Veterans Equitable Resource Allocation (VERA)

- Two years ago VA began transforming the veterans health-care system. VA shifted from a system of individual medical centers and clinics focused on inpatient care to a fully integrated system of health-care.

- Today, 22 management hubs covering defined geographical areas called Veterans Integrated Service Networks (VISNs) administer the new patient-centered approach to delivering VA health-care.

- The changes in health-care delivery, geographic redistribution of veterans, and tighter budgets required a review of how VA distributes its resources to make sure eligible veterans receive appropriate care.

- Past allocation systems created funding imbalances across the country and were too complex.

- This meant dollars were spent inefficiently in over-funded facilities in given areas of the country and, thus, limited access and the level of service to veterans who got care from under-funded facilities elsewhere.

- VERA is a new way of distributing VA's $17 billion medical-care budget to the VISNs.

- VERA will correct past geographic funding imbalances and will help make sure equitable access to care is available to all eligible veterans.

- No veteran currently receiving VA care will be denied care as a result of this action. In fact, VA expects more veterans to be treated under VERA.

- Veterans will have improved access to care, improved quality of care and a wider spectrum of services.

- VERA allocates funds to Networks based primarily on a national price for two different types of patients -- those with routine health-care needs and those with special, and generally long-term, health-care needs that are relatively expensive.

- The new system supports VA's goals of:

  - treating the greatest number of veterans who have the highest priority for health-care;

  - allocating funds equitably based on the number of veterans having the highest priority for health-care;

  - creating an understandable resource allocation system that is reasonably predictable; and

  - aligning resource allocation policies to the best practices in heath-care.

- The shifting of funds will begin in April 1997 (halfway through the fiscal year) and will take place over a three-year period.

- This year, 16 of the 22 networks will receive increases in funding while 6 will have a reduction, and the most any network will be reduced is 1.26 percent below the FY 1996 funding level.

- Networks with decreasing funds will achieve their budget targets by becoming more efficient. This will not mean less services to priority veterans in those Networks.

1/14/1997

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Veterans Equitable Resource Allocation (VERA)
Questions and Answers – Continued from 12/23/96 List

Question #18: Will those Networks with budget reductions under VERA treat less veterans and offer less services?

Answer: No. Networks with budget reductions will achieve those reductions through increased efficiencies. The achievement of such efficiencies are not unrealistic to expect, because VERA allocates funds based on a VHA national average price. This means that Networks facing reductions are simply being asked to operate at an average cost – they are not being asked to operate at the cost of the most efficient, or lowest-cost Networks. It is important to note that the Network budgets are adjusted to reflect the differences in labor costs across the country as well as the variance in levels of research, education, equipment and non-recurring maintenance. In the end, we firmly believe that VERA will result in no fewer veterans being treated; instead it should allow for more veterans to be treated.

Question #19: What happens if a Network cannot make it through the year with its current budget without turning away veterans who we currently treat?

Answer: We do not expect this to happen. The shifts in funding are being phased in at a very conservative rate. The most any Network is decreased in FY 1997 is 1.26%. If, however, unforeseen circumstances bring about the scenario in question, VHA Corporate Headquarters would make available reserve funding to accommodate the needs of the veterans in that Network. Headquarters is maintaining a $100 million reserve to ensure that veterans continue to receive their care from the VA.

Question #20: Veterans in our area of the country are older and sicker than those in other parts of the country. What's being done to take care of that?

Answer: Our data show that across the Networks there is no significant difference in the average age of our veteran patients. The lowest average age is 54.3 years in Network 7 and the highest is 58.3 years in Network 1.

Question # 21: The decreasing budgets are in the colder areas of the country. Wouldn't energy expenses be one of the reasons their costs are higher and explain why they are losing money?

Answer: No. Energy costs are not significant enough to influence the model allocations. In fact, systemwide, energy costs average only 1.5% of Network budgets. The Network with the highest energy cost is less than 1% above the system average. Energy costs and other moderate variances in the cost of doing business in the Networks will be managed by the Network Directors within their total allocations.

Question #22: The new system has only two patient groups (Basic and Special). The old system had five groups (Basic, Transplants, Chronic Mental Illness, Extended Care, and Special Care). By reducing the number of patient groups won't you reduce funding to those networks with patients who require more care because transplants, chronic mental illness, etc. are no longer identified separately for allocation purposes?

Answer: Analysis revealed that moving from five to two patient groups did not effect the amount of funds that would move across networks, or the bottom line for individual network budgets. As a result, the decision was made to reduce the number of patient groups to simplify the system.

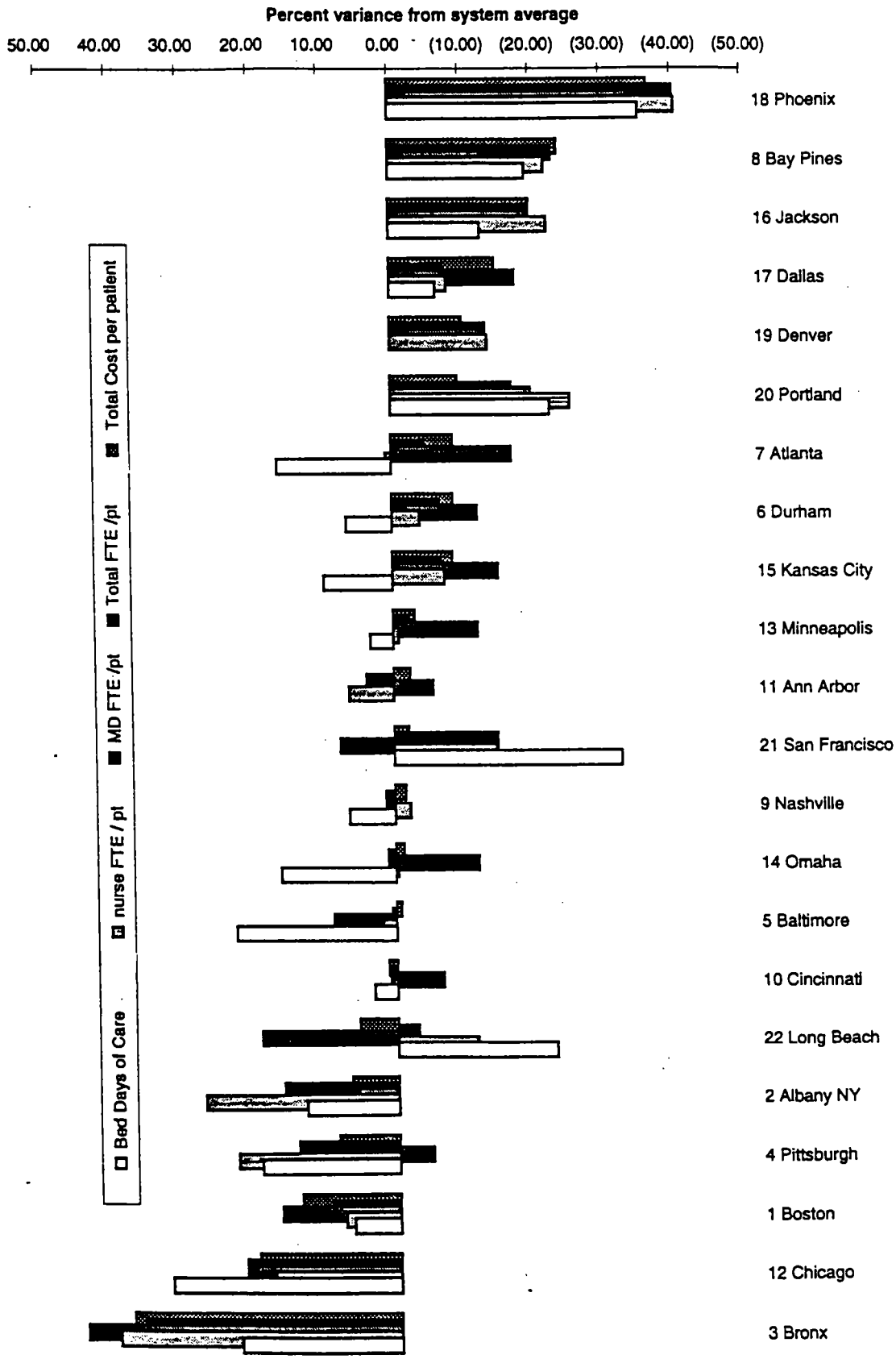
Veterans Health Administration

Veterans Equitable Resource Allocation (VERA)

January 1997

GAO Report gives similar assessment

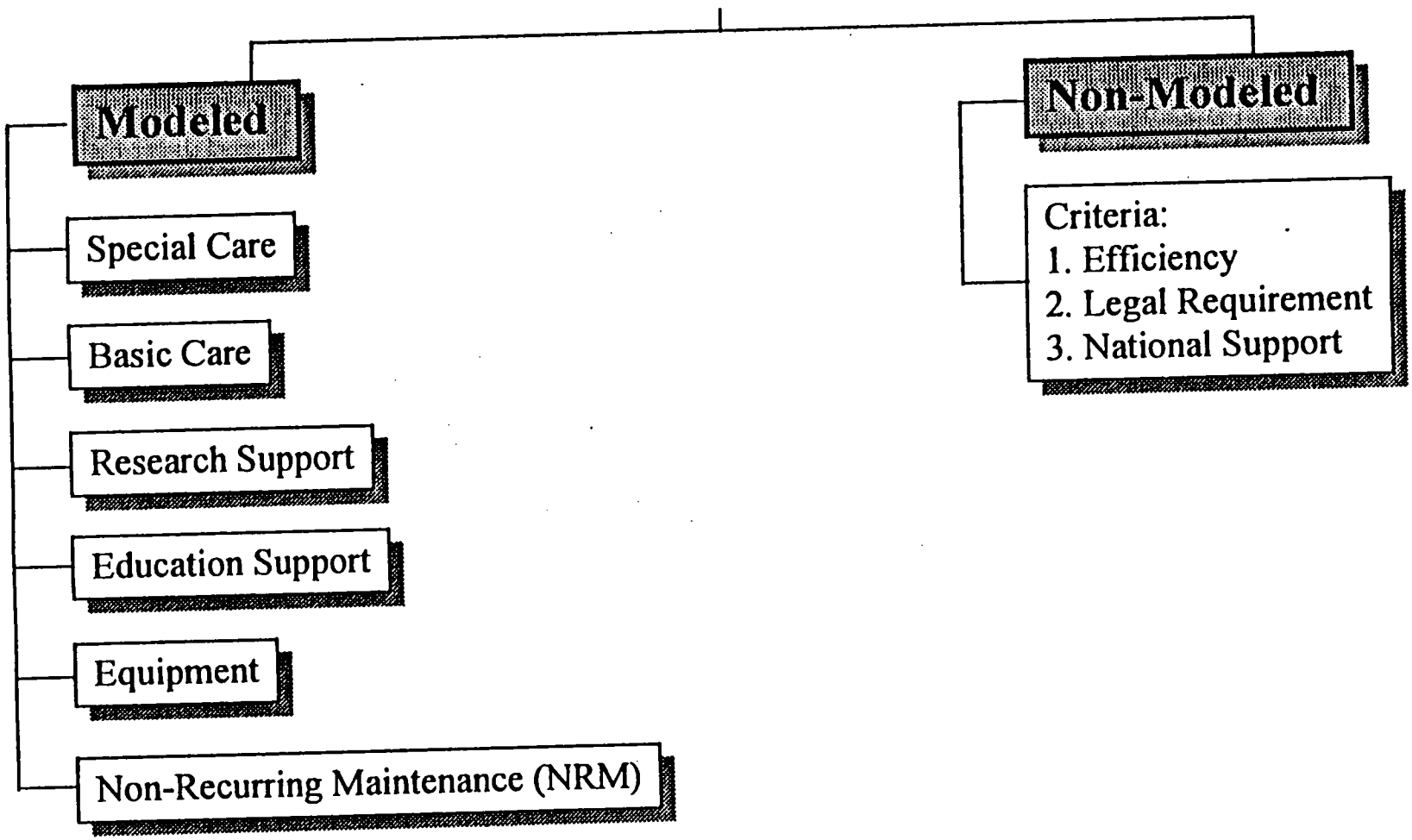
Graph 1: Historic resources per patient



FY 1997 Funding - Two Phases

- Hold Harmless Period - Portion of FY 1996 Plus Inflation (Oct - March)
- Remainder of Year - ERA System

Veterans Equitable Resource Allocation (VERA)



The President's Budget *($s x1000)*

- *Medical Care appropriation* *$17,079,447*
- *Special Care allocation (30.4%)* *$5,197,414*
- *Basic Care allocation (49.5%)* *$8,452,505*
- *Research (2.3%)* *$399,439*
- *Education (2.3%)* *$384,749*
- *Equipment (2.1%)* *$352,666*
- *Non-Recur Maint (NRM) (1.4%)* *$235,653*
- *Non-modeled $s (12.0%)* *$2,057,021*

Special and Basic Care Workload Models:

- *Patient Groups*
- *Price*
- *Volume*

Patient Groups

1996

- Basic
- Transplants
- Extended Care
- AIDS
- Chronic Care

1997

- Basic
- Special

Number of allocation groups will be reduced from five to two. High cost patients in VHA's Special Emphasis Programs are included in the ERA Special Patient Group as well as other high cost care groups (e.g., end stage renal and HIV categories 3/4).

Price Setting

1996	1997
• Blended Rate used to create price (70/5/5/20).	• No blended rate -- National prices are used (0/0/0/100).
• Price set for each of the five care groups at each VAMC.	• Price set for each of the two care groups at a national level.
• Over 800 prices set across the system.	• Only two prices set across the system.

Price Setting (cont.)

1996

1997

- National prices (est.):

  $2,608: Basic Care

  $35,687: Special Care

Determining Volume

1996

- For all five care groups a historical-based projection was made to determine the expected number of users in the budget year.

1997

- Basic Care Group: Three-years of user data accounts for Category A veterans who use VHA, but have not needed care every year.

Determining Volume (cont.)
1997

- Special Care:

  Same as used in 1996 for all groups.

Care Across Networks

1996

- Pro-rated person concept.
- Proportionately distributed costs of care to facilities based on share of costs for each veteran.

1997

- Same as 1996.

Adjustments to the Price

1996

- Complex, detailed computer model.

1997

- Only one --

  * Labor index to account for differences in labor markets across the country.

Labor Index

1	1.041	12	1.010
2	0.966	13	0.993
3	1.089	14	0.961
4	0.993	15	0.971
5	1.033	16	0.976
6	0.964	17	0.960
7	0.961	18	0.964
8	0.948	19	0.975
9	0.955	20	1.004
10	0.992	21	1.123
11	0.999	22	1.058

Non-Workload Models

Research Support, Education Support, Equipment and NRM

Research Support

Recognizes different levels of research that is performed across Networks.

Distributes total research support funding on each Network's proportional share of VHA's total Research budget.

1997 Education Support

- Recognizes differences across Networks in level of medical education programs.

- Allocation of education support funds will be a proportional distribution based on each Network's share of medical residents.

1997 Equipment Allocation

50% case-mix

25% unique patient count

25% CMR historical purchase rate

1997 NRM Allocation

- 90% square foot (Boeckh) index
- 10% in national pricing pool

1997 - Transition Year

Fiscal Year 1997 is a transition year for resource allocation and serves as a bridge to moving toward 1998.

In order to have an adjustment period for Networks to adapt to the new allocation system, there is a need for caps and limits on dollars moved.

Limits will be adjusted to "hold harmless" the portion of FY where ERA is not applied.

Full Impact of VERA Model
($$ in millions)

VISN	FY 96	FY97 ERA Allocation subtotal	$ Gain or loss from FY96 allocation	% Budget shift no delay
1 Boston	$822	$770	($52)	(6.36)
2 Albany NY	$421	$389	($32)	(7.51)
3 Bronx	$988	$840	($148)	(14.94)
4 Pittsburgh	$744	$729	($15)	(1.99)
5 Baltimore	$408	$425	$17	4.10
6 Durham	$656	$685	$29	4.36
7 Atlanta	$748	$832	$83	11.13
8 Bay Pines	$928	$1,021	$93	10.03
9 Nashville	$662	$666	$4	0.60
10 Cincinnati	$489	$512	$22	4.51
11 Ann Arbor	$633	$617	($16)	(2.51)
12 Chicago	$801	$744	($57)	(7.12)
13 Minneapolis	$400	$400	$0	0.01
14 Omaha	$277	$266	($11)	(4.07)
15 Kansas City	$560	$604	$43	7.76
16 Jackson	$1,032	$1,156	$123	11.95
17 Dallas	$566	$634	$68	11.99
18 Phoenix	$466	$541	$75	16.02
19 Denver	$353	$376	$23	6.60
20 Portland	$561	$645	$84	15.01
21 San Francisco	$665	$706	$41	6.21
22 Long Beach	$868	$879	$11	1.28
VHA	$14,048	$14,434	$386	2.75

Note: these figures reflect VISN allocatins prior to Equipment and NRM

- will get there over 3 years
- this ∆ gets them to System Average

Full Impact of VERA Model

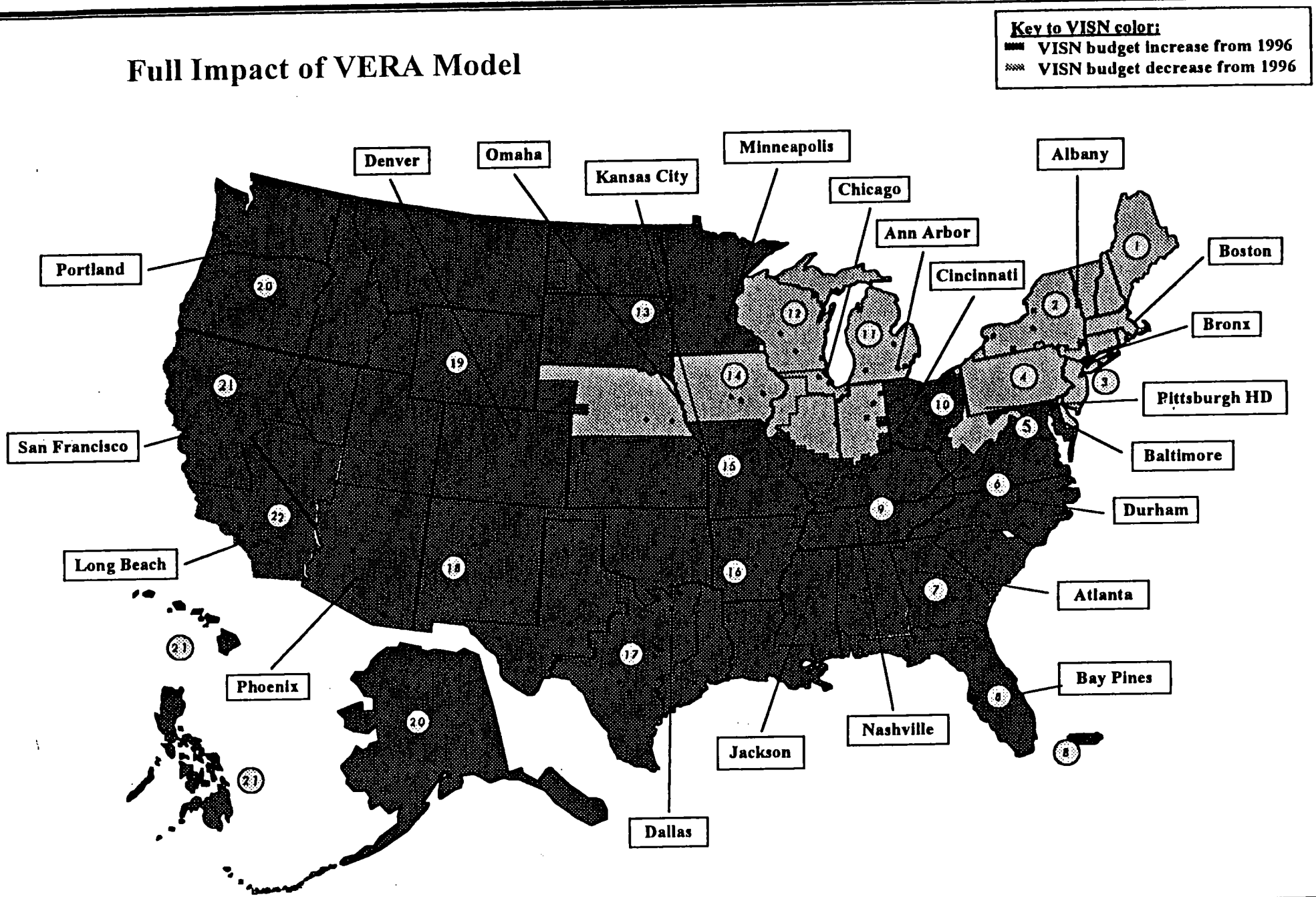


Table 15: Changes in Network Budgets - 1996 and 1997 with phase-in implementation

($s in millions)

VISN	FY 96	FY 97 Allocation with phase-in	$Difference from FY96	% Difference from FY96
1 Boston	$822	$811	($10)	(1.26)
2 Albany NY	$421	$416	($5)	(1.17)
3 Bronx	$988	$976	($11)	(1.16)
4 Pittsburgh	$744	$745	$1	0.16
5 Baltimore	$408	$425	$17	4.07
6 Durham	$656	$681	$25	3.78
7 Atlanta	$748	$785	$37	4.93
8 Bay Pines	$928	$985	$57	6.15
9 Nashville	$662	$671	$10	1.47
10 Cincinnati	$489	$508	$19	3.84
11 Ann Arbor	$633	$631	($1)	(0.23)
12 Chicago	$801	$793	($8)	(1.05)
13 Minneapolis	$400	$406	$6	1.50
14 Omaha	$277	$276	($1)	(0.40)
15 Kansas City	$560	$590	$30	5.30
16 Jackson	$1,032	$1,090	$58	5.58
17 Dallas	$566	$601	$35	6.15
18 Phoenix	$466	$498	$32	6.90
19 Denver	$353	$369	$17	4.75
20 Portland	$561	$595	$34	6.09
21 San Francisco	$665	$696	$31	4.70
22 Long Beach	$868	$884	$17	1.93
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