Total	1.49%	1.48%	1.52%	1.49%	1.57%	1.80%

The **cost of pharmaceuticals** was also reviewed. It was found that more than 90% of all pharmaceuticals are purchased through the Federal Supply Schedule – so all networks pay the same price. Therefore, no adjustment for pharmaceutical costs was necessary.

Another factor considered as a potential adjustment was **the number of ambulatory care patients using the VA just once during a 3-year period**. Figure 7 shows the Basic single outpatient visit patients who used VA one time between FY 1995 and FY 1997, as a percentage of Basic Care workload during this period. This is consistent with the Basic single outpatient visits and Basic Care workload presented in the FY 1999 VERA book. Figure 7 depicts that Networks 4 and 10 have a significantly higher percentage of Basic single outpatient visits (both 16.2%) compared to the system wide average of 10.62%. If this trend continued, or increases of this nature throughout the system were unchecked, they would pull funding away from more expensive Basic Care workload. There was concern that the Basic single outpatient visits should not be funded at the national Basic Care price because that would provide financial incentives to see relatively healthy patients only once at the expense of more appropriate activities. Therefore, for FY 1999, a new price group was established for Basic single outpatient visits, with a national price per patient based on cost. The national Basic single outpatient visit price for FY 1999 was \$66. For the FY 2000 allocation, VHA established criteria for a fully vested patient even with one visit, and those patients are funded at the full Basic Vested Care price.

Figure 7: Basic Single Outpatient Visits as Percent of 3-Year Basic Workload, by Network, FY 1995 - FY 1997



For the FY 2000 allocation, a process based on clinical coding was developed to distinguish between the fully vested Basic patients and the non-vested Basic patient. This process replaced the Basic Care single outpatient visit distinction that was used in the FY 1999 allocation. Instead of identifying the low cost Basic Care price group strictly on utilization (one outpatient visit during the three year period), the intention was to identify the patients who were likely to have limited use of the VA in the future, the Basic Care non-vested patients. The Basic Care fully vested patient used inpatient services or received an appropriate, detailed medical evaluation during the three-year period. This medical evaluation was determined through the presence of an appropriate CPT code. Figure 8 depicts the percent of the Basic Care patients for each network who are single outpatient visits, and those who are non-vested using the new definition for the time period FY 1996 through FY 1998. It shows that for this time period, nationally, 11.6% of the Basic patients were single outpatient visits (seen only once in the three-year period), and 18.1% of the Basic Care patients were non-vested. There are differences among networks in the percent of single outpatient visits or non-vested Basic Care patients. Networks 4 and 10 had a significantly higher percentage of Basic single outpatient visits. They also have the highest percents for the Basic

Non-Vested patient counts. Generally, networks that had a relatively high percentage of single outpatient visits also have a relatively high percentage of non-vested patients. The price for the Basic Care non-vested patients is based on costs, consistent with the methodology used to establish the FY 1999 price for the single outpatient visits. The national Basic Care non-vested price for FY 2000 was \$105.

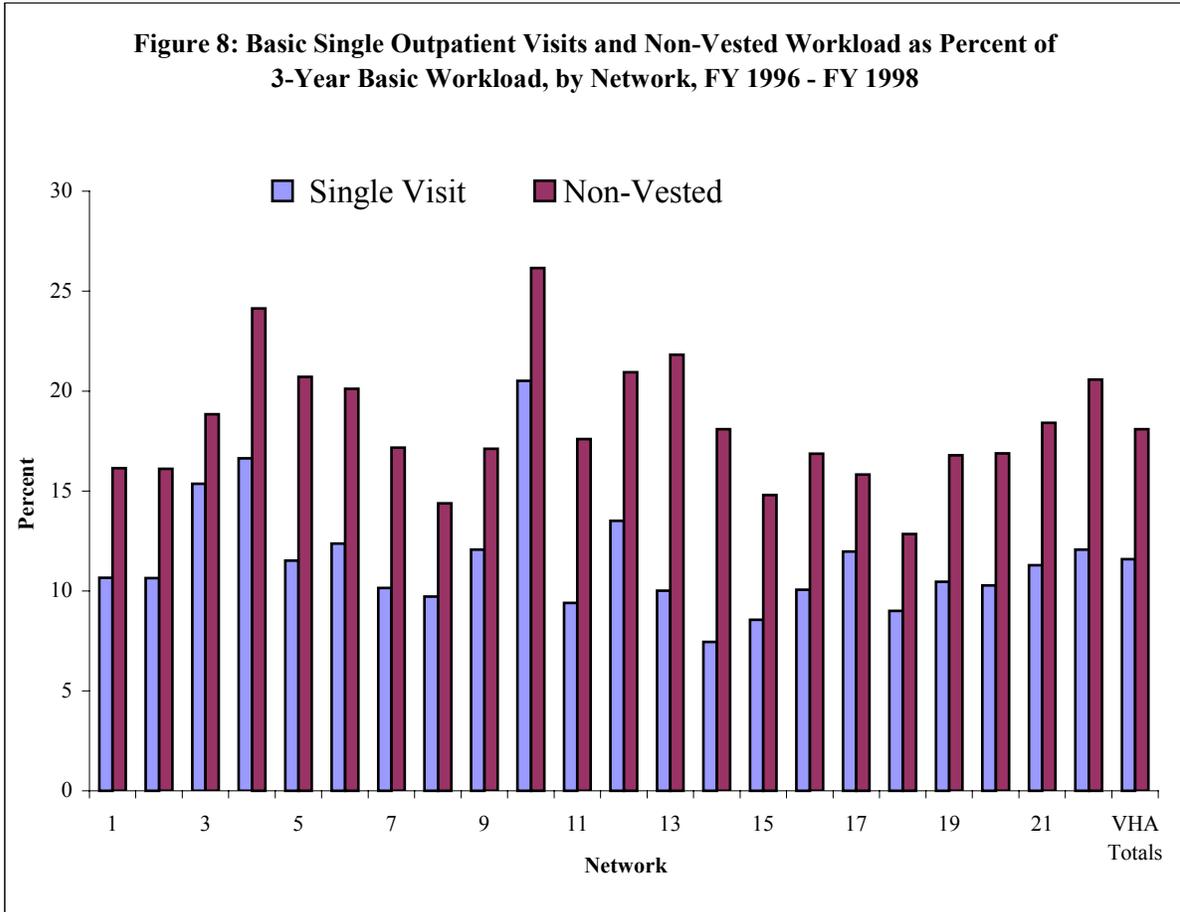
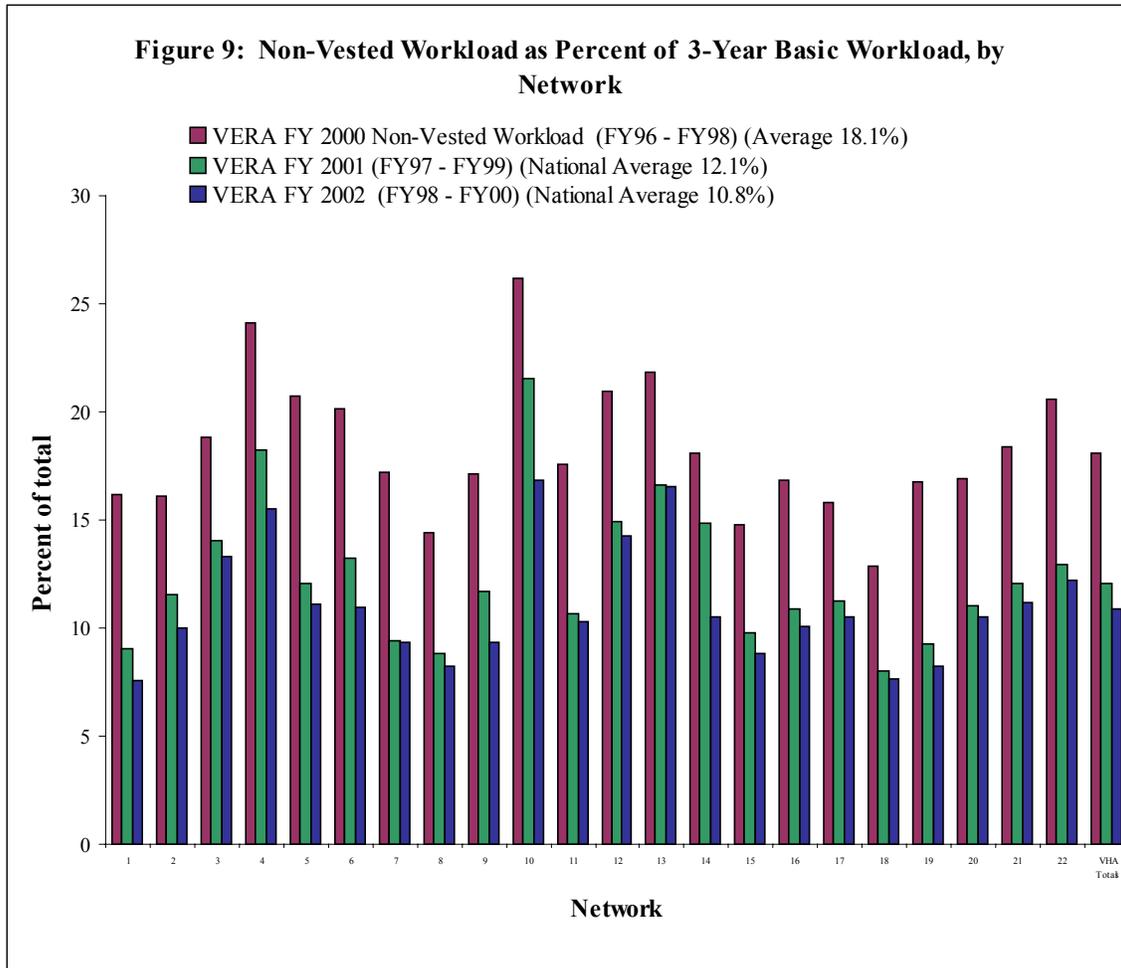


Figure 9 shows the percent of Basic Non-Vested as a percent of total Basic Care workload by network for the three-year VERA time periods for FY 2000 (FY 1996 through FY 1998), FY 2001 (FY 1997 through FY 1999) and FY 2002 (FY 1998 through FY 2000). It shows for these time periods, nationally, the Basic Non-Vested workload decreased from 18.1% to 12.1% to 10.8%. For the FY 2002 VERA time period Networks 10 (16.8%) and 4 (15.5%), while decreasing their percentage of Basic Non-Vested workload from the FY 2001 time period, continue to have a higher than average percentage than all the other networks with the exception of Network 13 (second highest for FY 2002 at 16.5%).



Geographic Price Adjustment

As previously stated, the VERA system recognizes that national prices for Basic and Complex Care do not account for some geographic differences in the cost of providing health care that are not under the control of network and local management. VA determined that the most significant factor that is uncontrollable at the network level is the cost of labor. VA labor costs account for about 65% of the total Basic and Complex Care funding. Salary costs continue to vary across the country due to geographic differences in labor costs. Generally, the costs tend to be higher in the northeast, the West Coast and large urban areas, and lower in rural, southern and mid-western areas. To account for the variations in the cost of labor in different parts of the country, network allocations are adjusted according to the cost of wages. This geographic price (labor) adjustment has been based on actual labor costs paid by VA facilities as they compare to a national average salary. The purpose of the adjustment is to "level the playing field" and equalize the effect of salary differences among networks.

VA considered several approaches to calculating the labor index, including that used by the Centers for Medicare and Medicaid Services (CMS). However, the CMS data had several limitations when applied to VA. These limitations included the lack of inclusion of physician salaries and the cost of outpatient care. As a result, for the FY 1997, FY 1998 and FY 1999 network allocations, VA decided to use a VA-specific index, computing differences in average salary determined at the payroll personal services sub-account level. The sub-accounts were used to make the index as specific as possible for different classes of VA employees. For example, average salaries for registered nurses (RNs) at the network were compared to the RN national average salary; network clerical salaries were compared to the national VA average clerical salary, etc. The labor index included 93% of total systemwide salary dollars in its calculation.

For the FY 1999 network allocations, the geographic price (labor) adjustment was changed to use the most recent and accurate data available to properly reflect the considerable efforts of networks to manage their manpower expenditures. To that end, the labor index in the FY 1999 VERA model was based on the most recent four pay-periods during FY 1998. This was used in place of the cumulative actual year-end FY 1997 personal services data because it more accurately reflected current staffing levels and costs among the networks. Also in FY 1999, the geographic price index did not include the effect of holiday, standby, and overtime pay that reflects more truly the networks' controllable payroll. For the FY 2000 network allocations the geographic salary adjustment was changed to adopt the labor index methodology recommended by PricewaterhouseCoopers LLP in the *Veterans Equitable Resource Allocation Assessment Final Report*. This methodology differs from the previous methodology in that it uses a national market basket approach in the formula to create the index, instead of network level staffing patterns. By using national data, the index formula does not intermingle staffing differences with salary variables. Therefore, the index is generated based upon the specific differences in labor cost.

For FY 2001, the workload factor for computing the labor index was changed to weight Complex Care workload consistent with recent costs. This change accounts for the more intense and expensive staffing level required for Complex Care patients. It weights Complex Care patients approximately 10 times more heavily than Basic Vested Care patients in the application of the geographic price adjustment

Until now, only salary costs were included in computing the geographic price adjustment. However, the FY 2002 VERA methodology was modified to include additional network expenses that are affected by local cost of living factors. For example, network-level procurements for contracted labor and certain non-labor contracted goods (such as energy-related products, utilities and provisions) can vary due to local cost of living factors. To ensure that network allocations reflect these regional cost variances, expenditures for these goods and services are now subject to a geographic adjustment. This modification will account for expenses caused by geographic cost factors that are beyond a network's immediate control.

Table 6: Geographic Price Adjustment

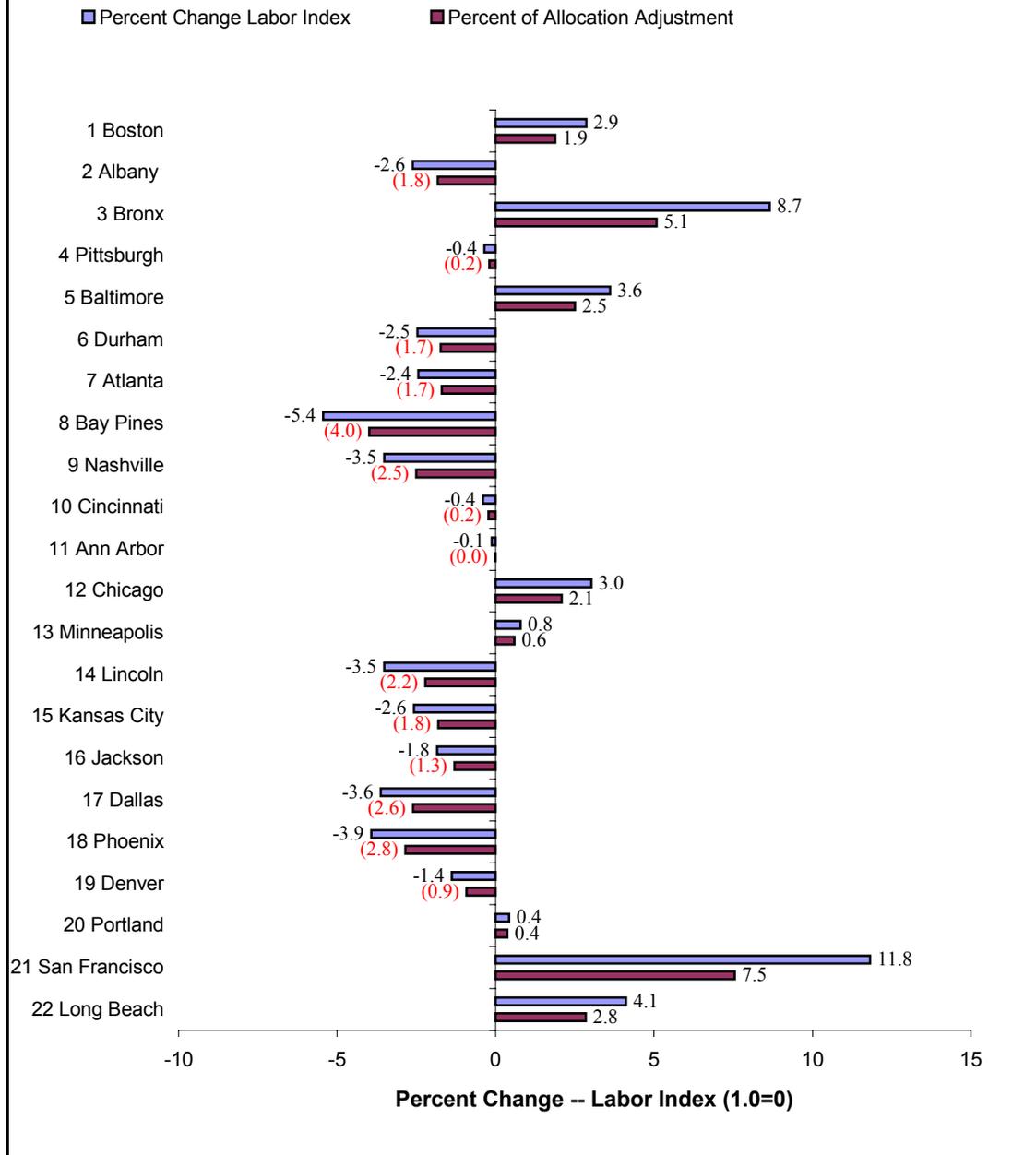
Network	(\$ in millions)		Impact of Geographic Price Adjustment on VERA Prices		
	Labor Index	Adjustment to Allocations	Complex	Basic Vested	Basic Non-Vested
1 Boston	1.029	\$17	\$42,394	\$3,201	\$202
2 Albany	0.974	-\$9	\$41,052	\$3,052	\$193
3 Bronx	1.087	\$53	\$43,812	\$3,372	\$213
4 Pittsburgh	0.996	-\$2	\$41,605	\$3,114	\$197
5 Baltimore	1.036	\$14	\$42,578	\$3,225	\$204
6 Durham	0.975	-\$15	\$41,088	\$3,056	\$193
7 Atlanta	0.976	-\$18	\$41,094	\$3,057	\$193
8 Bay Pines	0.946	-\$57	\$40,359	\$2,977	\$188
9 Nashville	0.965	-\$21	\$40,832	\$3,028	\$191
10 Cincinnati	0.996	-\$1	\$41,594	\$3,113	\$197
11 Ann Arbor	0.999	\$0	\$41,662	\$3,121	\$197
12 Chicago	1.030	\$18	\$42,432	\$3,212	\$203
13 Minneapolis	1.008	\$3	\$41,885	\$3,148	\$199
14 Lincoln	0.965	-\$8	\$40,831	\$3,027	\$191
15 Kansas City	0.974	-\$13	\$41,060	\$3,054	\$193
16 Jackson	0.982	-\$19	\$41,240	\$3,073	\$194
17 Dallas	0.964	-\$22	\$40,803	\$3,024	\$191
18 Phoenix	0.961	-\$20	\$40,731	\$3,019	\$191
19 Denver	0.986	-\$4	\$41,354	\$3,087	\$195
20 Portland	1.004	\$3	\$41,797	\$3,136	\$198
21 San Francisco	1.118	\$70	\$44,588	\$3,454	\$218
22 Long Beach	1.041	\$30	\$42,701	\$3,241	\$205
VHA totals	1.000	\$0	\$41,667	\$3,121	\$197

Note: The numbers may not add due to rounding.

Table 6 shows how much the network allocations under the Basic and Complex Care groups are adjusted by the geographic price (labor index) adjustment and the impact on VERA prices for Basic Vested, Basic Non-Vested and Complex Care. Specific formulas and back-up data used to create this table are included in Appendix 1.

Figure 10 on page 22 shows for FY 2002 the actual VHA labor index by network in terms of the percentage impact on the annual network allocation.

Figure 10: FY 2002 VERA Geographic Price Adjustment



Research Support

VA’s Medical Care appropriation funds a variety of activities that support its research mission. Research support is not included in the Basic and Complex Care allocation because the costs of research support are not directly related to patient workload. VA, however, designed all elements in the VERA system to allocate resources on the basis of workload. The total dollars of funded research was

selected as the appropriate workload indicator for allocating research support. For FY 2002, \$387 million will be allocated for research support. This amount is based on the estimates for Medical Care support to research as submitted in the President's FY 2002 Medical Programs Budget Request. Prior to FY 2000, this element simply allocated the national funding level for research support to the networks. The actual level of support expenditures was determined by network management in the context of network-wide operations. In FY 2000, networks passed through the research support allocation as it is computed for each Medical Center "Care Line" or "Product Line." Each Medical Center, Care Line, or Product Line explicitly accounted for and obligated research support funds allocated to the Medical Center, Care Line, or Product Line by the network to support the salaries of clinician-researchers, and research facilities and administrative costs. Also during FY 2000, VA was to develop and implement a system for complete and accurate accounting of the Medical Care appropriation spent in support of research. VA established a VERA Research Accounting Team who developed a methodology to allow explicit accounting of the salaries of clinician-researchers and research facilities.

For FY 2001 and FY 2002, VA has continued the pass-through of VERA research support allocations directly to each Medical Center, Care Line, or Product Line to support the salaries of clinician-researchers, and research facilities and administrative costs. During FY 2001, VA conducted a Beta Test of the new research support accounting system at selected facilities. As a result of this Beta Test, the new research support accounting system is being instituted at all VA facilities and applied to FY 2000 and FY 2001 data. VA is also taking action to integrate this new accounting system into DSS during FY 2002.

For the FY 1997 and FY 1998 VERA network allocations, research support dollars were computed by determining each network's portion of VA and Non-VA research dollars based on FY 1995 and FY 1996 data respectively. The FY 1997 and FY 1998 research support dollars were distributed by network in the same proportions.

Starting in FY 1999, the workload allocation factor for the distribution of the VERA research support dollars was changed from crediting 100% of the total amount of the funded research reported by the networks, to a revision that rewards VA-administered research. This change credits VA-administered research at 100%; non-VA funded, non-VA administered, peer reviewed research at 75%; and other non-VA funded, non-VA administered, non-peer reviewed research at 25%. VA-administered research expenditures can be reliably audited for accuracy because either the VA's own acquisition and fiscal offices are used or the VA research non-profits are used. Non-VA administered research expenditures are self-reported and cannot be reliably audited for accuracy. By counting VA-

administered dollars at 100% and non-VA administered dollars at a discount, there is an incentive to have the VA administer more of the non-VA research dollars. This results in better accountability, as well as in an increased likelihood of VA being able to recover indirect costs. In its *Veterans Equitable Resource Allocation Assessment Final Report*, (addressed later in Section III) PricewaterhouseCoopers LLP cited the limited ability to validate the non-VA research dollars.

PricewaterhouseCoopers LLP further reported that VA recognized this problem and addressed this issue with its revision to the research support component beginning with the FY 1999 VERA network allocations. Table 7 displays the FY 2002 network allocations for the research support component. Specific formulas and back-up data used to create the research support allocations are included in Appendix 1.

Research support from the Medical Care budget includes personal services costs for individuals on the Medical Care rolls who spend a portion of their VA time working on research projects. Additionally, administrative support provided to the Research Program by Fiscal, Engineering, Acquisition and Materiel Management, etc., are reported as research support. Research support also includes

support for all aspects of the program, including projects funded from VA's Research appropriation, through extramural grants, through the General Post Fund or, in some cases, through non-profit Medical Center Research Corporations. The total research funding that is used as the basis for prorating the research support funds does not include animal research or administrative costs. Table 7 shows that the total funded Research reported in FY 2000 was \$785 million. After applying the weighted credits for the FY 2000 VA and non-VA research expenditures, the amount of reported funded research is adjusted to \$667 million.

Table 7: Research Support Allocation
(\$ in millions)

Network	FY 2000 Funded Research Reported	FY 2000 Funded Research Reported and Weighted*	FY 2002 Research Support Allocation
1 Boston	\$67	\$60	\$35
2 Albany	\$9	\$8	\$5
3 Bronx	\$27	\$23	\$13
4 Pittsburgh	\$30	\$25	\$15
5 Baltimore	\$31	\$26	\$15
6 Durham	\$25	\$24	\$14
7 Atlanta	\$39	\$34	\$20
8 Bay Pines	\$23	\$19	\$11
9 Nashville	\$28	\$24	\$14
10 Cincinnati	\$29	\$24	\$14
11 Ann Arbor	\$35	\$28	\$16
12 Chicago	\$41	\$35	\$20
13 Minneapolis	\$16	\$14	\$8
14 Lincoln	\$35	\$28	\$16
15 Kansas City	\$10	\$8	\$5
16 Jackson	\$40	\$33	\$19
17 Dallas	\$30	\$25	\$15
18 Phoenix	\$15	\$13	\$8
19 Denver	\$17	\$15	\$9
20 Portland	\$49	\$41	\$24
21 San Francisco	\$87	\$75	\$44
22 Long Beach	\$103	\$86	\$50
VHA totals	\$785	\$667	\$387

Note: The numbers may not add due to rounding.
* Weights are based on the type of research activity: 100% for research which is administered by the VA; 75% for research which is peer reviewed but not VA administered; 25% for research which is not peer reviewed.

Prior to VERA, no adjustments were made to reflect differences in research activities among networks. Under the previous Resource Planning and Management allocation model, the research support adjustment was a “pass-through” account, providing an incentive for facilities to put as much cost as possible in the research support account.

Education Support

Similar to research, VA’s Medical Care appropriation funds a variety of activities supporting its education mission. Education support is not included in the Basic and Complex Care rates because the costs of education support are not consistent across all networks. Because VA designed all components of VERA to allocate resources on the basis of workload, the total number of residents was selected as the appropriate workload indicator for allocating education support funds to each network. A VERA education workgroup reviewed the education support allocation component methodology and concluded that the allocation should continue to be based on a national price per medical resident and the total number of residents in a network. The workgroup reached this conclusion because there is a strong statistical correlation between the number of medical residents and the reported educational support expenditures. Moreover, its analysis showed that there is also a strong statistical correlation between the number of medical resident positions and the number of individual associated health trainees. These findings strongly support the case of medical resident positions as the basis for the allocation of education support funds to the networks.

As shown in Table 8, \$362 million is allocated for education support in FY 2002. This figure is based on the reported amounts of expenditures for Medical Care support to education as estimated in the President's FY 2002 Medical Programs Budget Request.

Education support dollars are computed by determining each network’s portion of VA residents,

Table 8: Education Support Allocation (\$ in millions)		
Network	Number of Residents	Allocation
1 Boston	501	\$21
2 Albany	243	\$10
3 Bronx	603	\$25
4 Pittsburgh	329	\$14
5 Baltimore	246	\$10
6 Durham	348	\$15
7 Atlanta	427	\$18
8 Bay Pines	555	\$23
9 Nashville	529	\$22
10 Cincinnati	256	\$11
11 Ann Arbor	314	\$13
12 Chicago	657	\$27
13 Minneapolis	198	\$8
14 Lincoln	195	\$8
15 Kansas City	339	\$14
16 Jackson	674	\$28
17 Dallas	333	\$14
18 Phoenix	306	\$13
19 Denver	230	\$10
20 Portland	273	\$11
21 San Francisco	383	\$16
22 Long Beach	730	\$30
VHA totals	8,669	\$362

Note: The numbers may not add due to rounding.

compared to the national resident allocation for academic year 2001-2002. This equates to an education support allocation of \$41,781 for each resident. It is important to note that this element simply allocates the national funding level for education support to the networks, and that the actual level of support expenditures will be determined by network management in the context of network-wide operations. Specific formulas and back-up data used to create the education support allocations are included in Appendix 1.

Equipment

Equipment is also included as a separate element. For the first few years of VERA implementation, VA recognized that equipment funding ultimately might be moved into the Basic and Complex Care elements of the VERA system. However, as a transitional step in the FY 1997 and FY 1998 network allocations, VA distributed equipment funding to networks based on the following formula: 50% on the basis of clinical complexity, 25% on patient workload, and 25% on the distribution of existing equipment. Beginning with the FY 1999 network allocations, the equipment component of VERA was changed to recognize the need to fund patients, not facilities, and to gradually phase equipment into the VERA Basic and Complex Care elements. The equipment element of the model was revised to use the Basic and Complex Care workload for each network as the distribution factor. This element change was phased in over a two-year period to lessen the impact for those networks that would lose funds under this methodology. In FY 1999, 50% of the difference between the previous equipment methodology and the revised method was used to allocate equipment funds to networks. Beginning in FY 2000, the equipment allocation is based totally on patient workload. The total amount of equipment funding to be distributed to networks in FY 2002 is \$426 million. Table 9 shows the equipment allocation to each network. Specific formulas and back-up data used to create the equipment allocations are included in Appendix 1.

Network	Allocation
1 Boston	\$19
2 Albany	\$12
3 Bronx	\$19
4 Pittsburgh	\$24
5 Baltimore	\$11
6 Durham	\$21
7 Atlanta	\$25
8 Bay Pines	\$36
9 Nashville	\$21
10 Cincinnati	\$16
11 Ann Arbor	\$18
12 Chicago	\$18
13 Minneapolis	\$11
14 Lincoln	\$8
15 Kansas City	\$17
16 Jackson	\$38
17 Dallas	\$20
18 Phoenix	\$19
19 Denver	\$12
20 Portland	\$19
21 San Francisco	\$19
22 Long Beach	\$24
VHA Total	\$426

Note: The numbers may not add due to rounding.

Non-Recurring Maintenance (NRM)

In FY 1997 and FY 1998, network allocations of non-recurring maintenance required a separate adjustment to permit a smooth transition for funds to become fully patient-modeled and to allow flexibility in administering these funds. As with equipment, NRM was a separate element for several reasons. There is disparity among facilities in terms of NRM needs based on the cost of construction in each network, the square footage of buildings, and the number and age of buildings.

The workload indicators that were chosen as the basis for allocating NRM funds in FY 1997 and FY 1998 were the cost of construction adjusted for square footage and age of buildings in the network, and patient care workload. It was anticipated that initially a network's adjusted cost of construction would be used to allocate more of the funds, while later the majority of funds would be allocated based on patient care workload. For FY 1997 and FY 1998, 90% of the NRM dollars were allocated based on an index-adjusted cost of construction and 10% based on patient care workload. In the FY 1999 network allocations, the NRM component of VERA was changed to fund patients, not facilities, and was adjusted for differences in regional construction costs. This element change has been phased in over a three-year period in equal increments to lessen the impact for those networks that will lose funds under this methodology. This has been accomplished by: (1) using 100% of the patient care workload for each network and adjusting for the cost of construction using the Boeckh Index; and (2) adding 33% of the difference between the previous NRM methodology and the revised method in FY 1999, 66% in FY 2000 and 100% in FY 2001. FY 2001 completed the three-year phase-in of NRM being fully based on patient care workload and the cost of construction using the Boeckh Index. For FY 2002, VA will allocate \$258 million in NRM funds. Table 10 depicts the NRM allocation for each network. Appendix 1 includes specific formulas and back-up data used to create the non-recurring maintenance allocations.

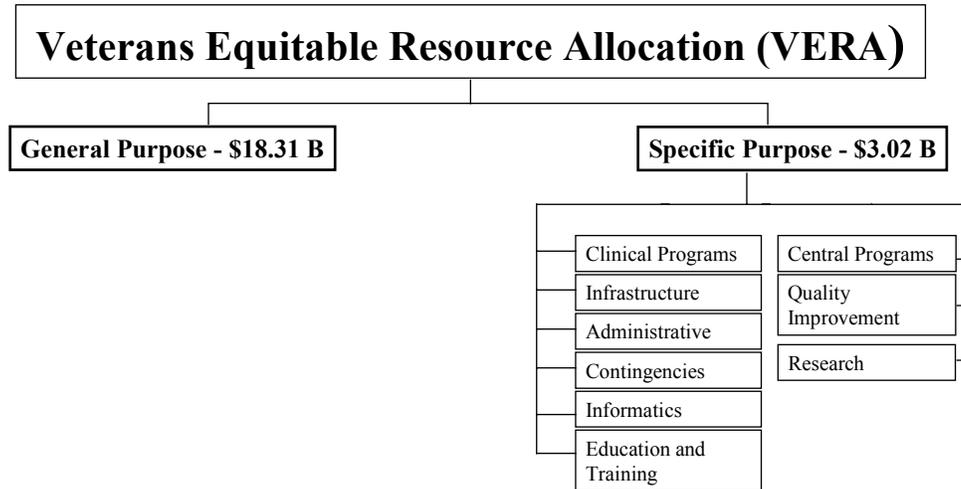
Table 10: Non-Recurring Maintenance Allocation (\$ in millions)	
Network	Allocation
1 Boston	\$13
2 Albany	\$8
3 Bronx	\$18
4 Pittsburgh	\$16
5 Baltimore	\$7
6 Durham	\$10
7 Atlanta	\$12
8 Bay Pines	\$18
9 Nashville	\$11
10 Cincinnati	\$10
11 Ann Arbor	\$12
12 Chicago	\$13
13 Minneapolis	\$7
14 Lincoln	\$4
15 Kansas City	\$11
16 Jackson	\$18
17 Dallas	\$10
18 Phoenix	\$10
19 Denver	\$6
20 Portland	\$13
21 San Francisco	\$15
22 Long Beach	\$17
VHA Total	\$258

Note: The numbers may not add due to rounding.

Specific Purpose Funds

Figure 11 reflects the Specific Purpose funding components.

Figure 11: Components of Specific Purpose VERA Funding



VERA also contributes to the goal of decentralizing day-to-day management of the system to the networks by transitioning from Specific Purpose to General Purpose funding. Under the previous RPM allocation model, a substantial portion of funding (21%) was controlled through VA Headquarters committees – i.e., those funds were not allocated through the model. To provide greater budget flexibility to networks, a higher proportion of funds have been shifted into the VERA model (funds distributed at the beginning of the fiscal year to the field based on projected workload). This shift from Specific Purpose to General Purpose was based on an examination of all Specific Purpose activities. That examination concluded that activities should be funded from Specific Purpose resources only if they meet at least one of the following three criteria:

1. Efficiency. There is a demonstrable savings with central management (e.g., leverage of buying power through national contracts).
2. Legal or programmatic requirements. There is a specific statutory requirement that limits VA’s ability to decentralize the program or function.

3. National support. The item is judged to be essential for the corporate management of VA and is something that would be outside of the scope of network operations.

After applying these criteria, it was determined that Specific Purpose funding should be reduced by 42% (from \$3.52 billion to \$2.06 billion), with the \$1.46 billion difference going into the VERA model funding for FY 1997. As a result, about 88% of the FY 1997 Medical Care budget was distributed through the VERA components and only 12% allocated to the field through Specific Purpose allocation. Some of the programs that were shifted to the model are: equipment, community nursing homes, non-recurring maintenance, tuition support, permanent change of station (moving expenses) and terminal leave. In FY 1998, VA continued to move funding from Specific Purpose to General Purpose. The FY 1998 allocations showed a slight increase in General Purpose funding and a slight decrease in Specific Purpose dollars – 89% (\$15.2 billion) of the FY 1998 Medical Care budget was distributed through the VERA components, and only 11% (\$1.9 billion) allocated to the field through Specific Purpose allocations. The amount distributed through VERA components in FY 1999 was 89% (\$15.3 billion) and 11% (\$2.0 billion) was managed as Specific Purpose funding. A field-based workgroup further reviewed the Specific Purpose activities in preparation for the FY 2000 allocation. As a result, the amount distributed through General Purpose funding in FY 2000 was 89% (\$16.8 billion) and 11% (\$2.1 billion) was managed as Specific Purpose funding. The Under Secretary for Health decided to centralize funding for prosthetics for FY 2001. As a result of this decision, \$205 million moved from General Purpose funding to Specific Purpose funding. With this decision and other actions from the Specific Purpose workgroup, the amount distributed through General Purpose funding in FY 2001 was 88% (\$17.75 billion) and 12% (\$2.54 billion) was managed as Specific Purpose funding. The field-based workgroup continued to review the Specific Purpose activities for the FY 2002 allocations. The amount distributed through General Purpose funding in FY 2002 will be 86% (\$18.31 billion) and 14% (\$3.02 billion) will be managed as Specific Purpose funding. This General Purpose amount includes the \$267 million distributed as VERA adjustments.

Section II

VERA Results

Table 11 summarizes the results of the FY 2002 VERA model for each network. Appendix 1 includes specific formulas and back-up data used to create these results.

Table 11: Results of VERA Model - FY 2002							
(\$ in millions)							
Network	Basic Vested, Basic Non-Vested and Complex Care	Research Support	Education Support	Equipment	NRM	VERA Adjustments	Total
	Workload with Labor Adjustment*						
1 Boston	\$781	\$35	\$21	\$19	\$13	\$41	\$910
2 Albany	\$463	\$5	\$10	\$12	\$8	\$0	\$497
3 Bronx	\$834	\$13	\$25	\$19	\$18	\$128	\$1,037
4 Pittsburgh	\$868	\$15	\$14	\$24	\$16	\$0	\$936
5 Baltimore	\$521	\$15	\$10	\$11	\$7	\$0	\$565
6 Durham	\$803	\$14	\$15	\$21	\$10	\$0	\$861
7 Atlanta	\$976	\$20	\$18	\$25	\$12	\$0	\$1,050
8 Bay Pines	\$1,350	\$11	\$23	\$36	\$18	\$0	\$1,437
9 Nashville	\$764	\$14	\$22	\$21	\$11	\$0	\$832
10 Cincinnati	\$632	\$14	\$11	\$16	\$10	\$0	\$683
11 Ann Arbor	\$691	\$16	\$13	\$18	\$12	\$0	\$750
12 Chicago	\$784	\$20	\$27	\$18	\$13	\$21	\$883
13 Minneapolis	\$431	\$8	\$8	\$11	\$7	\$44	\$509
14 Lincoln	\$279	\$16	\$8	\$8	\$4	\$33	\$348
15 Kansas City	\$656	\$5	\$14	\$17	\$11	\$0	\$703
16 Jackson	\$1,363	\$19	\$28	\$38	\$18	\$0	\$1,467
17 Dallas	\$774	\$15	\$14	\$20	\$10	\$0	\$832
18 Phoenix	\$666	\$8	\$13	\$19	\$10	\$0	\$715
19 Denver	\$438	\$9	\$10	\$12	\$6	\$0	\$474
20 Portland	\$757	\$24	\$11	\$19	\$13	\$0	\$825
21 San Francisco	\$838	\$44	\$16	\$19	\$15	\$0	\$932
22 Long Beach	\$941	\$50	\$30	\$24	\$17	\$0	\$1,062
VHA Total	\$16,608	\$387	\$362	\$426	\$258	\$267	\$18,309

Note: The numbers may not add due to rounding.
*This includes \$11.250 billion for special programs, see Appendix 1.

In each year since FY 1999, the initial VERA allocations of the Medical Care appropriation were subsequently adjusted through a supplemental funding process for those networks that required additional funding above their VERA allocation. This supplemental funding adjustment was provided from VHA's National Reserve Fund that is established at the beginning of each fiscal year as part of the Specific Purpose amount to cover unforeseen and unanticipated requirements. In

FY 1999, an adjustment of \$9 million was required for two networks, 8 and 9. In FY 2000, an adjustment of \$90.7 million was required for three networks, 3, 13, and 14. In FY 2001, an adjustment of \$220.1 million was required for four networks, 1, 3, 13, and 14. The size of the FY 2001 adjustment combined with a Congressional rescission of \$43 million that occurred after the initial distribution exceeded the amount available in the National Reserve Fund. This resulted in the need to withdraw network funds after the initial allocation to meet the requirements of the supplemental adjustment and the Congressional rescission.

Based on the FY 2001 experience, VHA reengineered the supplemental funding adjustment process in FY 2002 so that these adjustments were executed as part of the initial VERA allocation of the Medical Care appropriation. As part of the reengineered process, a concerted effort was made to develop updated estimates of each network's projected FY 2002 financial status. This included developing estimates of all the resources that would be available to each network and their corresponding estimated expenses for the year. The estimate of available resources included funds carried over from FY 2001, estimated collections, estimated reimbursements, and the estimated VERA allocation of the medical care appropriation. The estimated FY 2002 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. Table 12 provides a summary of the VERA adjustments from FY 1999 through FY 2002.

Table 12: VERA Adjustments FY 1999 - FY 2002				
(\$ in millions)				
Network	FY 1999	FY 2000	FY 2001	FY 2002
8 Bay Pines	\$4.0			
9 Nashville	\$5.0			
3 Bronx		\$66.2	\$73.8	\$128.5
13 Minneapolis		\$14.7	\$44.7	\$43.9
14 Lincoln		\$9.8	\$48.3	\$32.9
1 Boston			\$53.2	\$41.3
12 Chicago				\$20.8
Total	\$9.0	\$90.7	\$220.1	\$267.3
Percent of Total System-Wide Allocation	0.1%	0.5%	1.2%	1.5%
Note: Numbers may not add due to rounding.				

Table 13 shows the impact of the VERA allocation on network budgets from FY 2001 to FY 2002. Specific formulas and back-up data used to create this table are included in Appendix 1.

Table 13: Changes in Network Budgets FY 2001 - FY 2002				
(\$ in millions)				
Network	FY 2001 General Purpose	FY 2002 General Purpose	Increase or Decrease	% Increase or Decrease
1 Boston	\$895	\$910	\$15	1.62
2 Albany	\$495	\$497	\$2	0.47
3 Bronx	\$995	\$1,037	\$43	4.30
4 Pittsburgh	\$940	\$936	(\$4)	(0.40)
5 Baltimore	\$557	\$565	\$8	1.44
6 Durham	\$843	\$861	\$18	2.15
7 Atlanta	\$1,011	\$1,050	\$40	3.92
8 Bay Pines	\$1,354	\$1,437	\$83	6.13
9 Nashville	\$805	\$832	\$26	3.26
10 Cincinnati	\$657	\$683	\$25	3.88
11 Ann Arbor	\$753	\$750	(\$3)	(0.37)
12 Chicago	\$878	\$883	\$5	0.58
13 Minneapolis	\$498	\$509	\$11	2.22
14 Lincoln	\$351	\$348	(\$3)	(0.93)
15 Kansas City	\$676	\$703	\$28	4.08
16 Jackson	\$1,431	\$1,467	\$36	2.53
17 Dallas	\$792	\$832	\$40	5.11
18 Phoenix	\$713	\$715	\$2	0.26
19 Denver	\$458	\$474	\$16	3.46
20 Portland	\$798	\$825	\$27	3.36
21 San Francisco	\$893	\$932	\$38	4.28
22 Long Beach	\$1,042	\$1,062	\$20	1.95
VHA Total	\$17,835	\$18,309	\$474	2.66

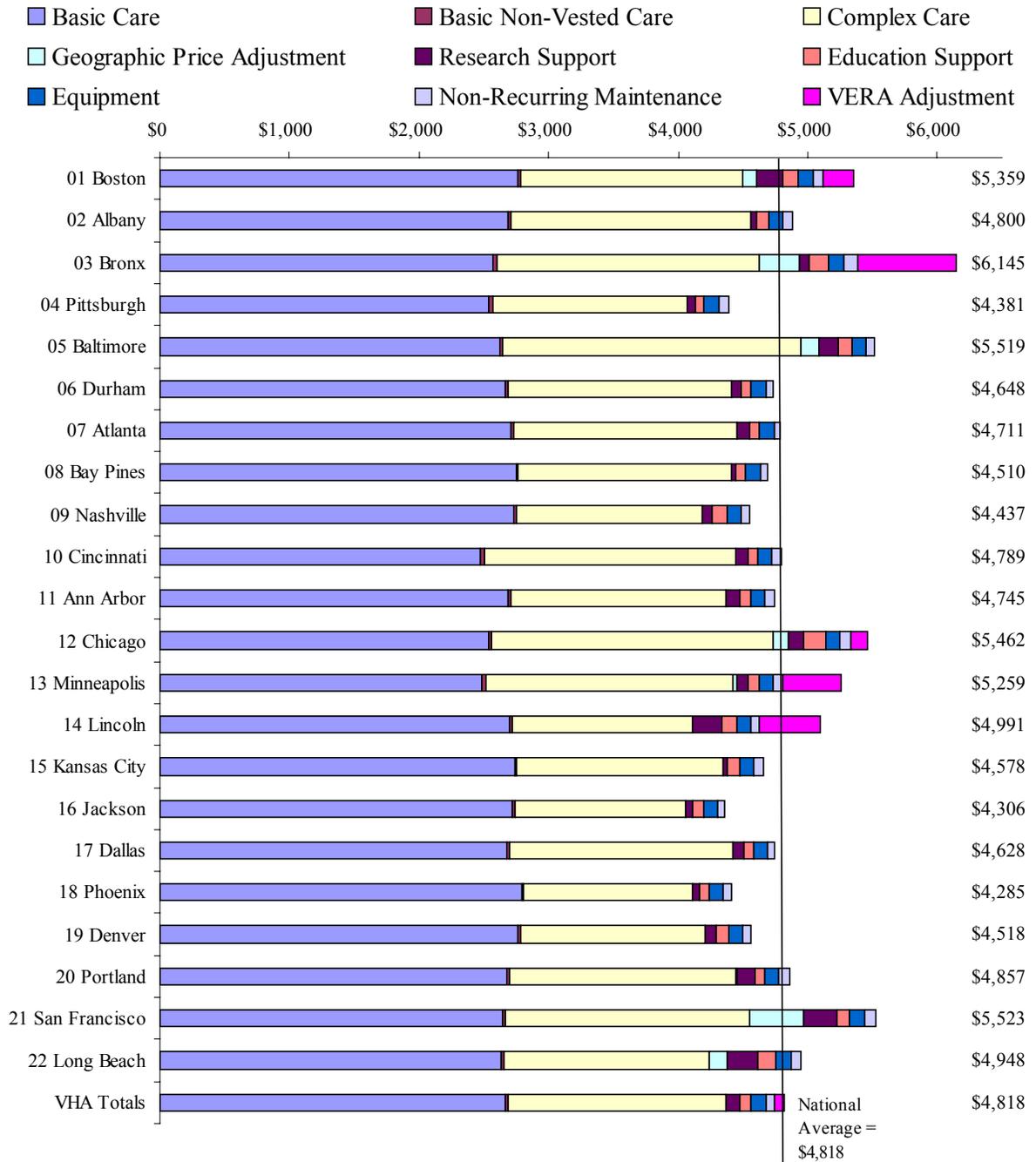
FY 2001 figures adjusted for rescission, loans, and supplemental. FY 2002 General Purpose includes VERA adjustment for five networks.
Note: Numbers may not add due to rounding.

Figure 12 on page 34 shows the projected FY 2002 average price per patient for each network under the full impact of the VERA model including VERA adjustments to five networks. The network average price is calculated by dividing each network's total VERA funding by each network's total workload volume (i.e., Basic and Complex Care workload as shown in Table 2 on page 8). The graph displays the average dollars allocated to each network for Basic Care, Complex Care, labor costs, support to research and education, equipment, non-recurring maintenance, and any VERA adjustment.

Variances from the national average will exist because VERA allocates funds in a manner that adjusts for differences in patient mix, labor costs, research and education support costs, and the VERA adjustment. Thus, even the networks that have less funding in FY 2002 compared to FY 2001 may still be provided a higher than average price than networks that receive more funding. For example, Network 14 that receives 0.93% less funding under VERA, has an average price of \$4,991, which is 3.6% above the system average of \$4,818. On the other hand, Network 8, which receives 6.13% more funding under VERA, has an average price of \$4,510 per patient, which is 6.4% below the system average.

These variances demonstrate that VERA is not simply moving all networks to an average expenditure per patient, but adjusts network allocations for differences in patient mix, labor costs, research and education support costs, equipment and non-recurring maintenance activities.

Figure 12: Projected VERA Average Price by Network FY 2002



Notes: Average price includes costs of long-term care, physicians' salaries, pharmaceuticals, treatment for mental illness, maintenance of historical buildings and other costs not included in all private or public health plans (e.g., Medicare).

Phase-In Implementation of VERA

To assure the magnitude of the impact on each network was manageable, VA phased-in the implementation of VERA by limiting the annual losses of any individual network to 5%, exclusive of equipment and non-recurring maintenance funds.

The purpose of the phase-in period was to bridge to the new system. With the additional \$1.62 billion increase (after a reduction in capital accounts) in FY 2000 over the FY 1999 budget level, the 5% cap limiting the loss of any network was no longer necessary because no network lost more than 5%. The phase-in period was completed in FY 2000. The phase-in period ensured that care was not disrupted and that veterans receiving care were not adversely affected by abrupt funding changes.

The Conference language that accompanied the Act (Public Law 104-204) (September 26, 1996) further explains congressional intent on the phase-in of VERA. The Conference Report (No.104-812) (September 20, 1996) states:

The conferees recognize that precipitous changes in allocations amongst VA's facilities could be very difficult for individual facilities to manage. While the conferees support VA's efforts to amend its resource allocation methodology based on a capitation model—which is intended to bring about a more equitable distribution of resources—they expect the Department to ensure that fiscal year 1997 serve as a “bridge” in moving to the new system so as to provide an adjustment period for facilities to adapt to the new model. The conferees further expect that no veteran currently receiving care by the VA will be denied VA health care services as a result of the new allocation methodology. The VA is to prepare a report by January 31, 1997, on its progress in adjusting to and impacts of the new methodology, and be prepared to discuss this matter during the fiscal year 1998 budget hearings.

VERA Progress to Date: FY 1996 to FY 2002

VERA has produced favorable results in achieving its goals. Independent reviews by the General Accounting Office (GAO), PricewaterhouseCoopers LLP, AMA Systems, Inc., and the RAND Corporation have validated the VERA methodology as meeting the intent of Congress. These assessments of VERA are discussed in the next section.

Table 16 on page 37 depicts the full impact of the VERA allocation on network budgets. This table shows VERA FY 2002 results for each network and compares the uncapped allocations from FY 1996 through FY 2002.

The VERA allocation system that was implemented during FY 1997, FY 1998 and FY 1999 limited allocation reductions (excluding equipment and non-recurring maintenance) to a maximum of 5% to ensure that networks who received reduced allocations would have enough time to adjust their financial plans and operations accordingly. Since the start of VERA, the number of networks that received a reduced allocation compared to the prior year, including VERA adjustments, declined to zero in FY 2000 and then increased to three in FY 2002 as shown in Table 14.

Table 14: Change in Network Allocations over Prior Year Including VERA Adjustments		
Fiscal Year	No. of Networks with Increases	No. of Networks with Decreases
1997	17	5
1998	13	9
1999	15	7
2000	22	0
2001	22	0
2002	19	3

Figure 13 on page 38 shows the results of the full impact of the VERA model for each network uncapped and without adjustments.

Table 17 on page 39 shows the impact of VERA with adjustments on network allocations with the funding shifts capped in FY 1997, FY 1998, FY 1999 and the results for FY 2000, FY 2001 and FY 2002, as well as the overall impact when compared to FY 1996. While the 5% cap ensured VERA was implemented in a manageable fashion, it is important to note that significant amounts of resources have been shifted to networks that were previously under-funded.

In three of the six years under VERA, more than half of the networks received an annual allocation including adjustments that exceeded the system-wide percent increase as shown in Table 15.

Table 15: Network Allocations Compared to System-Wide Increase over Prior Year Including VERA Adjustments			
Fiscal Year	System-wide % Increase	No. of Networks Above System-wide % Increase	No. of Networks Below System-wide % Increase
1997	2.91	12	10
1998	0.89	11	11
1999	1.33	13	9
2000	9.14	10	12
2001	6.40	13	9
2002	2.66	10	12

Table 18 on page 40 and the corresponding Figure 14 on page 41 display the percent change in the allocation for each VERA component from FY 1997 to FY 2002.

Table 16: Impact of VERA Model FY 1996 - FY 2002 (Uncapped and without VERA Adjustments)

(\$ in millions)

Network	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	% Change						
								FY 1996-1997	FY 1997-1998	FY 1998-1999	FY 1999-2000	FY 2000-2001	FY 2001-2002	
1 Boston	\$854	\$803	\$799	\$780	\$821	\$842	\$868	-5.9%	-0.5%	-2.4%	5.2%	2.6% #	3.1%	1.7%
2 Albany	\$437	\$407	\$405	\$411	\$460	\$498	\$497	-6.8%	-0.5%	1.7%	11.9%	8.1%	-0.1%	13.9%
3 Bronx	\$1,022	\$881	\$893	\$861	\$908	\$921	\$909	-13.8%	1.4%	-3.6%	5.5%	1.5%	-1.3%	-11.1%
4 Pittsburgh	\$775	\$762	\$779	\$790	\$862	\$945	\$936	-1.6%	2.1%	1.5%	9.1%	9.6%	-0.9%	20.8%
5 Baltimore	\$424	\$442	\$460	\$471	\$514	\$561	\$565	4.3%	4.1%	2.3%	9.1%	9.3%	0.7%	33.2%
6 Durham	\$682	\$711	\$704	\$716	\$788	\$847	\$861	4.3%	-1.0%	1.8%	10.1%	7.5%	1.7%	26.4%
7 Atlanta	\$778	\$861	\$882	\$884	\$946	\$1,018	\$1,050	10.6%	2.5%	0.2%	6.9%	7.6%	3.2%	34.9%
8 Bay Pines	\$960	\$1,054	\$1,077	\$1,126	\$1,290	\$1,361	\$1,437	9.9%	2.2%	4.5%	14.6%	5.5%	5.6%	49.8%
9 Nashville	\$688	\$694	\$704	\$705	\$772	\$809	\$832	0.8%	1.4%	0.1%	9.6%	4.8%	2.8%	20.8%
10 Cincinnati	\$511	\$534	\$535	\$558	\$621	\$660	\$683	4.5%	0.3%	4.3%	11.2%	6.3%	3.4%	33.7%
11 Ann Arbor	\$655	\$643	\$632	\$656	\$695	\$756	\$750	-1.8%	-1.7%	3.8%	6.0%	8.7%	-0.7%	14.6%
12 Chicago	\$834	\$779	\$780	\$781	\$831	\$883	\$863	-6.6%	0.1%	0.1%	6.3%	6.3%	-2.3%	3.4%
13 Minneapolis	\$417	\$420	\$415	\$428	\$434	\$453	\$465	0.5%	-1.2%	3.1%	1.4%	4.4%	2.6%	11.4%
14 Lincoln	\$291	\$278	\$277	\$285	\$296	\$303	\$315	-4.5%	-0.2%	2.9%	3.8%	2.4%	4.0%	8.3%
15 Kansas City	\$585	\$629	\$616	\$608	\$640	\$679	\$703	7.6%	-2.1%	-1.4%	5.4%	6.1%	3.5%	20.2%
16 Jackson	\$1,074	\$1,201	\$1,225	\$1,247	\$1,384	\$1,443	\$1,467	11.8%	2.0%	1.8%	10.9%	4.3%	1.7%	36.6%
17 Dallas	\$587	\$656	\$652	\$654	\$744	\$796	\$832	11.9%	-0.6%	0.3%	13.6%	7.1%	4.5%	41.8%
18 Phoenix	\$485	\$561	\$578	\$597	\$683	\$718	\$715	15.5%	3.0%	3.3%	14.4%	5.3%	-0.4%	47.3%
19 Denver	\$367	\$391	\$394	\$388	\$426	\$461	\$474	6.6%	0.6%	-1.5%	9.9%	8.1%	2.9%	29.1%
20 Portland	\$584	\$672	\$674	\$688	\$760	\$803	\$825	15.0%	0.3%	2.2%	10.5%	5.6%	2.7%	41.2%
21 San Francisco	\$688	\$730	\$733	\$749	\$821	\$898	\$932	6.1%	0.3%	2.2%	9.6%	9.4%	3.8%	35.3%
22 Long Beach	\$900	\$913	\$943	\$936	\$977	\$1,048	\$1,062	1.4%	3.3%	-0.8%	4.4%	7.3%	1.3%	18.0%
VHA Total	\$14,598	\$15,022	\$15,157	\$15,319	\$16,671	\$17,703	\$18,042	2.9%	0.9%	1.1%	8.8%	6.2%	1.9%	23.6%

Note: This reflects the impact of VERA prior to capping the amount of funds shifted among networks in relation to the FY 1996 allocations. These totals include equipment and NRM. The numbers may not add due to rounding. FY 1999 allocations do not include earmarks or adjustments. No caps or adjustments are applied at the FY 2000 or FY 2001 funding level. Only the FY 2000 figures have been adjusted to reflect the centralized funding of prosthetics for FY 2001. FY 2001 figures have been adjusted to reflect the rescission (\$43M).

Figure 13

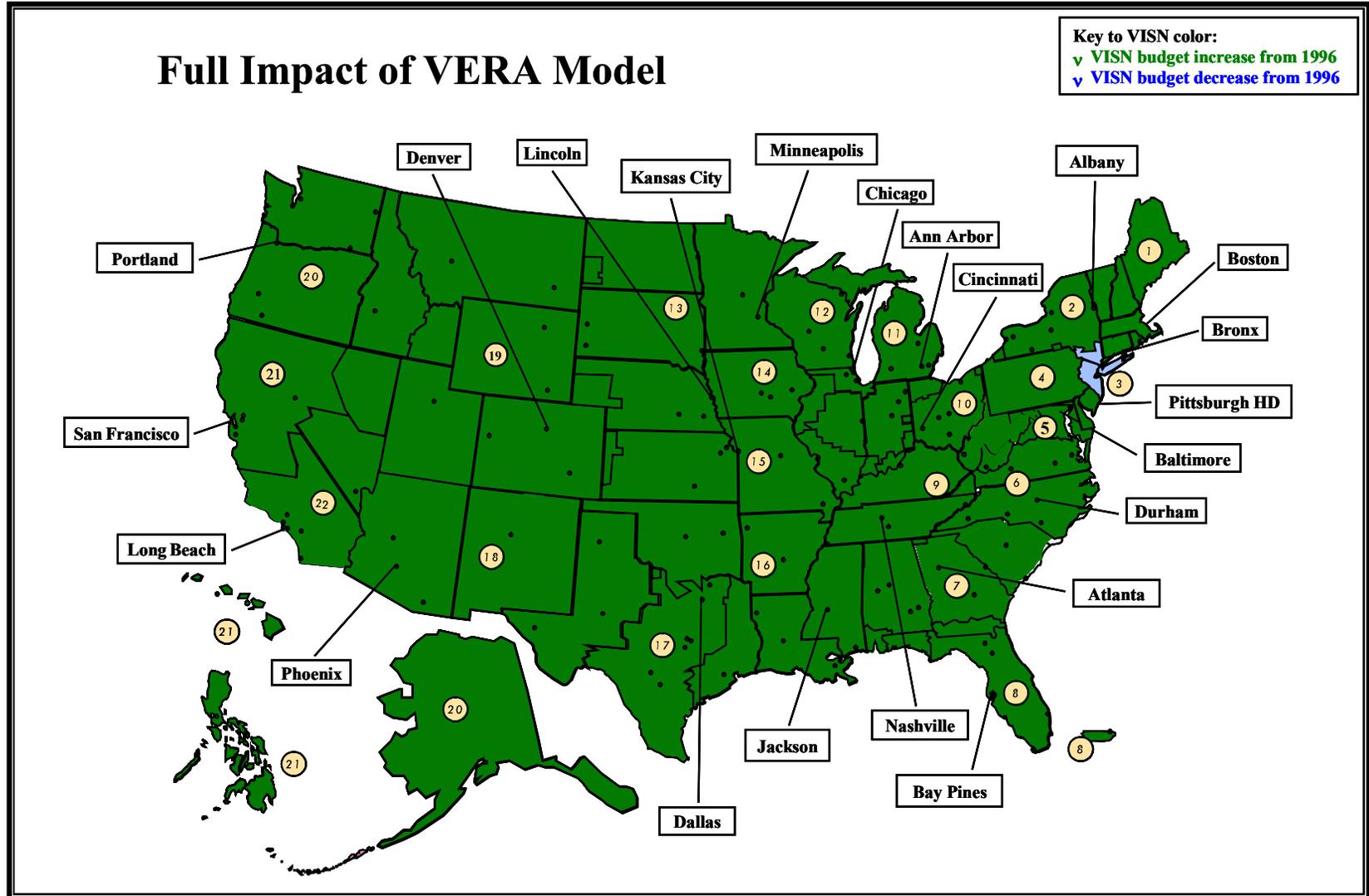


Table 17: FY 1996 - FY 2002 Resource Allocations by Network (Capped and with VERA Adjustments)

(\$ in millions)

Network	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	% Change						
								FY 1996- 1997	FY 1997- 1998	FY 1998- 1999	FY 1999- 2000	FY 2000- 2001	FY 2001- 2002	FY 1996- 2002
1 Boston	\$854	\$845	\$809	\$785	\$821	\$895	\$910	-1.0%	-4.2%	-3.0%	4.6%	9.1%	1.6%	6.6%
2 Albany	\$437	\$434	\$416	\$411	\$460	\$495	\$497	-0.7%	-4.1%	-1.1%	11.9%	7.5%	0.5%	13.9%
3 Bronx	\$1,022	\$1,017	\$974	\$952	\$974	\$995	\$1,037	-0.5%	-4.2%	-2.3%	2.3%	2.1%	4.3%	1.5%
4 Pittsburgh	\$775	\$779	\$779	\$790	\$862	\$940	\$936	0.5%	0.0%	1.5%	9.1%	9.0%	-0.4%	20.8%
5 Baltimore	\$424	\$442	\$460	\$471	\$514	\$557	\$565	4.2%	4.1%	2.3%	9.1%	8.5%	1.4%	33.2%
6 Durham	\$682	\$707	\$704	\$716	\$788	\$843	\$861	3.7%	-0.4%	1.8%	10.1%	7.0%	2.2%	26.4%
7 Atlanta	\$778	\$815	\$856	\$884	\$946	\$1,011	\$1,050	4.7%	5.1%	3.3%	6.9%	6.9%	3.9%	34.9%
8 Bay Pines	\$960	\$1,018	\$1,071	\$1,118	\$1,290	\$1,354	\$1,437	6.1%	5.2%	4.5%	15.4%	5.0%	6.1%	49.8%
9 Nashville	\$688	\$700	\$704	\$710	\$772	\$805	\$832	1.7%	0.6%	0.8%	8.8%	4.3%	3.3%	20.8%
10 Cincinnati	\$511	\$530	\$535	\$555	\$621	\$657	\$683	3.8%	0.9%	3.7%	11.9%	5.9%	3.9%	33.7%
11 Ann Arbor	\$655	\$657	\$632	\$656	\$695	\$753	\$750	0.4%	-3.8%	3.8%	6.0%	8.3%	-0.4%	14.6%
12 Chicago	\$834	\$828	\$795	\$781	\$831	\$878	\$883	-0.8%	-4.0%	-1.8%	6.3%	5.7%	0.6%	5.9%
13 Minneapolis	\$417	\$426	\$415	\$427	\$448	\$498	\$509	2.0%	-2.6%	3.0%	4.9%	11.0%	2.2%	21.9%
14 Lincoln	\$291	\$288	\$277	\$285	\$306	\$351	\$348	-1.1%	-3.8%	2.9%	7.2%	14.9%	-0.9%	19.6%
15 Kansas City	\$585	\$616	\$616	\$608	\$640	\$676	\$703	5.3%	0.1%	-1.4%	5.4%	5.5%	4.1%	20.2%
16 Jackson	\$1,074	\$1,135	\$1,194	\$1,238	\$1,384	\$1,431	\$1,467	5.7%	5.1%	3.7%	11.7%	3.4%	2.5%	36.6%
17 Dallas	\$587	\$623	\$652	\$654	\$744	\$792	\$832	6.2%	4.7%	0.3%	13.6%	6.4%	5.1%	41.8%
18 Phoenix	\$485	\$518	\$545	\$567	\$683	\$713	\$715	6.8%	5.1%	4.0%	20.4%	4.5%	0.3%	47.3%
19 Denver	\$367	\$385	\$394	\$388	\$426	\$458	\$474	4.8%	2.4%	-1.5%	9.9%	7.5%	3.5%	29.1%
20 Portland	\$584	\$622	\$652	\$677	\$760	\$798	\$825	6.4%	4.9%	3.8%	12.3%	4.9%	3.4%	41.2%
21 San Francisco	\$688	\$720	\$733	\$749	\$821	\$893	\$932	4.7%	1.7%	2.2%	9.6%	8.8%	4.3%	35.3%
22 Long Beach	\$900	\$918	\$943	\$936	\$977	\$1,042	\$1,062	2.0%	2.7%	-0.8%	4.4%	6.7%	1.9%	18.0%
VHA Total	\$14,598	\$15,022	\$15,157	\$15,359	\$16,762	\$17,835	\$18,309	2.9%	0.9%	1.3%	9.1%	6.4%	2.7%	25.4%

Note: This reflects the impact of VERA with caps, in relation to FY 1996. The 5% low cap is placed in Basic Vested, Basic Non-Vested, Complex, Research, and Education allocations only. These totals include Equipment and NRM added after the cap is in place. The numbers may not add due to rounding.

FY 1999 includes VERA plus \$20M earmarked by the Congressional Appropriations Conference Committee for Network 3. FY 1999 includes VERA plus adjustments for newly decentralized programs for networks which exceed the 5% limitation. FY 1998, FY 1999, FY 2000 and FY 2001 include supplemental funding adjustments. FY2000 figures have been adjusted to reflect the centralized funding of Prosthetics for FY 2001. FY 2002 includes the VERA adjustments for 5 networks. FY 2001 figures have also been adjusted to reflect the rescission (\$43M).

Table 18 and Figure 14 on page 40 display the percent change in the allocation for each VERA component from FY 1997 to FY 2002.

Table 18: Percent Change in Allocation in Each VERA Component, FY 1997 to FY 2002							
Network	Basic (Vested & Non- Vested)		Geo Price Adj	Research Support	Education Support	Equip ment	NRM
	Complex Care						
1 Boston	8.3	0.9	(0.4)	(0.6)	(0.3)	0.1	(0.3)
2 Albany	16.6	5.2	(0.4)	(0.4)	(0.4)	0.4	(0.0)
3 Bronx	4.9	(2.4)	1.0	(0.3)	(0.1)	0.0	(0.4)
4 Pittsburgh	22.3	(1.6)	(0.1)	0.8	(0.1)	0.8	0.1
5 Baltimore	5.9	20.5	0.9	0.3	(0.0)	0.3	(0.1)
6 Durham	10.0	10.4	0.1	0.4	(0.2)	0.5	0.2
7 Atlanta	13.5	8.4	0.3	0.3	(0.2)	0.7	0.2
8 Bay Pines	22.3	15.9	(2.1)	(0.3)	(0.1)	1.1	0.8
9 Nashville	15.8	4.2	(0.2)	(0.3)	(0.2)	0.3	0.1
10 Cincinnati	11.0	16.4	(0.0)	0.1	(0.1)	0.6	0.2
11 Ann Arbor	10.3	6.1	(0.2)	(0.3)	(0.1)	0.5	0.1
12 Chicago	3.6	6.1	1.4	(0.4)	(0.1)	(0.0)	(0.5)
13 Minneapolis	3.3	7.5	0.9	(0.3)	(0.3)	(0.3)	(0.2)
14 Lincoln	9.9	3.1	(0.4)	0.3	0.0	0.2	(0.1)
15 Kansas City	10.8	1.9	(0.4)	(0.7)	(0.1)	0.3	0.2
16 Jackson	12.5	10.4	(0.1)	(0.2)	(0.2)	0.6	0.4
17 Dallas	16.0	11.5	(0.9)	0.6	(0.1)	0.8	0.4
18 Phoenix	19.7	9.6	(1.3)	0.2	(0.0)	0.9	0.7
19 Denver	13.3	8.9	0.4	(1.7)	(0.1)	0.5	0.2
20 Portland	13.3	10.5	(0.1)	(0.0)	(0.0)	0.6	0.3
21 San Francisco	12.8	10.7	2.4	0.8	(0.1)	0.7	0.6
22 Long Beach	8.5	7.7	(0.5)	(0.2)	(0.1)	0.6	0.2
VHA Totals	12.1	7.6	0.0	(0.1)	(0.2)	0.5	0.2

Note: The numbers may not add due to rounding.

Figure 14: Percent Change in Allocation by VERA Component, FY 1997 to FY 2002 (no caps, supplementals)

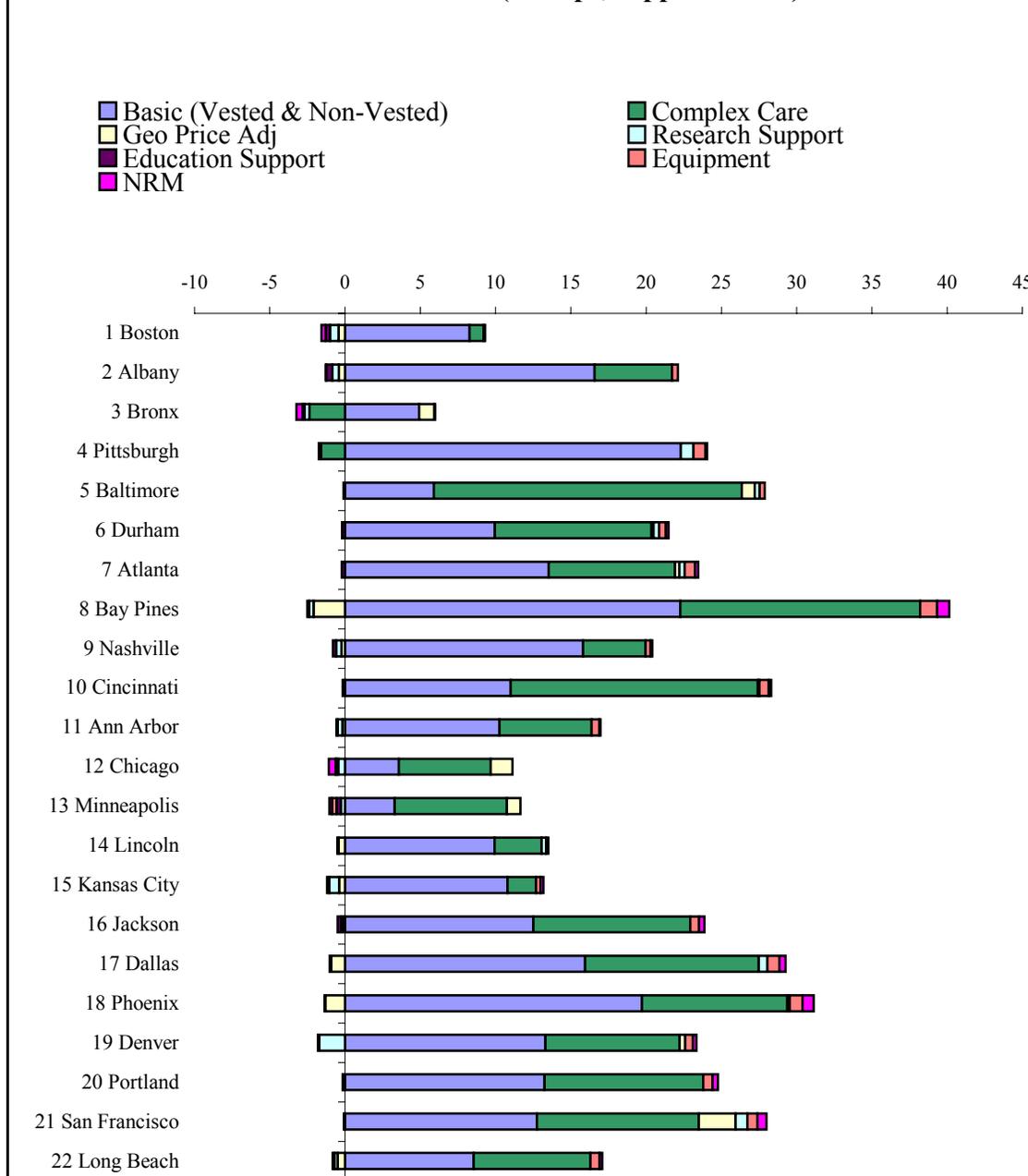


Figure 15 on page 44 depicts the overall result from FY 1996 to FY 2000 on how the VHA allocation was spent. It displays the dollars that are expended by each network, both the VERA General Purpose allocations and also the Specific Purpose allocations. The chart shows the percent variance from the national average for each network's total dollars spent per patient in FYs 1996 – 2000. These changes over time demonstrate that VERA is meeting its objective of

funding networks based on their unique needs, not at a single national average rate. There has not been an arbitrary movement to the mean. The changes are the result primarily of two factors:

1. The networks' average projected price per patient (displayed previously in Figure 12 on page 34), which is derived from the network's Basic and Complex Care workload volume, the geographic price adjustment, education support, research support, equipment and non-recurring maintenance components of VERA, or
2. Recent changes in workload experiences, particularly Basic and Complex Care workload volume.

The number of patients treated systemwide has increased from 2,936,347 in FY 1996 to 3,887,177 in FY 2000 or by 32.4%. The systemwide average dollars spent per patient has decreased by 14.6% from \$5,349 in FY 1996 to \$4,570 in FY 2000.

Some of the networks that were at the high end in FY 1996 show a percentage decrease in deviation from the system average. For example, Network 3 (Bronx) decreased from 33.0% above the national average in FY 1996 to 24.3% above the average in FY 2000. Within its overall decrease, Network 3 experienced an increase from a low of 14.8% in FY 1998 to 24.3% in FY 2000. Network 4 (Pittsburgh) was above the system average in FY 1996 at 5.3% and has decreased to -11.2% in FY 2000. Network 2 (Albany) also was above the system average in FY 1996 at 4.6% and has decreased each year to -11.5% in FY 2000.

Other networks at the high end show a percentage increase in deviation from the system average. For example, Network 12 (Chicago) increased from 19.0% in FY 1996 to 24.5% in FY 2000. Within its overall increase, Network 12 increased from 19.0% to 20.1% relative to the average from FY 1996 to FY 1997 and then reversed in FY 1998 to 12.2% and increased to 14.1% in FY 1999 and continued the increase to 24.5% in FY 2000. Network 21 (San Francisco) increased from 11.5% in FY 1996 to 13.0% in FY 2000, increasing from a low of 4.3% in FY 1998. Network 5 increased from 8.5% above the system average in FY 1996 to 29.3% in FY 2000. Network 1 increased from 12.6% in FY 1996 to 17.1% in FY 2000. Network 22 (Long Beach) increased from 1.0% in FY 1996 to 12.7% in FY 2000. Network 10 (Cincinnati) increased from being at the national average in FY 1996 to 13.3% above the average in FY 2000, increasing from -4.3% in FY 1997 and 1.7% in FY 1998.

Some of the networks at the low end with below average total dollars per patient have increased toward the average. For example, Network 18 (Phoenix) increased

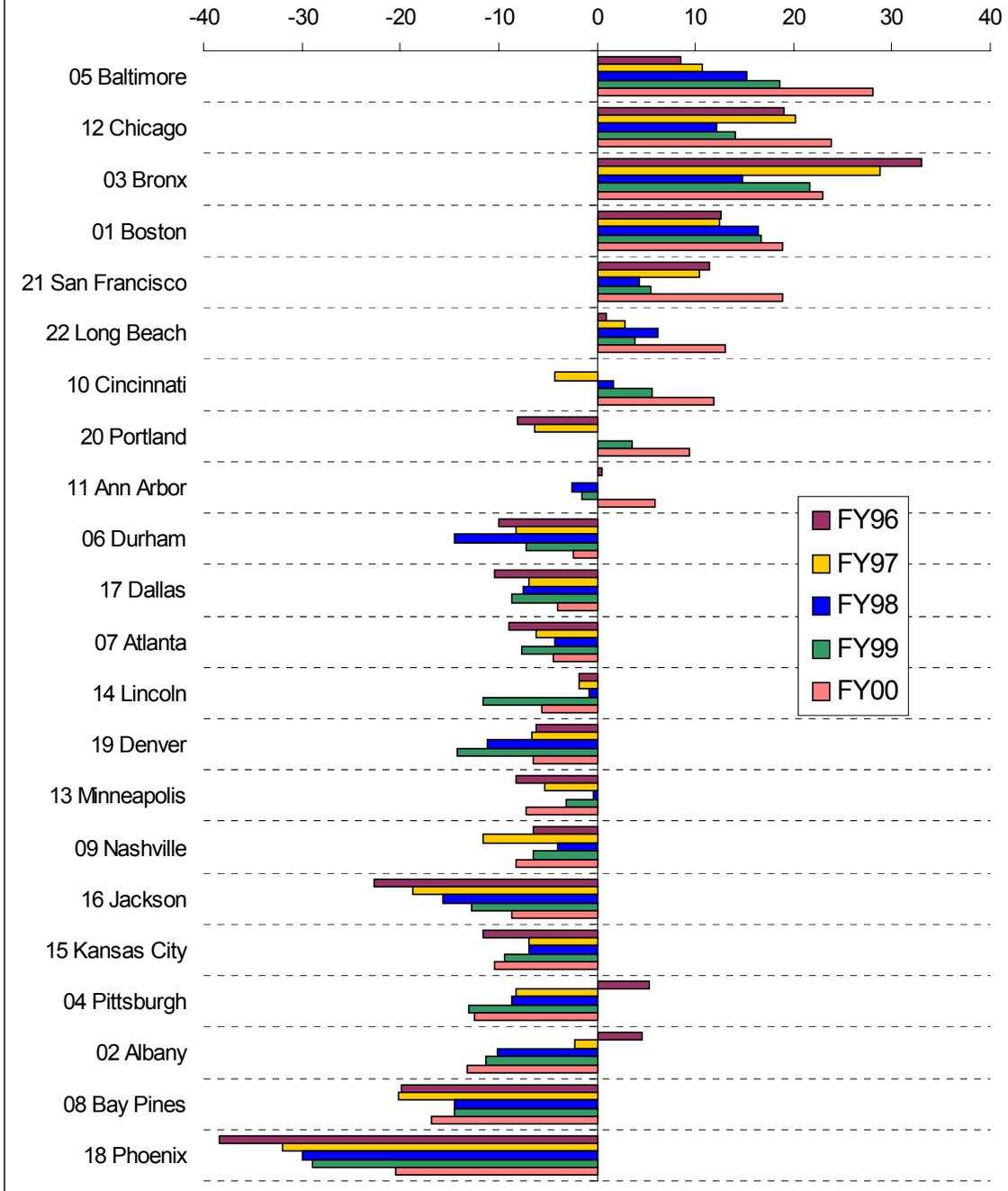
from -38.4% in FY 1996 to -21.2% in FY 2000. Network 16 (Jackson) increased from -22.6% in FY 1996 to -7.0% in FY 2000. Bay Pines increased from -19.9% in FY 1996 to -16.6% in FY 2000.

The trends for other networks at the low end follow. Network 19 (Denver) continues to be below the national average from -6.1% in FY 1996 to -5.6% in FY 2000, after reaching a low of -14.2% in FY 1999. Network 7 (Atlanta) also continues to be below the system average from -9.0% in FY 1996 to -4.1% in FY 2000. Kansas City also continues to be below the system average from -11.6% in FY 1996 to -11.3% in FY 2000. Network 14 (Lincoln) has also decreased from -1.8% in FY 1996 to -6.1% in FY 2000.

**Figure 15: FY 1996 - FY 2000 Dollars Spent per Patient
Percent Variance from National Average**

(FY 2000 is Base Year for FY 2002 VERA Allocation)

(FY 1996 is Base Year before VERA Implementation)



Collections and VERA

Congress enacted provisions in FY 1998 for VA to retain medical collections rather than return them to the Department of Treasury as had been required in the past. The legislation terminated the Medical Care Cost Recovery (MCCR) Fund and, in June 1997, established the Medical Care Collections Fund (MCCF). Since July 1, 1997, all collections from third-party reimbursements, copayments, per diems, and certain torts were deposited in this new fund. Amounts in the MCCF are available for transfer to the Medical Care appropriation and will remain available until expended. A total of \$825 million in collections is projected to be transferred for FY 2002. Also, a total of \$128 million in other reimbursement estimates should be available for networks in FY 2002. Those reimbursements include sharing and TRICARE. In addition, a total of \$225 million in collections for the Health Services Improvement Fund (HSIF) should be available for networks in FY 2002. PL 106 – 117, the Veterans Millennium Health Care and Benefits Act,

authorized the Secretary to increase the \$2 medication copayment, establish a maximum annual and monthly payment applicable to veterans with multiple outpatient prescriptions, revise copayments in outpatient care for “higher-income” veterans, authorizes VHA to receive reimbursements from Department of Defense for certain military retirees using the VA system covered by TRICARE and expands VA’s enhanced-use authority. Receipts and collections under the new authority (i.e. the medication copayment increase of \$5 from \$2 to \$7) will be deposited in the Health Services Improvement Fund. The original \$2 medication copayment will continue to be deposited in MCCF. Table 19 displays estimated network collections for FY 2002. Table 20 on page 47 depicts the sum of VERA allocations and collections (receipts) for each network.

Table 20 reflects that the largest percentage increase from FY 2001 in current-year funds available is +7.59 in Network 8, while Network 14 experiences the smallest

Table 19: MCCF and Other Collections - FY 2002
(\$ in millions)

Network	MCCF	Sharing/Other
1 Boston	\$40	\$16
2 Albany	\$20	\$10
3 Bronx	\$43	\$14
4 Pittsburgh	\$47	\$21
5 Baltimore	\$17	\$8
6 Durham	\$49	\$14
7 Atlanta	\$47	\$15
8 Bay Pines	\$70	\$28
9 Nashville	\$49	\$17
10 Cincinnati	\$24	\$11
11 Ann Arbor	\$40	\$15
12 Chicago	\$45	\$20
13 Minneapolis	\$36	\$12
14 Lincoln	\$22	\$10
15 Kansas City	\$39	\$18
16 Jackson	\$63	\$25
17 Dallas	\$30	\$20
18 Phoenix	\$31	\$19
19 Denver	\$29	\$8
20 Portland	\$29	\$16
21 San Francisco	\$26	\$19
22 Long Beach	\$30	\$14
VHA Totals	\$825	\$353

Note: The numbers may not add due to rounding. These totals do not include national support programs.

percentage increase in total funding with 1.39% when estimated receipts are considered. The minimum any network budget will increase from FY 1996 to FY 2002 is 6.87% in Network 3, while the greatest increase is 59.54% in Network 8.

Table 20: FY 1996 - FY 2002 VERA Allocations with Adjustments and Estimated Receipts

(\$ in millions)

Network								% Change						
	FY 1996 Allocations and Receipts	FY 1997 VERA and Receipts	FY 1998 VERA and Receipts	FY 1999 VERA and Receipts	FY 2000 VERA and Receipts	FY 2001 VERA and Receipts	FY 2002 VERA and Receipts	FY 1996- 1997	FY 1997- 1998	FY 1998- 1999	FY 1999- 2000	FY 2000- 2001	FY 2001- 2002	FY 1996- 2002
1 Boston	\$856	\$848	\$854	\$821	\$853	\$936	\$965	-1.02	0.78	-3.89	3.91	9.72	3.09	12.68
2 Albany	\$438	\$435	\$441	\$431	\$478	\$516	\$527	-0.68	1.32	-2.12	10.81	7.94	2.18	20.38
3 Bronx	\$1,024	\$1,019	\$1,021	\$994	\$1,010	\$1,038	\$1,094	-0.48	0.16	-2.61	1.57	2.84	5.38	6.87
4 Pittsburgh	\$776	\$781	\$819	\$828	\$901	\$988	\$1,004	0.53	4.85	1.21	8.72	9.71	1.61	29.31
5 Baltimore	\$426	\$444	\$484	\$489	\$527	\$575	\$590	4.21	9.00	1.15	7.74	9.17	2.48	38.48
6 Durham	\$687	\$713	\$749	\$754	\$828	\$893	\$924	3.68	5.12	0.67	9.77	7.88	3.50	34.49
7 Atlanta	\$781	\$816	\$896	\$922	\$983	\$1,057	\$1,113	4.54	9.83	2.88	6.62	7.49	5.27	42.52
8 Bay Pines	\$962	\$1,021	\$1,113	\$1,161	\$1,339	\$1,427	\$1,535	6.06	9.03	4.34	15.34	6.56	7.59	59.54
9 Nashville	\$691	\$703	\$741	\$746	\$811	\$857	\$897	1.76	5.37	0.69	8.74	5.58	4.76	29.86
10 Cincinnati	\$513	\$533	\$558	\$574	\$639	\$682	\$717	3.86	4.78	2.95	11.32	6.66	5.14	39.87
11 Ann Arbor	\$656	\$659	\$665	\$687	\$726	\$794	\$805	0.39	0.97	3.36	5.58	9.38	1.43	22.72
12 Chicago	\$839	\$832	\$840	\$820	\$868	\$928	\$948	-0.78	0.91	-2.38	5.87	6.95	2.13	13.02
13 Minneapolis	\$420	\$428	\$443	\$455	\$474	\$536	\$557	1.96	3.43	2.69	4.17	13.28	3.91	32.78
14 Lincoln	\$293	\$290	\$294	\$301	\$324	\$374	\$380	-1.18	1.35	2.59	7.64	15.50	1.39	29.52
15 Kansas City	\$587	\$618	\$645	\$635	\$669	\$717	\$760	5.25	4.41	-1.56	5.36	7.23	6.00	29.54
16 Jackson	\$1,077	\$1,139	\$1,245	\$1,283	\$1,434	\$1,497	\$1,555	5.76	9.30	3.08	11.73	4.39	3.90	44.40
17 Dallas	\$592	\$630	\$688	\$687	\$774	\$831	\$883	6.32	9.17	-0.13	12.72	7.39	6.21	49.04
18 Phoenix	\$495	\$528	\$579	\$597	\$715	\$752	\$766	6.58	9.67	3.16	19.64	5.25	1.84	54.62
19 Denver	\$368	\$386	\$412	\$407	\$449	\$488	\$512	4.82	6.79	-1.27	10.28	8.70	4.95	39.05
20 Portland	\$589	\$626	\$681	\$704	\$789	\$834	\$870	6.38	8.64	3.51	11.95	5.73	4.36	47.77
21 San Francisco	\$690	\$724	\$755	\$773	\$850	\$929	\$977	4.93	4.29	2.29	10.00	9.35	5.13	41.54
22 Long Beach	\$903	\$921	\$966	\$957	\$1,000	\$1,076	\$1,106	2.00	4.88	-0.95	4.51	7.60	2.84	22.54
VHA Totals	\$14,664	\$15,092	\$15,886	\$16,028	\$17,439	\$18,726	\$19,487	2.92	5.27	0.89	8.81	7.38	4.06	32.89

Note: The FY 1998 MCCF totals include FY 1997 4th quarter collections. The FY 2002 MCCF and Reimbursement figures represent projected collections. The numbers may not add due to rounding.

FY 1999 Includes VERA plus \$20M earmarked by the Congressional Appropriations Conference Committee for Network 3. FY 1999 includes VERA plus adjustments for newly decentralized programs for networks which exceed the 5% limitation. FY 1998, FY 1999, FY 2000 and FY 2001 include supplemental funding adjustments. FY 2000 figures have been adjusted to reflect the centralized funding of Prosthetics for FY 2001. FY 2002 includes the VERA adjustments for 5 networks. FY 2001 figures have also been adjusted to reflect the rescission (\$43M).

Section III

Assessments of VERA

During the past three years the General Accounting Office (GAO) and a private sector contractor (PricewaterhouseCoopers LLP) have evaluated VERA. The following section discusses the purpose of these evaluations and their findings. Overall, both studies found that VERA is an improvement over previous VA health care funding allocation systems. In fact, PricewaterhouseCoopers LLP concluded that VERA is ahead of other global health care funding systems around the world. Both studies recommended changes to strengthen VA's allocation system. The recommended changes and VA's actions taken and plans for addressing these recommendations are also discussed in this section.

In addition, in May 1999 VA retained a contractor, AMA Systems, Inc. and its sub-contractor the Center for Naval Analyses Corporation (CNAC), to assess the relative status of patient health care across VA's 22 networks, and to the extent those differences require disproportionate resource consumption in the affected network that go beyond current VERA adjustments. Early during the course of the study, as a result of increasing concerns from a number of stakeholders, VA amended its evaluation of patient health status contract study to include an analysis of the efficiency of resource allocation to rural areas within the VERA process. The findings, conclusions and recommendations of both studies were completed in July 2000, and are discussed in this section.

In FY 2001, the Senate Appropriations Committee directed VA to contract with a Federally Funded Research and Development Center to conduct a VERA study to determine whether VERA's methodology leads to a distribution of funds that covers the special needs of some veterans. This study was completed and provided to Congress in August 2001. The findings and recommendations are also discussed in this section.

GAO Evaluation

In its September 1997 report, *VA Health Care: Resource Allocation Has Improved, but Better Oversight Needed* (GAO/HEHS-97-178), the GAO recognized the impact of VA's progress in implementing VERA. GAO cited that "VERA shows promise for correcting long-standing regional funding imbalances that have impeded veterans' equitable access to services. Specifically, VERA allocates more comparable amounts of resources to the 22 networks for high-priority VA health service users – those with service-connected disabilities, low

incomes or special health care needs – than the resource allocation process it has replaced.” In its report, GAO made the following two recommendations:

GAO Recommendation 1:

“Develop more timely and detailed indicators of changes in key VERA workload measures and medical care practices to maintain VERA’s ability to equitably allocate resources in the future and help ensure that veterans receive the most appropriate care.”

VA accomplished several activities to implement the GAO’s recommendation. Specifically, a tracking system was developed to monitor Complex Care workload relative to VERA funding allocations. This system compared FY 1996 workload levels to FY 1997 workload levels for all Complex Care workload classes, as defined in VERA. That analysis concluded that for the period in question, Complex Care workload did not change significantly. VA has continued to monitor Complex Care workload tracking on a quarterly basis in FY 1998, FY 1999, FY 2000, FY 2001 and will do so again in FY 2002. Also, VA conducted a review of three-year Basic patient single encounter workload by network for each of the three-year periods FY 1993-FY 1995, FY 1994-FY 1996, and FY 1995-FY 1997. Single encounter Basic Care patients comprised about 12.5% to 13% of the Basic Care workload in each of the previously mentioned three-year groups. Virtually all of the single encounter Basic Care patients were outpatient visits. Just over \$1 billion was allocated to the single encounter patients for FY 1998 because they were funded at the full Basic Care price. The Complex Care workload analyses and single encounter Basic Care patients’ analyses were shared with the 22 networks. In FY 1999, VA established a Basic single outpatient visits patient class and allocated \$66 for each patient. Also in FY 1999, VA completed a review of three-year Basic single encounter workload with three-year Basic Non-Vested care for FY 1996-FY 1998. In FY 2000, VA established a Basic Non-Vested patient class instead of the Basic single outpatient visits class and allocated \$105 for each patient. During FYs 2000 and FY 2001, VA completed an analysis of the three-year Basic Non-Vested workload as a percent of the total three-year Basic workload. The VERA Component Section on page 18 shows this analysis for the three-year periods FY 1996-FY 1998, FY 1997-FY 1999, and FY 1998-FY 2000.

VHA’s Chief Financial Officer and Chief Information Officer continue their efforts to improve the manner in which VERA’s underlying data are reported and retrieved. Additionally, VA had a contractor evaluate the following components of VERA:

- The accuracy and integrity of secondary data.
- Methods of data collection and analysis.

- Models and methodologies underlying the models.
- Documentation of the models.
- Timeliness of work processes.

As these activities indicated, VA Headquarters continued to monitor the numbers of patients provided care compared to previous years to ensure that access to quality care was not compromised.

GAO Recommendation 2:

“Improve oversight of VISN’s allocations of resources to their facilities by: (1) developing criteria for use in designing VISN resource allocation methodologies; (2) reviewing and improving the resulting methodologies, and (3) monitoring the impact of these methodologies on veterans’ equitable access to care.”

The Under Secretary for Health issued a VHA Directive in October 1997, establishing that the allocation of resources at all levels within VA should be guided by ten principles that move the organization toward accomplishing its systemwide goals and objectives. These principles must be upheld when networks allocate funds to facilities or programs. While VERA is an effective system for allocating resources at the network level, VERA is not as useful to the networks at the facility level. This is due to significant differences at the facility level that, in the aggregate, are not a factor when allocating at the network level. Among the factors that significantly affect facility-level health care environments are: the size, mission, and locality of local facilities; levels of affiliations with academic institutions; efficiency of operations; proportions of “shared patients;” and patient complexity and case mix. As a result, the following guiding principles were to be used by networks in providing FY 1998, FY 1999, FY 2000, FY 2001 and now FY 2002 allocations below the network level. Network allocation systems must:

- Be readily understandable and result in predictable allocations.
- Support high quality health care delivery in the most appropriate setting.
- Support integrated patient-centered operations.
- Provide incentives to ensure continued delivery of appropriate Complex Care.
- Support the goal of improving equitable access to care and ensure appropriate allocation of resources to facilities to meet that goal.
- Provide adequate support for the VA’s research and education missions.
- Be consistent with eligibility requirements and priorities.
- Be consistent with the network’s strategic plans and initiatives.
- Promote managerial flexibility, (e.g., minimize “earmarking” funds) and innovation.
- Encourage increases in alternative revenue collections.

These principles coupled with the VA Headquarters' review process will continue to guide network allocations.

In August 1998, the GAO issued a report, *VA Health Care: More Veterans Are Being Served, but Better Oversight Is Needed*. Concerned that some networks would be required to implement significant cost-saving steps to manage within the diminished resources they would receive under VERA and that these networks would reduce veterans' access to care as a result, the Congressional Committees on Appropriations directed GAO to analyze changes in access to care in two networks, Network 3 (Bronx) and Network 4 (Pittsburgh). When VERA was initially implemented in FY 1997, VA projected that Network 3 would lose the highest proportion of resources compared with other networks, and that Network 4 would lose some resources, but the change would be the lowest for any network. As directed, GAO reported on three issues: (1) changes in overall access to care, changes in access to certain specialized services, and a comparison of changes in these networks with VA national data from fiscal years 1995 to 1997; (2) the extent to which VA headquarters is working to allocate resources equitably to facilities within networks; and (3) the adequacy of VA's oversight of changes in access to care. Overall, GAO concluded that VA increased access to care for veterans in Networks 3 and 4 and VA nationally. VA increased access mainly by expanding outpatient services through conversion of inpatient resources for that purpose. This increased the efficiency of VA health care delivery and allowed Networks 3 and 4 to serve more veterans with fewer inflation adjusted dollars under VERA. In its August 1998 report, GAO made the following two recommendations:

GAO Recommendation 1:

"Develop uniform definitions and institute timely reporting of changes in access to care, including the number and eligibility priority of patients served, waiting times for care, and patient satisfaction for specific services at the network and facility level."

VA is working to improve its information systems so that they will be more useful to network and headquarters management. During the past few years, VA has held Data Summits and one of the items it has specifically addressed is the development of uniform definitions to the extent they are practical. Implementing enrollment beginning October 1, 1998 has allowed reporting service utilization by eligibility category, type of provider and geographic distribution among other demographic variables. There are numerous improvements in timely reporting in areas such as performance and quality that were implemented too late to be included in GAO's report. For example, accessibility to performance measure data, including Priority 1 – 7c and market penetration information, is now on a real time basis. Patient satisfaction surveys and the report to Congress, *Maintaining*

Capacity to Provide for the Specialized Treatment of Rehabilitative Needs of Disabled Veterans are completed annually. The national and network planning processes also include plans for ensuring equitable access to care. The FY 2002 VHA Performance Plan includes most of the special care outcome measures as well as reporting of the number and eligibility priority of patients served. These are being used to monitor achievements in patient satisfaction and access issues.

GAO Recommendation 2:

"Develop criteria for equitably allocating resources to facilities and monitor any improvements in equity of access among and within networks."

The VA philosophy concerning network allocations to facilities is to continue balancing oversight with flexibility. VA does not want to dictate how each network should fulfill its responsibilities. VA believes that this philosophy has been effective in network implementation. Nevertheless, in FY 1999, VA added a criterion in the network allocation principles directive concerning the equity of resource allocations to facilities, but the directive does not prescribe how this should be done. VA continues to allow networks the flexibility they need to meet local needs. The directive was distributed to networks in early FY 1999. Although the GAO report states that headquarters did not review the network allocations methodologies in the past, VA has in fact completed these reviews. VA will continue to review the network allocation plans and methodologies to assure equitable resource allocation within networks. Additionally, VA established a workgroup to evaluate the allocation principles and the networks' allocation processes. Its purpose was to determine if the principles were sufficient as well as to ensure that network allocations to facilities are fair and equitable. The results of this review enabled the sharing among networks of the best practices in network-to-facilities allocations methods. All of the network allocation methods have been described and submitted to Congress in accordance with the requirements of the House Appropriations Committee Report 106-286. VHA's guiding resource allocation principles have been used in providing FY 1998, FY 1999, FY 2000, FY 2001 and now FY 2002 allocations below the network level. These principles coupled with the VA Headquarters' review process will continue to guide future network allocations.

Private Sector Contractor Evaluations

PricewaterhouseCoopers LLP VERA Assessment

FY 1998 was the first full year for VERA-based allocations, and significant amounts of resources were shifted to networks that were previously under-funded. Therefore, to help ensure that VERA was, and is, a sound basis for allocating health care resources, VA retained a private contractor, PricewaterhouseCoopers

LLP, to evaluate whether VERA was sound and was meeting its stated objectives. The assessment evaluated VERA's effectiveness and made recommendations for refining VERA.

In general, the study answered three questions: (1) Are VERA's conceptual underpinnings sound? (2) Are VERA's methodological underpinnings and assumptions underlying the components sound? and, (3) After its first year, is VERA meeting its established objectives? PricewaterhouseCoopers LLP determined the following:

- VERA is ahead of other global budgeting systems across the world. It allocates resources on objective measures of need such as patient volume as compared to other global health care funding systems that are built on historical allocations with periodic adjustments for inflation or politics.
- VERA's conceptual underpinnings are sound. They include: a top-down budgeting system that insures solvency, a funding base that follows patients, the vast majority of funding flows through the model, and a funding flow to networks.
- VERA's methodological underpinnings are fundamentally sound. They are: a data driven, formula-based system that promotes credibility; a model structure that is relatively easy to understand; national prices that ensure standardization; and an allocation method that accounts for local cost variations.
- Overall, VERA is meeting its specified objectives. VERA equitably distributes funds across networks; focuses funding on highest priority veterans; addresses veteran special health care needs; complies with PL 104-204 requirements; has a framework that is predictable and easily understood; aligns management and incentives with best practice; accounts for uncontrollable cost differences across networks; improves accountability for research and education support; and conforms to principles of sound financial management.

PricewaterhouseCoopers LLP also provided seven recommendations to strengthen and refine VERA. The recommendations were classified as either immediate or long-term.

Immediate recommendations, that do not depend on how VERA changes, are: simplify data inputs; revise patient classifications; strengthen data accuracy and accountability; clarify and improve the allocation process timetable, and establish a forum to obtain suggestions.

Those recommendations that would be implemented depending on how VERA changes over time are: implement a strategic enrollment system; revise patient classes; and tie performance measures to the budget.

VA has made much progress on the implementation of the immediate recommendations as follows:

- Simplify data inputs
 1. Equipment – Future allocations will be based solely on patient workload. This change was implemented over a 2-year period beginning in FY 1999. The final phase was implemented with the FY 2000 allocation. This completed the phase-in of 100% of equipment allocations being based on patient workload.
 2. Non-recurring maintenance – Future allocations will be based on patient workload with an adjustment for differences in regional construction costs. This change was implemented over a 3-year period beginning in FY 1999. The third and final phase was implemented with the FY 2001 allocation.
 3. Labor adjustment – Future adjustments would use an index based on a single national market basket for labor. A workgroup evaluated this alternative to the current method. The establishment of a single national market basket for labor was approved and was implemented for the FY 2000 allocation.
- Revise patient classifications and budget split
 1. Patient classification – The patient classification system would be based on diagnosis and functional data. Classifying patients on the basis of diagnostic and functional data instead of utilization characteristics is an issue being evaluated for a potential change in FY 2003.
 2. Budget split – The split between Basic Care and Complex Care budgets would be revised to reflect the most recent costs of these two groups of patients. VA does not want to set a national policy that would divert, or appear to divert, resources from its Complex Care patients; therefore, this issue will be carefully reviewed before a change is made. This issue is being examined within the context of the review of the entire patient classification system. This change was considered for implementation in the FY 2002 allocation, but action was deferred pending further analysis.

- Strengthen data accuracy and accountability

1. In the fall of 1998, the Data Integrity Workgroup was formed and comprises representatives from field facilities, networks, and Headquarters including the Allocation Resource Center and Decision Support System staff. Each component of the VERA allocation process was reviewed for the FY 2002 allocation:

- Prorated Patients and Cost: This is derived from tracking costs for each patient in the system, and was validated by comparing the total social security numbers in the Allocation Resource Center (ARC) system to those in the VHA Data System in Austin, Texas. Matching allocated patient costs back to the Cost Distribution Report (CDR) validates costs. Each facility is asked to validate that its CDR report is reviewed for completeness and accuracy. Information is published, showing areas of cost reporting and workload that may be inaccurate, to assist facilities throughout the year. A sample also is taken of patient class assignments to ensure accuracy.

Beginning with the FY 2002 allocation process, the Decision Support System (DSS), was introduced into the process. After adjusting for the full cost factors in DSS that include national, network, and depreciation costs, specific patient cost is used to calculate the share of workload assignment in cases where a patient has been treated in more than one network.

- Research Support: Three resource category areas are identified for funding allocation: those funds administered by the VA; those not administered by the VA but peer reviewed; and those not administered by the VA and not peer reviewed. The Headquarters Research and Development Office records entries to these three areas, and the ARC calculates the allocation. All calculations were reviewed.
- Education Support: These dollars are distributed based on residency positions as designated by the Office of Academic Affiliations. This is one of the last pieces of the VERA methodology to be completed.
- Non-recurring Maintenance (NRM): In FY 2002, as in FY 2001, the entire NRM calculation is based on construction cost adjusted patient workload. Construction cost numbers by area of the country is derived from the nationally recognized Boeckh Index. These numbers are applied to each VA-owned medical center property. All calculations were verified as correct.

- Equipment: These dollars are distributed based on patient workload, and calculations have been verified.
- Geographic Price Adjustment (Labor Index): VA bases this adjustment on the variance in labor costs in different parts of the country. An index that compares network cost with national cost is created. The geographic price adjustment is computed using actual salary dollars expended in FY 2000, weighted workload, and the network labor index. All calculations have been thoroughly reviewed. Starting in FY 2001, VA approved a change in the geographic price adjustment calculation to reflect the resource intensity of caring for Complex Care patients. Complex Care patients are weighted to reflect the costs of caring for these patients. Weighting factors were derived from FY 2000 cost data.

The VERA 2002 model was modified to include a new adjustment that adjusts for funding inequities caused by local procurement practices for contracted goods and services including: labor; service agreements; and locally purchased energy-related products, utilities, and provisions. In brief, these Network-level purchases are subject to regional price variations resulting from local cost of living factors.

The VERA model now contains a new adjustment that compensates high-cost Networks for these expenditures. The adjustment is computed using the model's labor adjustment methodology, which is calculated and validated each year. The primary adjustment factor is the VHA labor index, which is derived from VHA staff salaries. The VHA labor index adjusts allocations associated with regional variations in costs.

2. Standardize procedure for field review of data outputs – The data integrity workgroup also implemented a procedure for field review of data output. This process was used in FY 1999, FY 2000, FY 2001, and again in FY 2002, and will continue in the future.
- Clarify and improve process
 1. Improve allocation process timetable – VA has increased efforts to speed the data closeout and input data to the allocation system. This improved the FY 1999, FY 2000, and FY 2001 allocation timetables by nearly two months, thereby giving the field more time to plan their budgets as well as to review the data on which they were based. Preliminary FY 2002 planning allocations based on the President's budget were issued to the networks in January 2001, less than four months after the end of FY 2000. This timeframe is also cyclical for FY 2002 and beyond.

2. Use a suggestion box – A suggestion box has been established and is accessible through the Allocation Resource Center website.

VA also has begun to implement the long-term recommendations of PricewaterhouseCoopers LLP in anticipation that some future changes will be made to VERA. The status of these recommendations is listed as follows.

- Implement a strategic enrollment system
 1. Develop a strategy-based enrollment system – VA implemented an enrollment system in FY 1999, as required by law. VERA allocations based on enrollment may not be the most equitable distribution of resources because all of those enrolled may not use VA services. As the enrollment data system continues to mature and become fully populated, a VERA workgroup will evaluate the relationship between VERA and enrollment for potential consideration in future allocations beyond FY 2002.
 2. Implement a transfer pricing system – A recommendation for implementing a transfer pricing system in FY 1999, but not actually transferring funds, was approved by the Under Secretary for Health. The Care Across Network workgroup was charged with planning the implementation of transfer pricing. VA tested the proposed transfer pricing system in FY 2000 to help determine the benefits of implementing a transfer pricing program. A recommendation by the Care Across Networks Workgroup not to proceed with transfer pricing in FY 2001 was approved by VA in March 2000. Key issues that were responsible for not implementing transfer pricing included: impact on improving coordination of care; whether level of effort is worth the benefit; and technical and software challenges to implement. VA will continue to use the existing pro rated person (PRP) concept to ensure that the care across networks is compensated. The workgroup recommended that the default pricing system should be completed and made available to networks that are trying to understand care patterns as well as other issues.
- Revise patient classes
 1. For the FY 1999 allocation an additional patient class was created within the basic care group that included the lowest cost patients. This issue was refined for the FY 2000 allocation. VA's goal was to determine what constitutes a fully vested patient, even with one visit, and fund those patients at the Basic Vested Care price. As a result, VHA decided that Basic Care patients will now consist of two groups, fully vested and non-vested patients. In addition, VHA approved nine other refinements to the

VERA patient classifications that were implemented in FY 2000, two that were implemented in FY 2001, and three refinements for the FY 2002 allocation process.

2. A workgroup will determine if additional patient class changes are needed for future years.
- Tie performance measures to budget
 1. Use rewards based on performance using reasonable and effective incentives – A review of both VERA and the performance measures systems will be necessary to ensure that they are mature and stable enough to support a direct link to budget allocations. Significant policy questions would have to be resolved as VERA’s intent is to fund veterans’ health care needs, not the performance of management and staff within each network.

AMA Systems, Inc. – Evaluation of Patient Health Status by VISN

VERA adjusts for the differences across networks for high cost patients and patients in need of specialized services by providing a higher price for Complex Care patients as compared to the prices for Basic Vested Care and Basic Non-Vested Care patients. Nevertheless, feedback from internal and external stakeholders indicates that they believe VERA may not adequately distinguish the differences across networks for variances in patient health status.

VHA retained AMA Systems, Inc. and its subcontractor, The Center for Naval Analyses Corporation (CNAC) to conduct a study entitled “Evaluation of Patient Health Status by VISN.” The scope of the analysis was later expanded to include research into costs associated with providing VHA health care in rural areas to satisfy Section 108 of Public Law 106-74, the “Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 2000.” The report, “Evaluation of Rural Healthcare in the 22 Veterans Integrated Service Networks” was provided to Congress on April 25, 2000.

The following tasks were included in the contractor’s scope of work:

- Determine whether the health status of VHA patients varies across the 22 Veterans Integrated Service Networks (VISNs) and whether such differences have an adverse impact on distribution of funds as provided for by the VERA system.
- If the proportion of high-cost patients varies across the VISNs, determine whether the variance is the result of inefficiencies in resource management or differences in patient health status.

- Determine whether practice patterns and infrastructure (e.g., physical plant) affect healthcare costs.
- If cost variances exist because of differences in patient health status and other factors, identify the relative contribution to cost variances of patient health status and these other factors.

The contractor reviewed VERA, analyzed more than ten million individual patient records for the period FY 1997 through FY 1999, and conducted site visits at medical centers and VISN offices. On the basis of this data collection and preliminary analysis, it developed a quantitative model to assess the cost contribution of various factors (e.g., case mix, age, practice patterns). In addition, the contractor examined the issue of whether developing additional price categories for the Complex and Basic patient groups would provide a “better fit” in terms of matching patient group prices with actual VHA cost profiles.

The report concluded the following with regard to patient health status:

- Systematic influences affect the deviation of VISN-level average costs from the overall national average; these costs are not completely captured by VERA formulation.
- Five separate and statistically significant patient characteristics influence the deviation in average cost for each VISN compared to the national average: age, case mix index, proportion of patients in the Community Nursing Home category, proportion of patients in the fee for service category, and the proportion of patients that are female.
- Age of patients is considered in the current rates in VERA, but in a linear fashion. The impact of age is non-linear, and becomes increasingly important at the upper end of the age distribution (i.e., above age 75).
- Two infrastructure characteristics influence the deviation in average cost: total VA beds and the ratio of direct VA staff to indirect VA staff.
- The contractor’s model explains 70 percent of the deviation in cost. Other influences on the deviation may exist.
- There was no statistically significant difference due to practice patterns.
- At the VISN level, the additions to and subtractions from average cost may cancel each other. As a result, without additional study, it is impossible to identify specific modifications that would be appropriate to make to the current VERA formulation. However, the contractor’s model can be used to evaluate the relative predicted funding across VISNs, and to verify if VERA gives results similar to the predictions. Such comparisons must be done with care, as VERA funding does not map perfectly to patient-level costs used to build the model.

- Expanding the number of VERA patient groups and reimbursing at the national price levels does not yield sufficient additional precision to merit serious consideration by VHA.

AMA Systems, Inc. submitted a final report to VA on July 25, 2000. This study was widely shared by VA both internally and externally and included, Network Directors, VHA Headquarters Chief Officers, VERA Workgroups and Congress for information purposes. The VERA Workgroups were asked to review it to determine if adjustments to the VERA model were needed to ensure resources continue to be equitably allocated throughout the country.

The reports', "Evaluation of Patient Health Status by VISN" and "Evaluation of Rural Health Care in the 22 Veterans Integrated Service Networks", four recommendations for further study include:

- A study to determine the precise way to implement funding modifications because it is not immediately clear how the contractor's model information can or should translate into VERA modifications.
- A comparison of predicted costs for each VISN to actual funding allocations that can identify VISNs with funding misallocations.
- A study to determine if rural patients receive the same level of care and if their outcomes are similar to what is observed for urban patients.
- The report suggested that more knowledge about veterans who are enrolled and those eligible to use the system but not enrolled is needed. In addition, it suggested a survey to assess veterans' income, availability and preferences for health care, and access to alternate insurance coverage.

The VHA Office of Finance asked VHA's Offices of Quality and Performance as well as Policy and Planning to review the latter two of the reports' four recommendations above to determine follow-up action:

The Office of Policy and Planning responded that the survey proposed in the last recommendation above would be duplicative of four surveys listed below that provide that information, and therefore is unnecessary:

1. The 1999 Survey of Veterans Enrollees' Health and Reliance Upon VA
2. The 2000 Survey of Veterans Enrollees' Health and Reliance Upon VA
3. The pending National Survey of Veterans
4. The 1999 Health Survey of Enrollees (Veterans SF-36 and Health Behaviors)

AMA Systems, Inc. – Evaluation of Rural Health Care in the 22 Veterans Integrated Service Networks

As a result of increasing concerns from a number of stakeholders, VA amended its evaluation of patient health status contract study to include an analysis of the efficiency of resource allocation to rural areas within the VERA process. The contractor reviewed the differences in costs for care across the VHA's 22 networks due to provision of care in rural settings. The contractor visited seven sites identified as rural areas throughout the country to attain the findings. The sites visited were: Northampton, Massachusetts; Togus, Maine; Grand Island, Lincoln and Omaha, Nebraska; Fort Harrison, Montana; and Vancouver, Washington. The project time constraints limited the contractor's ability to visit all networks. The contractor used an Office of Management and Budget approved rural-urban index. The report concluded the following with regard to rural health care:

- Rural veteran patient distribution by VISN varies across the country.
- Statistically significant factors that influenced the report's regression model were patient characteristics and infrastructure.
- It was not possible to detect the independent impact of the variables for rural health care and practice patterns due to the limited amount of historical data for analysis.
- None of the sites maintained systematic records of distance that veterans travel to receive health care.
- None of the sites maintained systematic records of waiting times for appointments. It should be noted that VA recently implemented a new methodology to measure waiting times as part of the service and access initiative. GAO indicated they are satisfied with the new methodology.
- The rural variable decomposed into two variables, rural and very rural. Six networks were deemed rural (6, 7, 9, 16, 18, and 19) and three networks were deemed very rural (13, 14, and 15).
- Providing care in rural areas is less costly than providing care in urban areas.
- Providing care in very rural areas is more costly than providing care in urban areas.

The information provided during site interviews was anecdotal and based on staff perceptions and hands-on experiences. Only selected sites were visited, thus the findings are more illustrative than definitive of issues that may impact VA health care. These issues included:

- Staffs indicated some population segments utilize more resources than others, but there was no consistent pattern from site to site.

- Private practice patterns impact how VA provides services. Staff at rural sites noted concerns about the difficulty in establishing community based outpatient clinics (CBOCs) due to inability to hire or convince staff to move; lack of private providers in Western rural areas; and some private providers' refusal to compete to operate CBOCs.
- Staff stated transportation costs are higher in rural areas than urban.
- In reviewed sites, the report noted the extreme distance and amount of time it could take a veteran to travel to a major VISN facility if they lived at the far edge of the region. It also noted no systematic records of patient travel time or distances. However, it contains VA's analysis of average and maximum straight-line distances between zip codes.
- An indication that rural areas rely more on fee-for-service arrangements for patients who do not live within reasonable proximity of VA facility.

AMA Systems, Inc. submitted a rural report to VA on March 1, 2000. VA provided this study to Congress per legislative requirements and shared it with Headquarters Chief Officers, Network Directors, and the VERA Workgroups. Workgroups were asked to review it to determine if adjustments to the VERA model are needed to ensure that resources continue to be equitably allocated to rural and urban areas throughout the country. VHA anticipates, through the Network to Facilities allocation processes, that those networks having the highest number of rural patients will receive their fair share of resources.

RAND Corporation Study

Congress directed by language in the Senate Appropriations Report (September 13, 2000) and the enactment of H.R. 4635 (October 18, 2000) that VHA enter into a contract with a federally-funded research and development center to conduct an analysis of VERA. This was to be done no later than 60 days from the enactment of H.R. 4635. VHA contracted with the RAND Corporation to conduct this study. The following three tasks were included in the legislative language and subsequent scope of work developed by VHA:

- An assessment of the impact of the allocation of funds under the VERA methodology on VISNs and sub-regions with older-than-average medical facilities; those with older or more disabled enrolled veterans; those undergoing major consolidation; and those in both rural and urban sub-regions with appointment backlogs and waiting periods.
- An assessment of issues associated with the maintenance of direct affiliations between the VA medical centers and university teaching and research hospitals.

- An assessment of whether the VERA methodology accounts for differences in weather conditions when calculating costs of construction and maintenance of health care facilities, and whether VISNs that experience harsh weather require more resources.

In light of the study's short timeframe, the RAND Corporation used qualitative research techniques to address these three issues. The data for the report were gathered from three sources: government documents, including reports on earlier evaluations of VERA as well as various editions of the annual VERA Book; extensive searches of health services research literature from the past 15 to 20 years; and finally, RAND relied heavily on a series of case studies conducted at a sample of VISNs and facilities. In addition, to address the issues related to affiliations between VA medical centers and academic medical centers, RAND conducted a series of interviews with representatives of organizations and institutions that have a stake in academic medicine. A brief summary of the contractor's findings and conclusions listed below address the task requirements.

Overall, the study (September 18, 2001) concluded the following:

- VERA is only one piece of the veterans' health care puzzle, albeit an important one. In evaluating the impact of VERA, it was noted that a broad range of factors influence the cost and manner in which health care is provided to the veteran population. Other critical factors include, but are not limited to, financial considerations, such as the size of the annual VA Medical Care appropriation and the ways in which VISN directors allocate resources to individual facilities; the demographic characteristics and health care needs of the veteran population; VA's mission of providing health care of the highest possible quality; the availability of non-VA sources of care; and a myriad of local, state, and Federal political demands that often create significant barriers to cost efficiency and occasionally mandate services that are in excess of what is needed.
- VERA has been largely successful in meeting its objectives of reallocating resources to better match the geographic distribution of the veteran population. The overwhelming majority of interviewees indicated that VERA was preferable to previous resource allocation systems in terms of its incentive structure, degree of fairness, and simplicity.
- It was recognized that VERA is continuously being refined. This study represents one in a series of about a half dozen that have been performed by external organizations since VERA was introduced in 1997. In addition, nine internal workgroups, composed of representatives from the 22 VISNs are constantly monitoring aspects of the VERA methodology and recommending refinements they deem appropriate. It was noted that VHA has implemented

many of the recommendations in both the external evaluators' reports as well as the workgroups' executive decision memoranda.

With regard to the three critical issues identified by the Congress, the study concluded the following:

- Evidence suggests that health care delivery costs may be affected by the age and physical condition of a VISN's capital infrastructure, and VERA does not account for these factors in VISN allocations. A quantitative analysis of this issue to determine the impact at the VISN level is recommended.
- VA is currently evaluating the use of a DCG (Diagnostic Cost Groups) – based case mix methodology in the future. Refining the current case mix adjustment in this manner would represent a significant improvement to VERA.
- Political pressure from key stakeholders presents a formidable barrier to efforts to consolidate facilities and services.
- To the extent that the size of the teaching program or level of teaching intensity might affect per resident education support costs raises a potential issue for further analysis.
- VERA equipment allocations to VISNs are based on patient workload without case mix adjustments. Facilities with major affiliations generally benefit as referral centers in these equipment allocations from the VISNs. The costs of both purchasing and operating needed equipment should be considered in an overall evaluation of the effects of academic affiliations.
- The effect of teaching and research on patient care costs and facility financial performance are closely related to issues involving case mix measurement and raise the following questions:
 - Are there systematic differences in case mix between teaching-intensive facilities and other facilities that are not currently recognized in VERA?
 - Are there systematic differences in costs between teaching intensive facilities and other facilities that are not accounted for by case mix?
 - To what extent are the effects of academic affiliations offset by other factors that are not accounted for under VERA?
- From the review of the literature and the case studies, there is no clear reason for adjusting VISN allocations under VERA for weather-related cost differences. Rather it was stated that VA should investigate the extent to which prices of all non-labor inputs vary geographically to determine if appropriate allocation adjustments should be made if the amount of variation is significant.

- Any case mix adjustment linked to weather should be accounted for through a comprehensive case mix adjustment, in lieu of one that is simply targeted to weather-related conditions and procedures.
- It was noted that any potential adjustment should not be considered in isolation, rather, adjustments should be examined as part of a broader context of a comprehensive health care delivery cost model.

The study provided the following other conclusions:

- There is a lack of geographic adjustment to the means test used to determine a veteran's financial status concerning eligibility for services. Because the means test threshold is the same for all regions of the country, the study found that there are inequities in access to covered services for veterans in high cost of living areas. VHA is well aware of this inequity. However, a change in the eligibility measures is not within its purview and would require Congressional action.
- The workload forecasting process can be improved by using a more sophisticated approach to obtain workload estimates. For instance, a model that incorporates demographic characteristics and historical use patterns would provide a set of allocations that matches the needs of the VISNs more closely.
- Another area that needs additional data collection concerns contract services. VISN and facility directors frequently reported difficulty in managing the cost of these services, particularly in rural areas where the choice of providers is relatively limited. The contractors recognized that the cost data on contract services are typically presented as an aggregate number in facility cost reports making it difficult to analyze the impact of various kinds of contract services on total facility costs or cost per case.

VHA shared this study widely both internally and externally. Included were Network Directors, VHA Central Office Chief Officers, VERA Workgroups, and on September 18, 2001, the Senate and House Appropriations Committees.

The various VERA workgroups will review this report in their continuing assessment of VERA for possible future refinements in the areas related to case mix, geographic differences in the prices paid for non-labor inputs (including energy prices and contract labor costs), teaching and research hospital affiliations, and the condition of facilities' physical plants. In fact, with regard to case mix and geographic adjustments, VERA workgroups are making good progress in completing ongoing developmental work. The Patient Classification Workgroup is expected to complete its work on the use of a DCG system for potential application in the FY 2003 VERA methodology. The Geographic Price Adjustment Workgroup recommended geographic adjustments for contract labor

and non-labor goods and services and they have been incorporated in the FY 2002 allocation.

Section IV

The Future of VERA

Based on the GAO and PricewaterhouseCoopers LLP evaluations, as well as VA's own internal assessments of VERA, there are three areas that are currently under review for potential changes to VERA in FY 2003 and beyond.

Patient Classification

During FY 2002, the VERA Patient Classification Workgroup will complete a review of the feasibility of classifying patients on the basis of diagnostic and functional data instead of utilization characteristics. The use of Diagnostic Cost Groups (DCGs) and risk adjusters are being studied by the Houston Health Services Research and Development Office and the VHA Management Science Group in Bedford, Massachusetts for the workgroup. The Centers for Medicare and Medicaid Services uses a modified version of DCGs in a portion of the Medicare+Choice program. The Medicare+Choice program is used by a very small percentage of Medicare beneficiaries who must enroll to participate in this HMO-like program. The DCG system under review uses diagnostic information (ICD-9 codes) to group patients into similar cost categories. The workgroup is developing modifications to the current DCG system using actual VA cost data. If the review demonstrates identifiable benefits, a DCG or modified DCG system could replace VHA's classification process in the FY 2003 allocation process.

Specific Purpose Funding

As part of an annual review to ensure that Specific Purpose accounts meet established criteria for centralized management, the VERA Specific Purpose Workgroup is reviewing all Specific Purpose accounts and will make recommendations for FY 2003 before the end of FY 2002.

GAO Study

During FY 2001, Congress asked the GAO to conduct a follow-up VERA evaluation to address the following questions:

- Has the implementation of the VERA methodology resulted in a more equitable allocation of VA health care resources?
- What specific problems are networks and medical facilities experiencing with the VERA methodology?

The GAO evaluation of the VERA methodology was completed in early FY 2002. VA received GAO's Draft Report, *VA HEALTH CARE: Allocation Changes Would Better Align Resources with Workload*, Report No. GAO-02-338 on January 23, 2002. A discussion of the report's findings, conclusions, recommendations and VA's action plan on the recommendations will be provided in the next edition of the VERA book.

Sliding Scale Means Test

The Under Secretary for Health requested that the VHA Headquarters Health Administration Service examine the option of establishing a sliding scale means test based on a geographic cost of living scale. In response to this request, the Director, Health Administration Service, convened a small workgroup to determine the VHA's legal authority to implement a Sliding Scale Means Test without new legislation. The workgroup concluded that VA's Means Test authority would need to be amended before VA could implement a Sliding Scale Means Test.

Geographic Price Adjustment

The Geographic Price Adjustment Workgroup continues to review indexing methodologies to ensure that VHA is using the most accurate and reliable processes and data in the VERA geographic price adjustment methodology. This ongoing process includes continuous monitoring of VHA data and external (non-VA) practices for geographically adjusting costs.

RAND Corporation Study

The Senate Appropriations Committee, in its report (July 20, 2001) for FY 2002, stated that it was pleased with the results of the VERA study done by the RAND Corporation, which indicated that a detailed analysis outlined in the study might yield greater specificity and fairness in distributing medical care resources. The language in the Committee's report directed VHA to continue the federally-funded research and development center study through FY 2002, with interim reports to be provided in February and June and a complete study by the end of FY 2002. VHA has contracted with the RAND Corporation to do the second phase of this study.

APPENDICES

Appendix 1: Key formulas and data in the FY 2002 VERA

Appendix 2: The Veterans Integrated Service Networks

Appendix 3: History: Previous Allocation Models and Funding Inequities

Appendix 1

Key Formulas and Data in the FY 2002 VERA

Key formulas and data in the FY 2002 VERA

Allocation factors	Total dollars allocated	Mechanism to determine total dollars	Definitions of workload (unit of measure)	National total workload (unit of measure)	National Price/allocation rate
Basic Vested Care	\$10,148,273,755	61.25% of Basic Care (Vested and Non-Vested) and Complex Care dollars; Percentage updated based on FY 2000 cost experience	Number of Basic Care patients in the 3 year Cat A/X user file. Three year file includes FYs 1998, 1999, and 2000 patients who rely on VA for their care. These patients have used inpatient services or have had an appropriate detailed medical evaluation during the past three years. Includes compensation and pension exam visits. Workload units based on historical utilization are adjusted to reflect care across networks.	3,251,103	\$3,121 per basic workload unit
Basic Non-Vested Care	\$78,156,587	0.32% of Basic Care (Vested and Non-Vested) and Complex Care dollars; Percentage updated based on FY 2000 cost experience	Number of Basic Care patients in the 3 year Cat A/X user file who use some VA health care services but are less reliant on the VA system. Excludes compensation and pension exam patients. Excludes all collateral visits. Workload units based on historical utilization are adjusted to reflect care across networks.	396,188	\$197 per non-vested patient
Complex Care	\$6,381,534,658	38.42 % of Basic Care, (Vested and Non-Vested), and Complex Care dollars (same % as previous years)	Number of Complex Care patients forecasted to use the VISN in FY 2002. This one year forecasted number is based on historical utilization over five years (FYs 1996-2000). Workload units based on historical utilization are adjusted to reflect care across networks. The forecast continues to include a factor for age, but no longer for veteran population trends.	153,155	\$41,667 per complex workload unit
Geographic Price Adjustment	\$0	The Geographic Price Adjustment (labor index), is applied against \$12.9 billion labor dollars expended in FY 2000.	The FY 2002 VERA labor index is computed using 4 pay periods of FY 2000 normal pay data only and a national market basket methodology. For FY 2002, the labor index is unchanged. Revised: Adjustment created to account for local cost of living factors associated with procuring contracted labor and non-labor contracted goods such as energy-related products, utilities and provisions.		
Research support	\$386,938,000	Total of research support \$s in the FY 2002 President's budget	Dollars of FY 2000 funded research (intra- and extra-mural research). Applies weights: 100% for VA administered research; 75% for peer reviewed research which is not VA administered; 25% for non-peer reviewed research which is not VA administered.	\$784,993,066 unweighted; \$666,898,966 weighted	\$0.58 per dollar of reported funded research
Education support	\$362,202,000	Total of education support \$s in the FY 2002 President's budget	Number of residents for Academic Year 2001/2002.	8,669	\$41,781 per resident
Subtotal	\$17,357,105,000				

Key formulas and data in the FY 2002 VERA

Allocation factors	Total dollars allocated	Mechanism to determine total dollars	Definitions of workload (Unit of measure)	National total workload (unit of measure)	National Price/allocation rate
Equipment - capitation	\$426,241,000	Total of equipment \$s in the FY 2002 Medical Care budget	The Equipment allocation is based totally on workload (Sum of Basic Vested, Basic Non-Vested and Complex Care workload).	3,800,446 PRPs (Prorated Patients). (Basic Vested, Basic Non-Vested plus Complex Care PRPs)	\$112
NRM -Boeckh Index times total workload NEW MODEL	\$258,307,000	Derived from non-recurring maintance \$s in the FY 2002 Medical Care budget	The NRM allocation is based on workload adjusted by the Boeckh Index (Workload (PRPs) times Boeckh Index). This Boeckh Index is an external inflation index that measures the relative cost of building and/or renovating space.	70,564 units - sum of (Network PRPs times Network Boeckh Index)	\$3,661
Total Capital Accounts	\$684,548,000	Derived from FY 2001 Medical Care budget			
VERA Adjustments	\$267,349,000	Comparison of projected expenditures to projected revenues including VERA allocations	5 networks received Adjustments: 1 (\$41.3M); 3 (\$128.5M); 12 (\$20.8M); 13 (\$43.9M); 14 (\$32.9M).		
Total \$ General Purpose	\$18,309,002,000	Derived from FY 2002 Medical Care budget less Specific Purpose funding plus VERA Adjustments			

Basic Vested Care: Back-up data

Network	FY 1997 VERA Basic workload units (FYs 1993-1995)	FY 1998 VERA Basic workload units (FYs 1994-1996)	FY 1999 VERA Basic Vested workload units (FYs 1995-1997)	FY 2000 VERA Basic Vested workload units (FYs 1996-1998)	FY 2001 VERA Basic Vested workload units (FYs 1997-1999)	FY 2002 VERA Basic Vested workload units (FYs 1998-2000) (V _{bv})	National price for Basic Vested Care (N _{bv})	Budget for Basic Vested Care (B _{bv}) (\$000s)
1 Boston	154,885	155,917	142,585	137,722	150,148	150,422	\$3,121	\$469,540
2 Albany	80,230	80,577	75,521	76,965	85,730	89,109	\$3,121	\$278,153
3 Bronx	149,736	147,502	131,910	132,174	142,060	139,182	\$3,121	\$434,455
4 Pittsburgh	144,747	150,922	143,454	146,099	167,941	174,025	\$3,121	\$543,218
5 Baltimore	94,150	94,327	84,477	76,489	85,388	85,970	\$3,121	\$268,355
6 Durham	164,500	165,619	151,097	141,509	154,690	158,110	\$3,121	\$493,537
7 Atlanta	191,987	193,256	176,353	168,441	190,067	193,670	\$3,121	\$604,537
8 Bay Pines	252,403	254,034	237,300	239,267	262,562	280,937	\$3,121	\$876,940
9 Nashville	155,876	156,168	143,393	143,140	156,552	164,015	\$3,121	\$511,969
10 Cincinnati	115,276	114,258	102,431	99,792	109,368	113,122	\$3,121	\$353,108
11 Ann Arbor	138,945	140,674	129,736	122,913	134,910	136,167	\$3,121	\$425,044
12 Chicago	148,300	145,862	130,402	122,919	132,847	131,391	\$3,121	\$410,134
13 Minneapolis	88,440	88,864	80,691	70,146	75,699	77,065	\$3,121	\$240,559
14 Lincoln	62,098	62,043	58,075	52,459	55,996	60,348	\$3,121	\$188,375
15 Kansas City	137,310	136,079	125,426	120,986	131,477	134,637	\$3,121	\$420,269
16 Jackson	304,362	301,751	276,043	265,405	288,951	296,532	\$3,121	\$925,620
17 Dallas	148,494	147,530	132,846	132,427	146,761	154,180	\$3,121	\$481,272
18 Phoenix	141,059	143,950	135,050	136,892	147,353	149,301	\$3,121	\$466,040
19 Denver	92,703	92,843	83,786	80,912	91,237	92,954	\$3,121	\$290,154
20 Portland	144,635	145,403	133,988	128,976	141,339	145,592	\$3,121	\$454,463
21 San Francisco	137,994	140,718	128,123	124,320	138,310	143,053	\$3,121	\$446,538
22 Long Beach	189,728	193,137	173,939	162,097	181,266	181,322	\$3,121	\$565,995
VHA total	3,237,858	3,251,434	2,976,624	2,882,051	3,170,651	3,251,103	\$3,121	\$10,148,274

Notes: 1. All workload units are adjusted for care across networks.

2. A policy decision was made to fund Basic Vested patients separately from single outpatient visits, effective for the FY 1999 VERA allocations. Effective for the FY 2000 VERA allocations, a policy decision was made to fund Basic Non-Vested patients separately from Basic Vested patients. Basic Vested patients rely on VA for their care and have used inpatient services or have had an appropriate detailed medical evaluation during the past three years.

3. FY 1997 and FY 1998 VERA Basic Workload includes the Single Outpatient Visits and Non-Vested Workload, since those funding groups were created subsequent to the FY 1998 VERA allocation.

4. Numbers may not add due to rounding.

Formula for Basic Vested Care allocation: $V_{bv} * N_{bv} = B_{bv}$

V_{bv} = Volume Basic Vested Care patients = 3 years Compensation and Pension exams, Category A (SC, low income NSC), Fee patients, and Category X (Agent Orange, radiation, etc...) users of Basic Care. Excludes all Basic Non-Vested Care patients.

N_{bv} = National price for Basic Vested Care

B_{bv} = Budget for Basic Vested Care

Basic Non-Vested Care: Back-up data

Network	FY 1999 VERA Basic Single Outpatient Visit Workload (FYs 1995-1997)	FY 2000 VERA Basic Non-Vested Workload (FYs 1996-1998)	FY 2001 VERA Basic Non-Vested Workload (FYs 1997-1999)	FY 2002 VERA Basic Non-Vested Workload (FYs 1998-2000) (V _{nv})	National price for Basic Non-Vested Care (N _{nv})	Budget for Basic Non-Vested Care (B _{nv}) (\$000s)
1 Boston	17,142	26,518	14,966	12,315	\$197	\$2,429
2 Albany	8,331	14,786	11,213	9,874	\$197	\$1,948
3 Bronx	17,119	30,683	23,233	21,404	\$197	\$4,222
4 Pittsburgh	27,764	46,484	37,472	31,958	\$197	\$6,304
5 Baltimore	10,567	19,989	11,738	10,724	\$197	\$2,116
6 Durham	18,485	35,651	23,577	19,488	\$197	\$3,844
7 Atlanta	19,745	34,933	19,727	20,028	\$197	\$3,951
8 Bay Pines	27,397	40,224	25,402	25,192	\$197	\$4,970
9 Nashville	18,591	29,566	20,686	16,941	\$197	\$3,342
10 Cincinnati	19,819	35,343	29,977	22,877	\$197	\$4,513
11 Ann Arbor	12,993	26,265	16,135	15,657	\$197	\$3,089
12 Chicago	15,417	32,562	23,351	21,904	\$197	\$4,321
13 Minneapolis	7,053	19,584	15,122	15,249	\$197	\$3,008
14 Lincoln	4,234	11,586	9,775	7,069	\$197	\$1,395
15 Kansas City	11,528	21,008	14,293	13,062	\$197	\$2,577
16 Jackson	28,505	53,848	35,383	33,264	\$197	\$6,562
17 Dallas	15,463	24,900	18,602	18,161	\$197	\$3,583
18 Phoenix	13,575	20,191	12,849	12,377	\$197	\$2,442
19 Denver	9,371	16,327	9,283	8,350	\$197	\$1,647
20 Portland	13,880	26,213	17,547	17,124	\$197	\$3,378
21 San Francisco	14,560	28,049	18,914	17,966	\$197	\$3,544
22 Long Beach	22,324	41,985	27,019	25,205	\$197	\$4,972
VHA total	353,861	636,696	436,265	396,188	\$197	\$78,157

- Notes: 1. All workload units are adjusted for care across networks.
 2. A policy decision was made to fund Basic Single Outpatient visits separately from Basic Vested patients, effective for the FY 1999 VERA allocations. For the FY 2000 VERA allocations, the policy decision was to fund Basic Non-Vested patients separately from Basic Vested patients, and define the Non-Vested as patients who use some VA health care services, but are less reliant on the VA system.
 3. Numbers may not add due to rounding.

<p>Formula for Basic Non-Vested allocation: $B_{nv} = V_{nv} * N_{nv}$</p> <p>V_{nv} = Volume Basic Care patients who use some VA health care services but are less reliant on the VA system during the VERA Basic Care time period. Includes Category A, Fee patients, Category X patients and excludes any C & P visits.</p> <p>N_{nv} = National price for Basic Non-Vested Care</p> <p>B_{nv} = Budget for Basic Non-Vested Care</p>

Complex Care: Back-up data

Network	VERA FY 1997	VERA FY 1998	VERA FY 1999	VERA FY 2000	VERA FY 2001	Historical FY 1996	Historical FY 1997	Historical FY 1998	Historical FY 1999	Historical FY 2000	VERA FY 2002	National price for Complex Care (N _c)	Budget for Complex Care (B _c) (\$000s)
	Special Care workload units	Special Care workload units	Complex Care workload units	Complex Care workload units	Complex Care workload units						Complex Care workload units (V _c)		
1 Boston	7,951	7,616	7,022	6,410	6,209	8,372	8,117	7,894	7,476	7,463	7,002	\$41,667	\$291,766
2 Albany	4,750	4,433	4,396	4,268	4,606	5,116	4,946	4,837	4,821	4,799	4,607	\$41,667	\$191,969
3 Bronx	10,253	10,309	9,944	8,656	8,220	10,619	10,374	10,053	9,628	9,159	8,210	\$41,667	\$342,103
4 Pittsburgh	9,308	8,847	8,416	7,645	8,069	9,055	8,822	8,749	8,677	8,204	7,682	\$41,667	\$320,068
5 Baltimore	4,090	4,302	4,667	5,040	5,502	4,694	4,909	5,189	5,377	5,347	5,675	\$41,667	\$236,472
6 Durham	6,912	6,270	6,451	6,706	7,244	7,378	7,564	7,623	7,556	7,558	7,688	\$41,667	\$320,344
7 Atlanta	8,881	8,922	8,698	8,085	8,290	9,651	9,582	9,455	9,303	9,397	9,252	\$41,667	\$385,515
8 Bay Pines	10,158	10,210	10,718	10,979	11,278	10,651	11,106	11,586	11,689	11,909	12,598	\$41,667	\$524,915
9 Nashville	6,725	6,561	6,384	6,029	6,050	7,366	7,158	6,939	6,983	6,690	6,462	\$41,667	\$269,253
10 Cincinnati	5,284	5,229	5,635	5,775	6,061	5,896	6,451	6,096	6,242	6,450	6,618	\$41,667	\$275,743
11 Ann Arbor	6,243	5,792	6,082	5,601	6,313	6,487	6,582	6,454	6,610	6,449	6,315	\$41,667	\$263,137
12 Chicago	8,407	8,177	8,315	7,931	8,578	8,892	8,890	8,689	8,739	8,700	8,418	\$41,667	\$350,767
13 Minneapolis	4,276	3,908	4,254	4,024	4,120	4,381	4,393	4,255	4,240	4,644	4,427	\$41,667	\$184,449
14 Lincoln	2,455	2,382	2,471	2,368	2,241	2,749	2,669	2,559	2,418	2,423	2,321	\$41,667	\$96,703
15 Kansas City	6,550	6,018	5,554	4,967	5,246	6,464	6,279	5,974	6,043	6,148	5,893	\$41,667	\$245,525
16 Jackson	9,298	9,540	9,992	10,307	10,280	10,715	11,068	11,362	11,210	10,831	10,806	\$41,667	\$450,250
17 Dallas	6,679	6,472	6,520	6,591	6,882	6,988	7,221	7,263	7,312	7,241	7,450	\$41,667	\$310,410
18 Phoenix	4,715	4,704	4,881	4,938	5,147	5,000	5,085	5,109	5,255	5,231	5,240	\$41,667	\$218,326
19 Denver	3,241	3,111	2,976	3,049	3,207	3,544	3,518	3,512	3,550	3,494	3,602	\$41,667	\$150,088
20 Portland	6,463	6,242	6,482	6,553	6,750	6,695	6,955	7,182	7,019	6,979	7,112	\$41,667	\$296,334
21 San Francisco	6,732	6,423	6,467	6,611	7,316	6,266	6,651	7,082	7,336	7,166	7,627	\$41,667	\$317,803
22 Long Beach	7,517	7,500	7,667	7,075	7,775	7,983	7,984	7,821	8,196	8,078	8,150	\$41,667	\$339,595
VHA total	146,888	142,969	143,991	139,607	145,385	154,961	156,322	155,681	155,680	154,361	153,155	\$41,667	\$6,381,535

- Notes: 1. All the workload units are adjusted for care across networks.
2. A policy decision was made to change the name of this patient care group from "Special Care" to "Complex Care" effective for the FY 1999 VERA allocations. Additionally, effective for the FY 2000 allocation, several policy decisions affecting workload were approved; the cumulative impact of these policy decisions are reflected in both the FY 2001 workload as well as the FYs 1995-1999 historical workload figures.
3. The FY 2002 Complex Care workload includes approved policy changes for: eliminating the requirement for having twice as many days in a long-term care setting as an acute care setting to qualify for Complex Care; revising Complex Care designations in long-term residential and psychiatric care; and creating a new Complex Care patient class entitled Mental Health Intensive Care Management. These changes are reflected in both the FY 2002 VERA workload as well as the FY 1996 - FY 2000 historical workload figures.
4. VERA workload is projected based on the past 5 years experience, where-as the columns labeled "Historical" is the actual workload which occurred in those years. The FY 2001 and FY 2002 Complex Care workload forecast continues to include a factor for age, but no longer for veteran population trends.
5. Numbers may not add due to rounding.

Formula for Complex Care allocation: $V_c * N_c = B_c$
V_c = Volume Complex Care patients = Forecasted trend of workload (based on FYs 1996-2000), adjusted for care across networks
N_c = National price for Complex Care
B_c = Budget for Complex Care

Total Workload: Back-up data

Network	FY 1997 VERA Total Workload	FY 1998 VERA Total Workload	FY 1999 VERA Total Workload	FY 2000 VERA Total Workload	FY 2001 VERA Total Workload	FY 2002 VERA Basic Vested workload (V _b)	FY 2002 VERA Basic Non-Vested workload (V _{nv})	FY 2002 VERA Complex workload (V _c)	FY 2002 VERA Total Workload (V _{b+nc})
1 Boston	162,836	163,533	166,748	170,650	171,323	150,422	12,315	7,002	169,739
2 Albany	84,980	85,010	88,247	96,019	101,549	89,109	9,874	4,607	103,590
3 Bronx	159,989	157,811	158,972	171,513	173,512	139,182	21,404	8,210	168,797
4 Pittsburgh	154,055	159,770	179,634	200,228	213,482	174,025	31,958	7,682	213,665
5 Baltimore	98,240	98,629	99,711	101,518	102,628	85,970	10,724	5,675	102,370
6 Durham	171,412	171,890	176,032	183,865	185,511	158,110	19,488	7,688	185,286
7 Atlanta	200,868	202,179	204,796	211,458	218,084	193,670	20,028	9,252	222,950
8 Bay Pines	262,561	264,244	275,415	290,469	299,242	280,937	25,192	12,598	318,727
9 Nashville	162,601	162,729	168,368	178,736	183,288	164,015	16,941	6,462	187,417
10 Cincinnati	120,560	119,487	127,884	140,910	145,406	113,122	22,877	6,618	142,616
11 Ann Arbor	145,188	146,465	148,811	154,779	157,358	136,167	15,657	6,315	158,139
12 Chicago	156,707	154,039	154,133	163,412	164,776	131,391	21,904	8,418	161,713
13 Minneapolis	92,716	92,772	91,998	93,754	94,941	77,065	15,249	4,427	96,741
14 Lincoln	64,553	64,425	64,779	66,413	68,012	60,348	7,069	2,321	69,738
15 Kansas City	143,860	142,097	142,509	146,961	151,016	134,637	13,062	5,893	153,592
16 Jackson	313,660	311,291	314,540	329,560	334,613	296,532	33,264	10,806	340,602
17 Dallas	155,173	154,002	154,829	163,918	172,246	154,180	18,161	7,450	179,791
18 Phoenix	145,774	148,653	153,506	162,022	165,349	149,301	12,377	5,240	166,918
19 Denver	95,944	95,955	96,132	100,288	103,727	92,954	8,350	3,602	104,906
20 Portland	151,098	151,644	154,351	161,742	165,637	145,592	17,124	7,112	169,827
21 San Francisco	144,726	147,141	149,150	158,980	164,540	143,053	17,966	7,627	168,646
22 Long Beach	197,245	200,637	203,930	211,157	216,060	181,322	25,205	8,150	214,677
VHA total	3,384,746	3,394,403	3,474,476	3,658,354	3,752,301	3,251,103	396,188	153,155	3,800,446

Notes: 1. All workload units are adjusted for care across networks.

2. A policy decision was made to fund Basic Vested patients separately from single outpatient visits, effective for the FY 1999 VERA allocations.

For the FY 2000 VERA allocation, the policy decision was to fund Basic Non-Vested patients separately from Basic Vested patients.

3. Numbers may not add due to rounding.

Formula for total workload: $V_{b+nc} = V_b + V_{nv} + V_c$
V_b = Volume Basic Vested Care
V_{nv} = Volume Basic Non-Vested Care
V_c = Volume projected Complex Care
V_{b+nc} = Volume Basic Vested, Basic Non-Vested and Complex Care

Geographic Price Adjustment: Back-up data

(\$ in thousands)

Network	VISN Salary Rate (V _{sr}) computed by multiplying the national FTE by the VISN average salary using 4 recent pay periods, NORMAL pay only	National Salary Rate (N _{sr}) computed by multiplying the national FTE by the national average salary using 4 recent pay periods, NORMAL pay only	Labor Index (Li)	Volume Basic and Complex Care		National price for labor (N1)	Labor dollars budgeted based on workload (Lb)	Personal Service Dollars Indexed (PSi)	Scaling factor	Personal Services Dollars Indexed and Scaled (PSis)	Labor Adjustment (LA)
				unweighted workload (Vbc)	Volume Basic and Complex Care weighted workload (Vbcw)						
1 Boston	\$1,707,203	\$1,659,620	1.02867	169,739	231,869	\$2,493	\$577,978	\$594,549	1.001	\$595,142	\$17,165
2 Albany	\$1,615,546	\$1,658,854	0.97389	103,590	144,469	\$2,493	\$360,117	\$350,715	1.001	\$351,065	(\$9,052)
3 Bronx	\$1,803,372	\$1,659,794	1.08650	168,797	241,646	\$2,493	\$602,347	\$654,452	1.001	\$655,105	\$52,758
4 Pittsburgh	\$1,653,811	\$1,659,699	0.99645	213,665	281,821	\$2,493	\$702,493	\$700,000	1.001	\$700,699	(\$1,794)
5 Baltimore	\$1,718,262	\$1,658,324	1.03614	102,370	152,725	\$2,493	\$380,696	\$394,456	1.001	\$394,850	\$14,153
6 Durham	\$1,618,741	\$1,659,620	0.97537	185,286	253,501	\$2,493	\$631,899	\$616,335	1.001	\$616,949	(\$14,950)
7 Atlanta	\$1,619,239	\$1,659,699	0.97562	222,950	305,043	\$2,493	\$760,376	\$741,840	1.001	\$742,580	(\$17,796)
8 Bay Pines	\$1,569,565	\$1,659,794	0.94564	318,727	430,504	\$2,493	\$1,073,113	\$1,014,777	1.001	\$1,015,789	(\$57,323)
9 Nashville	\$1,601,542	\$1,659,794	0.96490	187,417	244,753	\$2,493	\$610,093	\$588,682	1.001	\$589,269	(\$20,824)
10 Cincinnati	\$1,653,201	\$1,659,794	0.99603	142,616	201,334	\$2,493	\$501,863	\$499,870	1.001	\$500,368	(\$1,495)
11 Ann Arbor	\$1,657,612	\$1,659,620	0.99879	158,139	214,173	\$2,493	\$533,866	\$533,221	1.001	\$533,753	(\$114)
12 Chicago	\$1,709,927	\$1,659,794	1.03020	161,713	236,407	\$2,493	\$589,288	\$607,087	1.001	\$607,693	\$18,405
13 Minneapolis	\$1,672,722	\$1,659,620	1.00789	96,741	136,018	\$2,493	\$339,051	\$341,728	1.001	\$342,069	\$3,018
14 Lincoln	\$1,599,493	\$1,657,726	0.96487	69,738	90,330	\$2,493	\$225,164	\$217,255	1.001	\$217,472	(\$7,693)
15 Kansas City	\$1,617,043	\$1,659,794	0.97424	153,592	205,875	\$2,493	\$513,182	\$499,964	1.001	\$500,463	(\$12,719)
16 Jackson	\$1,628,518	\$1,659,075	0.98158	340,602	436,480	\$2,493	\$1,088,008	\$1,067,969	1.001	\$1,069,034	(\$18,974)
17 Dallas	\$1,598,934	\$1,659,075	0.96375	179,791	245,891	\$2,493	\$612,929	\$590,711	1.001	\$591,300	(\$21,629)
18 Phoenix	\$1,593,762	\$1,658,789	0.96080	166,918	213,409	\$2,493	\$531,962	\$511,108	1.001	\$511,618	(\$20,344)
19 Denver	\$1,634,681	\$1,657,488	0.98624	104,906	136,867	\$2,493	\$341,166	\$336,471	1.001	\$336,807	(\$4,359)
20 Portland	\$1,666,537	\$1,659,398	1.00430	169,827	232,930	\$2,493	\$580,622	\$583,120	1.001	\$583,701	\$3,080
21 San Francisco	\$1,855,345	\$1,659,250	1.11818	168,646	236,320	\$2,493	\$589,072	\$658,690	1.001	\$659,347	\$70,275
22 Long Beach	\$1,727,985	\$1,659,620	1.04119	214,677	286,992	\$2,493	\$715,381	\$744,850	1.001	\$745,593	\$30,212
VHA total	\$1,659,873	\$1,659,873	1.00000	3,800,446	5,159,359	\$2,493	\$12,860,666	\$12,847,849	1.001	\$12,860,666	\$0

Notes: 1. Numbers may not add due to rounding.

2. For the FY 2000 allocations, a policy decision was made to use a national staffing pattern rather than actual VISN staffing patterns for the Geographic Price Index.

3. For the FY 2001 allocations, a policy decision was made to change the workload factor for computing the labor index to weight Complex Care workload consistent with recent costs.

4. For the FY 2002 allocation, a policy decision was made to change the geographic price adjustment to account for local cost of living factors associated with procuring contracted labor and non-labor contracted goods such as energy related products, utilities and provisions.

Formulas for Geographic Price Adjustment (Labor Index): LA = PSis-Lb

$Li = (V_{sr}) / (N_{sr})$	Labor Index = VISN Salary Rate (V _{sr}) (national FTE * VISN average salary) / National Salary Rate (N _{sr}) (national FTE * national average salary) (Weighting factor= 9.9 = National Cost Complex Care / National Cost Basic Vested Care)
Vbcw=	Volume Basic Complex Weighted Workload= Volume Complex * Weighting factor + Volume Basic (Vested plus Non-Vested)
$NI = L_b / V_{bcw}$	National price for labor VHA labor dollars budgeted based on workload / total volume of Basic and Complex Care workload weighted
$L_b = V_{bcw} * NI$	Labor dollars based on workload = Volume of Basic and Complex weighted * National price for labor
$PSi = L_b * Li$	Personal services dollars indexed = Labor dollars budgeted based on weighted workload * Labor Index
$PSis = PSi * 1.001$	Personal service dollars indexed and scaled = Personal services dollars indexed * 1.001 scaling factor
$LA = PSis - Lb$	Labor Adjustment = Personal service dollars indexed and scaled - labor dollars based on workload

Research Support Budget: Back-up data
(\$ in millions)

Network	Funded Research Reported for FYs 1995, 1996, 1997, 1998, and 1999					FY 2000 Total Dollars of Research Reported				FY 2000 Total Dollars Research Reported and Weighted				National Price for Research Support (N _{rs})	Budget for Research Support (B _{rs}) (\$000s)
	Funded Research Reported for FY 1995	Funded Research Reported for FY 1996	Funded Research Reported for FY 1997	Funded Research Reported for FY 1998	Funded Research Reported for FY 1999	Administered by VA (VA)	Peer Reviewed Administered by VA (PR)	Not Peer Reviewed (NPR)	FY 2000 Funded Research Reported for FY 2002 VERA(V _r)	Administered by VA (weighted at 100%) (VA _w)	Not Administered by VA (weighted at 75%) (PR _w)	Not Peer Reviewed (weighted at 25%) (NPR _w)	FY 2000 Weighted Research Activity for FY 2002 VERA (V _{rw})		
1 Boston	\$50	\$46	\$58	\$63	\$67	\$40	\$25	\$1	\$67	\$40	\$19	\$0.31	\$60	\$0.58	\$34,548
2 Albany	\$8	\$9	\$9	\$9	\$9	\$6	\$3	\$0	\$9	\$6	\$2	\$0.02	\$8	\$0.58	\$4,610
3 Bronx	\$21	\$22	\$19	\$23	\$24	\$15	\$10	\$2	\$27	\$15	\$7	\$0.41	\$23	\$0.58	\$13,240
4 Pittsburgh	\$10	\$12	\$17	\$19	\$27	\$12	\$17	\$1	\$30	\$12	\$13	\$0.16	\$25	\$0.58	\$14,563
5 Baltimore	\$18	\$17	\$21	\$24	\$34	\$19	\$9	\$4	\$31	\$19	\$7	\$0.88	\$26	\$0.58	\$15,370
6 Durham	\$14	\$15	\$16	\$18	\$22	\$20	\$5	\$1	\$25	\$20	\$4	\$0.20	\$24	\$0.58	\$13,653
7 Atlanta	\$21	\$21	\$28	\$32	\$39	\$22	\$15	\$2	\$39	\$22	\$11	\$0.41	\$34	\$0.58	\$19,657
8 Bay Pines	\$18	\$16	\$17	\$19	\$20	\$14	\$6	\$2	\$23	\$14	\$5	\$0.57	\$19	\$0.58	\$11,281
9 Nashville	\$21	\$23	\$24	\$24	\$25	\$15	\$11	\$2	\$28	\$15	\$9	\$0.42	\$24	\$0.58	\$13,920
10 Cincinnati	\$17	\$13	\$20	\$24	\$28	\$14	\$14	\$2	\$29	\$14	\$10	\$0.51	\$24	\$0.58	\$14,094
11 Ann Arbor	\$23	\$14	\$20	\$30	\$31	\$13	\$19	\$3	\$35	\$13	\$14	\$0.78	\$28	\$0.58	\$16,368
12 Chicago	\$30	\$29	\$29	\$37	\$43	\$23	\$14	\$3	\$41	\$23	\$11	\$0.73	\$35	\$0.58	\$20,143
13 Minneapolis	\$12	\$12	\$11	\$14	\$15	\$9	\$6	\$2	\$16	\$9	\$4	\$0.44	\$14	\$0.58	\$7,915
14 Lincoln	\$19	\$19	\$19	\$18	\$34	\$10	\$23	\$2	\$35	\$10	\$17	\$0.41	\$28	\$0.58	\$15,980
15 Kansas City	\$11	\$9	\$12	\$12	\$12	\$5	\$3	\$1	\$10	\$5	\$3	\$0.21	\$8	\$0.58	\$4,656
16 Jackson	\$26	\$24	\$29	\$36	\$37	\$21	\$14	\$6	\$40	\$21	\$11	\$1.44	\$33	\$0.58	\$18,933
17 Dallas	\$14	\$13	\$15	\$20	\$23	\$13	\$15	\$2	\$30	\$13	\$12	\$0.38	\$25	\$0.58	\$14,619
18 Phoenix	\$9	\$7	\$10	\$11	\$15	\$10	\$3	\$1	\$15	\$10	\$3	\$0.24	\$13	\$0.58	\$7,648
19 Denver	\$20	\$15	\$20	\$20	\$19	\$10	\$7	\$1	\$17	\$10	\$5	\$0.22	\$15	\$0.58	\$8,718
20 Portland	\$30	\$28	\$30	\$39	\$41	\$22	\$24	\$3	\$49	\$22	\$18	\$0.64	\$41	\$0.58	\$23,706
21 San Francisco	\$48	\$50	\$72	\$71	\$86	\$53	\$28	\$6	\$87	\$53	\$21	\$1.62	\$75	\$0.58	\$43,704
22 Long Beach	\$65	\$92	\$97	\$112	\$99	\$51	\$43	\$9	\$103	\$51	\$32	\$2.13	\$86	\$0.58	\$49,612
VHA total	\$507	\$506	\$593	\$677	\$752	\$418	\$315	\$53	\$785	\$418	\$236	\$13.13	\$667	\$0.58	\$386,938

Note: Numbers may not add due to rounding.

Formulas for Research Support: $B_{rs} = V_{rw} * N_{rs}$	
$B_{rs} = V_{rw} * N_{rs}$	Budget for research support = research reported and weighted* National price for research support
$VA_w = VA$	Research which is administered by the VA is weighted at 100%
$PR_w = PR * .75$	Research which is peer reviewed, but not VA administered is weighted at 75%
$NPR_w = NPR * .25$	Research which is not peer reviewed and not administered by VA is weighted at 25%
$V_{rw} = VA_w + PR_w + NPR$	Research activity weighted = Sum of weighted research activity
$N_{rs} = B_{rs} / V_{rw}$	National price for research support = Budget for Research reported divided by research reported and weighted.

Education Support: Back-up data
(\$ in thousands)

Network	Volume Resident FTE for FY 1997 VERA	Volume Resident FTE for FY 1998 VERA	Volume Resident FTE for FY 1999 VERA	Volume Resident FTE for FY 2000 VERA	Volume Resident FTE for FY 2001 VERA	Volume Resident FTE (V _e) for FY 2002 VERA	National Price for Education Support (N _{es})	Budget for Education Support (B _{es})
1 Boston	542	534	525	515	506	501	\$41,781	\$20,950
2 Albany	276	264	249	246	243	243	\$41,781	\$10,165
3 Bronx	611	609	584	588	601	603	\$41,781	\$25,194
4 Pittsburgh	338	304	304	321	320	329	\$41,781	\$13,729
5 Baltimore	239	244	241	246	239	246	\$41,781	\$10,278
6 Durham	367	366	364	349	353	348	\$41,781	\$14,552
7 Atlanta	455	455	441	438	436	427	\$41,781	\$17,824
8 Bay Pines	563	554	546	547	548	555	\$41,781	\$23,189
9 Nashville	547	555	549	528	531	529	\$41,781	\$22,116
10 Cincinnati	265	261	251	254	255	256	\$41,781	\$10,692
11 Ann Arbor	315	324	323	319	317	314	\$41,781	\$13,119
12 Chicago	662	673	658	657	656	657	\$41,781	\$27,452
13 Minneapolis	220	213	210	198	193	198	\$41,781	\$8,256
14 Lincoln	188	196	198	195	194	195	\$41,781	\$8,147
15 Kansas City	346	346	343	339	336	339	\$41,781	\$14,164
16 Jackson	713	695	675	682	680	674	\$41,781	\$28,158
17 Dallas	336	337	333	333	331	333	\$41,781	\$13,931
18 Phoenix	300	296	310	305	305	306	\$41,781	\$12,772
19 Denver	229	236	228	234	230	230	\$41,781	\$9,610
20 Portland	269	262	269	269	276	273	\$41,781	\$11,420
21 San Francisco	384	382	387	380	385	383	\$41,781	\$16,003
22 Long Beach	730	745	736	719	728	730	\$41,781	\$30,479
VHA total	8,891	8,848	8,721	8,659	8,662	8,669	\$41,781	\$362,202

Note: Numbers may not add due to rounding.

Formula for Education support allocation: $B_{es} = V_e * N_{es}$

B_{es} = Network budget for education support = Volume of Residents * National price for education support

$N_{es} = B_{es} / V_e$ = National price for education support = Budget for education support divided by volume of residents

Equipment Distribution: Back-up data
(\$ in thousands)

Network	FY 1997 VERA	FY 1998 VERA	FY 1999 VERA	FY 2000 VERA	FY 2001 VERA	Volume Basic Vested, Basic Non-Vested, and Complex (V _{bnvc})		Price (N _{eq})	Total Equipment Budget (B _{eq})
	Equipment Allocation								
1 Boston	\$18,193	\$23,566	\$23,664	\$25,970	\$27,625	171,323	\$112	\$19,037	
2 Albany	\$9,962	\$12,937	\$12,813	\$14,613	\$16,374	103,590	\$112	\$11,618	
3 Bronx	\$18,538	\$24,367	\$23,369	\$26,102	\$27,978	168,797	\$112	\$18,931	
4 Pittsburgh	\$17,685	\$23,460	\$24,836	\$30,472	\$34,423	213,665	\$112	\$23,964	
5 Baltimore	\$9,956	\$13,207	\$13,931	\$15,450	\$16,548	102,370	\$112	\$11,481	
6 Durham	\$17,522	\$22,084	\$24,130	\$27,982	\$29,913	185,286	\$112	\$20,781	
7 Atlanta	\$19,442	\$24,984	\$27,032	\$32,181	\$35,165	222,950	\$112	\$25,005	
8 Bay Pines	\$24,076	\$31,079	\$35,619	\$44,205	\$48,252	318,727	\$112	\$35,747	
9 Nashville	\$18,661	\$24,094	\$24,481	\$27,201	\$29,555	187,417	\$112	\$21,020	
10 Cincinnati	\$12,612	\$16,583	\$17,540	\$21,444	\$23,446	142,616	\$112	\$15,995	
11 Ann Arbor	\$14,434	\$18,309	\$20,097	\$23,555	\$25,373	158,139	\$112	\$17,736	
12 Chicago	\$18,421	\$24,105	\$22,973	\$24,869	\$26,570	161,713	\$112	\$18,137	
13 Minneapolis	\$12,051	\$15,278	\$13,916	\$14,268	\$15,309	96,741	\$112	\$10,850	
14 Lincoln	\$7,370	\$9,468	\$9,202	\$10,107	\$10,967	69,738	\$112	\$7,821	
15 Kansas City	\$15,406	\$19,360	\$19,731	\$22,365	\$24,351	153,592	\$112	\$17,226	
16 Jackson	\$31,533	\$40,664	\$42,820	\$50,154	\$53,955	340,602	\$112	\$38,200	
17 Dallas	\$15,138	\$19,779	\$20,846	\$24,946	\$27,774	179,791	\$112	\$20,165	
18 Phoenix	\$14,244	\$18,518	\$20,251	\$24,657	\$26,662	166,918	\$112	\$18,721	
19 Denver	\$9,804	\$12,766	\$13,126	\$15,262	\$16,726	104,906	\$112	\$11,766	
20 Portland	\$15,114	\$20,068	\$21,113	\$24,615	\$26,708	169,827	\$112	\$19,047	
21 San Francisco	\$14,122	\$19,161	\$20,206	\$24,194	\$26,532	168,646	\$112	\$18,915	
22 Long Beach	\$18,381	\$24,531	\$26,826	\$32,135	\$34,839	214,677	\$112	\$24,077	
VHA total	\$352,666	\$458,369	\$478,522	\$556,748	\$605,047	3,800,446	\$112	\$426,241	

Note: Numbers may not add due to rounding.

Formulas for Equipment Distribution: $B_{eq} = V_{bnvc} * N_{eq}$
V _{bnvc} = Volume Basic Vested, Basic Non-Vested and Complex Care patients
N _{eq} = National price for equipment = Budget for equipment (B _{eq}) divided by Basic Vested, Basic Non-Vested and Complex patients(V _{bnvc})
B _{eq} = Budget for equipment

NRM Distributions: Back-up data
(\$ in thousands)

Network	FY 1997 VERA NRM Distribution	FY 1998 VERA NRM Distribution	FY 1999 VERA NRM Distribution	FY 2000 VERA NRM Distribution	FY 2001 VERA NRM Distribution	FY 2002 VERA Volume Basic Vested, Basic Non-Vested, and Complex (V _{bvnc})	Unadjusted FY 2000 Boeckh Index (BI)	Workload * BI	National Price	Budget based on Workload adjusted by Boeckh Index (Workload*BI* Price) (B _{nrm})
1 Boston	\$15,259	\$15,033	\$14,767	\$13,658	\$14,040	169,739	0.0209	3,542	\$3,661	\$12,965
2 Albany	\$7,887	\$7,952	\$7,889	\$7,412	\$8,084	103,590	0.0205	2,127	\$3,661	\$7,787
3 Bronx	\$22,195	\$22,403	\$21,501	\$19,648	\$19,878	168,797	0.0290	4,894	\$3,661	\$17,913
4 Pittsburgh	\$15,219	\$15,048	\$15,399	\$15,221	\$17,108	213,665	0.0204	4,362	\$3,661	\$15,968
5 Baltimore	\$7,110	\$6,989	\$7,145	\$6,642	\$7,116	102,370	0.0179	1,831	\$3,661	\$6,704
6 Durham	\$8,277	\$9,072	\$8,953	\$9,016	\$10,165	185,286	0.0140	2,601	\$3,661	\$9,523
7 Atlanta	\$9,818	\$10,515	\$11,086	\$10,734	\$11,916	222,950	0.0142	3,172	\$3,661	\$11,612
8 Bay Pines	\$9,548	\$10,797	\$13,122	\$14,125	\$17,688	318,727	0.0151	4,827	\$3,661	\$17,669
9 Nashville	\$9,997	\$9,994	\$10,487	\$10,217	\$11,325	187,417	0.0157	2,949	\$3,661	\$10,796
10 Cincinnati	\$9,493	\$9,572	\$9,991	\$10,041	\$11,184	142,616	0.0197	2,814	\$3,661	\$10,301
11 Ann Arbor	\$11,488	\$11,572	\$12,093	\$11,583	\$12,643	158,139	0.0206	3,265	\$3,661	\$11,950
12 Chicago	\$16,913	\$18,127	\$17,067	\$14,829	\$14,261	161,713	0.0222	3,595	\$3,661	\$13,159
13 Minneapolis	\$7,581	\$7,592	\$7,499	\$6,826	\$6,982	96,741	0.0191	1,852	\$3,661	\$6,778
14 Lincoln	\$4,649	\$4,761	\$4,791	\$4,341	\$4,561	69,738	0.0173	1,209	\$3,661	\$4,426
15 Kansas City	\$10,227	\$10,449	\$10,900	\$10,393	\$11,769	153,592	0.0203	3,116	\$3,661	\$11,405
16 Jackson	\$13,912	\$13,893	\$15,638	\$16,287	\$18,946	340,602	0.0145	4,931	\$3,661	\$18,052
17 Dallas	\$7,231	\$7,189	\$7,972	\$8,318	\$10,021	179,791	0.0148	2,663	\$3,661	\$9,747
18 Phoenix	\$5,808	\$5,795	\$7,367	\$8,216	\$10,269	166,918	0.0159	2,646	\$3,661	\$9,685
19 Denver	\$5,504	\$5,468	\$5,923	\$5,704	\$6,689	104,906	0.0166	1,738	\$3,661	\$6,361
20 Portland	\$11,317	\$10,261	\$11,711	\$12,087	\$13,994	169,827	0.0216	3,665	\$3,661	\$13,417
21 San Francisco	\$10,403	\$10,324	\$11,754	\$12,522	\$15,260	168,646	0.0239	4,022	\$3,661	\$14,724
22 Long Beach	\$15,816	\$15,475	\$16,504	\$16,420	\$18,564	214,677	0.0221	4,744	\$3,661	\$17,366
VHA total	\$235,653	\$238,282	\$249,562	\$244,240	\$272,463	3,800,446		70,564	\$3,661	\$258,307

Note: Numbers may not add due to rounding.

Formulas for NRM distribution: $B_{nrm} = \text{Workload} * \text{BI} * \text{National Price}$

B_{nrm} = NRM Budget = unadjusted Boeckh Index (BI) times Basic Vested, Non-Vested, and Complex Care workload (V_{bvnc}) times National Price

National Price = Total Dollars available nationally divided by (sum of Network Basic Vested, Basic Non-Vested, and Complex Care workload times Network Boeckh Index)

FY 2002 VERA Outcome
(\$ in thousands)

Network	FY 2001	Total General		
		Purpose	Increase	% Increase
1 Boston	\$895,196	\$909,715	\$14,519	1.62
2 Albany	\$494,872	\$497,198	\$2,326	0.47
3 Bronx	\$994,576	\$1,037,301	\$42,725	4.30
4 Pittsburgh	\$939,770	\$936,020	(\$3,750)	(0.40)
5 Baltimore	\$556,928	\$564,929	\$8,001	1.44
6 Durham	\$843,148	\$861,286	\$18,137	2.15
7 Atlanta	\$1,010,734	\$1,050,304	\$39,571	3.92
8 Bay Pines	\$1,354,357	\$1,437,387	\$83,030	6.13
9 Nashville	\$805,368	\$831,591	\$26,223	3.26
10 Cincinnati	\$657,467	\$682,951	\$25,485	3.88
11 Ann Arbor	\$753,097	\$750,330	(\$2,767)	(0.37)
12 Chicago	\$878,175	\$883,268	\$5,093	0.58
13 Minneapolis	\$497,673	\$508,738	\$11,065	2.22
14 Lincoln	\$351,318	\$348,050	(\$3,268)	(0.93)
15 Kansas City	\$675,538	\$703,102	\$27,564	4.08
16 Jackson	\$1,430,641	\$1,466,801	\$36,160	2.53
17 Dallas	\$791,661	\$832,097	\$40,436	5.11
18 Phoenix	\$713,403	\$715,290	\$1,887	0.26
19 Denver	\$458,112	\$473,985	\$15,873	3.46
20 Portland	\$798,021	\$824,844	\$26,823	3.36
21 San Francisco	\$893,245	\$931,506	\$38,261	4.28
22 Long Beach	\$1,042,003	\$1,062,308	\$20,305	1.95
VHA total	\$17,835,304	\$18,309,002	\$473,698	2.66

Note: Numbers may not add due to rounding.

FY 2001 figures adjusted for rescission, loans, and supplemental. FY 2002 General Purpose includes VERA adjustment for five networks.

FY 2002 Network Allocations
(\$ in thousands)

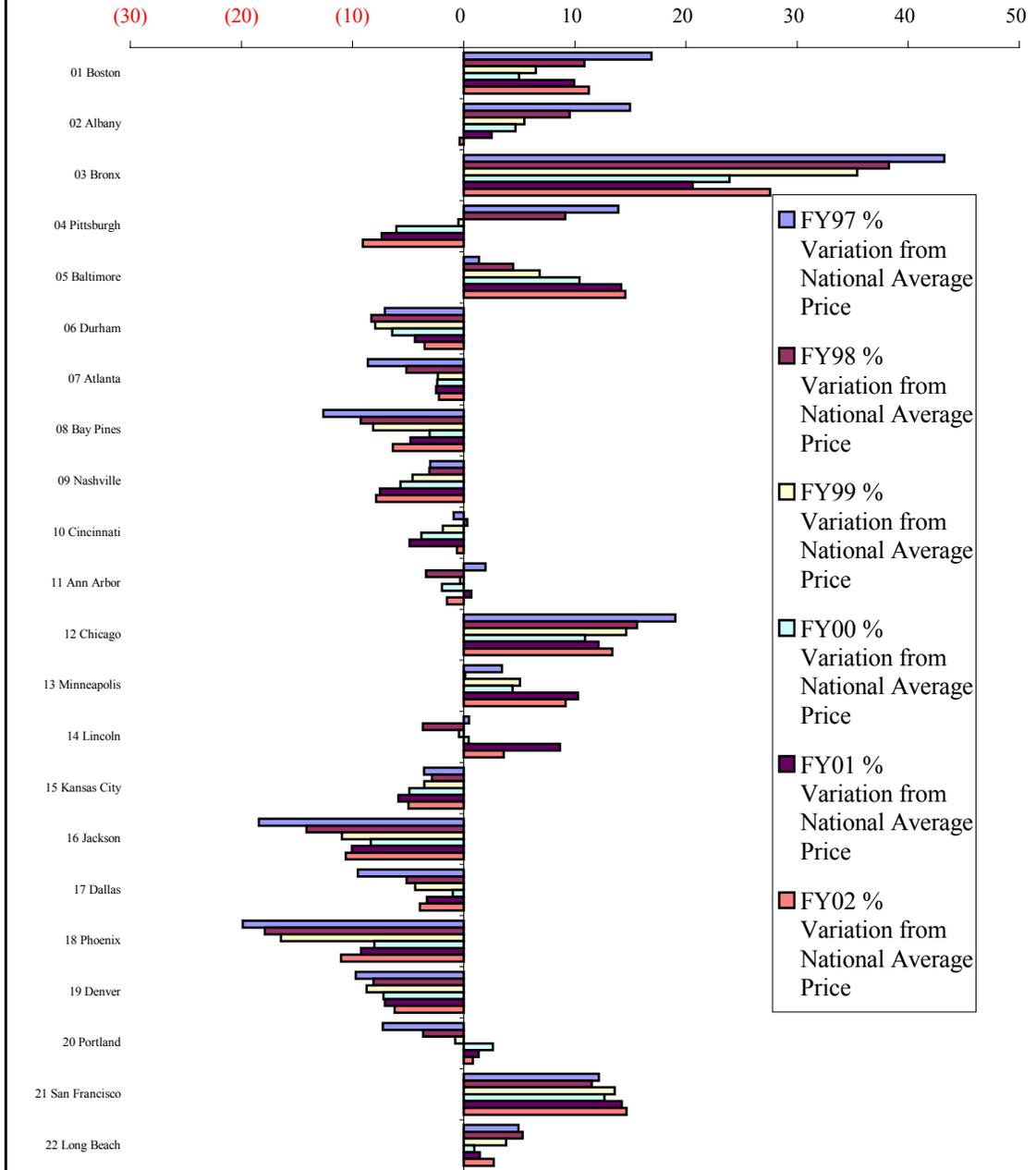
Network	Basic Vested Allocation	Basic Non-Vested Allocation	Complex Allocation	Geographic Price Adjustment	Research Support Allocation	Education Support Allocation	Equipment Allocation	Total NRM Allocation	VERA Adjustments	Total General Purpose Allocations
1 Boston	\$469,540	\$2,429	\$291,766	\$17,165	\$34,548	\$20,950	\$19,037	\$12,965	\$41,314	\$909,715
2 Albany	\$278,153	\$1,948	\$191,969	(\$9,052)	\$4,610	\$10,165	\$11,618	\$7,787	\$0	\$497,198
3 Bronx	\$434,455	\$4,222	\$342,103	\$52,758	\$13,240	\$25,194	\$18,931	\$17,913	\$128,484	\$1,037,301
4 Pittsburgh	\$543,218	\$6,304	\$320,068	(\$1,794)	\$14,563	\$13,729	\$23,964	\$15,968	\$0	\$936,020
5 Baltimore	\$268,355	\$2,116	\$236,472	\$14,153	\$15,370	\$10,278	\$11,481	\$6,704	\$0	\$564,929
6 Durham	\$493,537	\$3,844	\$320,344	(\$14,950)	\$13,653	\$14,552	\$20,781	\$9,523	\$0	\$861,286
7 Atlanta	\$604,537	\$3,951	\$385,515	(\$17,796)	\$19,657	\$17,824	\$25,005	\$11,612	\$0	\$1,050,304
8 Bay Pines	\$876,940	\$4,970	\$524,915	(\$57,323)	\$11,281	\$23,189	\$35,747	\$17,669	\$0	\$1,437,387
9 Nashville	\$511,969	\$3,342	\$269,253	(\$20,824)	\$13,920	\$22,116	\$21,020	\$10,796	\$0	\$831,591
10 Cincinnati	\$353,108	\$4,513	\$275,743	(\$1,495)	\$14,094	\$10,692	\$15,995	\$10,301	\$0	\$682,951
11 Ann Arbor	\$425,044	\$3,089	\$263,137	(\$114)	\$16,368	\$13,119	\$17,736	\$11,950	\$0	\$750,330
12 Chicago	\$410,134	\$4,321	\$350,767	\$18,405	\$20,143	\$27,452	\$18,137	\$13,159	\$20,750	\$883,268
13 Minneapolis	\$240,559	\$3,008	\$184,449	\$3,018	\$7,915	\$8,256	\$10,850	\$6,778	\$43,905	\$508,738
14 Lincoln	\$188,375	\$1,395	\$96,703	(\$7,693)	\$15,980	\$8,147	\$7,821	\$4,426	\$32,896	\$348,050
15 Kansas City	\$420,269	\$2,577	\$245,525	(\$12,719)	\$4,656	\$14,164	\$17,226	\$11,405	\$0	\$703,102
16 Jackson	\$925,620	\$6,562	\$450,250	(\$18,974)	\$18,933	\$28,158	\$38,200	\$18,052	\$0	\$1,466,801
17 Dallas	\$481,272	\$3,583	\$310,410	(\$21,629)	\$14,619	\$13,931	\$20,165	\$9,747	\$0	\$832,097
18 Phoenix	\$466,040	\$2,442	\$218,326	(\$20,344)	\$7,648	\$12,772	\$18,721	\$9,685	\$0	\$715,290
19 Denver	\$290,154	\$1,647	\$150,088	(\$4,359)	\$8,718	\$9,610	\$11,766	\$6,361	\$0	\$473,985
20 Portland	\$454,463	\$3,378	\$296,334	\$3,080	\$23,706	\$11,420	\$19,047	\$13,417	\$0	\$824,844
21 San Francisco	\$446,538	\$3,544	\$317,803	\$70,275	\$43,704	\$16,003	\$18,915	\$14,724	\$0	\$931,506
22 Long Beach	\$565,995	\$4,972	\$339,595	\$30,212	\$49,612	\$30,479	\$24,077	\$17,366	\$0	\$1,062,308
VHA totals	\$10,148,274	\$78,157	\$6,381,535	\$0	\$386,938	\$362,202	\$426,241	\$258,307	\$267,349	\$18,309,002

Calculation of Case Mix Index
(\$ in millions)

Network	Basic Vested Care Allocation	Non Vested Care Allocation	Complex Care Allocation	VERA Patient Workload Allocation (Basic Care plus Complex Care)	Total VERA Workload	Single Price Allocation for all workload (Price = \$4,370) (Total VERA Workload * \$4,370)	Case Mix Index (Ratio VERA Allocation to Single Price Allocation)
1 Boston	\$470	\$2	\$292	\$764	169,739	\$742	1.03
2 Albany	\$278	\$2	\$192	\$472	103,590	\$453	1.04
3 Bronx	\$434	\$4	\$342	\$781	168,797	\$738	1.06
4 Pittsburgh	\$543	\$6	\$320	\$870	213,665	\$934	0.93
5 Baltimore	\$268	\$2	\$236	\$507	102,370	\$447	1.13
6 Durham	\$494	\$4	\$320	\$818	185,286	\$810	1.01
7 Atlanta	\$605	\$4	\$386	\$994	222,950	\$974	1.02
8 Bay Pines	\$877	\$5	\$525	\$1,407	318,727	\$1,393	1.01
9 Nashville	\$512	\$3	\$269	\$785	187,417	\$819	0.96
10 Cincinnati	\$353	\$5	\$276	\$633	142,616	\$623	1.02
11 Ann Arbor	\$425	\$3	\$263	\$691	158,139	\$691	1.00
12 Chicago	\$410	\$4	\$351	\$765	161,713	\$707	1.08
13 Minneapolis	\$241	\$3	\$184	\$428	96,741	\$423	1.01
14 Lincoln	\$188	\$1	\$97	\$286	69,738	\$305	0.94
15 Kansas City	\$420	\$3	\$246	\$668	153,592	\$671	1.00
16 Jackson	\$926	\$7	\$450	\$1,382	340,602	\$1,488	0.93
17 Dallas	\$481	\$4	\$310	\$795	179,791	\$786	1.01
18 Phoenix	\$466	\$2	\$218	\$687	166,918	\$729	0.94
19 Denver	\$290	\$2	\$150	\$442	104,906	\$458	0.96
20 Portland	\$454	\$3	\$296	\$754	169,827	\$742	1.02
21 San Francisco	\$447	\$4	\$318	\$768	168,646	\$737	1.04
22 Long Beach	\$566	\$5	\$340	\$911	214,677	\$938	0.97
VHA totals	\$10,148	\$78	\$6,382	\$16,608	3,800,446	\$16,608	1.00

Note: Numbers may not add due to rounding.

**Percent Variation from National Average: VERA
Network Average Price including, caps and
adjustments, FY 1997 to FY 2002**



Network Percent Variation from VERA National Average Price, including caps and adjustments, FY 1997 to FY 2002

Network	FY 1997 % Variation from National Average Price	FY 1998 % Variation from National Average Price	FY 1999 % Variation from National Average Price	FY 2000 % Variation from National Average Price	FY 2001 % Variation from National Average Price	FY 2002 % Variation from National Average Price
1 Boston	16.9	10.9	6.5	5.0	9.9	11.2
2 Albany	15.0	9.5	5.5	4.7	2.5	(0.4)
3 Bronx	43.2	38.3	35.4	23.9	20.6	27.6
4 Pittsburgh	13.9	9.1	(0.5)	(6.1)	(7.4)	(9.1)
5 Baltimore	1.4	4.5	6.8	10.4	14.2	14.5
6 Durham	(7.1)	(8.3)	(8.0)	(6.4)	(4.4)	(3.5)
7 Atlanta	(8.6)	(5.2)	(2.3)	(2.4)	(2.5)	(2.2)
8 Bay Pines	(12.6)	(9.3)	(8.1)	(3.1)	(4.8)	(6.4)
9 Nashville	(3.0)	(3.1)	(4.6)	(5.7)	(7.6)	(7.9)
10 Cincinnati	(0.9)	0.3	(1.9)	(3.8)	(4.9)	(0.6)
11 Ann Arbor	2.0	(3.4)	(0.3)	(2.0)	0.7	(1.5)
12 Chicago	19.0	15.6	14.6	10.9	12.1	13.4
13 Minneapolis	3.4	0.1	5.1	4.4	10.3	9.2
14 Lincoln	0.5	(3.7)	(0.4)	0.5	8.7	3.6
15 Kansas City	(3.6)	(2.8)	(3.5)	(4.9)	(5.9)	(5.0)
16 Jackson	(18.4)	(14.1)	(10.9)	(8.4)	(10.0)	(10.6)
17 Dallas	(9.5)	(5.1)	(4.4)	(1.0)	(3.3)	(3.9)
18 Phoenix	(19.9)	(17.9)	(16.4)	(8.0)	(9.2)	(11.0)
19 Denver	(9.7)	(8.1)	(8.7)	(7.2)	(7.1)	(6.2)
20 Portland	(7.3)	(3.7)	(0.8)	2.6	1.4	0.8
21 San Francisco	12.2	11.5	13.6	12.7	14.2	14.7
22 Long Beach	4.9	5.3	3.8	0.9	1.5	2.7
VHA Totals	0.0	0.0	0.0	0.0	0.0	0.0

**VERA General Purpose Allocations and Receipts include funds for special programs and facility maintenance
(Dollars in millions)**

Network	VERA General Purpose Plus Receipts	AIDS/HIV	Blind Rehabilit ation	Geriatrics & Extended Care (LTC)	Gulf War	Hepatitis C	Homeless	Pharmacy	Post Traumatic Stress Disorder	Seriously Mentally Ill	Spinal Cord Injury	Substance Abuse	Women Veterans	Facility Main- tenance
01 Boston	\$965	\$15	\$3	\$155	\$14	\$8	\$62	\$132	\$5	\$93	\$11	\$18	\$1	\$137
02 Albany	\$527	\$9	\$2	\$96	\$9	\$5	\$39	\$82	\$3	\$58	\$7	\$11	\$1	\$86
03 Bronx	\$1,094	\$15	\$3	\$158	\$14	\$8	\$64	\$135	\$5	\$95	\$11	\$19	\$1	\$190
04 Pittsburgh	\$1,004	\$17	\$3	\$176	\$16	\$9	\$71	\$150	\$6	\$106	\$13	\$21	\$1	\$151
05 Baltimore	\$590	\$10	\$2	\$103	\$9	\$5	\$41	\$88	\$3	\$62	\$7	\$12	\$1	\$95
06 Durham	\$924	\$16	\$3	\$166	\$15	\$8	\$67	\$141	\$5	\$100	\$12	\$19	\$1	\$114
07 Atlanta	\$1,113	\$20	\$4	\$201	\$18	\$10	\$81	\$172	\$6	\$121	\$14	\$24	\$1	\$177
08 Bay Pines	\$1,535	\$28	\$5	\$285	\$26	\$15	\$115	\$243	\$9	\$172	\$20	\$33	\$2	\$175
09 Nashville	\$897	\$16	\$3	\$159	\$14	\$8	\$64	\$136	\$5	\$96	\$11	\$19	\$1	\$117
10 Cincinnati	\$717	\$13	\$2	\$128	\$12	\$7	\$52	\$110	\$4	\$77	\$9	\$15	\$1	\$98
11 Ann Arbor	\$805	\$14	\$3	\$140	\$13	\$7	\$57	\$120	\$4	\$84	\$10	\$16	\$1	\$119
12 Chicago	\$948	\$15	\$3	\$155	\$14	\$8	\$63	\$132	\$5	\$93	\$11	\$18	\$1	\$153
13 Minneapolis	\$557	\$8	\$2	\$87	\$8	\$4	\$35	\$74	\$3	\$52	\$6	\$10	\$1	\$65
14 Lincoln	\$380	\$6	\$1	\$58	\$5	\$3	\$23	\$50	\$2	\$35	\$4	\$7	\$0	\$50
15 Kansas City	\$760	\$13	\$3	\$135	\$12	\$7	\$55	\$116	\$4	\$81	\$10	\$16	\$1	\$103
16 Jackson	\$1,555	\$27	\$5	\$280	\$25	\$14	\$113	\$239	\$9	\$169	\$20	\$33	\$2	\$209
17 Dallas	\$883	\$16	\$3	\$161	\$15	\$8	\$65	\$138	\$5	\$97	\$12	\$19	\$1	\$112
18 Phoenix	\$766	\$14	\$3	\$139	\$13	\$7	\$56	\$119	\$4	\$84	\$10	\$16	\$1	\$104
19 Denver	\$512	\$9	\$2	\$89	\$8	\$5	\$36	\$76	\$3	\$54	\$6	\$11	\$1	\$68
20 Portland	\$870	\$15	\$3	\$153	\$14	\$8	\$62	\$130	\$5	\$92	\$11	\$18	\$1	\$103
21 San Francisco	\$977	\$15	\$3	\$155	\$14	\$8	\$63	\$133	\$5	\$94	\$11	\$18	\$1	\$135
22 Long Beach	\$1,106	\$18	\$3	\$184	\$17	\$9	\$74	\$157	\$6	\$111	\$13	\$22	\$1	\$198
VHA Totals	\$19,487	\$328	\$63	\$3,362	\$304	\$172	\$1,358	\$2,872	\$106	\$2,025	\$242	\$395	\$24	\$2,758

Note: Numbers may not add due to rounding. Columns presented are not mutually exclusive. For example, Pharmacy and Facility Maintenance are included in programs such as AIDS/HIV, PTSD, etc. Also, funding for these programs includes both VERA General Purpose funds as well as receipts.

VHA totals are amounts in volume 2 of the President's FY 2002 budget on p. 2-91. Funding for receipts are also derived from the FY 2002 President's Budget.

This table takes the total VHA program funds and distributes them to each network based on VERA workload. The Facility Management column represents FY01 actual costs inflated by 4.6% for FY02 and is the sum of 27 separate cost centers identified, based on a methodology developed in coordination with GAO.

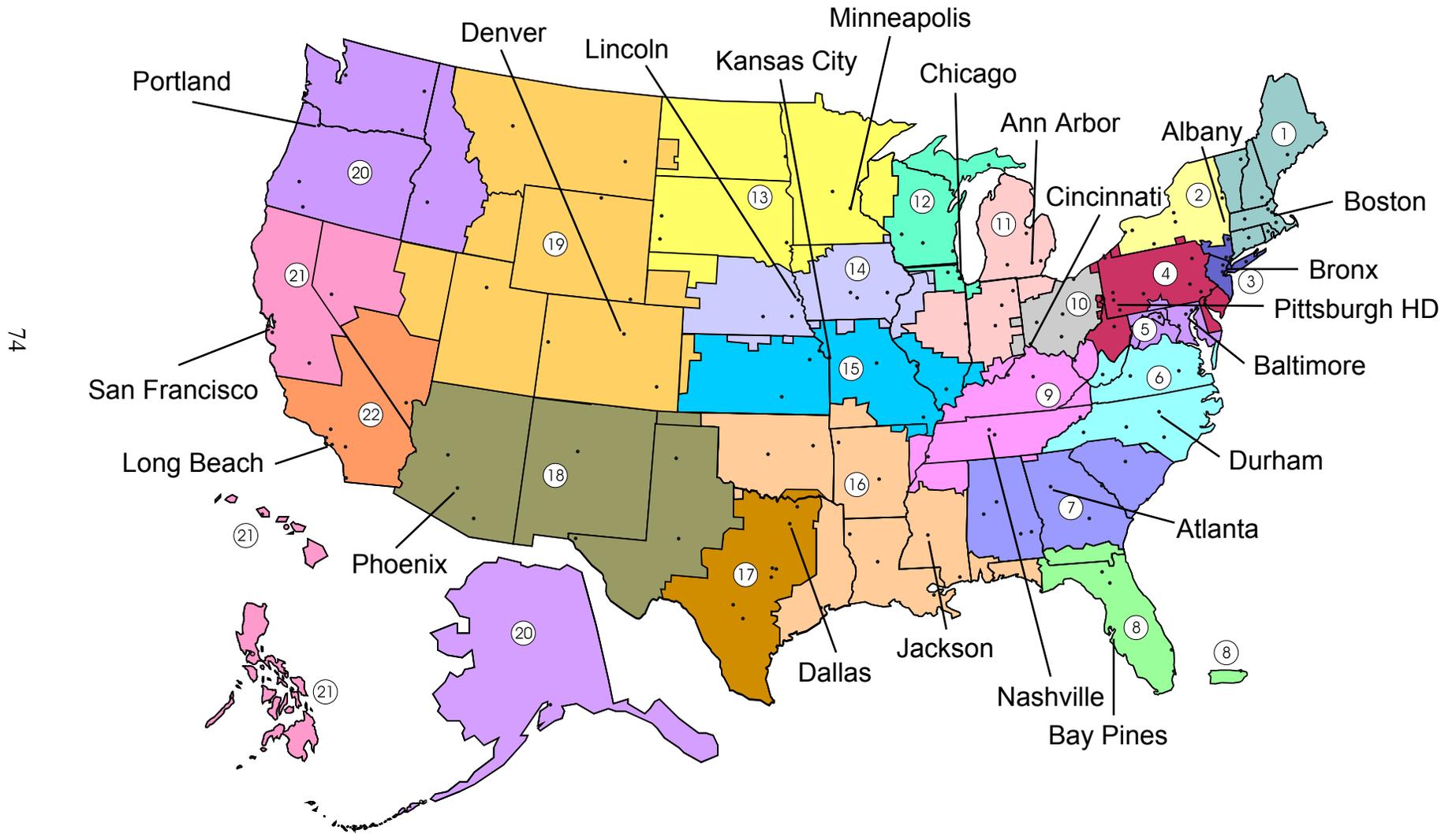
This information sets neither a program floor nor ceiling for network expenditures in these programs. Rather it illustrates that funds are allocated for these purposes according to the budget, and these funds are included in the overall resources available to networks (VERA General Purpose and Receipts).

Appendix 2

The Veterans Integrated Service Networks

Network	States
1 Boston	Massachusetts, Connecticut, Maine, New Hampshire, Rhode Island, Vermont
2 Albany	New York
3 Bronx	New York, New Jersey
4 Pittsburgh	Pennsylvania, Delaware, West Virginia
5 Baltimore	Maryland, District of Columbia, West Virginia
6 Durham	North Carolina, Virginia, West Virginia
7 Atlanta	Georgia, Alabama, South Carolina
8 Bay Pines	Florida, Puerto Rico
9 Nashville	Tennessee, Kentucky, West Virginia
10 Cincinnati	Ohio
11 Ann Arbor	Michigan, Illinois, Indiana
12 Chicago	Illinois, Michigan, Wisconsin
13 Minneapolis	Minnesota, North Dakota, South Dakota
14 Lincoln	Nebraska, Iowa
15 Kansas City	Missouri, Illinois, Kansas
16 Jackson	Mississippi, Arkansas, Louisiana, Oklahoma, Texas
17 Dallas	Texas
18 Phoenix	Arizona, New Mexico, Texas
19 Denver	Colorado, Montana, Utah, Wyoming
20 Portland	Oregon, Alaska, Idaho, Washington
21 San Francisco	California, Hawaii, Nevada, Philippines
22 Long Beach	California, Nevada

22 Veterans Integrated Service Networks



Appendix 3

History: Previous Allocation Models and Funding Inequities

History: Previous Allocation Models and Funding Inequities

Since 1985, VA has used four funding allocation systems, including VERA. These systems are briefly discussed below. In general, the previous VA funding allocation systems perpetuated funding imbalances across the country, and they were too complex. This led to:

- dollars being spent inefficiently in some facilities, resulting in limited access and services at other facilities, and
- loss of credibility because the systems were too difficult to understand.

Resource Allocation Methodology (1985 – 1990)

From FY 1985 to FY 1990, VA operated a Diagnosis Related Groups (DRG)-based Resource Allocation Methodology (RAM). RAM made retrospective adjustments to a facility's current year operating budget based on 2-year old workload and performance data. The RAM system rewarded facilities for performing as many medical procedures as possible. Under RAM, VA medical centers had incentives to perform work beyond their resources because increases in the number of patients treated or procedures performed resulted in receiving increased funding.

Resource Planning and Management (1990 – 1996)

During the late summer 1990, VA began moving to a new prospective, patient-based system along the lines of what private-sector health care was doing. The private sector was increasingly emphasizing primary care and preventive services, shifting medical and surgical treatment from inpatient to ambulatory settings, reducing lengths of hospital stays, and taking a managed care approach to the operation of large health care organizations. VA's patient-based resource allocation system, known as Resource Planning and Management (RPM), was initiated for budget allocation purposes in FY 1994 and modified for use in FY 1995, based upon refinements suggested from operational experience and clinical and field input.

The system was highly complex. In the end, the model and the process to negotiate final budget allocations proved to be too complex and onerous to effectively and credibly allocate resources. In addition, RPM was not created to fund all facilities at a nationally adjusted average price. This perpetuated the inequities in funding, efficiency, and access that existed in the VA health care system.

Even though the old systems were not used to shift resources across the country to correct funding imbalances, the data available from these systems demonstrated that such shifts were needed. For example, if RAM had been allowed to run without limits or caps, the systemwide shifting of dollars would have been more than \$200 million in any one year.

Blended Rates (1996 – First step to national adjusted prices)

During FY 1996, under a methodology known as “blended rates”, VA made an initial move toward a national pricing system by combining the local VA medical center’s historical costs with the national, network and peer group facility cost. For transition in FY 1996, the blend of the rate structure was heavily weighted toward facilities’ historical costs - that is, the FY 1996 blend was weighted at 70% for the facility rate and only 20% for the national rate. The peer group and network rates were 5% each.

In FY 1996, the blended rates model called for a shift of \$150 million from high-cost networks to low-cost networks; however, due to the system’s instability during network formation and development, reserve funds were used to minimize the shift among networks. The net effect of the shift of resources systemwide in FY 1996 was approximately \$23 million.

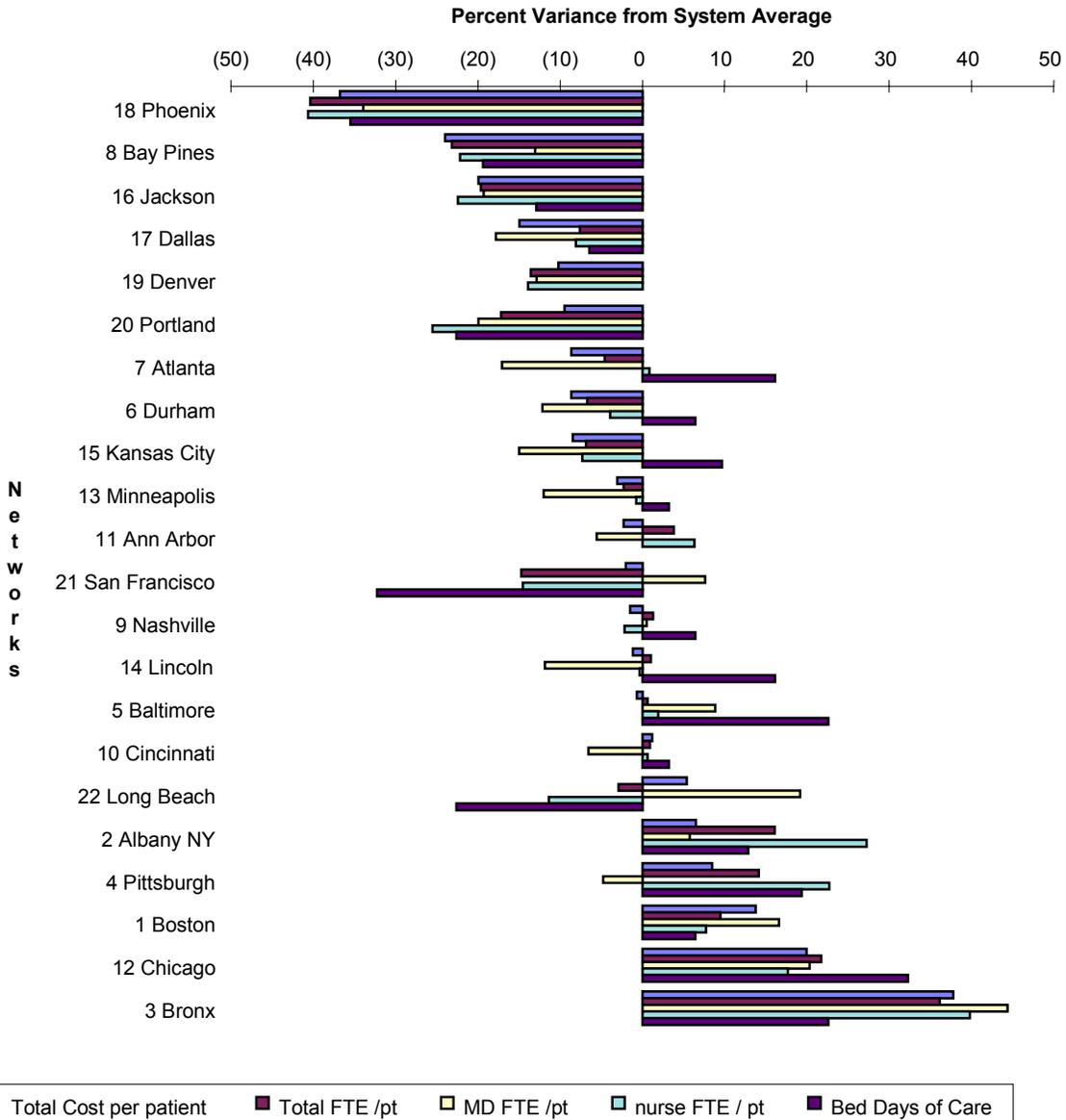
Measuring Funding Imbalances

In simple terms, “funding imbalances” or “funding inequities” occur when, after adjusting for labor and other uncontrollable costs, one network has more funding than another network that is not justified by patient care workload. In 1996, GAO noted, “While considerable numbers of veterans have migrated to southeastern and southwestern states, there was little shift in VA resources. As a result, facilities mainly in the eastern states were more likely to have adequate resources to treat all veterans seeking care than other facilities.”

The historic funding imbalances can be measured through various indicators of resource consumption. Those data include total costs per patient, number of staff per patient, and bed days of care per patient. Some of these measures are presented in Figure 16 on page 94.

Figure 16 shows that in several critical indicators of resource consumption, the Boston, Albany, Bronx, Pittsburgh and Chicago Networks (Networks 1, 2, 3, 4 and 12) significantly exceeded the VA national averages. These per patient indicators show that these networks were higher in total costs, total staff, physician staff, nurse staff, and bed days of care.

**Figure 16: Historic resource consumption per patient
(Based on FY 1995 data)**



The funding imbalances that were perpetuated by the old systems were also recognized by GAO in a report to Congress in February 1996. GAO concluded that “the [old] resource allocation system . . . produces data that point to potential inequities so that VA can better link resources to facility workloads. However, VA has not yet used the system for this purpose.” As a result, GAO also concluded that “inconsistencies remain in veterans’ access to care across the VHA

system.” They noted “the facilities in the eastern states were more likely to have adequate resources to treat all veterans seeking care than other facilities and, the [RPM] system does not distinguish between facilities’ discretionary and mandatory workload.” The report recommended that VA pursue its plans to improve the equity of its allocations, and stated: “We considered the following two elements to be characteristics of an equitable system:

- It provides comparable resources for comparable workload.
- It provides resources so that veterans within the same priority categories have the same availability of care, to the extent practical, throughout the VA health care system.”

GAO reviewed the projected change in veteran population by state, 1989 to 2000, and noted that “although the overall veteran population has decreased, veterans have been migrating from northeastern and midwestern states to southeastern and southwestern states.”

GAO recognized that while VA had been advancing its workload and expenditure measurement analysis capability, it had not moved forward aggressively in the past with RAM and RPM to implement the full impact of the resource allocation changes that these systems demonstrated. As a result, the old systems perpetuated funding imbalances across the country in the VA system.

Network allocations under VERA are made in a manner that recognizes there are legitimate and unavoidable variances among networks in the costs of providing care. These variances include the health care needs of our patients, the cost of labor in different parts of the country, and the level of support devoted to our research and education missions. The complexities of the veterans’ health care system are discussed on page 1. The VERA system addresses these complexities and, as a result, each network’s average price will vary from the national average. VERA only indicates the need for funding shifts when high or low network costs are not explained by the system’s complexities. Figure 12 on page 34 shows the projected average price each network is paid under the full impact of the VERA model in FY 2002. Figure 15 on page 44 shows the overall result from FY 1996 to FY 2000 on how the VHA allocation was spent, that is, the percent variance from the national average for each network’s total dollars per patient in FYs 1996 – 2000.

Goals of VERA

VERA was created to address the problems of the previous systems and support VA's goals of:

- treating the greatest number of veterans having the highest priority for health care,
- allocating funds fairly according to the number of veterans having the highest priority for health care,
- recognizing the special health care needs of veterans,
- creating an understandable funding allocation system that results in having a reasonably predictable budget,
- aligning resource allocation policies to the best practices in health care,
- improving the accountability in expenditures for research and education support, and
- complying with the congressional mandate.

VERA achieves these objectives and, at the same time, strikes a balance between simplifying resource allocation and recognizing the complexities of the veterans' health care system. For example, the VERA methodology recognizes that VA treats two general sets of patients – those with “routine” health care needs (Basic Care) and those with complex and typically chronic health care needs (Complex Care). Examples of Complex Care include spinal cord injury, long-term care, blind rehabilitation, chronic mental illness, end stage renal disease, and advanced AIDS.

In FY 2000, the Basic Care group was divided into two sub-components: Basic Vested Care and Basic Non-Vested Care. Basic Vested Care patients are those who rely on VA for their care. Basic Non-Vested Care patients are those who use some VA health care services but are less reliant on the VA system. A patient is considered fully vested in the veterans' health care system if he or she has used inpatient services or received an appropriate, detailed medical evaluation during the past three years. This medical evaluation is determined through the presence of an appropriate CPT code. By applying relevant CPT codes to outpatients seen in Fiscal Years 1996, 1997, and 1998, and counting the inpatients for those same years, vested patients were identified for the FY 2000 VERA.

FY 2000 Patient Classification Workload Changes: In the spring of 1998, the VHA CFO established the VERA Patient Classification Workgroup. The mission of this workgroup is to review the patient classification structure and recommend improvements as needed. When the workgroup began, there were 25 Basic Care Group classes and 29 Special Care Group classes, with a VERA price in the

allocation system for each of the two groups. As a result of their review, in FY 2000 there were 18 Basic Care classes, and 24 Complex Care classes (as compared to 19 Basic Care classes and 26 Complex Care classes in the FY 2002 VERA methodology). The workgroup recommended the following series of patient classification workload refinements that were approved for implementation beginning in the FY 2000 allocation process.

1. The four Transplant VERA Classes, (Heart/Lung, Liver, Kidney, and Bone Marrow) were combined into one class, and this class was revised from a one-year designation to a three-year designation. The move to a three-year designation recognized the extreme high cost of transplants that continues beyond the initial procedure year.
2. Compensation and Pension (C&P) Exam patients are funded workload in VERA, with assignment to the VERA Price Group indicated by their levels of care and the title of the VERA Class “One Administrative Visit” was changed to “Compensation and Pension Exams.”
3. The Blind Rehabilitation VERA Patient Class was converted from a three-year designation to a one-year designation. This was done because the average cost of caring for a Blind Rehabilitation patient declines significantly after the first year and the cost in the following years is not necessarily associated with the treatment provided in a Blind Rehabilitation center or the patient’s blind condition.
4. The VERA Patient Class, “End Stage Renal Disease, (ESRD) – Home Care,” was combined with the ESRD Class, and contract workload for patients in this class is now captured for VERA funding.
5. Collateral Visits are no longer funded in VERA. In prior years a collateral (someone associated with a veteran receiving VA health care) visit was counted and included in some cases as Complex Care workload. Now collateral visits do not qualify as VERA workload.
6. All workload associated with Home Care is considered the same without regard to provider source or designation.
7. The four HIV/AIDS classes were redefined into two classes: one for Complex Care related to infection or malignancy (current Category 4 definition) and patients who are on specific antiretroviral HIV medications; and one for Basic Care (all other HIV cases).

8. All VERA outpatient classes were eliminated (High Medical, High Rehabilitation, Standard Outpatient, Standard Outpatient greater than 12 visits, and Day Psychiatry Care), and those patients are now assigned to one of the remaining VERA classes.
9. The VERA patient class “Alcohol and Drug Abuse” was renamed “Addictive Disorders.”

FY 2001 Patient Classification Workload Changes: The following two patient classification workload refinements were approved for implementation in the FY 2001 allocation process.

Since the beginning of the VERA methodology, the Complex Care patient workload has been calculated in part by using a veteran population factor, historical experience, and age. Because the veteran population is now declining, and VA market share is increasing, the forecast based on veteran population trends predicts declines in workload numbers when in fact, workloads are rising or remaining somewhat stable overall. Therefore, beginning in FY 2001, the Complex Care projection methodology in VERA was changed to delete the veteran population factor from the calculation. It is now based on historical experience and the impact of age.

Hepatitis C virus infection is now recognized as a serious national problem and is more prevalent in the veteran population. Hepatitis C is a complicated condition that requires a high demand on staff and in cases of active treatment, has a high drug cost. In FY 2001 VERA patient classes for hepatitis C patients were developed at the Basic and Complex Care levels and are based on appropriate diagnosis and active drug therapy.

VERA also recognizes that these national prices do not account for some geographic differences in the cost of providing health care that are not under the control of network and local management. VA examined numerous factors in this regard and determined that an adjustment for the cost of labor was needed. The labor adjustment increases or decreases the network budgets depending on the wages the network must pay its employees in its part of the country. Other factors such as energy costs, age of patients, and cost of drugs were evaluated and found to be insignificant in terms of variance across networks.

FY 2001 Geographic Price Adjustment Change: For the FY 2001 network allocations, the computation of the geographic price adjustment was modified to reflect the resource intensity of Complex Care patients. The adjustment was computed using the personnel salary dollars expended in FY 1999. These salary dollars were used in a formula that accounts for two network-level factors: patients

treated and the geographic differences in labor costs. The network-level differences in labor costs are measured by a labor index that quantifies the difference between a network's salary costs and the national average salary costs. In FY 2001, the process for computing the labor index remained the same as in FY 2000, using a standard market basket approach. The adjustment formula, however, was modified to account for the resource intensity of caring for Complex Care patients. Analysis revealed that it is approximately 10 times more costly to care for Complex Care patients as compared to Basic Vested patients. These costs differences are attributed to the more costly staff mix required to care for Complex Care patients.

VERA also accounts for veterans who receive care in more than one network during the year – i.e., veterans who receive “care across networks”. This includes the veterans who are commonly known as “snowbirds”. Network budgets are adjusted based on the historical usage patterns and costs for these veterans.

In addition to labor and care across networks, VERA adjusts for four other factors: research support, education support, equipment, and non-recurring maintenance. These adjustments recognize that the level of research and education support, as well as the need for equipment and non-recurring maintenance, is not the same among the networks. VERA begins with the Basic Vested Care, Basic Non-Vested Care, and Complex Care prices and adjusts each network's budget for the components discussed above. As a result, each network receives a budget that recognizes its individual characteristics.

The results, if the VERA model had been fully applied in FY 1997, demonstrated that resource shifts would range from a loss of 15% to a gain of 16%, as compared to FY 1996 budget allocations. VA believed that such funding shifts could not realistically occur in a single fiscal year. As a result, the funding shifts from VERA have been implemented incrementally.

In FY 1997, VERA was not implemented until April 1, 1997 – halfway through the fiscal year. Therefore, two methods were used to allocate resources in FY 1997. For the first half of the year, the networks were funded at approximately one half of the FY 1996 level, plus an increase equal to the change in the total systemwide Medical Care appropriation from FY 1996 to FY 1997. This increase was 2.75%. For the months that VERA was used in FY 1997, the maximum amount that any network was reduced was limited to 5% on an annualized basis. When both of these limitations were applied to the VERA methodology, the largest full year reduction (including equipment and non-recurring maintenance) for any network was 1.1% below FY 1996. The largest gain was 6.8% above FY 1996. In FY 1997, 17 networks received more funding than in FY 1996.

Twelve of the networks (55%) had increases greater than the total rate of increase in the system's funding from FY 1996 to FY 1997 (i.e., 2.9%).

For FY 1998 VERA was used to allocate funds at the beginning of the fiscal year. The amount that any network was reduced below FY 1997 was limited to 5%. Based on the model's results, 13 networks received increases over funding levels for FY 1997; nine networks received less funding. Comparing FY 1998 funding with FY 1996 (the baseline year for VERA), six networks had increases of 10% or more, with the greatest increase at 12.3%.

In addition, Congress enacted provisions in the FY 1998 budget for VA to retain medical collections rather than return them to the Department of Treasury, as had been required in the past. The legislation terminated the Medical Care Cost Recovery (MCCR) Fund and established the Medical Care Collections Fund (MCCF). Since July 1, 1997, all collections from third-party reimbursements, copayments, per diems, and certain torts were deposited in this new fund. Amounts in the MCCF are available for transfer to the Medical Care account and will remain available until expended. A total of \$647 million was collected in MCCF for FY 1998. In addition, a total of \$83 million in other reimbursements was collected in FY 1998. These include reimbursements for sharing and TRICARE. Thus, each network's FY 1998 budget included these reimbursements plus VERA allocations.

In FY 1999, the amount any network was reduced below FY 1998 was limited to 5%. Seven networks received less funding than in FY 1998, while 15 networks received increases. Comparing FY 1999 to FY 1996, seven networks had increases of 10% or more with the greatest increase at 16.8%. \$571 million was collected in MCCF and \$98 million was collected in other reimbursements in FY 1999.

For FY 2000, all networks received more funding than in FY 1999. The 5% cap applied in previous years was no longer necessary because no network was reduced more than 5% from its FY 1999 level. Comparing FY 2000 with FY 1996, eight networks had increases of 20% or more with the greatest increase at 40.6%. \$573 million was collected in MCCF and \$104 million was collected in other reimbursements in FY 2000.

In FY 2001, all networks received increases over funding levels for FY 2000. The FY 2000 VERA funding base was adjusted to reflect the centralized funding of prosthetics for FY 2001. Comparing FY 2001 funding with FY 1996, six networks had increases of 30% or more, with the greatest increase at 46.9%. \$771 million was collected in MCCF and \$120 million was collected in other reimbursements in FY 2001.

A major premise of VERA is that networks receiving relatively fewer funds will adjust by becoming more efficient - not by reducing services or numbers of veterans served. VA firmly believes that these networks will be able to operate closer to the national average cost per patient, because the Department is taking into consideration that there are variances among networks for the number of Basic and Complex Care patients, labor costs, research support, education support, equipment, and non-recurring maintenance. Experience has shown that networks have continued to provide quality care and expand services to veterans.