



VA | U.S. Department
of Veterans Affairs

V E R A

**Veterans
Equitable
Resource
Allocation**



2015

Equitable Funding Across
21 Health Care Networks



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Veterans Equitable Resource Allocation System

Nineteenth Edition

May 2015

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DEPARTMENT OF VETERANS AFFAIRS

Veterans Health Administration

Washington DC 20420

Foreword

The Veterans Health Administration (VHA) instituted the Veterans Equitable Resource Allocation (VERA) Model in April 1997 to allocate funds to the Veterans Integrated Service Networks (VISNs). VERA ensures that the allocation of funds is equitably distributed based on Veterans who use the VA health care system rather than simply being based on historic funding patterns. The implementation of VERA has aided in the transformation of VA's health care system from individual medical centers and clinics focused primarily on inpatient care to a fully integrated system with expanded primary and ambulatory care capability. VERA has been, and will continue to be, a critical component of VA's success in implementing the mission and vision of VHA.

The VERA Model gives each network a "tailored" allocation price that reflects the unique characteristics of each network. For example, network funding is based on a combination of the number of patients, adjustments for regional variances in labor and contract costs, high cost patients, education support, research support and equipment. While VERA has significantly improved the allocation of the Veterans' health care budget, VHA will continue to review and examine the VERA Allocation Model to assure its continued relevance and to identify needed improvements.

Since VERA was introduced in 1997, there have been nine external assessments of VERA. These independent reviews have validated that the VERA methodology is meeting its objectives and the original intent of Congress under Public Law 104-204. Refinements to the VERA methodology, based on findings and recommendations from these nine assessments, are described in Appendix 3 of the FY 2015 VERA Book. The process for refining the VERA methodology can be internally generated by VA users of the VERA system or externally generated by outside VERA evaluators. The VERA refinements generated by the internal and external stakeholders are reviewed and recommended by the VHA National Leadership Council (NLC) and then approved by the Secretary.

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This VERA Book is the nineteenth edition and updates the 2014 eighteenth edition with the incorporated changes and technical modifications for FY 2015 and the ongoing evaluation of the VERA Model. VHA will continue to ensure that the allocation of taxpayer dollars for Veterans' health care remains fair, equitable, and effective.

A handwritten signature in black ink, appearing to read "Carolyn M. Clancy" followed by a small "MD" to the right.

Carolyn M. Clancy, MD
Interim Under Secretary for Health

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EXECUTIVE SUMMARY

VERA Model Works at the VISN Level

The VERA Model is designed to fund patient care at the VISN level using a “capitated” funding methodology. Capitated funding is a process that results in a series of nationally computed prices designed to fund major groupings of patients at the VISN level. The process utilizes similar groups of patients based on well defined criteria outlined in the VERA Patient Classification system. The Patient Classification system is a risk-adjusted system used to categorize patients based on clinical complexity and resource utilization patterns. This system provides the national patient case-mix that is used to establish the VERA Model Prices.

The VERA Model consists of 10 price groups that are used to distribute VERA patient care dollars to VISNs. By design, a “capitated” funding methodology is an appropriate funding mechanism when the funding units are sufficiently populated and clinically diverse. For this reason, the VERA funding methodology is appropriate at the VISN level because the VISN patient population is both large in terms of the number of patients and sufficiently diverse in terms of clinical case-mix. However, unlike VISNs, facilities within a VISN are often specialized or organized by major treating specialties, thereby lacking a representative case-mix of patients. This lack of patient diversity precludes the VERA methodology from serving as a reliable facility-level funding strategy.

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Total Network Resources for General Purpose and Specific Purpose Funding shown in the tables below:

In FY 2015, VERA allocated \$37.2 billion in General Purpose funds of as shown below in Table 1 Results of VERA Model - FY2015. The table displays the network distribution of General Purpose funding for each VERA component.

Table 1: Results of VERA Model - FY 2015						
(\$ in thousands)						
Network	Basic and Complex Care Allocations with Geographic Price Adjustment, Long Stay Allocation, and High Cost	Research Support and Education Support	Equipment	Non-VA Care	CBO Staff	Total
01 Boston	\$1,830,244	\$114,580	\$17,883	(\$165,668)	(\$4,134)	\$1,792,907
02 Albany	\$899,074	\$24,670	\$9,644	(\$71,884)	(\$2,090)	\$859,414
03 Bronx	\$1,550,965	\$65,862	\$12,901	(\$62,987)	(\$1,795)	\$1,564,945
04 Pittsburgh	\$1,908,839	\$48,018	\$22,162	(\$190,268)	(\$5,372)	\$1,783,379
05 Baltimore	\$1,056,686	\$49,369	\$10,177	(\$80,989)	(\$1,319)	\$1,033,924
06 Durham	\$2,230,924	\$64,837	\$24,817	(\$247,515)	(\$7,837)	\$2,065,226
07 Atlanta	\$2,384,792	\$73,502	\$28,320	(\$272,148)	(\$8,194)	\$2,206,272
08 Bay Pines	\$3,532,876	\$81,340	\$39,073	(\$458,348)	(\$16,519)	\$3,178,421
09 Nashville	\$1,808,551	\$67,334	\$20,762	(\$210,524)	(\$4,568)	\$1,681,555
10 Cincinnati	\$1,636,152	\$41,828	\$16,136	(\$189,114)	(\$3,702)	\$1,501,300
11 Ann Arbor	\$1,719,302	\$65,211	\$20,230	(\$155,205)	(\$4,696)	\$1,644,842
12 Chicago	\$1,802,499	\$81,353	\$17,876	(\$166,238)	(\$3,943)	\$1,731,547
15 Kansas City	\$1,549,699	\$36,901	\$17,333	(\$206,698)	(\$4,185)	\$1,393,050
16 Jackson	\$3,084,906	\$95,357	\$35,566	(\$379,582)	(\$7,857)	\$2,828,391
17 Dallas	\$1,918,613	\$58,796	\$21,368	(\$212,433)	(\$4,353)	\$1,781,992
18 Phoenix	\$1,653,772	\$48,324	\$18,673	(\$255,036)	(\$2,548)	\$1,463,185
19 Denver	\$1,225,042	\$43,354	\$14,057	(\$252,624)	(\$4,554)	\$1,025,275
20 Portland	\$1,860,630	\$68,520	\$19,991	(\$334,797)	(\$4,812)	\$1,609,532
21 San Francisco	\$2,211,069	\$115,837	\$19,291	(\$300,803)	(\$4,096)	\$2,041,298
22 Long Beach	\$2,358,829	\$122,994	\$22,929	(\$246,296)	(\$6,127)	\$2,252,329
23 Minneapolis	\$2,024,750	\$72,012	\$23,035	(\$309,591)	(\$5,240)	\$1,804,966
VHA Totals	\$40,248,214	\$1,440,000	\$432,224	(\$4,768,748)	(\$107,943)	\$37,243,747

Note: These are one-time adjustments.

Additional estimated network funding is available from collections, reimbursements, and Specific Purpose funding. Specific Purpose funding for Prosthetics, State Home, Trainees, Readjustment Counseling Service, Homeless Veteran Programs, Transplants, Activations, Mental Health (Staffing), Hepatitis C (HEP C), Non-VA Care, CBO Staff, Non-Recurring Maintenance (NRM) and Other Specific Purpose funds totaling \$18.5 billion; \$3.1 billion from the Medical Care Collection Fund (MCCF), and \$146 million in Reimbursements for networks in FY 2015. Table 2, shown on the next page, provides a comparison of the FY 2014 total allocations to projected FY 2015 total allocations as well as a comparison of VERA General Purpose allocations from FY 2014 to FY 2015.

The fiscal year comparisons are represented as a percent change from FY 2014 to FY 2015. The minimum any total network budget increases from FY 2014 to FY 2015 is 0.5% in Network 7, while the greatest increase is 7.5% in Network 6.

Table 2: VERA Allocations, Specific Purpose, Transformation and Estimated Receipts - FY 2014 - FY 2015

(\$ in million)

Network	FY 2014 Total Available Funding	FY 2014 VERA General Purpose Total	'FY 2015 VERA General Purpose Total	GP Percent Change from FY 2014	FY 2015 Estimated Specific Purpose	FY 2014 Projected Collections	FY 2014 Projected Reimbursements	FY 2014 Projected Total	Total Percent Change from FY 2014 to FY 2015
01 Boston	\$2,458	\$1,995	\$1,793	-10.1%	\$606	\$148	\$6	\$2,553	3.8%
02 Albany	\$1,154	\$935	\$859	-8.1%	\$289	\$59	\$4	\$1,211	5.0%
03 Bronx	\$2,032	\$1,637	\$1,565	-4.4%	\$413	\$100	\$9	\$2,087	2.7%
04 Pittsburgh	\$2,434	\$2,010	\$1,783	-11.3%	\$591	\$133	\$7	\$2,513	3.2%
05 Baltimore	\$1,443	\$1,122	\$1,034	-7.8%	\$380	\$82	\$3	\$1,499	3.8%
06 Durham	\$2,913	\$2,247	\$2,065	-8.1%	\$836	\$221	\$8	\$3,130	7.5%
07 Atlanta	\$3,112	\$2,479	\$2,206	-11.0%	\$735	\$184	\$2	\$3,128	0.5%
08 Bay Pines	\$4,524	\$3,567	\$3,178	-10.9%	\$1,228	\$320	\$17	\$4,743	4.8%
09 Nashville	\$2,338	\$1,879	\$1,682	-10.5%	\$581	\$163	\$5	\$2,431	4.0%
10 Cincinnati	\$2,004	\$1,660	\$1,501	-9.6%	\$484	\$116	\$4	\$2,106	5.1%
11 Ann Arbor	\$2,157	\$1,756	\$1,645	-6.3%	\$502	\$117	\$2	\$2,266	5.1%
12 Chicago	\$2,462	\$1,915	\$1,732	-9.6%	\$624	\$168	\$9	\$2,533	2.9%
15 Kansas City	\$2,046	\$1,613	\$1,393	-13.6%	\$608	\$137	\$5	\$2,143	4.7%
16 Jackson	\$4,061	\$3,197	\$2,828	-11.5%	\$1,217	\$220	\$8	\$4,274	5.3%
17 Dallas	\$2,492	\$1,999	\$1,782	-10.8%	\$580	\$146	\$18	\$2,526	1.3%
18 Phoenix	\$2,114	\$1,719	\$1,463	-14.9%	\$586	\$119	\$7	\$2,176	2.9%
19 Denver	\$1,654	\$1,233	\$1,025	-16.8%	\$606	\$124	\$3	\$1,758	6.3%
20 Portland	\$2,405	\$1,904	\$1,610	-15.4%	\$734	\$148	\$6	\$2,499	3.9%
21 San Francisco	\$2,822	\$2,287	\$2,041	-10.8%	\$835	\$126	\$13	\$3,016	6.9%
22 Long Beach	\$3,052	\$2,456	\$2,252	-8.3%	\$823	\$118	\$9	\$3,203	4.9%
23 Minneapolis	\$2,602	\$2,106	\$1,805	-14.3%	\$695	\$191	\$0	\$2,690	3.4%
VHA Totals	\$52,280	\$41,715	\$37,244	-10.7%	\$13,952	\$3,141	\$146	\$54,483	4.2%

Notes:

1. 'FY 2015 Actual Data will not be available until the end of the fiscal year and if it is Actual Funding it is noted in the column heading.
2. General Purpose Total versus the Projected Total is Specific Purpose, Collections and Reimbursements are not included in the General Purpose Total.

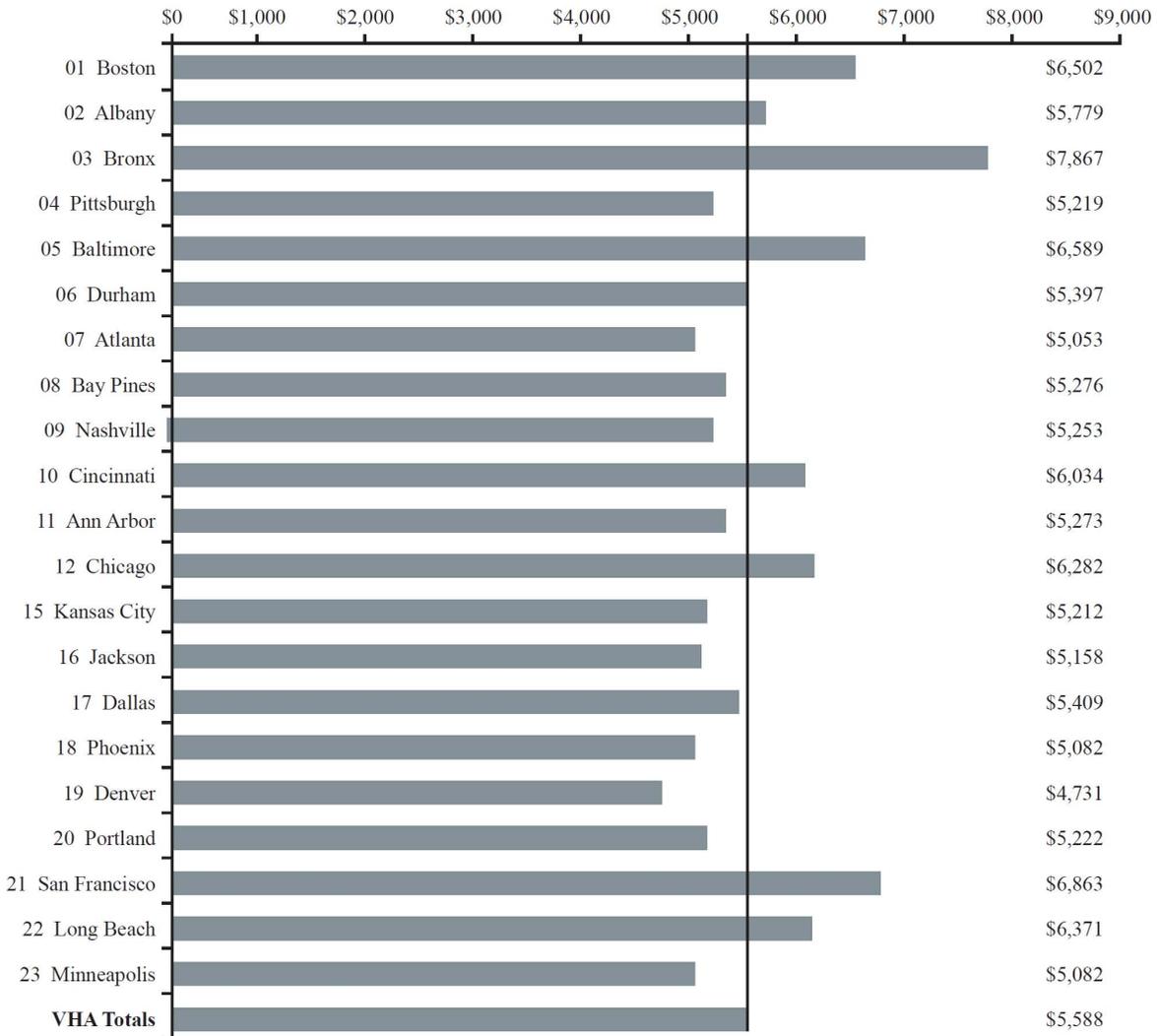
Table 3, shown below displays the impact of the VERA allocation on network budgets from FY 2014 to FY 2015. Specific formulas and back-up data to create this table are included in Appendix 1.

Table 3: Changes in Network VERA Budgets				
FY 2014 - FY 2015				
(\$ in millions)				
Network	FY 2014 General Purpose	FY 2015 General Purpose	Decrease/ Increase	Total Percent Change from FY 2014 to FY 2015
01 Boston	\$1,995	\$1,793	(\$202)	-10.1%
02 Albany	\$935	\$859	(\$75)	-8.1%
03 Bronx	\$1,637	\$1,565	(\$72)	-4.4%
04 Pittsburgh	\$2,010	\$1,783	(\$226)	-11.3%
05 Baltimore	\$1,122	\$1,034	(\$88)	-7.8%
06 Durham	\$2,247	\$2,065	(\$182)	-8.1%
07 Atlanta	\$2,479	\$2,206	(\$273)	-11.0%
08 Bay Pines	\$3,567	\$3,178	(\$389)	-10.9%
09 Nashville	\$1,879	\$1,682	(\$198)	-10.5%
10 Cincinnati	\$1,660	\$1,501	(\$159)	-9.6%
11 Ann Arbor	\$1,756	\$1,645	(\$111)	-6.3%
12 Chicago	\$1,915	\$1,732	(\$183)	-9.6%
15 Kansas City	\$1,613	\$1,393	(\$220)	-13.6%
16 Jackson	\$3,197	\$2,828	(\$369)	-11.5%
17 Dallas	\$1,999	\$1,782	(\$217)	-10.8%
18 Phoenix	\$1,719	\$1,463	(\$256)	-14.9%
19 Denver	\$1,233	\$1,025	(\$208)	-16.8%
20 Portland	\$1,904	\$1,610	(\$294)	-15.4%
21 San Francisco	\$2,287	\$2,041	(\$246)	-10.8%
22 Long Beach	\$2,456	\$2,252	(\$204)	-8.3%
23 Minneapolis	\$2,106	\$1,805	(\$302)	-14.3%
VHA Totals	\$41,715	\$37,244	(\$4,472)	-10.7%

Note: The numbers may not add due to rounding.

Figure 1 on the next page shows FY 2015 projected average price per patient for each network under the impact of the VERA Model, including the additional allocation for the top 1% high cost patients. The network average price is calculated by dividing each network's total VERA funding by each network's total patients. The figure displays the average dollars allocated to each network. Variances from the national average demonstrate that VERA is not simply moving all networks to an average price per patient, but adjusts network allocations for differences in patient mix, high cost patients, geographic costs, research and education support costs, equipment, Non-VA Care and CBO Staff costs.

Figure 1: Projected VERA Average Price by Network - FY 2015



Note: Average Price includes 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).

VERA Principles

Based on the work generated by internal VA users of the VERA system and external VERA evaluations, the following principles were instituted in VERA in FY 2003 and continue for the FY 2015 VERA methodology. These VERA principles are:

- Improve the equity of the allocation process and decisions.
- Be responsive to GAO, RAND and other recommendations.
- Recognize price and cost differences in “core mission” patients (those Veterans with service-connected disabilities; those with incomes below the current income threshold or special needs patients, such as homeless Veterans).
- Provide education for VERA users.
- Eliminate any need to provide networks with supplemental funding adjustments.

FY 2015 VERA Changes

The VERA 2015 Model contains a few changes from the prior year. These changes include three modifications to the VERA Patient Classification System and process improvements for identifying the VHA’s Basic Care patient population. The enhancements to the VERA Patient Classification System include two new classes focusing on improving recognition of non-institutional care initiatives and modifications to the existing Home Based Care patient class for skilled home care services.

In addition to patient classification improvements, the VERA Model has been refined to better identify the active Basic Care patient population which will improve the annual funding to this population. For example, to date, VERA funds a rolling three-year Basic Care population. This population will migrate to a rolling two-year population over the next three years. Refining this population will increase the actual VERA price per Basic Care patient and improve funding to this population.

FY 2015 National Average Prices Per Patient - the ten price groups and allocation prices in FY 2015 for Priorities 1-6 and Priorities 7-8 respectively are:

Price Groups	Priority Groups 1-6	Priority Groups 7-8
1. Non-Reliant	\$329	\$245
2. Basic Medical, Heart, Lung & GI	\$2,736	\$1,652
3. Mental Health	\$3,520	\$2,375
4. Oncology, Legally Blind	\$5,637	\$3,850
5. Multiple Problem	\$12,533	\$10,378
6. Significant Diagnosis	\$22,202	\$18,603
7. Specialized Care	\$17,857	\$12,725
8. Supportive Care	\$29,696	\$21,911
9. Chronic Mental Illness	\$28,824	\$27,836
10. Critically Ill	\$64,085	\$58,534
10a. Long Stay CLC	\$172,944	\$172,944

Threshold for Top 1% High-Cost Patients - In FY 2015, the threshold for the additional allocation adjustment for the top 1% high-cost patients decreased from \$108,000 in FY 2014 to \$105,000. In FY 2015, additional allocation adjustment is subject to an upper limit of ten standard deviations above the national average cost for providing that service, i.e., treating specialty and/or clinic costs. Networks will receive an additional allocation equal to the amount that these costs exceeded \$105,000. This addresses not only the highest cost Complex Care patients but also those in the Basic Care group.

Threshold for Long Stay Patients - The allocation adjustment threshold for Long Stay patients increased from \$242,000 in FY 2014 to \$252,000 in FY 2015. This adjustment is, designed to compensate VISNs for extremely costly long stay patients.

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 because of the varying health care needs of VA's patients and the complexity of 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.
- ***VA patients are identified in one of 60 patient classes*** which are further aggregated into ten case-mix price groups.
- ***Two types of funds:*** funding for medical care is divided into general purpose funds allocated based on patients treated and specific purpose funds allocated differently because of special legal or programmatic requirements, national support functions, and projects where economies of scale can be achieved at a national level by having some allocations outside the VERA Model.
- ***The cost of providing care across the country varies*** because of factors that are beyond the control of VA management (e.g., the cost of labor and contracts in New York are higher than in Mississippi).
- ***Not all Veterans receive all of their VA health care in the same network:*** many Veterans receive care in more than one network. 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.
- ***Not all Veterans receive all of their health care from VA*** because some Veterans have access to other sources of health care and elect to use them.
- ***The top 1% highest cost patients*** patients are not proportionally distributed across all networks.

- *Costs for Research and Education vary* because of differences across the country in VA's academic affiliations and research programs.

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

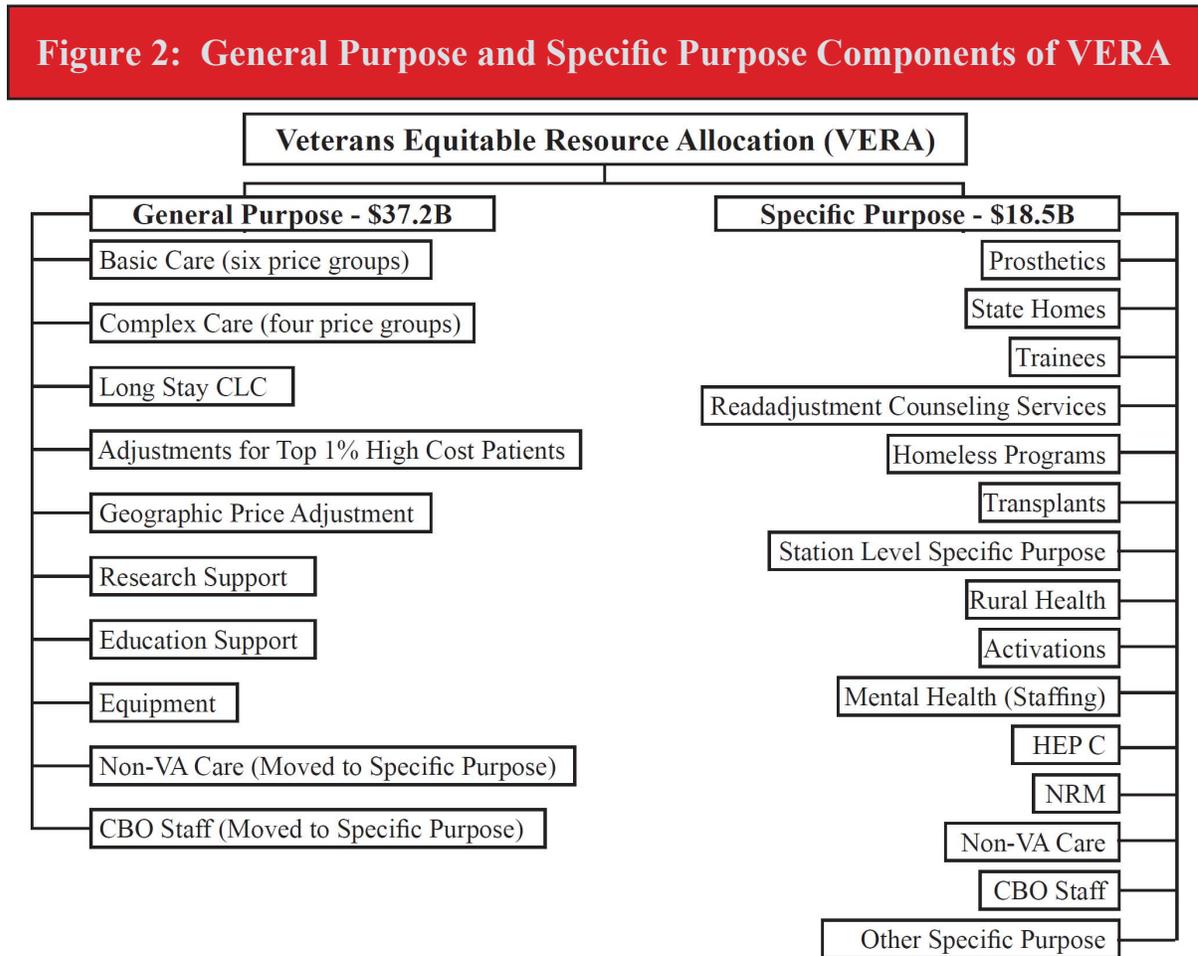
General Purpose Funds

VHA's medical care funding is divided into two major components: (1) General Purpose funding and (2) Specific Purpose funding. For FY 2015, General Purpose funds will constitute 67% (\$37.2 billion) of VA's Medical Care budget and are distributed to the 21 networks using the VERA Model. The Specific Purpose portion will constitute the estimated remaining 33% (\$18.5 billion) and is allocated separately.

To recognize the complexities discussed in the section above, VERA incorporated 10 elements used to allocate General Purpose funds. They are:

1. Basic Care (with six price groups)
2. Complex Care (with four price groups)
3. Long Stay CLC
4. Adjustment for top 1% High Cost Patients
5. Geographic Price Adjustment
6. Research Support
7. Education Support
8. Equipment
9. Non-VA Care
10. CBO Staff

Figure 2 depicts the VERA system and the dollar amounts in General Purpose and Specific Purpose funds.



The 10 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 equitable. Each of the 10 elements is discussed in the following sections.

Patient Elements: Basic and Complex Care

Funding the Basic and Complex Care elements accounts for the overwhelming majority of medical care funding, \$35.7 billion (96%), excluding all Long Stay Patients and all High Cost Patients. These two elements allocate funding based on the number of patients that the networks are expected to treat in FY 2015.

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

1. Patient Groups (types of patients)
2. Users (number of patients within each patient group)
3. Price Setting (dollar value of patients within each patient group)

Each component 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-five percent of VA’s patients receive Basic Care. These patients represent 68% of the dollars allocated through the Basic and Complex Care elements of VERA before the 1% high cost adjustment and Long Stay Allocations. 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 time frame. These Veterans had very little reliance on the VA health care system.

Differences between the 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 vested patient, even with one visit, and fund those patients at the full Basic Care price.

Table 4: Components of VERA 10 Price Groups

VERA 10 Group	VERA Class #	VERA Class Name
1. Non Reliant Care: Basic Non-Vested / Vested		
	1	Employee/Collateral *
	2	Pharmacy *
	3	Compensation and Pension (C&P) Exams
	4	Non-Vested
2. Basic Medical, Heart, Lung, GI: Basic Vested		
	5	Central Nervous System
	6	Musculoskeletal Disorder
	7	Endo Nutr Metab Disorders
	8	Ear, Nose and Throat
	9	Other Acute Diseases
	10	Gastroenterology
	11	Cardiovascular Disease
	12	Pulmonary Disease
3. Mental Health: Basic Vested		
	13	Addictive Disorders
	14	Acute Mental Disease
4. Oncology, Legally Blind: Basic Vested		
	15	HIV+ w/out Anti Retro-Viral Therapy
	16	Legally Blind
	17	Oncology
	18	Hepatitis C w/out Anti-Viral Therapy
	19	Basic Home and Community Services (HCS)**
	20	Epilepsy
	21	Multiple Sclerosis
5. Multiple Problem: Basic Vested		
	22	CCHT - Chronic Care Management
	23	Homeless Multiple Medical
	24	Psych+Substance Abuse
	25	Medical/Psych+Substance
	26	PTSD Acute
	27	Multiple Sclerosis w/Rx
	28	Multiple Medical
	29	History of Transplant
6. Significant Diagnoses: Basic Vested		
	30	Metastatic Cancer
	31	Acute MI
	32	Respiratory Failure
	33	High Cost Pneumonia
	34	High Cost Conditions
7. Specialized Care: Complex		
	35	Traumatic Brain Injury (TBI)/PT
	36	CCHT-Noninstitutional Care
	37	Chronic PTSD
	38	Stroke
	39	AIDS or HIV+ w/ Anti RV Therapy
	40	Hepatitis C with Anti-Viral Therapy
	41	Multiple Problem HCS**
8. Supportive Care: Complex		
	42	Legacy LTC/Intermediate
	43	SCI Para-old Injury
	44	Home-Based Primary Care (HBPC)
	45	SCI Quad-old Injury
	46	Community Nursing Home
	47	Residential Rehab. (Domiciliary)
	48	Skilled Nursing w/Rehab & High Rehab
	49	Blind Rehabilitation Service
9. Chronic Mental Illness: Complex		
	50	Mental Health Inten. Case Mgt (MHICM)
	51	Substance Abuse
	52	Homeless-CMI
	53	Other Psychosis
	54	Schizophrenia & Dementia
10. Critically Ill: Complex		
	55	End Stage Renal Disease
	56	Short Stay CLC
	57	SCI Para-New Injury/ SCI Instit.
	58	SCI Quad-New Injury/ SCI Instit.
	59	Polytrauma (PT)
	60	Transplant
	61	Ventilator Dependent
10a. Long Stay: Complex		
	62	Long Stay CLC

* Care delivered to a Veteran classified as “employee/collateral” and/or “pharmacy” is only included under the VERA methodology in conjunction with care delivered to that Veteran in other classes.

** Indicates new class for VERA 2015.

Note: Detailed information on patient classification can be found in the VERA Patient Classification Handbook, available on the Allocation Resource Center Website (<http://vaww.arc.med.va.gov>).

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; vested, those who rely on VA for their care, and non-vested, those who use some VA health care services but do not necessarily receive their primary care services from VA and are less reliant on the VA system. A patient receiving exclusively outpatient services must receive a level-3 history and physical at least once in a three-year period to remain in a Basic Vested patient class. Note that an inpatient admission or observation stay satisfies the requirement for the level-3 history and physical. This type of medical evaluation is typically completed upon admission to a VA facility or determined through the presence of a specific Current Procedural Terminology (CPT) code, indicating that a medical history and physical examination has been completed by an authorized clinician. By applying relevant CPT codes to outpatients seen in Fiscal Years 2011, 2012, and 2013, and counting the inpatients for those same years, patients identified for the FY 2015 VERA as either vested or non-vested are classified into 34 of the 62 patient classification groups. These 34 classes are then aggregated to one of six Basic Care price groups as shown in Table 4 on page 12.

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, chronic 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 32% of the dollars available for the Basic and Complex Care groups. Based on the Complex Care patients seen in Fiscal Years 2009, 2010, 2011, 2012 and 2013, a forecast of FY 2015 Complex Care patients is made. These patients are classified into 28 of the 62 patient classes. These 28 classes are further aggregated into the five Complex Care price groups shown in Table 4 on page 12.

Ten VERA Price Groups: The VERA price groups were expanded from three to ten in FY 2003 to recognize a differentiation in VA's "core mission" patients (Veterans with service-connected disabilities or those with incomes below the current threshold or special needs patients, e.g., the homeless) not present in the previous three VERA price groups. This change was consistent with the recommendations in the GAO and RAND reports and improved equity of resource allocation among networks. This change also modified the initial funding allocation split between Basic Care and Complex Care to reflect the current base year cost experience rather than continuing to use the fixed FY 1995 cost split ratio.

Users

For each price group, 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 metric 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, a one-year forecast 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 non-users) by network for the years covered by the VERA patient 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 2011, FY 2012 and FY 2013. Any patient seen exclusively in FY2011 had their workload reduced by 66% as part of the transition to the rolling two-year Basic Care population. Beginning in FY 2005, “eligible Veterans” was defined as all Priority 1-8 Veteran patients. In FY 2003, VERA expanded from three to ten price groups. There are six (1 through 6) Basic Care price groups and four (7 through 10a) Complex Care price groups. For FY 2015, the Basic Care price groups are 1) Non Reliant Care, 2) Basic Medical, Heart, Lung, and Gastrointestinal, 3) Mental Health, 4) Oncology, Legally Blind, 5) Multiple Problem, and 6) Significant Diagnosis. These six price groups are shown on Table 4 on page 12.

All Veterans seen over a 3-year period (FY2011 through FY 2013) and classified in a VERA Basic Care category are incorporated in a VISN’s FY 2015 VERA allocation. Basic Care funding will be migrated to a two-year population by VERA 2017.

Table 5: Basic and Complex Care Patients - FY 2015

Network	Total Basic Care	Total Complex Care
01 Boston	258,137	17,603
02 Albany	139,256	9,447
03 Bronx	183,121	15,798
04 Pittsburgh	325,106	16,600
05 Baltimore	147,142	9,771
06 Durham	362,377	20,269
07 Atlanta	414,543	22,121
08 Bay Pines	570,569	31,894
09 Nashville	303,817	16,315
10 Cincinnati	230,914	17,887
11 Ann Arbor	296,055	15,866
12 Chicago	258,037	17,584
15 Kansas City	251,304	15,948
16 Jackson	522,191	26,197
17 Dallas	313,149	16,329
18 Phoenix	272,446	15,469
19 Denver	203,581	13,155
20 Portland	292,964	15,282
21 San Francisco	281,372	16,076
22 Long Beach	334,156	19,384
23 Minneapolis	334,183	20,990
VHA Totals	6,294,421	369,984

Note: The numbers may not add due to rounding.

Complex Care: The nature and treatment needs of the Complex Care user population are considerably different than that of the Basic Care users. Complex Care patients are high-intensity users. Their average price is nearly 10 times greater than that of the average Basic Care patient, they are cared for by VA throughout each year (with multiple visits over 12 months), and they receive care over the course of many years (i.e., they use VA year after year). Almost all of these patients will use VA's special emphasis programs services at some time during each year. As in the past, the number of Complex Care patients is forecast based on the number of Complex Care patients who used VA services during the past five years. In FY 2011, Long Stay CLC 10a was added to capture the higher cost patients in Community Living Centers. Long Stay CLC 10a is a component of Price Group 10 that includes high cost patients with greater than 90 bed days of care.

The FY 2015 Complex Care patients are based on Veterans who used the VA health care system from FY 2009 - FY 2013. For FY 2015, the Complex Care price groups represent the five highest groups in the VERA Model. They are: 7) Specialized Care, 8) Supportive Care, 9) Chronic Mental Illness, 10) Critically Ill and 10a) Long Stay CLC. These five price groups are shown in Table 4 on page 12.

When determining the users 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. 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 credit for a Basic Care Veteran, and the Florida Network may get 40% credit if 60% of the cost of the Veteran's care was incurred at New York facilities and 40% at Florida facilities. The proportions are based on the actual base year costs of the care for these Veterans in each network. Table 5 on page 14 shows the expected network-specific patients (in numbers of Veterans) for Basic Care and Complex Care elements for the FY 2015 VERA allocation. The six price group Basic Care and five price group Complex Care allocation method ensures that the differences in case-mix are appropriately resourced. VERA provides each VISN an allocation that recognizes its individual characteristics and its appropriate share of the ten price groups. Patients in the ten price groups as well as specific formulas and back-up data used to create this table are included in Appendix 1.

Setting the Price

The VERA methodology establishes a national price for Priorities 1-6 for each of the ten price groups by dividing the total dollars available in each of the groups by the patients in each group. The total dollars available in the ten price groups is determined by taking the FY 2015 Medical Care budget and allocating to each of the ten groups based on the ratio of each group's actual FY 2013 Managerial Cost Accounting (MCA) costs to total cost of all groups. Similarly, a separate national price is established for Priority Groups 7-8 in each of the ten price groups based on their relative cost to Priority Groups 1-6. The total dollars available for the Basic, Complex Care and Long Stay groups in FY 2015 is \$37.5 billion after removing the allocation for the top 1% high-cost patients. Of this amount, 5% is available for Long Stay (\$1.8 billion), 27% is available for Complex Care (\$10.2 billion) and 68% is available for Basic Care (\$25.4 billion). The percent of the Basic Care provided to the six Basic Care price groups is based on the proportion of FY 2013 Basic Care actual FY 2013 MCA costs experienced in these price groups. The amount provided to the five Complex Care price groups is based on the proportion of FY 2013 Complex Care to actual total FY 2013 MCA costs experienced in these price groups.

Figure 3 on page 17 shows the FY 2015 VA health care budget; total funding for the six Basic Care and four Complex Care price groups; the VERA patients; and the resultant national prices per patient in the ten groups for Priority Groups 1-6 and Priority Groups 7-8.

These national prices for the ten groups are multiplied by the number of patients for each group in a network to calculate the ten price group allocations.

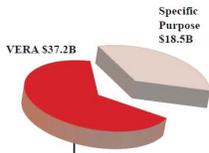
Figure 3: Establishing VERA National Prices - FY 2015

Total VA Healthcare Allocation (\$55.7B)

33.2% - Specific Purpose \$18.5B

66.8% - VERA General Purpose \$37.2B

**FY 2015 VERA National Prices
(Budget Dollars and High Cost in thousands, Prices in Actual Dollars)**



	<u>Basic Care (P1-6)</u>	<u>High Cost</u>	<u>Budget (000's)</u>	<u>No. of Patients</u>	<u>National Price Budget No. of Patients</u>	Geographic Price Adjustment	
59.5%	1. Non-Reliant	\$376	\$88,181	267,946	\$329		
	2. Basic Medical, Heart, Lung GI	\$16,800	\$8,355,934	3,053,549	\$2,736		
	3. Mental Health	\$1,340	\$1,750,685	497,288	\$3,520		
	4. Oncology, Legally Blind	\$8,828	\$1,196,717	212,298	\$5,637		
	5. Multiple Problem	\$101,397	\$8,123,197	648,145	\$12,533		
	6. Significant Diagnoses	\$302,745	\$2,629,175	118,423	\$22,202		
	Total	\$431,487	\$22,143,890	87.0%	4,797,651		76.2%
08.9%	<u>Basic Care (P7-8)</u>	<u>High Cost</u>	<u>Budget (000's)</u>	<u>No. of Patients</u>	<u>National Price Budget No. of Patients</u>		
	1. Non-Reliant	\$0	\$30,863	126,103	\$245		
	2. Basic Medical, Heart, Lung GI	\$2,299	\$1,927,032	1,166,400	\$1,652		
	3. Mental Health	\$93	\$156,045	65,712	\$2,375		
	4. Oncology, Legally Blind	\$1,554	\$233,716	60,704	\$3,850		
	5. Multiple Problem	\$7,074	\$624,707	60,198	\$10,378		
	6. Significant Diagnoses	\$33,228	\$328,418	17,654	\$18,603		
	Total	\$44,248	\$3,300,782	13.0%	1,496,770	23.8%	
26.0%	<u>Complex Care (P1-6)</u>	<u>High Cost</u>	<u>Budget (000's)</u>	<u>No. of Patients</u>	<u>National Price Budget No. of Patients</u>		
	7. Specialized Care	\$75,478	\$1,864,053	104,387	\$17,857		
	8. Supportive Care	\$348,776	\$3,164,996	106,579	\$29,696		
	9. Chronic Mental Illness	\$305,168	\$2,650,925	91,971	\$28,824		
	10. Critically Ill	\$1,069,281	\$2,008,255	31,337	\$64,085		
	Total	\$1,798,703	\$9,688,228	80.2%	334,274	90.3%	
01.4%	<u>Complex Care (P7-8)</u>	<u>High Cost</u>	<u>Budget (000's)</u>	<u>No. of Patients</u>	<u>National Price Budget No. of Patients</u>		
	7. Specialized Care	\$5,601	\$168,970	13,278	\$12,725		
	8. Supportive Care	\$17,402	\$159,768	7,292	\$21,911		
	9. Chronic Mental Illness	\$7,136	\$55,565	1,996	\$27,836		
	10. Critically Ill	\$63,017	\$132,054	2,256	\$58,534		
	Total	\$93,156	\$516,357	4.3%	24,822	6.7%	
05.1%	<u>Long Stay (CLC) (P1-6 & P7-8)</u>	<u>High Cost</u>	<u>Budget (000's)</u>	<u>No. of Patients</u>	<u>National Price Budget No. of Patients</u>		
	10a. Long Stay	\$348,343	\$1,883,019	10,888	\$172,944		
	Total	\$348,343	\$1,883,019	15.6%	10,888	2.9%	
07.3%	<u>High Cost Adjustment for Top 0.8%</u>			Basic	\$475,735		
		\$2,715,937		Complex	\$2,240,202		
05.0%	<u>Research, Education and Equipment</u>			Research Support	31.5%	\$589,000	
				Education Support	45.5%	\$851,000	
		\$1,872,224		Equipment	23.1%	\$432,224	
-13.1%	<u>Non-VA Care and CBO Staff</u>			Non-VA Care	97.8%	(\$4,768,748)	
		(\$4,876,691)		CBO Staff	2.2%	(\$107,943)	
100.0%	Three Appropriation Account Structure						
	<u>Medical Services</u>		<u>Medical Support & Compliance</u>		<u>Medical Facilities</u>		
	\$29,669,764		\$3,763,360		\$3,810,623		
	79.7%		10.1%		10.2%		

In FY 2015, the Appropriations Act continues the three appropriation structure for medical care. VERA is not directly affected by the three appropriation structure because network allocations are based on the combined funding in the three appropriations.

Network allocations for the six Basic Care price groups and the four Complex Care price groups are combined into the Basic Care and Complex Care allocations and are presented in Table 6. Formulas and back-up data used to create these allocations are included in Appendix 1.

Table 6: Network Basic Care and Complex Care Allocations - FY 2015			
(\$ in millions)			
Network	Total Basic Care	Total Complex Care	Total Allocations
01 Boston	\$1,008	\$573	\$1,580
02 Albany	\$556	\$322	\$878
03 Bronx	\$711	\$517	\$1,228
04 Pittsburgh	\$1,205	\$581	\$1,786
05 Baltimore	\$576	\$347	\$923
06 Durham	\$1,456	\$681	\$2,138
07 Atlanta	\$1,641	\$707	\$2,348
08 Bay Pines	\$2,436	\$1,006	\$3,441
09 Nashville	\$1,277	\$487	\$1,764
10 Cincinnati	\$940	\$615	\$1,555
11 Ann Arbor	\$1,164	\$493	\$1,657
12 Chicago	\$1,015	\$604	\$1,618
15 Kansas City	\$1,026	\$488	\$1,514
16 Jackson	\$2,165	\$841	\$3,006
17 Dallas	\$1,263	\$564	\$1,827
18 Phoenix	\$1,107	\$506	\$1,614
19 Denver	\$815	\$375	\$1,190
20 Portland	\$1,244	\$481	\$1,725
21 San Francisco	\$1,183	\$579	\$1,762
22 Long Beach	\$1,408	\$617	\$2,025
23 Minneapolis	\$1,250	\$704	\$1,954
VHA Totals	\$25,445	\$12,088	\$37,532

Note: Basic Care allocations are the sum of Basic Care price groups 1-6. Complex Care Allocations are the sum of Complex Care price groups 7-10a. This chart does not include the allocations for cost exceeding \$105,000 for High Cost Patients. The allocation adjustment threshold for Long Stay patients is set at \$252,000, designed to compensate VISNs for extremely costly patients.

VERA Ten Price Group Case-Mix

The VERA ten price groups establish the patient case-mix in VERA. 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 network differences in patients and separate prices for the six Basic Care and four Complex Care groups of patients. The case-mix at VHA national level is 1.0 and each network's case-mix is shown in Table 7. The table displays that there are variances in case-mix among networks. For example, Network 10, Cincinnati, has a VERA case-mix of 1.110 which is 11.0% above the national average, and Network 4, Pittsburgh, has a VERA case-mix of .928, which is 7.2% below the national average. Network total patients 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 elements of VERA. Formulas and back-up data used to create the VERA ten price group case-mix are included in Appendix 1.

Table 7: VERA Ten Price Group Case-Mix Index - FY 2015			
Network	Basic Care Case-Mix Index	Complex Care Case-Mix Index	Total Case-Mix Index
01 Boston	0.966	0.996	1.018
02 Albany	0.988	1.043	1.048
03 Bronx	0.960	1.002	1.096
04 Pittsburgh	0.917	1.072	0.928
05 Baltimore	0.968	1.087	1.044
06 Durham	0.994	1.029	0.992
07 Atlanta	0.979	0.978	0.955
08 Bay Pines	1.056	0.965	1.014
09 Nashville	1.040	0.914	0.978
10 Cincinnati	1.007	1.052	1.110
11 Ann Arbor	0.973	0.950	0.943
12 Chicago	0.973	1.051	1.042
15 Kansas City	1.010	0.936	1.006
16 Jackson	1.025	0.983	0.973
17 Dallas	0.998	1.056	0.985
18 Phoenix	1.006	1.002	0.995
19 Denver	0.990	0.873	0.975
20 Portland	1.050	0.963	0.994
21 San Francisco	1.040	1.102	1.052
22 Long Beach	1.042	0.974	1.017
23 Minneapolis	0.925	1.027	0.977
VHA Totals	1.000	1.000	1.000

Long Stay

For VERA 2015, Price Group 10a funds patients in the Long Stay CLC patient class. Each network's Long Stay CLC allocations is shown in Table 8. This Price Group includes patients with at least 90 bed days of care (BDOC) in VHA's Community Living Centers (CLC) resulting in very high annual costs. To ensure adequate funding for this population, a Long Stay CLC price is set for this population. The Long Stay CLC workload is weighted higher in proportion to the patient costs. This enhances the effect of the adjustments in accounting for uncontrollable local costs. As shown in Table 8, in FY 2015 the following two Networks 4 and 8 both received (7.3%) which was the largest overall allocation for Long Stay and Network 19 (2.0%) received the smallest overall allocation. In FY 2015 VISNs with patients in this patient class are entitled to a High Cost payment in addition to the VERA Price.

Table 8: Long Stay Allocations - FY 2015		
(\$ in millions)		
Network	Allocation	% of Allocation
01 Boston	\$95	5.0%
02 Albany	\$71	3.8%
03 Bronx	\$120	6.4%
04 Pittsburgh	\$137	7.3%
05 Baltimore	\$93	4.9%
06 Durham	\$99	5.2%
07 Atlanta	\$108	5.8%
08 Bay Pines	\$137	7.3%
09 Nashville	\$45	2.4%
10 Cincinnati	\$106	5.6%
11 Ann Arbor	\$85	4.5%
12 Chicago	\$109	5.8%
15 Kansas City	\$43	2.3%
16 Jackson	\$104	5.5%
17 Dallas	\$93	5.0%
18 Phoenix	\$61	3.3%
19 Denver	\$39	2.0%
20 Portland	\$48	2.5%
21 San Francisco	\$129	6.9%
22 Long Beach	\$61	3.2%
23 Minneapolis	\$101	5.4%
VHA Totals	\$1,883	100.0%

Note: 10a. Long Stay includes both P1-6 and P7-8 Complex Care patients.

Adjustment for Top 1% High Cost and Long Stay Patients

Beginning in FY 2003, VHA established a 1% high cost threshold that recognizes the impact on networks with patients whose annual costs exceed a threshold of \$70,000. In FY 2011, this threshold increased from \$95,000 to \$107,000 subject to an upper limit of ten standard deviations above the national average cost for providing that service, i.e., treating specialty and/or clinic costs. In FY 2012, the threshold increased from \$107,000 to \$108,000. In FY 2013, the threshold remained the same as in FY 2014 at \$108,000. In FY 2015, the threshold decreased from \$108,000 to \$105,000. The networks will receive an additional allocation for patients whose cost exceeds the current \$105,000 threshold. The allocation adjustment threshold for Long Stay patients is set at \$252,000, designed to compensate VISNs for extremely costly patients. Table 9 shows the high cost allocations for Basic and Complex Care patients.

Specific formulas and back-up data used to create this table are included in Appendix 1.

For example, the VERA 2015 High Cost allocation for a Basic Care patient with costs of \$118,000 would be \$13,000.

The Network is compensated dollar for dollar for costs over \$105,000. The High Cost Allocation for a patient classified as Long Stay with costs of \$300,000 would be \$48,000. The allocation for Long Stay patients is dollar for dollar over the \$252,000 threshold.

Table 9: Basic Care and Complex Care High Cost Allocations - FY 2015			
(\$ in millions)			
Network	Total Basic Care Allocation	Total Complex Care Allocation	Total Allocations
01 Boston	\$24	\$137	\$161
02 Albany	\$12	\$42	\$54
03 Bronx	\$44	\$161	\$205
04 Pittsburgh	\$18	\$122	\$140
05 Baltimore	\$16	\$70	\$86
06 Durham	\$21	\$117	\$138
07 Atlanta	\$25	\$100	\$125
08 Bay Pines	\$34	\$198	\$232
09 Nashville	\$21	\$93	\$114
10 Cincinnati	\$13	\$85	\$98
11 Ann Arbor	\$18	\$68	\$86
12 Chicago	\$21	\$142	\$162
15 Kansas City	\$18	\$65	\$83
16 Jackson	\$35	\$110	\$144
17 Dallas	\$19	\$84	\$103
18 Phoenix	\$17	\$66	\$83
19 Denver	\$12	\$50	\$62
20 Portland	\$26	\$84	\$110
21 San Francisco	\$39	\$174	\$213
22 Long Beach	\$29	\$180	\$209
23 Minneapolis	\$14	\$92	\$106
VHA Totals	\$476	\$2,240	\$2,716

Note: These are costs exceeding \$105,000 per patient. The allocation adjustment threshold for Long Stay patients is set at \$252,000, designed to compensate VISNs for extremely costly patient.

National Price Adjustment

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 for factors that were outside the network's management control. These included such things as: age of patients, cost of labor, fuel and utilities costs, grounds management, fire departments, contract services, pharmaceuticals and beneficiary travel. However, after careful analysis and review, it was determined that only one adjustment was necessary. This was called the geographic price adjustment.

Geographic Price Adjustment

The geographic price adjustment uses a labor index to adjust for the most significant factor that is uncontrollable at the network level, which is the cost of labor. VA salary costs, contracted labor, and certain non-labor contracted goods account for about 75% of the total funding. These 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 these costs 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 labor 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) in 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 system wide 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 factor for computing the labor index was changed to weight Complex Care patients consistent with recent costs. This change accounts for the more intense and expensive staffing level required for Complex Care patients. It weighs Complex Care patients approximately 11 times more heavily than Basic Vested Care patients in the application of the geographic price adjustment.

Prior to FY 2002, 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 accounts for expenses caused by geographic cost factors that are beyond a network's immediate control. This method was used in FY 2002 through FY 2015.

Table 10 shows how much the network allocations under the Basic and Complex Care groups that are adjusted by the geographic price (labor index) adjustment. Specific formulas and back-up data used to create this table are included in Appendix 1.

Table 10: Geographic Price Adjustment - FY 2015		
(\$ in millions)		
Network	Labor Index	Adjustment to Allocations
01 Boston	1.058	\$89
02 Albany	0.958	(\$33)
03 Bronx	1.098	\$118
04 Pittsburgh	0.989	(\$18)
05 Baltimore	1.054	\$48
06 Durham	0.975	(\$45)
07 Atlanta	0.959	(\$88)
08 Bay Pines	0.953	(\$140)
09 Nashville	0.955	(\$70)
10 Cincinnati	0.987	(\$17)
11 Ann Arbor	0.984	(\$23)
12 Chicago	1.014	\$22
15 Kansas City	0.965	(\$47)
16 Jackson	0.974	(\$65)
17 Dallas	0.992	(\$11)
18 Phoenix	0.969	(\$43)
19 Denver	0.975	(\$27)
20 Portland	1.016	\$26
21 San Francisco	1.150	\$235
22 Long Beach	1.069	\$125
23 Minneapolis	0.980	(\$35)
VHA Totals	1.000	\$0

Note: The numbers may not add due to rounding.

Research Support

VA's three Medical Care appropriations fund 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 the number of patients. VA, however, designed all elements in the VERA system to allocate resources based on a relevant unit of measure. Accordingly, research grants were identified as the appropriate metric for allocating research support funds. For FY 2015, \$589 million was allocated for research support. This budget was derived from Medical Care support estimates for research submitted in the President's FY 2015 Medical Programs Budget Request Networks pass through the research support allocation as it is computed for each Medical Center. Each Medical Center explicitly accounts for, and obligates, research support funds to support the salaries of clinician-researchers, and research facilities and administrative costs.

Table 11: Research Support Allocation - FY 2015			
(\$ in millions)			
Network	FY 2013 Volume Funded Research Reported	FY 2013 Weighted Volume of Research Activity	FY 2015 Research Support Allocation
01 Boston	\$128	\$115	\$67
02 Albany	\$11	\$6	\$4
03 Bronx	\$31	\$27	\$16
04 Pittsburgh	\$48	\$40	\$23
05 Baltimore	\$54	\$46	\$27
06 Durham	\$47	\$43	\$25
07 Atlanta	\$58	\$52	\$30
08 Bay Pines	\$34	\$31	\$18
09 Nashville	\$40	\$34	\$20
10 Cincinnati	\$25	\$23	\$13
11 Ann Arbor	\$66	\$57	\$33
12 Chicago	\$51	\$42	\$24
15 Kansas City	\$16	\$13	\$8
16 Jackson	\$42	\$36	\$21
17 Dallas	\$39	\$32	\$19
18 Phoenix	\$32	\$32	\$19
19 Denver	\$41	\$35	\$20
20 Portland	\$70	\$65	\$38
21 San Francisco	\$132	\$124	\$72
22 Long Beach	\$102	\$92	\$54
23 Minneapolis	\$85	\$67	\$39
VHA Totals	\$1,154	\$1,014	\$589

Notes:

1. The Weighted Volume is based on the type of research activity: 100% for research and QUERI dollars which is administered by VA, 75% for research which is peer reviewed but not VA administered; 25% for research which is not peer reviewed and not VA administered.
2. The numbers may not add due to rounding.

Since FY 1999, the allocation factor for the distribution of the VERA research support dollars has been weighted research grants. Specifically, VA-administered research and Quality Enhancement Research Initiative (QUERI) are weighted

at 100%; non-VA funded, non-VA administered, peer reviewed research at 75%; other non-VA funded, non-VA administered and non-peer reviewed research at 25%. By weighting VA-administered research at 100% and discounting non-VA administered research, there is an incentive to encourage VA administered research. Research grants are reported and certified locally on an annual basis using the Research and Development Information System Part II (RDIS-II). The RDIS system serves as the official data source for research grant information used in the VERA Model. Table 11 on page 25 displays the FY 2015 network allocations for the research support component based on FY2013 research grant data. Specific formulas and back-up data used to create the research support allocations are included in Appendix 1.

The VERA Research Support dollars are intended to acknowledge the additional expense and provide an allocation of dollars for a facility to support and sustain a research mission. 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, and includes administrative and indirect support provided to the Research Program by Fiscal, Engineering, Acquisition and Material Management, various R&D Committees and subcommittees, etc. Research Support includes support for all 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 (this excludes animal research and associated administrative costs). Table 11 on page 25 shows that the total funded research reported in FY 2013 was \$1,154 million. After applying the weights for the FY 2013 VA and non-VA research expenditures, the weighted amount of reported funded research is adjusted to \$1,014 million.

Education Support

Similar to research, VA's Medical Services 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 a unit of measure, the total number of residents was selected as the appropriate metric 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 selection of medical resident positions as the basis for the allocation of education support funds to the networks.

As shown on Table 12, \$851 million is allocated for education support in FY 2015. In FY 2015, Network 16 (8.7%) received the largest overall allocation for Education Support and Network 2 (2.5%) received the smallest overall allocation. This figure is based on the reported amounts of expenditures for Medical Care support to education as estimated in the President's FY 2015 Medical Programs Budget. Education support dollars are computed by determining each network's portion of VA residents, compared

Table 12: Education Support Allocation - FY 2015			
(\$ in millions)			
Network	Number of Residents	Allocation	% of Allocation
01 Boston	590	48	5.6%
02 Albany	259	21	2.5%
03 Bronx	620	50	5.9%
04 Pittsburgh	305	25	2.9%
05 Baltimore	279	23	2.6%
06 Durham	491	40	4.7%
07 Atlanta	533	43	5.1%
08 Bay Pines	782	63	7.4%
09 Nashville	586	47	5.6%
10 Cincinnati	355	29	3.4%
11 Ann Arbor	394	32	3.7%
12 Chicago	704	57	6.7%
15 Kansas City	363	29	3.4%
16 Jackson	920	74	8.7%
17 Dallas	497	40	4.7%
18 Phoenix	368	30	3.5%
19 Denver	285	23	2.7%
20 Portland	383	31	3.6%
21 San Francisco	540	44	5.1%
22 Long Beach	857	69	8.1%
23 Minneapolis	409	33	3.9%
VHA Totals	10,519	\$851	100.0%

Notes:

- 1. The allocations are based on the number of residents for academic year 2014-2015.*
- 2. The numbers may not add due to rounding.*

to the national resident allocation for academic year 2013-2014. This equates to an education support allocation of \$80,900 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 VERA. 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 volume, 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. The equipment element of the Model was revised to use the Basic and Complex Care patients 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 and through FY 2015, the equipment allocation is based totally on patients. The total amount of equipment funding to be distributed to networks in FY 2015 is \$432 million. Table 13, shows the equipment allocation to each network. In FY 2015 Network 8 (9.0%) received the largest overall equipment allocation. Network 2 (2.2%) received the smallest overall allocations. Specific formulas and back-up data used to create the equipment allocations are included in Appendix 1.

Table 13: Equipment Allocation - FY 2015		
(\$ in millions)		
Network	Allocation	% of Allocation
01 Boston	\$18	4.1%
02 Albany	\$10	2.2%
03 Bronx	\$13	3.0%
04 Pittsburgh	\$22	5.1%
05 Baltimore	\$10	2.4%
06 Durham	\$25	5.7%
07 Atlanta	\$28	6.6%
08 Bay Pines	\$39	9.0%
09 Nashville	\$21	4.8%
10 Cincinnati	\$16	3.7%
11 Ann Arbor	\$20	4.7%
12 Chicago	\$18	4.1%
15 Kansas City	\$17	4.0%
16 Jackson	\$36	8.2%
17 Dallas	\$21	4.9%
18 Phoenix	\$19	4.3%
19 Denver	\$14	3.3%
20 Portland	\$20	4.6%
21 San Francisco	\$19	4.5%
22 Long Beach	\$23	5.3%
23 Minneapolis	\$23	5.3%
VHA Totals	\$432	100.0%

Note: The numbers may not add due to rounding.

Non-VA Care Funds to be Administered by CBO Allocations

The different types of care purchased

Non-VA medical care that may be purchased through a non-VA medical care provider is the same care as authorized to Veterans in a VA medical facility under Title 38 United States Code (U.S.C. 1710). Specifically, the medical care purchased would be the same as afforded to eligible Veterans in the VA's comprehensive Medical Benefits Package to include all the necessary inpatient hospital care, outpatient services, maternity care, dental, and pharmaceutical services to promote, preserve, or restore health. Some of the top medical care purchased in 2014 include: dialysis, skilled and unskilled home health services, radiation therapy, diagnostic testing, physical therapy, inpatient hospitalization and emergency care services (displayed as a subsection below).

The different scenarios for why

care is purchased VA may authorize a non-VA health care facility or individual health care provider to perform necessary medical care services when such services are not routinely available at a VA health care facility, or

VA determines that such services can be obtained outside the VA more economically or more appropriately due to geographic inaccessibility. Non-VA medical care must be authorized by VA in advance, unless the medical event is an emergency.

Non-VA emergency medical care may be reimbursed for both service-connected Veterans (38 U.S.C. 1728) and non-service connected Veterans (38 U.S.C. 1725) when certain criteria has been met.

Table 14: Non-VA Care Allocation - FY 2015

(\$ in millions)

Network	Allocation	% of Allocation
01 Boston	(\$166)	3.5%
02 Albany	(\$72)	1.5%
03 Bronx	(\$63)	1.3%
04 Pittsburgh	(\$190)	4.0%
05 Baltimore	(\$81)	1.7%
06 Durham	(\$248)	5.2%
07 Atlanta	(\$272)	5.7%
08 Bay Pines	(\$458)	9.6%
09 Nashville	(\$211)	4.4%
10 Cincinnati	(\$189)	4.0%
11 Ann Arbor	(\$155)	3.3%
12 Chicago	(\$166)	3.5%
15 Kansas City	(\$207)	4.3%
16 Jackson	(\$380)	8.0%
17 Dallas	(\$212)	4.5%
18 Phoenix	(\$255)	5.3%
19 Denver	(\$253)	5.3%
20 Portland	(\$335)	7.0%
21 San Francisco	(\$301)	6.3%
22 Long Beach	(\$246)	5.2%
23 Minneapolis	(\$310)	6.5%
VHA Totals	(\$4,769)	100.0%

Note: The numbers may not add due to rounding.

CBO Staff Allocation

VHA CBO Staff is responsible for a broad range of activities to support the delivery of health care benefits for Veterans and eligible dependents.

Table 15: CBO Staff Allocation - FY 2015		
(\$ in thousands)		
Network	Allocation	% of Allocation
01 Boston	(\$4)	3.8%
02 Albany	(\$2)	1.9%
03 Bronx	(\$2)	1.7%
04 Pittsburgh	(\$5)	5.0%
05 Baltimore	(\$1)	1.2%
06 Durham	(\$8)	7.3%
07 Atlanta	(\$8)	7.6%
08 Bay Pines	(\$17)	15.3%
09 Nashville	(\$5)	4.2%
10 Cincinnati	(\$4)	3.4%
11 Ann Arbor	(\$5)	4.4%
12 Chicago	(\$4)	3.7%
15 Kansas City	(\$4)	3.9%
16 Jackson	(\$8)	7.3%
17 Dallas	(\$4)	4.0%
18 Phoenix	(\$3)	2.4%
19 Denver	(\$5)	4.2%
20 Portland	(\$5)	4.5%
21 San Francisco	(\$4)	3.8%
22 Long Beach	(\$6)	5.7%
23 Minneapolis	(\$5)	4.9%
VHA Totals	(\$108)	100.0%

Note: The numbers may not add due to rounding.

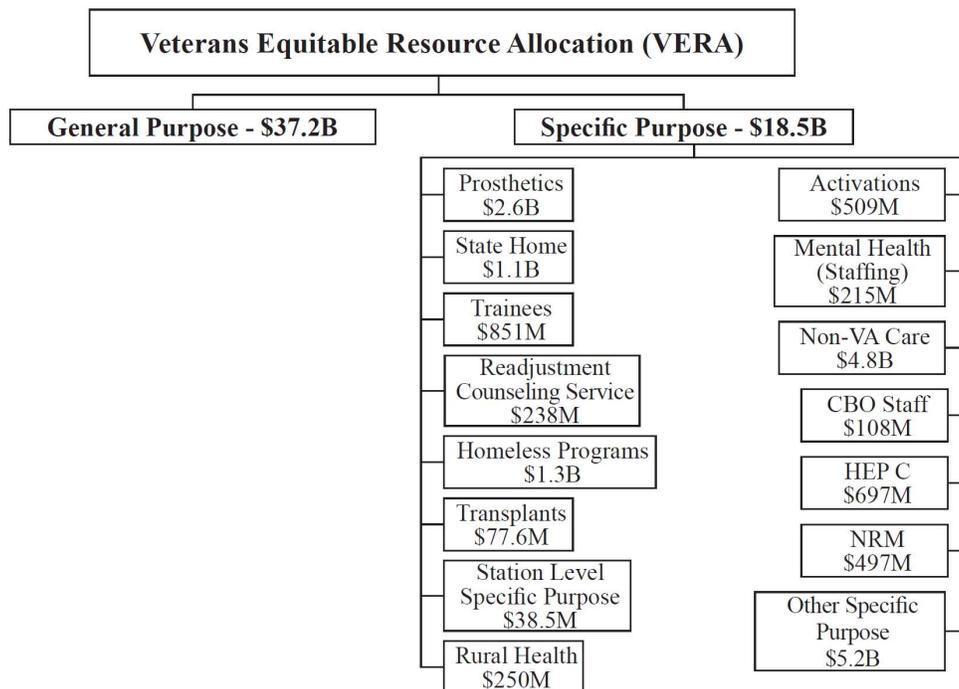
Specific Purpose Funds

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. 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 patients). 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.

Figure 4 reflects the Specific Purpose funding components.

Figure 4: Components of Specific Purpose VERA Funding



In the FY 2015 VA Health care budget, the amount distributed through General Purpose funding was 67% (\$37.2 billion) and 33% (\$18.5 billion) was managed as Specific Purpose funding. Over 32% (\$5.9 billion) of these Specific Purpose funds are for the following four programs: Prosthetics, State Home, Trainees and Homeless Veteran Programs.

Section II

Process for Refining VERA

The process for refining the VERA methodology can be internally generated by VA users of VERA or externally generated by outside VERA evaluators. VHA National Leadership Council (NLC) Finance Committee reviews refinements and recommendations generated by internal and external groups. The Finance Committee provides its recommended changes to the NLC for approval by the Under Secretary for Health and the Secretary.

Section III

VERA Acronyms

Acronym	Meaning	Acronym	Meaning
ABO	Absent Bed Occupied	CPTs	Common Procedure Terminology
ADHC	Adult Day Health Care	CQMPH	Center for Quality Management in Public Health
ADL	Activities of Daily Living	CS	Clinic Stop
ADPAC	Automatic Data Processing Application Coordinator	CVT	Clinical Video Telehealth
AFR	Assessment Final Report	CWT	Compensation Work Therapy
AITC	Austin Information Technology Center	DCG	Diagnostic Cost Group
ARC	Allocation Resource Center	DoD	Department of Defense
AVM	All Variables Model	DRG	Diagnostic Related Groups
BDOC or BDC	Bed Days of Care	DSS	Decision Support System
BRM	Base Regression Model	Dx	Diagnostic
C&P	Compensation and Pension Exam	EES	Employee Education System
CAMPS	Capital Assets Management and Planning Service	ESRD	End Stage Renal Disease
CARF	Commission on Accreditation for Rehabilitation Facilities	FCA	Facility Condition Assessment
CAC	Clinical Applications Coordinator	FDA	U.S. Food and Drug Administration
CBOCs	Community Based Outpatient Clinics	FTE	Full-Time Employee
CCHT	Care Coordination Home Telehealth	GAO	Government Accountability Office
CCM	Chronic Care Management	GP	General Purpose
CCR	Clinical Case Registry	GPA	Geographic Price Adjustment
CDCO	Corporate Data Center Operations	HBC	Home Based Care
CFM	Construction and Facilities Management	HBPC	Home Based Primary Care
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs	HCMH	Homeless Chronic Mental Illness
CLC	Community Living Center	HCPCS	Healthcare Common Procedure Coding System
CMI	Chronically Mentally Ill	HCS	Home and Community Services
CMS	Centers for Medicare and Medicaid Services	H/HHA	Homemaker and Home Health Aides
CNH	Community Nursing Home	HSMI	Homeless Seriously Mentally Ill
CPT	Current Procedural Terminology	HT	Home Telehealth
		ICD-9	International Classification of Diseases
		IE	Inpatient Encounter
		IT	Information Technology
		ISO	International Organization for Standards

VERA Acronyms (cont.)

Acronym	Meaning	Acronym	Meaning
LOINC	Logical Observation Identifiers Names and Codes	PRRTP	Psychiatric Residential and Rehabilitation Treatment Program
LTC	Long Term Care	PT	Polytrauma
MCA	Managerial Cost Accounting	PTF	Patient Treatment Files
MCAS	Medical Centers Allocation System	PTSD	Post-Traumatic Stress Disorder
MCCF	Medical Care Collection Fund	PWW	Patient Weighted Work
MDC	Major Diagnostic Categories	PWWC	Patient Weighted Work Cube
MDC0	Non Diagnosis Code	QUERI	Quality Enhancement Research Initiative
MHI	Mental Health Initiative	RAM	Resource Allocation Model
MHICM	Mental Health Intensive Case Management	RBRVUs	Resource Based Relative Value Units
MI	Myocardial Infarction	RITs	Resource Intensive Treatments
MPCR	Monthly Program Cost Report	RMS	Rehabilitative Medical Services
MS	Multiple Sclerosis	RN	Registered Nurse
NDRI	National Defense Research Institute	RPM	Resource Planning Model
NIC	Non-Institutional Care	RUG III	Resource Utilization Groups III
NLB	National Leadership Board	RVU	Relative Value Unit
NLC	National Leadership Council	SCAN-ECHO	Speciality Care Access Network-Extension for Community Healthcare Outcomes
NPCD	National Patient Care Database	SCI	Spinal Cord Injury
NRM	Non-Recurring Maintenance	SCS	Speciality Care Services
NTEO	National Training and Education Office	SCT	Speciality Care Transformation
OCAMES	Office of Capital Asset Management and Engineering Support	SFT	Store and Forward Telehealth
OIT	Office of Information Technology	SP	Specific Purpose
OP	Outpatient	SVM	Selected Variables Model
OTS	Office of Telehealth Services	TBI	Traumatic Brain Injury
PACT	Patient Care Aligned Teams	TR	Transitional Residence
PBM	Pharmacy Benefits Management	TS	Treating Specialties
PCC	Patient Centered Care	VA	Veterans Affairs
PCMM	Primary Care Management Model	VERA	Veterans Equitable Resource Allocation
POV	Purpose of Visit	VISNs	Veterans Integrated Service Networks
PRP	Pro-Rated Person		

Section IV

Definitions for VERA Formulas

Formula	Meaning
B_{eq}	Budget for Equipment
B_{es}	Network Budget For Education Support
BI	Boeckh Index
B_{nrm}	NRM Budget
B_{rs}	Budget for Research Support
LA	Labor Adjustment
L_b	Labor Dollars Based on Patients
Lb	Labor Dollars Budgeted Based on Weighted Patients
Li	Labor Index
Neq	National Price for Equipment
N_{es}	National Price for Education Support
NI	National Price for Labor
NPR	Not Peer Reviewed
NPR_w	Not Peer Reviewed and not Administered by VA is Weighted at 25%
N_{rs}	National Price for Research Support
N_{sr}	National Salary Rate
PR_w	Peer Reviewed Weighted
PSi	Personal Service Dollars Indexed
Psis	Personal Service Dollars Indexed and Scaled
PWW	(FacWork+RITs+Geographic Adjustment) X Facility Complexity Level Adjustment
VA_w	Veterans Affairs Weighted 100%
‘Vbc’	Volume Basic and Complex Care patients
V_{bcw}	Volume Basic and Complex Weighted Patient
VISN	Veterans Integrated Service Networks
V_r	VERA
V_{rw}	Research Reported and Weighted
V_{sr}	Vision Salary Rate

APPENDICES

Appendix 1: FY 2015 VERA Key Formulas and Data

Appendix 2: The Veterans Integrated Service Networks

Appendix 3: History: Previous Allocation Models, Changes to VERA, and VERA Supplemental Adjustments

Appendix 4: Previous VERA Assessments
GAO, PricewaterhouseCooper LLP, AMA Systems, Inc.,
RAND Corporation Phase I, RAND Corporation Phase II, and
RAND Corporation Phase III

Appendix 1

FY 2015 VERA Key Formulas and Data

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FY 2015 VERA Key Formulas and Data - Basic Care P1-6

Allocation Factors	Total Dollars Allocated	Mechanism to Determine Total Dollars	Definitions of Unit of Measure	National Total Patients (Unit of Measure)	National Price/Allocation Rate
Basic Care (Sum of 6 Basic Care Price Groups)	\$22,143,889,652	59.00% of Basic Care and Complex Care dollars available. The Basic Care and Complex Care dollars are the total General Purpose (GP) funding less the funding for High Cost, Research Support, Education Support, Equipment and Non-Recurring Maintenance (NRM).	Number of patients in the 3 year P1-6 user file. Three year file includes FYs 2011, 2012, and 2013 patients who rely on VA for their care. There are 6 Basic Care Price Groups, and each includes VERA Patient Classes described below. Patients are based on historical utilization adjusted to reflect care provided in more than one network.	4,797,651	Each of the 6 Basic Care Price Groups has a separate price based on the dollars allocated divided by the total number of Patients
1. Non-Reliant Care	\$88,181,460	0.23% of Basic Care and Complex Care dollars, less the High Cost Payments of \$375,822.	This group includes 4 Patient Classes: 1) Employee/Collaterals; 2) Pharmacy; 3) Compensation and Pension Exams; and 4) Non-Vested Patients. The FY 2013 Patients in the Employee/Collaterals and Pharmacy classes represent shared care between other VERA funded classes.	267,946	\$329 per Non-Reliant Care Basic Care Patient
2. Basic Medical, Heart, Lung, GI	\$8,355,933,673	22.26% of Basic Care and Complex Care dollars, less the High Cost Payments of \$16,800,038.	This group includes 8 Patient Classes: 5) Central Nervous System; 6) Musculoskeletal Disorder; 7) Endocrine, Nutritional and Metabolic Disorders; 8) Ear, Nose and Throat; 9) Other Acute Disease; 10) Gastroenterology; 11) Cardiovascular Disease; and 12) Pulmonary Disease.	3,053,549	\$2,736 per Basic Medical, Heart, Lung, GI Basic Care Patient
3. Mental Health	\$1,750,685,031	4.66% of Basic Care and Complex Care dollars, less the High Cost Payments of \$1,339,925.	This group includes 2 Patient Classes: 13) Addictive Disorders; 14) Acute Mental Disease.	497,288	\$3,520 per Basic Medical Basic Care Patient
4. Oncology, Legally Blind	\$1,196,717,325	3.19% of Basic Care and Complex Care dollars, less the High Cost Payments of \$8,828,206.	This group includes 7 Patient Classes: 15) HIV without Anti-retroviral Therapy; 16) Legally Blind; 17) Oncology; 18) Hepatitis C without anti-viral Therapy; 19) Basic Home and Community Services (HCS)**; 20) Epilepsy; and 21) Multiple Sclerosis.	212,298	\$5,637 per Oncology, Legally Blind Basic Care Patient
5. Multiple Problem	\$8,123,197,278	21.64% of Basic Care and Complex Care dollars, less the High Cost Payments of \$101,397,248.	This group includes 8 Patient Classes: 22) CCHT - Chronic Care management; 23) Homeless Multiple Medical; 24) Psychiatry + Substance Abuse; 25) Medical/Psychiatry + Substance Abuse; 26) Post Traumatic Stress Disorder (PTSD) Acute; 27) Multiple Sclerosis w/Rx; 28) Multiple Medical; and 29) History of Transplant.	648,145	\$12,533 per Multiple Problem Basic Care Patient
6. Significant Diagnoses	\$2,629,174,885	7.01% of Basic Care and Complex Care dollars, less the High Cost Payments of \$302,745,314.	This group includes 5 Patient Classes: 30) Metastatic Cancer; 31) Acute MI; 32) Respiratory Failure; 33) High Cost Pneumonia; and 34) High Cost Conditions.	118,423	\$22,202 per Significant Diagnoses Basic Care Patient
Subtotal	\$22,143,889,652				

Note: ** Indicates new class for VERA 2015

FY 2015 VERA Key Formulas and Data - Basic Care - P7-8

Allocation Factors	Total Dollars Allocated	Mechanism to Determine Total Dollars	Definitions of Unit of Measure	National Total Patients (Unit of Measure)	National Price/Allocation Rate
Basic Care (Sum of 6 Basic Care Price Groups)	\$3,300,781,843	8.79% of Basic Care and Complex Care dollars available. The Basic Care and Complex Care dollars are the total General Purpose (GP) funding less the funding for High Cost, Research Support, Education Support, Equipment and Non-Recurring Maintenance (NRM).	Number of patients in the 3 year P7-8 user file. Three year file includes FYs 2011, 2012, and 2013 patients who rely on VA for their care. There are 6 Basic Care Price Groups, and each includes VERA Patient Classes described below. Patients are based on historical utilization adjusted to reflect care provided in more than one network.	1,496,770	Each of the 6 Basic Care Price Groups has a separate price based on the dollars allocated divided by the total number of Patients
1. Non-Reliant Care	\$30,863,384	0.08% of Basic Care and Complex Care dollars, less the High Cost Payments of \$000,000.	This group includes 4 Patient Classes: 1) Employee/Collaterals; 2) Pharmacy; 3) Compensation and Pension Exams; and 4) Non-Vested Patients. The FY 2013 Patients in the Employee/Collaterals and Pharmacy classes represent shared care between other VERA funded classes.	126,103	\$245 per Non-Reliant Care Basic Care Patient
2. Basic Medical, Heart, Lung, GI	\$1,927,031,900	5.13% of Basic Care and Complex Care dollars, less the High Cost Payments of \$2,298,598.	This group includes 8 Patient Classes: 5) Central Nervous System; 6) Musculoskeletal Disorder; 7) Endocrine, Nutritional and Metabolic Disorders; 8) Ear, Nose and Throat; 9) Other Acute Disease; 10) Gastroenterology; 11) Cardiovascular Disease; and 12) Pulmonary Disease.	1,166,400	\$1,652 per Basic Medical, Heart, Lung, GI Basic Care Patient
3. Mental Health	\$156,045,132	0.42% of Basic Care and Complex Care dollars, less the High Cost Payments of \$93,034.	This group includes 2 Patient Classes: 13) Addictive Disorders; 14) Acute Mental Disease.	65,712	\$2,375 per Mental Health Basic Care Patient
4. Oncology, Legally Blind	\$233,716,463	0.62% of Basic Care and Complex Care dollars, less the High Cost Payments of \$1,554,288.	This group includes 7 Patient Classes: 15) HIV without Anti-retroviral Therapy; 16) Legally Blind; 17) Oncology; 18) Hepatitis C without anti-viral Therapy; 19) Basic Home and Community Services (HCS)**; 20) Epilepsy; and 21) Multiple Sclerosis.	60,704	\$3,850 per Oncology, Legally Blind Basic Care Patient
5. Multiple Problem	\$624,707,098	1.66% of Basic Care and Complex Care dollars, less the High Cost Payments of \$7,073,608.	This group includes 8 Patient Classes: 22) CCHT - Chronic Care management; 23) Homeless Multiple Medical; 24) Psychiatry + Substance Abuse; 25) Medical/Psychiatry + Substance Abuse; 26) Post Traumatic Stress Disorder (PTSD) Acute; 27) Multiple Sclerosis w/Rx; 28) Multiple Medical; and 29) History of Transplant.	60,198	\$10,378 per Multiple Problem Basic Care Patient
6. Significant Diagnoses	\$328,417,865	0.88% of Basic Care and Complex Care dollars, less the High Cost Payments of \$33,228,476.	This group includes 5 Patient Classes: 30) Metastatic Cancer; 31) Acute MI; 32) Respiratory Failure; 33) High Cost Pneumonia; and 34) High Cost Conditions.	17,654	\$18,603 per Significant Diagnoses Basic Care Patient
Subtotal	\$3,300,781,843				

Note: ** Indicates new class for VERA 2015

FY 2015 VERA Key Formulas and Data - Complex Care - P1-6

Allocation Factors	Total Dollars Allocated	Mechanism to Determine Total Dollars	Definitions of Unit of Measure	National Total Patients (Unit of Measure)	National Price/Allocation Rate
Complex Care (Sum of 4 Complex Care Price Groups)	\$9,688,228,365	25.81% of Basic Care and Complex Care dollars available. The Basic and Complex dollars are the total GP funding less the funding for High Cost, Research, Education, Equipment and NRM. The percentage for each group is updated based on FY13 cost experience.	Number of P1-6 Complex Care patients forecasted to use the VISA in FY 2015. This one year forecasted number is based on historical utilization over five years (FY's 2009-2013). Patients are based on historical utilization adjusted to reflect care provided in more than one network. The forecast continues to include a factor for age but no longer for Veteran population trends.	334,274	Each of the 4 Complex Care Price Groups has a separate price based on the dollars allocated divided by the total number of Patients
7. Specialized Care	\$1,864,052,561	4.97% of Basic Care and Complex Care dollars, less the High Cost Payments of \$75,478,338.	This group includes 7 Patient Classes: 35) TBI/Polytrauma Aftercare; 36) CCHT - Noninstitutional Care; 37) Post Traumatic Stress Disorder (PTSD) - Chronic; 38) Stroke; 39) AIDS or HIV with Anti-Retroviral Therapy; 40) Hepatitis C with Anti-viral Therapy; and 41) Multiple Problem HCS**.	104,387	\$17,857 per Specialized Care Complex Care Patient
8. Supportive Care	\$3,164,996,050	8.43% of Basic Care and Complex Care dollars, less the High Cost Payments of \$348,776,448.	This group includes 8 Patient Classes: 42) Legacy LTC/ Intermediate; 43) SCI Para-Old Injury; 44) Home Based Care (HBC); 45) SCI Quad-Old Injury; 46) Community Nursing Home; 47) Residential Rehabilitation (Domestic); 48) Skilled Nursing w/ Rehab and High Rehab; and 49) Blind Rehabilitation Service.	106,579	\$29,696 per Supportive Care Complex Care Patient
9. Chronic Mental Illness	\$2,650,924,916	7.06% of Basic Care and Complex Care dollars, less the High Cost Payments of \$305,167,689.	This group includes 5 Patient Classes: 50) Mental Health Intensive Case Management (MHICM); 51) Substance Abuse; 52) Homeless-CMI; 53) Other Psychosis; and 54) Schizophrenia and Dementia.	91,971	\$28,824 per Chronic Mental Illness Patient
10. Critically Ill	\$2,008,254,838	5.35% of Basic Care and Complex Care dollars, less the High Cost Payments of \$1,069,280,827.	This group includes 7 Patient Classes: 55) End Stage Renal Disease (ESRD); 56) Short Stay CLC; 57) SCI Para-New Injury/SCI Inst.; 58) SCI Quad-New Injury/SCI Inst.; 59) Polytrauma (PT); 60) Transplant; and 61) Ventilator Dependent.	31,337	\$64,085 per Critically Ill Complex Care Patient
Subtotal	\$9,688,228,365				

Note: ** Indicates new class for VERA 2015

FY 2015 VERA Key Formulas and Data - Complex Care - P7-8						
Allocation Factors	Total Dollars Allocated	Mechanism to Determine Total Dollars	Definitions of Unit of Measure	National Total Patients (Unit of Measure)	National Price/Allocation Rate	
Complex Care (Sum of 4 Complex Care Price Groups)	\$2,399,376,842	6.39% of Basic Care and Complex Care dollars available. The Basic and Complex dollars are the total GP funding less the funding for High Cost, Research, Education, Equipment and NRM. The percentage for each group is updated based on FY12 cost experience.	Number of P7-8 Complex Care and P1-8 Long Stay patients forecasted to use the VISN in FY 2015. This one year forecasted number is based on historical utilization over five years (FYs 2009-2013). Patients are based on historical utilization adjusted to reflect care provided in more than one network. The forecast continues to include a factor for age but no longer for Veteran population trends.	35,710	Each of the 4 Complex Care Price Groups has a separate price based on the dollars allocated divided by the total number of Patients	
7. Specialized Care	\$168,970,017	0.45% of Basic Care and Complex Care dollars, less the High Cost Payments of \$5,601,237.	This group includes 7 Patient Classes: 35) TBI/Polytrauma Aftercare; 36) CCHT - Noninstitutional Care; 37) Post Traumatic Stress Disorder (PTSD) - Chronic; 38) Stroke; 39) AIDS or HIV with Anti-Retroviral Therapy; 40) Hepatitis C with Anti-viral Therapy; and 41) Multiple Problem HCS**.	13,278	\$12,725 per Specialized Care Complex Care Patient	
8. Supportive Care	\$159,767,955	0.43% of Basic Care and Complex Care dollars, less the High Cost Payments of \$17,401,789.	This group includes 8 Patient Classes: 42) Legacy LTC/Intermediate; 43) SCI Para-Old Injury; 44) Home Based Care (HBC); 45) SCI Quad-Old Injury; 46) Community Nursing Home; 47) Residential Rehabilitation (Domiciliary); 48) Skilled Nursing w/ Rehab & High Rehab; and 49) Blind Rehabilitation Service.	7,292	\$21,911 per Supportive Care Complex Care Patient	
9. Chronic Mental Illness	\$55,565,073	0.15% of Basic Care and Complex Care dollars, less the High Cost Payments of \$7,135,860.	This group includes 5 Patient Classes: 50) Mental Health Intensive Case Management (MHICM); 51) Substance Abuse; 52) Homeless-CMI; 53) Other Psychosis; and 54) Schizophrenia and Dementia.	1,996	\$27,836 per Chronic Mental Illness Complex Care Patient	
10. Critically Ill	\$132,054,394	0.35% of Basic Care and Complex Care dollars, less the High Cost Payments of \$63,016,853.	This group includes 7 Patient Classes: 55) End Stage Renal Disease (ESRD); 56) Short Stay CLC; 57) SCI Para-New Injury/SCI Inst.; 58) SCI Quad-New Injury/SCI Inst.; 59) Polytrauma (PT); 60) Transplant; and 61) Ventilator Dependent.	2,256	\$58,534 per Critically Ill Complex Care Patient	
10a. Long Stay	\$1,883,019,403	5.02% of Basic Care and Complex Care dollars, less the High Cost Payments of \$348,343,372.	This group includes 1 Patient Class: 62) Long Stay CLC. Networks receive an additional allocation equal to the amount that these costs exceeded the \$252,000 threshold.	10,888	\$172,944 per Long Stay Patient	
Subtotal	\$2,399,376,842					

Notes:

1. 10a. Long Stay includes both P1-6 and P7-8 Complex Care patients.

2. ** Indicates new class for VERA 2015.

FY 2015 VERA Key Formulas and Data - High Cost Patient Funding, Geographic Price Adjustment, Research Support and Education Support

Allocation Factors	Total Dollars Allocated	Mechanism to Determine Total Dollars	Definitions of Unit of Measure	National Total Patients (Unit of Measure)	National Price/Allocation Rate
High Cost Patient Funding	\$2,715,936,970	The networks will receive an additional allocation for patients whose cost exceeds the high cost threshold. The threshold for Price Group 1-10 is \$105,000 and for Price Group 10a Long Stay the threshold is set at \$252,000. High Cost Patient Funding is removed from the pool of funds for each of the 10 Price Groups.	High Cost Patient funding is designed to compensate VISNs for extremely costly patients. Networks receive an additional allocation equal to the amount that these costs exceeded the high cost threshold. High Costs are subject to a limit of 10 standard deviations above national average cost for providing the service (treating specialty/clinic cost).	41,492	
Geographic Price Adjustment	\$0	The Geographic Price Adjustment (labor index), is applied against \$26,108 billion labor, contractual labor and non-labor contractual goods dollars expended in FY 2013, which is approximately 75% of FY 2013 total obligations.	The FY 2015 VERA labor index is computed using 4 pay periods of FY 2014 normal pay data only and a national market basket methodology. The adjustment continues (as began in FY 2002) to account for local cost of living factors associated with procuring contracted labor and non-labor contractual goods such as energy related products, utilities and provisions.		
Research Support	\$589,000,000	Total of research support funds in the FY 2015 President's Budget.	'Dollars of FY 2013 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.	\$1,153,718,973 unweighted \$1,013,730,445 weighted	\$0.58 per dollar for Research
Education Support	\$851,000,000	Total of education support funds based on FY 2015 President's Budget.	Number of residents for Academic Year 2014/2015.	10,519	\$80,901 per Resident
Subtotal	\$4,155,936,970				

FY 2015 VERA Key Formulas and Data - Equipment-Capitation, Non-VA Care and CBO Staff					
Allocation Factors	Total Dollars Allocated	Mechanism to Determine Total Dollars	Definitions of Patients (Unit of Measure)	National Total Patients (Unit of Measure)	National Price/Allocation Rate
Equipment - Capitation	\$432,224,000	Derived from Equipment funds in the FY 2015 President's budget.	The Equipment allocation is based totally on PRP Patients (Sum of Basic Care (6 price groups) and Complex Care (4 price groups) Patient).	6,664,405	\$65
Non-VA Care	(\$4,768,748,230)	Derived from the FY 2015 President's budget.	<p>The different types of care purchased</p> <p>Non-VA medical care that may be purchased through a non-VA medical care provider is the same care as authorized to Veterans in a VA medical facility under Title 38 United States Code (U.S.C.) 1710. Specifically, the medical care purchased would be the same as afforded to eligible Veterans in the VA's comprehensive Medical Benefits Package to include all the necessary inpatient hospital care, outpatient services, maternity care, dental, and pharmaceutical services to promote, preserve, or restore health. Some of the top medical care purchased in 2014 include: dialysis, skilled and unskilled home health services, radiation therapy, diagnostic testing, physical therapy, inpatient hospitalization and emergency care services (displayed as a subsection below).</p> <p>The different scenarios for why care is purchased</p> <p>VA may authorize a non-VA health care facility or individual health care provider to perform necessary medical care services when such services are not routinely available at a VA health care facility, or VA determines that such services can be obtained outside the VA more economically or more appropriately due to geographic inaccessibility. Non-VA medical care must be authorized by VA in advance, unless the medical event is an emergency.</p> <p>Non-VA emergency medical care may be reimbursed for both service-connected Veterans (38 U.S.C. 1728) and non-service connected Veterans (38 U.S.C. 1725) when certain criteria has been met.</p>		
CBO Staff	(\$107,942,931)	Derived from FY 2015 President's budget.	VHA CBO Staff is responsible for a broad range of activities to support the delivery of health care benefits for Veterans and eligible dependents.		
Subtotal	(\$4,444,467,161)				
Total \$ General Purpose in VERA	\$37,243,746,511	Derived from FY 2015 Medical Care Budget less Specific Purpose funding.			

P1-6 Basic Care and Complex Care Patients

Network	Basic Care						Complex Care							
	1 Non-Reliant including Non-Vested	2 Basic Medical, Heart, Lung, GI	3 Mental Health	4 Oncology, Legally Blind	5 Multiple Problem Diagnoses	6 Significant Diagnoses	Basic Care Total	7 Specialized Care	8 Supportive Care	9 Chronic Mental Illness	10 Critically Ill	10a Long Stay	Complex Care Total	Total
01 Boston	10,682	111,735	20,449	8,618	25,034	4,191	180,709	4,056	5,522	5,363	988	523	16,452	197,161
02 Albany	5,180	64,211	9,633	4,601	13,727	2,795	100,147	2,633	2,672	2,402	645	398	8,751	108,898
03 Bronx	8,172	73,316	13,040	6,296	18,880	2,689	122,394	4,859	3,075	4,774	840	677	14,225	136,619
04 Pittsburgh	11,770	140,174	23,348	9,933	28,855	4,443	218,524	4,405	3,775	5,155	1,187	767	15,288	233,812
05 Baltimore	8,112	69,854	9,978	4,921	15,666	1,939	110,469	2,960	1,707	3,179	710	506	9,062	119,531
06 Durham	14,477	188,511	31,405	13,495	34,802	6,765	289,453	5,765	6,381	4,044	2,263	566	19,020	308,473
07 Atlanta	18,220	218,531	39,242	13,826	39,088	7,460	336,367	7,367	5,333	5,748	1,885	597	20,929	357,296
08 Bay Pines	18,261	262,735	39,459	22,840	67,602	11,824	422,721	10,831	9,279	6,370	2,797	766	30,043	452,764
09 Nashville	13,022	154,121	25,904	10,217	31,000	7,816	242,080	6,199	4,342	2,986	1,503	251	15,280	257,360
10 Cincinnati	6,878	111,430	18,393	7,689	24,717	3,820	172,928	3,611	6,579	4,632	1,476	583	16,881	189,808
11 Ann Arbor	13,859	146,575	22,504	10,339	28,632	5,291	227,199	5,636	4,076	3,509	1,005	454	14,680	241,880
12 Chicago	9,176	111,320	16,725	7,463	26,843	3,841	175,366	3,750	5,104	5,296	1,479	601	16,229	191,595
15 Kansas City	10,299	117,926	19,234	8,933	25,548	5,476	187,416	4,514	5,064	3,683	1,336	229	14,826	202,241
16 Jackson	21,093	265,043	48,323	17,395	51,041	12,880	415,776	7,439	7,234	6,959	2,463	585	24,680	440,456
17 Dallas	14,499	163,402	28,566	9,976	33,272	4,991	254,706	4,555	3,858	4,583	1,891	531	15,418	270,124
18 Phoenix	14,074	135,250	21,142	9,593	28,103	5,387	213,549	3,728	5,580	3,400	1,472	345	14,524	228,072
19 Denver	10,360	98,988	15,911	6,104	21,275	3,587	156,223	4,816	3,581	2,818	665	206	12,087	168,310
20 Portland	15,012	147,765	24,268	9,896	33,908	6,185	237,033	3,955	4,830	4,098	1,294	266	14,443	251,476
21 San Francisco	15,240	138,003	21,890	9,579	31,964	5,907	222,583	4,632	4,334	3,369	1,803	714	14,852	237,435
22 Long Beach	16,249	164,945	27,976	10,036	40,956	5,657	265,820	4,905	5,176	5,851	1,883	341	18,157	283,977
23 Minneapolis	13,311	169,715	19,899	10,548	27,234	5,480	246,187	3,773	9,077	3,753	1,753	563	18,919	265,106
VHA Totals	267,946	3,053,549	497,288	212,298	648,145	118,423	4,797,651	104,387	106,579	91,971	31,337	10,469	344,743	5,142,394

Notes:

1. Basic PRPs are 3 year total PRPs.
2. Complex PRPs are 1 year projected PRPs based on 5 years' historical experience.
3. Long Stay CLC (Community Living Center), in Price Group 10a funds patients with greater than 90 BDOC and a RUG III Full Assessment. This class makes no priority distinction. There is a High Cost adjustment for those patients above the \$252,000 threshold.
4. Numbers may not add due to rounding.

P7-8 Basic Care and Complex Care Patients

Network	Basic Care							Complex Care						
	1 Non Reliant including Non-Vested	2 Basic Medical, Heart, Lung, GI	3 Mental Health	4 Oncology, Legally Blind	5 Multiple Problem Diagnoses	6 Significant Diagnoses	Basic Care Total	7 Specialized Care	8 Supportive Care	9 Chronic Mental Illness	10 Critically Ill	10a Long Stay	Complex Care Total	Total
01 Boston	5,305	61,307	3,629	3,364	2,961	862	77,428	480	445	129	73	25	1,152	78,580
02 Albany	3,115	30,894	1,576	1,685	1,390	450	39,109	391	188	49	56	13	696	39,805
03 Bronx	5,571	46,877	2,810	2,597	2,345	528	60,727	1,058	278	153	68	17	1,573	62,300
04 Pittsburgh	8,115	86,093	4,329	3,942	3,290	814	106,582	620	299	235	129	28	1,312	107,894
05 Baltimore	3,779	27,836	1,620	1,412	1,726	300	36,673	396	154	77	51	31	709	37,382
06 Durham	5,701	56,999	3,208	3,195	2,899	923	72,924	543	470	66	167	4	1,250	74,174
07 Atlanta	6,690	61,645	3,767	2,654	2,552	867	78,176	791	202	78	92	29	1,192	79,367
08 Bay Pines	10,093	117,251	5,832	6,657	6,261	1,753	147,848	1,148	394	89	195	24	1,851	149,698
09 Nashville	5,669	47,548	2,632	2,381	2,508	1,000	61,737	657	226	39	105	8	1,035	62,772
10 Cincinnati	3,757	46,003	3,035	1,985	2,629	578	57,987	377	399	126	76	27	1,006	58,993
11 Ann Arbor	5,645	54,786	2,934	2,629	2,143	718	68,855	817	222	44	65	38	1,186	70,041
12 Chicago	5,827	65,957	3,176	3,170	3,681	861	82,671	589	468	152	118	28	1,355	84,026
15 Kansas City	5,063	50,603	2,558	2,499	2,380	785	63,888	633	295	77	99	18	1,122	65,011
16 Jackson	8,522	83,173	5,098	3,917	4,149	1,555	106,415	865	353	128	154	17	1,516	107,932
17 Dallas	5,860	44,424	2,797	2,332	2,421	609	58,443	537	134	76	155	9	911	59,354
18 Phoenix	6,215	44,144	2,448	2,754	2,498	839	58,898	479	297	52	108	10	946	59,843
19 Denver	4,759	36,053	1,984	2,061	1,925	575	47,358	607	320	56	68	17	1,068	48,426
20 Portland	5,657	41,320	2,687	2,549	2,911	808	55,931	389	273	86	81	10	839	56,770
21 San Francisco	7,289	42,006	2,914	2,531	3,090	961	58,789	698	271	77	144	35	1,224	60,014
22 Long Beach	6,883	50,855	3,598	2,571	3,532	897	68,335	643	340	125	109	10	1,227	69,563
23 Minneapolis	6,589	70,628	3,083	3,819	2,906	971	87,996	559	1,264	82	144	21	2,071	90,068
VHA Totals	126,103	1,166,400	65,712	60,704	60,198	17,654	1,496,770	13,278	7,292	1,996	2,256	419	25,241	1,522,011

Notes:

1. Basic PRPs are 3 year total PRPs.
2. Complex PRPs are 1 year projected PRPs based on 5 years' historical experience.
3. Long Stay CLC (Community Living Center), in Price Group 10a funds patients with greater than 90 BDOC and a RUG III Full Assessment. This class makes no priority distinction, and the High Cost adjustment is \$252,000.
4. Numbers may not add due to rounding.

Basic Care VERA Patients Used for VERA Allocations FY 1997, FY 2012 - FY 2015

Network	FY 1997		FY 2012		FY 2013		FY 2014		FY 2015		% Change			
	VERA		VERA		VERA		VERA		VERA		FY 2012 - FY 2013	FY 2013 - FY 2014	FY 2014 - FY 2015	FY 1997 - FY 2015
01 Boston	154,885	254,760	259,134	262,923	258,137						1.7%	1.5%	-1.8%	66.7%
02 Albany	80,230	139,989	141,362	142,756	139,256						1.0%	1.0%	-2.5%	73.6%
03 Bronx	149,736	193,793	193,895	193,250	183,121						0.1%	-0.3%	-5.2%	22.3%
04 Pittsburgh	144,747	332,954	336,130	336,365	325,106						1.0%	0.1%	-3.3%	124.6%
05 Baltimore	94,150	140,476	144,754	147,485	147,142						3.0%	1.9%	-0.2%	56.3%
06 Durham	164,500	331,163	347,401	360,578	362,377						4.9%	3.8%	0.5%	120.3%
07 Atlanta	191,987	380,735	399,261	413,015	414,543						4.9%	3.4%	0.4%	115.9%
08 Bay Pines	252,403	560,939	571,955	579,810	570,569						2.0%	1.4%	-1.6%	126.1%
09 Nashville	155,876	296,066	303,761	308,750	303,817						2.6%	1.6%	-1.6%	94.9%
10 Cincinnati	115,276	223,963	230,083	235,270	230,914						2.7%	2.3%	-1.9%	100.3%
11 Ann Arbor	138,945	281,261	290,081	298,194	296,055						3.1%	2.8%	-0.7%	113.1%
12 Chicago	148,300	257,124	260,268	263,723	258,037						1.2%	1.3%	-2.2%	74.0%
15 Kansas City	137,310	253,559	254,735	257,133	251,304						0.5%	0.9%	-2.3%	83.0%
16 Jackson	304,362	512,848	521,353	530,253	522,191						1.7%	1.7%	-1.5%	71.6%
17 Dallas	148,494	292,719	302,968	312,296	313,149						3.5%	3.1%	0.3%	110.9%
18 Phoenix	141,059	263,071	269,622	274,774	272,446						2.5%	1.9%	-0.8%	93.1%
19 Denver	92,703	187,638	197,062	202,968	203,581						5.0%	3.0%	0.3%	119.6%
20 Portland	144,635	266,855	280,288	291,567	292,964						5.0%	4.0%	0.5%	102.6%
21 San Francisco	137,994	263,563	273,412	281,295	281,372						3.7%	2.9%	0.0%	103.9%
22 Long Beach	189,728	314,599	325,701	335,114	334,156						3.5%	2.9%	-0.3%	76.1%
23 Minneapolis	150,538	323,868	332,288	340,016	334,183						2.6%	2.3%	-1.7%	122.0%
VHA Totals	3,237,858	6,071,941	6,235,514	6,367,535	6,294,421						2.7%	2.1%	-1.1%	94.4%

Notes:

- All patient units are adjusted for care provided in more than one network.
- Policy decisions affecting Basic Care Patients were made effective for the:
 - FY 2012 Classification changes include the C&P patients qualifying for Vested patient classes.
 - FY 2013 Classification changes include a new Epilepsy Class.
 - FY 2014 Classification changes made to the hierarchical order of some Patient Classes within certain Price Groups.
 - FY 2015 Classification changes include one new Basic Class; Basic Home and—Community Services (HCS).
- The VERA patients shown above are based on the following fiscal years:
 - FY 1997 VERA Basic Care is the sum of patients seen in FYs 1993-1995.
 - FY 2012 VERA Basic Care is the sum of patients in Price Groups 1-6 for FYs 2008-2010.
 - FY 2013 VERA Basic Care is the sum of patients in Price Groups 1-6 for FYs 2009-2011.
 - FY 2015 VERA Basic Care is the sum of patients in Price Groups 1-6 for FYs 2011-2013.
- Numbers may not add due to rounding.

Complex Care VERA Patients Used for VERA Allocations FY 1997, FY 2012 - FY 2015

Network	FY 1997		FY 2012		FY 2013		FY 2014		FY 2015		% Change			
	VERA	VERA	VERA	VERA	VERA	VERA	VERA	VERA	VERA	VERA	FY 2012 - FY 2013	FY 2013 - FY 2014	FY 2014 - FY 2015	FY 1997 - FY 2015
01 Boston	7,951	14,820	15,815	17,302	17,603						6.7%	9.4%	1.7%	121.4%
02 Albany	4,750	7,887	8,566	8,566	9,447						8.6%	0.0%	10.3%	98.9%
03 Bronx	10,253	11,837	12,916	14,940	15,798						9.1%	15.7%	5.7%	54.1%
04 Pittsburgh	9,308	15,116	16,127	16,561	16,600						6.7%	2.7%	0.2%	78.3%
05 Baltimore	4,090	8,638	8,892	9,176	9,771						2.9%	3.2%	6.5%	138.9%
06 Durham	6,912	15,879	16,628	18,151	20,269						4.7%	9.2%	11.7%	193.2%
07 Atlanta	8,881	19,597	21,391	21,805	22,121						9.2%	1.9%	1.4%	149.1%
08 Bay Pines	10,158	25,598	27,415	28,407	31,894						7.1%	3.6%	12.3%	214.0%
09 Nashville	6,725	14,515	14,629	15,082	16,315						0.8%	3.1%	8.2%	142.6%
10 Cincinnati	5,284	14,694	16,154	16,807	17,887						9.9%	4.0%	6.4%	238.5%
11 Ann Arbor	6,243	12,050	13,202	13,734	15,866						9.6%	4.0%	15.5%	154.1%
12 Chicago	8,407	15,527	16,473	16,163	17,584						6.1%	-1.9%	8.8%	109.2%
15 Kansas City	6,550	12,132	14,474	15,223	15,948						19.3%	5.2%	4.8%	143.5%
16 Jackson	9,298	22,923	24,643	24,608	26,197						7.5%	-0.1%	6.5%	181.7%
17 Dallas	6,679	15,567	16,642	16,049	16,329						6.9%	-3.6%	1.7%	144.5%
18 Phoenix	4,715	12,484	14,112	15,300	15,469						13.0%	8.4%	1.1%	228.1%
19 Denver	3,241	8,650	10,231	11,524	13,155						18.3%	12.6%	14.2%	305.9%
20 Portland	6,463	13,857	14,565	14,752	15,282						5.1%	1.3%	3.6%	136.5%
21 San Francisco	6,732	11,927	14,094	14,940	16,076						18.2%	6.0%	7.6%	138.8%
22 Long Beach	7,517	14,816	16,289	17,681	19,384						9.9%	8.5%	9.6%	157.9%
23 Minneapolis	6,731	16,694	19,421	20,172	20,990						16.3%	3.9%	4.1%	211.8%
VHA Totals	146,888	305,208	332,678	346,943	369,984						9.0%	4.3%	6.6%	151.9%

Notes:

- All patient units are adjusted for care provided in more than one network.
- A number of policy decisions affect the Complex Care Patient. These are discussed in the text of this book in Appendix 3. Briefly, the effective dates of the changes are:
 - FY 2012 classification changes included a new Complex Care patient class for patients receiving care in a VHA Polytrauma Center.
 - FY 2013 classification changes include a new DX Class Rehabilitation to represent RMS patients receiving high levels of rehabilitation services.
 - FY 2014 classification changes made to the hierarchical order of some Patient Classes within certain Price Groups.
 - FY 2015 classification changes include one new Complex Class: Multiple Problem Home and Community Service (HCS).
- Figures in FY 1997, FY 2012, FY 2013, FY 2014 and FY 2015 are the sum of groups 7-10a.
- Numbers may not add due to rounding.

Total VERA Patients - FY 1997, FY 2012 - FY 2015

Network	VERA FY 1997 Total Patients	VERA FY 2013 Total Patients	VERA FY 2014 Total Patients	VERA FY 2015 Total Patients
01 Boston	162,836	269,579	274,949	275,741
02 Albany	84,980	147,876	149,927	148,703
03 Bronx	159,989	205,630	206,811	198,919
04 Pittsburgh	154,055	348,070	352,257	341,706
05 Baltimore	98,240	149,114	153,646	156,913
06 Durham	171,412	347,042	364,029	382,646
07 Atlanta	200,868	400,332	420,652	436,663
08 Bay Pines	262,561	586,536	599,370	602,463
09 Nashville	162,601	310,581	318,390	320,132
10 Cincinnati	120,560	238,657	246,237	248,801
11 Ann Arbor	145,188	293,311	303,283	311,921
12 Chicago	156,707	272,651	276,741	275,621
15 Kansas City	143,860	265,690	269,209	267,252
16 Jackson	313,660	535,771	545,996	548,388
17 Dallas	155,173	308,286	319,610	329,477
18 Phoenix	145,774	275,555	283,734	287,916
19 Denver	95,944	196,288	207,292	216,736
20 Portland	151,098	280,712	294,853	308,246
21 San Francisco	144,726	275,490	287,505	297,449
22 Long Beach	197,245	329,416	341,991	352,540
23 Minneapolis	157,269	340,562	351,709	355,174
VHA Totals	3,384,746	6,377,149	6,568,192	6,664,405

Notes:

1. All patient units are adjusted for care provided in more than one network.
2. These VERA patients are three-year basic plus one-year projected complex.
3. Numbers may not add due to rounding.

Basic and Complex Care Allocations - FY 2015

(\$ in millions)

Network	Basic Care						Complex Care							
	1 Non Reliant including Non-Vested	2 Basic Medical, Heart, Lung, GI	3 Mental Health	4 Oncology, Legally Blind	5 Multiple Problem	6 Significant Diagnoses	Basic Care Total	7 Specialized Care	8 Supportive Care	9 Chronic Mental Illness	10 Critically Ill	10a Long Stay	Complex Care Total	Total
01 Boston	\$5	\$407	\$81	\$62	\$344	\$109	\$1,008	\$79	\$174	\$158	\$68	\$95	\$573	\$1,580
02 Albany	\$2	\$227	\$38	\$32	\$186	\$70	\$556	\$52	\$83	\$71	\$45	\$71	\$322	\$878
03 Bronx	\$4	\$278	\$53	\$45	\$261	\$70	\$711	\$100	\$97	\$142	\$58	\$120	\$517	\$1,228
04 Pittsburgh	\$6	\$526	\$92	\$71	\$396	\$114	\$1,205	\$87	\$119	\$155	\$84	\$137	\$581	\$1,786
05 Baltimore	\$4	\$237	\$39	\$33	\$214	\$49	\$576	\$58	\$54	\$94	\$49	\$93	\$347	\$923
06 Durham	\$6	\$610	\$118	\$88	\$466	\$167	\$1,456	\$110	\$200	\$118	\$155	\$99	\$681	\$2,138
07 Atlanta	\$8	\$700	\$147	\$88	\$516	\$182	\$1,641	\$142	\$163	\$168	\$126	\$108	\$707	\$2,348
08 Bay Pines	\$8	\$913	\$153	\$154	\$912	\$295	\$2,436	\$208	\$284	\$186	\$191	\$137	\$1,006	\$3,441
09 Nashville	\$6	\$500	\$97	\$67	\$415	\$192	\$1,277	\$119	\$134	\$87	\$102	\$45	\$487	\$1,764
10 Cincinnati	\$3	\$381	\$72	\$51	\$337	\$96	\$940	\$69	\$204	\$137	\$99	\$106	\$615	\$1,555
11 Ann Arbor	\$6	\$492	\$86	\$68	\$381	\$131	\$1,164	\$111	\$126	\$102	\$68	\$85	\$493	\$1,657
12 Chicago	\$4	\$414	\$66	\$54	\$375	\$101	\$1,015	\$74	\$162	\$157	\$102	\$109	\$604	\$1,618
15 Kansas City	\$5	\$406	\$74	\$60	\$345	\$136	\$1,026	\$89	\$157	\$108	\$91	\$43	\$488	\$1,514
16 Jackson	\$9	\$863	\$182	\$113	\$683	\$315	\$2,165	\$144	\$223	\$204	\$167	\$104	\$841	\$3,006
17 Dallas	\$6	\$521	\$107	\$65	\$442	\$122	\$1,263	\$88	\$118	\$134	\$130	\$93	\$564	\$1,827
18 Phoenix	\$6	\$443	\$80	\$65	\$378	\$135	\$1,107	\$73	\$172	\$99	\$101	\$61	\$506	\$1,614
19 Denver	\$5	\$330	\$61	\$42	\$287	\$90	\$815	\$94	\$113	\$83	\$47	\$39	\$375	\$1,190
20 Portland	\$6	\$473	\$92	\$66	\$455	\$152	\$1,244	\$76	\$149	\$121	\$88	\$48	\$481	\$1,725
21 San Francisco	\$7	\$447	\$84	\$64	\$433	\$149	\$1,183	\$92	\$135	\$99	\$124	\$129	\$579	\$1,762
22 Long Beach	\$7	\$535	\$107	\$66	\$550	\$142	\$1,408	\$96	\$161	\$172	\$127	\$61	\$617	\$2,025
23 Minneapolis	\$6	\$581	\$77	\$74	\$371	\$140	\$1,250	\$74	\$297	\$110	\$121	\$101	\$704	\$1,954
VHA Totals	\$119	\$10,283	\$1,907	\$1,430	\$8,748	\$2,958	\$25,445	\$2,033	\$3,325	\$2,706	\$2,140	\$1,883	\$12,088	\$37,532

Note: Numbers may not add due to rounding.

Basic and Complex Care Patients Receiving High Cost Payments - FY 2015

Network	Basic Care						Complex Care						
	1 Non Reliant including Non-Vested	2 Basic Medical, Lung, GI	3 Mental Health	4 Oncology, Legally Blind	5 Multiple Problem Diagnoses	6 Significant Diagnoses	7 Specialized Care	8 Supportive Care	9 Chronic Mental Illness	10 Critically Ill	10a Long Stay	Complex Care Total	Total
01 Boston	0	15	4	8	164	296	111	439	589	526	145	1,809	2,297
02 Albany	0	19	3	6	71	158	55	156	168	216	127	722	980
03 Bronx	0	22	3	11	207	418	150	269	638	470	406	1,932	2,594
04 Pittsburgh	0	20	2	11	133	266	91	314	338	549	384	1,677	2,108
05 Baltimore	1	23	0	11	125	167	56	191	282	286	247	1,061	1,389
06 Durham	0	28	3	18	126	316	85	264	199	761	188	1,497	1,988
07 Atlanta	0	31	4	22	129	330	95	297	259	580	235	1,466	1,981
08 Bay Pines	0	28	0	18	243	542	147	656	348	1,169	298	2,618	3,449
09 Nashville	0	21	0	7	105	374	102	343	173	574	140	1,332	1,840
10 Cincinnati	0	12	0	3	68	214	46	376	323	536	158	1,440	1,737
11 Ann Arbor	0	15	0	12	105	262	53	204	311	374	225	1,168	1,562
12 Chicago	0	17	3	11	160	283	103	445	347	759	280	1,935	2,409
15 Kansas City	0	14	0	10	101	276	65	238	176	509	84	1,072	1,473
16 Jackson	1	32	3	14	190	590	118	334	281	724	202	1,659	2,489
17 Dallas	0	39	2	9	133	243	65	201	174	642	189	1,271	1,696
18 Phoenix	0	19	0	13	71	232	55	210	151	477	78	972	1,306
19 Denver	0	14	0	0	73	170	59	227	216	234	35	771	1,028
20 Portland	0	17	0	20	151	338	75	367	175	536	113	1,267	1,793
21 San Francisco	1	45	2	16	194	478	135	443	371	732	406	2,086	2,821
22 Long Beach	0	21	4	10	223	383	84	687	460	828	135	2,194	2,835
23 Minneapolis	0	13	1	8	92	252	36	368	149	676	120	1,350	1,716
VHA Totals	3	465	34	238	2,866	6,588	1,786	7,029	6,129	12,158	4,196	31,298	41,492

Note: Numbers may not add due to rounding.

Basic and Complex Care - Percent of Patients Receiving High Cost Payments - FY 2015

Network	Basic Care						Complex Care							
	1 Non-Reliant including Non-Vested	2 Basic Medical, Heart, Lung, GI	3 Mental Health	4 Oncology, Legally Blind	5 Multiple Problem Diagnoses	6 Significant Diagnoses	Basic Care Total	7 Specialized Care	8 Supportive Care	9 Chronic Mental Illness	10 Critically Ill	10a Long Stay	Complex Care Total	Total
01 Boston	0.0%	0.0%	0.0%	0.1%	0.6%	5.9%	0.2%	2.4%	7.4%	10.7%	49.5%	26.5%	10.3%	0.8%
02 Albany	0.0%	0.0%	0.0%	0.1%	0.5%	4.9%	0.2%	1.8%	5.5%	6.8%	30.8%	31.0%	7.6%	0.7%
03 Bronx	0.0%	0.0%	0.0%	0.1%	1.0%	13.0%	0.4%	2.5%	8.0%	12.9%	51.8%	58.5%	12.2%	1.3%
04 Pittsburgh	0.0%	0.0%	0.0%	0.1%	0.4%	5.1%	0.1%	1.8%	7.7%	6.3%	41.7%	48.3%	10.1%	0.6%
05 Baltimore	0.0%	0.0%	0.0%	0.2%	0.7%	7.5%	0.2%	1.7%	10.3%	8.7%	37.5%	46.0%	10.9%	0.9%
06 Durham	0.0%	0.0%	0.0%	0.1%	0.3%	4.1%	0.1%	1.4%	3.8%	4.9%	31.3%	32.9%	7.4%	0.5%
07 Atlanta	0.0%	0.0%	0.0%	0.1%	0.3%	4.0%	0.1%	1.2%	5.4%	4.4%	29.4%	37.5%	6.6%	0.5%
08 Bay Pines	0.0%	0.0%	0.0%	0.1%	0.3%	4.0%	0.1%	1.2%	6.8%	5.4%	39.1%	37.7%	8.2%	10.8%
09 Nashville	0.0%	0.0%	0.0%	0.1%	0.3%	4.2%	0.2%	1.5%	7.5%	5.7%	35.7%	54.3%	8.2%	0.6%
10 Cincinnati	0.0%	0.0%	0.0%	0.0%	0.2%	4.9%	0.1%	1.1%	5.4%	6.8%	34.5%	25.9%	8.0%	0.7%
11 Ann Arbor	0.0%	0.0%	0.0%	0.1%	0.3%	4.4%	0.1%	0.8%	4.8%	8.8%	35.0%	45.7%	7.4%	0.5%
12 Chicago	0.0%	0.0%	0.0%	0.1%	0.5%	6.0%	0.2%	2.4%	8.0%	6.4%	47.6%	44.5%	11.0%	0.9%
15 Kansas City	0.0%	0.0%	0.0%	0.1%	0.4%	4.4%	0.2%	1.3%	4.4%	4.7%	35.5%	34.0%	6.7%	0.6%
16 Jackson	0.0%	0.0%	0.0%	0.1%	0.3%	4.1%	0.2%	1.4%	4.4%	4.0%	27.7%	33.5%	6.3%	0.5%
17 Dallas	0.0%	0.2%	0.0%	0.0%	0.7%	1.2%	2.1%	1.3%	5.0%	3.7%	31.4%	35.0%	7.8%	0.5%
18 Phoenix	0.0%	0.0%	0.0%	0.1%	0.2%	3.7%	0.1%	1.3%	3.6%	4.4%	30.2%	22.0%	6.3%	0.5%
19 Denver	0.0%	0.0%	0.0%	0.0%	0.3%	4.1%	0.1%	1.1%	5.8%	7.5%	32.0%	15.7%	5.9%	0.5%
20 Portland	0.0%	0.0%	0.0%	0.2%	0.4%	4.8%	0.2%	1.7%	7.2%	4.2%	39.0%	40.9%	8.3%	0.6%
21 San Francisco	0.0%	0.0%	0.0%	0.1%	0.6%	7.0%	0.3%	2.5%	9.6%	10.8%	37.6%	54.2%	13.0%	0.9%
22 Long Beach	0.0%	0.0%	0.0%	0.1%	0.5%	5.8%	0.2%	1.5%	12.5%	7.7%	41.6%	38.4%	11.3%	0.8%
23 Minneapolis	0.0%	0.0%	0.0%	0.1%	0.3%	3.9%	0.1%	0.8%	3.6%	3.9%	35.6%	20.6%	6.4%	0.5%
VHA Totals	0.0%	0.0%	0.0%	0.1%	0.4%	4.8%	0.2%	1.5%	6.2%	6.5%	36.2%	38.5%	8.5%	0.7%

Note: Numbers may not add due to rounding.

Basic and Complex Care High Cost Patient Allocations - FY 2015

(\$ in thousands)

Network	Basic Care						Complex Care							
	1 Non Reliant including Non-Vested	2 Basic Medical, Heart, Lung, GI	3 Mental Health	4 Oncology, Legally Blind	5 Multiple Problem Diagnoses	6 Significant Diagnoses	Basic Care Total	7 Specialized Care	8 Supportive Care	9 Chronic Mental Illness	10 Critically Ill	10a Long Stay	Complex Care Total	Total
01 Boston	\$0	\$653	\$111	\$271	\$7,087	\$15,950	\$24,072	\$6,195	\$20,670	\$36,824	\$61,679	\$11,816	\$137,184	\$161,256
02 Albany	\$0	\$939	\$117	\$201	\$2,721	\$8,280	\$12,257	\$3,045	\$8,434	\$6,642	\$15,772	\$8,032	\$41,924	\$54,181
03 Bronx	\$0	\$1,176	\$223	\$232	\$9,046	\$33,177	\$43,855	\$7,573	\$17,585	\$44,939	\$56,018	\$34,791	\$160,905	\$204,759
04 Pittsburgh	\$0	\$602	\$59	\$350	\$4,901	\$11,918	\$17,830	\$4,062	\$17,464	\$15,657	\$51,302	\$33,880	\$122,365	\$140,195
05 Baltimore	\$181	\$1,009	\$0	\$716	\$5,015	\$9,047	\$15,967	\$2,144	\$10,359	\$12,212	\$24,118	\$21,037	\$69,870	\$85,837
06 Durham	\$0	\$809	\$289	\$638	\$4,252	\$15,387	\$21,375	\$3,526	\$13,917	\$10,321	\$74,719	\$14,485	\$116,968	\$138,342
07 Atlanta	\$0	\$1,790	\$138	\$1,358	\$5,151	\$16,283	\$24,720	\$5,166	\$15,303	\$10,015	\$52,763	\$16,863	\$100,110	\$124,830
08 Bay Pines	\$0	\$528	\$0	\$979	\$8,489	\$23,597	\$33,593	\$6,173	\$28,333	\$13,034	\$129,263	\$21,316	\$198,119	\$231,713
09 Nashville	\$0	\$579	\$0	\$246	\$4,027	\$16,535	\$21,387	\$4,281	\$17,219	\$7,995	\$48,171	\$14,966	\$92,632	\$114,019
10 Cincinnati	\$0	\$398	\$0	\$99	\$2,657	\$9,752	\$12,907	\$1,633	\$14,855	\$12,159	\$41,865	\$14,966	\$85,478	\$98,385
11 Ann Arbor	\$0	\$1,207	\$0	\$579	\$4,087	\$12,617	\$18,490	\$1,674	\$8,868	\$16,923	\$24,577	\$15,516	\$67,558	\$86,047
12 Chicago	\$0	\$478	\$38	\$406	\$6,001	\$13,586	\$20,510	\$4,751	\$26,164	\$15,432	\$72,065	\$23,148	\$141,561	\$162,070
15 Kansas City	\$0	\$622	\$0	\$626	\$4,689	\$11,725	\$17,662	\$2,430	\$11,558	\$6,604	\$38,416	\$6,287	\$65,296	\$82,958
16 Jackson	\$8	\$988	\$42	\$640	\$5,637	\$27,248	\$34,564	\$4,034	\$17,018	\$12,233	\$63,082	\$13,201	\$109,568	\$144,132
17 Dallas	\$0	\$1,392	\$153	\$300	\$4,607	\$12,671	\$19,123	\$3,556	\$10,980	\$7,310	\$49,624	\$12,551	\$84,021	\$103,143
18 Phoenix	\$0	\$688	\$0	\$450	\$2,387	\$13,371	\$16,895	\$2,248	\$10,366	\$7,005	\$35,950	\$10,900	\$66,469	\$83,365
19 Denver	\$0	\$338	\$0	\$0	\$2,565	\$9,164	\$12,067	\$2,535	\$11,554	\$10,675	\$23,706	\$1,648	\$50,119	\$62,186
20 Portland	\$0	\$1,492	\$0	\$467	\$5,565	\$18,953	\$26,477	\$3,029	\$19,858	\$6,601	\$45,925	\$8,368	\$83,782	\$110,258
21 San Francisco	\$186	\$2,005	\$173	\$974	\$8,566	\$27,202	\$39,106	\$7,849	\$28,177	\$21,351	\$73,173	\$43,767	\$174,317	\$213,423
22 Long Beach	\$0	\$1,032	\$41	\$731	\$8,367	\$18,379	\$28,550	\$3,998	\$40,945	\$28,492	\$94,932	\$11,787	\$180,153	\$208,703
23 Minneapolis	\$0	\$373	\$50	\$118	\$2,654	\$11,132	\$14,328	\$1,179	\$16,552	\$9,879	\$55,177	\$9,019	\$91,805	\$106,133
VHA Totals	\$376	\$19,099	\$1,433	\$10,382	\$108,471	\$335,974	\$475,735	\$81,080	\$366,178	\$312,304	\$1,132,298	\$348,343	\$2,240,202	\$2,715,937

Notes:

1. Figures represent the dollar amounts for costs exceeding the \$105,000 per patient threshold in Price Groups 1-10 and \$252,000 per patient for Long Stay 10a; designed to compensate VISNs for extremely costly patients.
2. Numbers may not add due to rounding.

Average High Cost Patient Allocations - FY 2015

Network	Basic Care						Complex Care						
	1 Non-Reliant including Non-Vested	2 Basic Medical, Heart, Lung, GI	3 Mental Health	4 Oncology, Legally Blind	5 Multiple Problem Diagnoses	6 Significant Diagnoses	Average Basic Care	7 Specialized Supportive Care	8 Chronic Mental Illness	9 10 Critically Ill	10a Long Stay	Average Complex Care	Total
01 Boston	\$0	\$43,559	\$27,712	\$33,549	\$43,206	\$53,824	\$49,385	\$56,004	\$47,131	\$62,507	\$117,279	\$81,405	\$75,819
02 Albany	\$0	\$49,434	\$38,936	\$33,418	\$38,078	\$52,397	\$47,605	\$55,027	\$53,996	\$39,643	\$73,005	\$63,052	\$58,027
03 Bronx	\$0	\$52,510	\$74,357	\$21,118	\$43,598	\$79,347	\$66,244	\$50,596	\$65,437	\$70,490	\$119,231	\$85,676	\$83,292
04 Pittsburgh	\$0	\$30,599	\$29,370	\$32,050	\$36,810	\$44,829	\$41,312	\$44,451	\$55,578	\$46,282	\$93,516	\$88,198	\$72,983
05 Baltimore	\$181,112	\$43,958	\$0	\$65,697	\$40,100	\$54,082	\$48,803	\$38,584	\$54,271	\$43,274	\$84,384	\$85,192	\$65,829
06 Durham	\$0	\$29,160	\$96,382	\$35,554	\$33,640	\$48,768	\$43,570	\$41,382	\$52,803	\$51,752	\$98,122	\$77,216	\$78,120
07 Atlanta	\$0	\$57,644	\$34,520	\$61,723	\$39,976	\$49,406	\$47,955	\$54,658	\$51,610	\$38,647	\$90,924	\$71,732	\$68,309
08 Bay Pines	\$0	\$18,706	\$0	\$54,367	\$34,974	\$43,542	\$40,429	\$41,859	\$43,197	\$37,488	\$110,592	\$71,498	\$75,675
09 Nashville	\$0	\$27,599	\$0	\$33,209	\$38,292	\$44,194	\$42,125	\$42,087	\$50,215	\$46,198	\$83,946	\$106,529	\$69,544
10 Cincinnati	\$0	\$33,253	\$0	\$33,119	\$39,208	\$45,493	\$43,442	\$35,646	\$39,493	\$37,617	\$78,079	\$94,497	\$59,370
11 Ann Arbor	\$0	\$80,371	\$0	\$48,346	\$38,929	\$48,145	\$46,924	\$31,430	\$43,373	\$54,363	\$65,684	\$69,078	\$57,850
12 Chicago	\$0	\$28,061	\$12,577	\$36,963	\$37,395	\$47,959	\$43,196	\$46,086	\$58,782	\$44,450	\$94,905	\$82,693	\$73,171
15 Kansas City	\$0	\$44,389	\$0	\$62,528	\$46,515	\$42,530	\$44,098	\$37,439	\$48,562	\$37,469	\$75,478	\$74,896	\$60,905
16 Jackson	\$8,416	\$31,111	\$14,086	\$45,708	\$29,600	\$46,221	\$41,658	\$34,112	\$50,897	\$43,529	\$87,100	\$65,490	\$66,026
17 Dallas	\$0	\$35,392	\$76,376	\$33,281	\$34,718	\$52,224	\$44,924	\$54,306	\$54,698	\$42,000	\$77,344	\$66,460	\$66,121
18 Phoenix	\$0	\$37,132	\$0	\$34,638	\$33,747	\$57,621	\$50,542	\$40,723	\$49,269	\$46,365	\$75,337	\$139,380	\$68,378
19 Denver	\$0	\$23,475	\$0	\$0	\$35,288	\$53,863	\$46,911	\$43,074	\$50,907	\$49,533	\$101,140	\$46,902	\$65,016
20 Portland	\$0	\$87,069	\$0	\$23,832	\$36,782	\$56,008	\$50,295	\$40,368	\$54,040	\$37,647	\$85,718	\$73,954	\$66,138
21 San Francisco	\$186,294	\$44,802	\$86,393	\$61,919	\$44,049	\$56,947	\$53,160	\$58,354	\$63,672	\$57,562	\$100,005	\$107,761	\$83,573
22 Long Beach	\$0	\$49,218	\$10,267	\$69,934	\$37,506	\$47,996	\$44,509	\$47,375	\$59,582	\$61,982	\$114,647	\$87,566	\$82,116
23 Minneapolis	\$0	\$28,607	\$49,668	\$14,874	\$28,770	\$44,092	\$39,068	\$32,989	\$44,957	\$66,122	\$81,650	\$74,851	\$68,025
VHA Totals	\$125,274	\$41,072	\$42,146	\$43,624	\$37,847	\$50,998	\$46,668	\$45,397	\$52,095	\$50,955	\$93,132	\$83,018	\$71,577

Notes:

1. Figures represent the dollar amounts for cost exceeding the \$105,000 per patient threshold in Price Groups 1-10 and \$252,000 for Long Stay 10a, designed to compensate VISNs for extremely costly patients.

2. Numbers may not add due to rounding.

Geographic Price Adjustment: Back-Up Data

(\$ in millions)

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	Volume Basic and Complex Care Unweighted Patients (Vbc)	Volume Basic and Complex Care Weighted Patients (Vbcw)	National Price for Labor (NI)	Labor Dollars Budgeted Based on Patients (Lb)	Personal Services Dollars Indexed (PSi)	Scaling Factor	Personal Services Dollars Indexed and Scaled (Psi)	FY 2015 Labor Adjustment (LA)
01 Boston	4,216	3,984	275,741	415,369	3,584	1,488,889	1,575,600	1.001	\$1,577,544	\$88,655
02 Albany	3,817	3,983	148,703	227,687	3,584	816,142	782,117	1.001	\$783,082	(\$33,060)
03 Bronx	4,375	3,984	198,919	331,223	3,584	1,187,268	1,303,912	1.001	\$1,305,521	\$118,253
04 Pittsburgh	3,939	3,984	341,706	482,994	3,584	1,731,292	1,711,551	1.001	\$1,713,663	(\$17,629)
05 Baltimore	4,198	3,983	156,913	242,477	3,584	869,158	915,969	1.001	\$917,099	\$47,941
06 Durham	3,886	3,984	382,646	541,335	3,584	1,940,413	1,892,820	1.001	\$1,895,156	(\$45,258)
07 Atlanta	3,820	3,984	436,663	609,978	3,584	2,186,465	2,096,314	1.001	\$2,098,901	(\$87,564)
08 Bay Pines	3,796	3,984	602,463	848,458	3,584	3,041,296	2,897,617	1.001	\$2,901,193	(\$140,104)
09 Nashville	3,804	3,984	320,132	440,942	3,584	1,580,555	1,509,091	1.001	\$1,510,953	(\$69,601)
10 Cincinnati	3,931	3,984	248,801	392,538	3,584	1,407,052	1,388,413	1.001	\$1,390,126	(\$16,925)
11 Ann Arbor	3,920	3,984	311,921	437,715	3,584	1,568,989	1,543,672	1.001	\$1,545,577	(\$23,412)
12 Chicago	4,039	3,984	275,621	417,911	3,584	1,498,002	1,518,396	1.001	\$1,520,270	\$22,268
15 Kansas City	3,844	3,984	267,252	385,137	3,584	1,380,522	1,331,940	1.001	\$1,333,583	(\$46,939)
16 Jackson	3,882	3,984	548,388	748,809	3,584	2,684,103	2,615,444	1.001	\$2,618,671	(\$65,432)
17 Dallas	3,951	3,984	329,477	460,101	3,584	1,649,231	1,635,719	1.001	\$1,637,738	(\$11,493)
18 Phoenix	3,860	3,983	287,916	406,251	3,584	1,456,205	1,411,117	1.001	\$1,412,858	(\$43,347)
19 Denver	3,883	3,984	216,736	314,648	3,584	1,127,855	1,099,253	1.001	\$1,100,610	(\$27,246)
20 Portland	4,046	3,984	308,246	422,584	3,584	1,514,751	1,538,382	1.001	\$1,540,280	\$25,529
21 San Francisco	4,582	3,984	297,449	433,558	3,584	1,554,086	1,787,350	1.001	\$1,789,556	\$235,469
22 Long Beach	4,258	3,984	353,540	498,574	3,584	1,787,138	1,909,933	1.001	\$1,912,290	\$125,152
23 Minneapolis	3,903	3,984	355,174	519,291	3,584	1,861,397	1,823,889	1.001	\$1,826,140	(\$35,257)
VHA Totals	3,629	3,629	6,664,405	9,577,578	3,584	\$34,330,811	34,288,497	1.001	\$34,330,811	\$0

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

$Lf = (V_{sr}) / (N_{sr})$
 $Vbcw =$
 $NI = Lb / Vbcw$
 $Lb = Vbcw * NI$
 $PSi = Lb * Li$
 $PSis = PSi * 1.001$
 $LA = PSis - Lb$

Labor Index = VISN Salary Rate (Vsr) / National FTE * VISN average salary / National Salary Rate (Nsr) (national FTE * national average salary) (Weighting Factor = 7.86 = National Cost Complex Care/National Cost Basic Care) and (Weighting Factor = 42.4 for Long Term Care (Long Stay))
 Volume Basic and Complex Weighted Patient = (Volume Complex * Weighting factor) + Volume Basic
 National price for labor VHA labor dollars budgeted based on patients / total volume of Basic and Complex Care weighted
 Labor dollars based on patients = Volume of Basic and Complex weighted * National price for labor
 Personal services dollars indexed = Labor dollars budgeted based on weighted patients * Labor Index
 Personal service dollars indexed and scaled = Personal services dollars indexed * 1.001 scaling factor
 Labor Adjustment = Personal service dollars indexed and scaled - labor dollars based on patients

Notes:

- 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.
- For the FY 2001 allocations, a policy decision was made to change the patient factor for computing the labor index to weight Complex Care consistent with recent costs.
- For the FY 2002 allocations, 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. This decision remains unchanged for FY 2003 - FY 2015.
- Numbers may not add due to rounding.

Research Support Budget: Back-Up Data

(\$ in millions)

Network	FY 2013 Total Dollars of Research Reported				FY 2013 Total Dollars Research Reported and Weighted				FY 2015 Budget for Research Support (B _{rs})	
	QUERI (VA) Administered by VA (VA)	Peer Reviewed Administered by VA (PR)	Not Peer Reviewed (NPR)	FY 2013 Funded Research Reported for FY 2015 VERA(V _r)	QUERI (VA) Administered by VA (VAw)	Peer Reviewed Administered by VA (PRw)	Not Peer Reviewed (NPRw)	FY 2013 Weighted Research Activity for FY 2015 VERA(V _{rw})		National Price for Research Support (N _{rs})
01 Boston	\$2	\$36	\$6	\$128	\$2	\$27	\$1	\$115	0.58	\$67
02 Albany	\$0	\$2	\$5	\$11	\$0	\$4	\$1	\$6	0.58	\$4
03 Bronx	\$0	\$15	\$1	\$31	\$0	\$15	\$0	\$27	0.58	\$16
04 Pittsburgh	\$0	\$24	\$2	\$48	\$0	\$22	\$18	\$40	0.58	\$23
05 Baltimore	\$0	\$17	\$5	\$54	\$0	\$32	\$13	\$46	0.58	\$27
06 Durham	\$0	\$8	\$2	\$47	\$0	\$37	\$6	\$43	0.58	\$25
07 Atlanta	\$0	\$17	\$2	\$58	\$0	\$39	\$13	\$52	0.58	\$30
08 Bay Pines	\$0	\$2	\$3	\$34	\$0	\$28	\$2	\$31	0.58	\$18
09 Nashville	\$0	\$20	\$2	\$40	\$0	\$19	\$15	\$34	0.58	\$20
10 Cincinnati	\$0	\$9	\$0	\$25	\$0	\$15	\$7	\$23	0.58	\$13
11 Ann Arbor	\$3	\$27	\$3	\$66	\$3	\$33	\$20	\$57	0.58	\$33
12 Chicago	\$1	\$16	\$7	\$51	\$1	\$27	\$12	\$42	0.58	\$24
15 Kansas City	\$0	\$3	\$3	\$16	\$0	\$10	\$2	\$13	0.58	\$8
16 Jackson	\$1	\$18	\$1	\$42	\$1	\$21	\$13	\$36	0.58	\$21
17 Dallas	\$0	\$18	\$4	\$39	\$0	\$18	\$13	\$32	0.58	\$19
18 Phoenix	\$0	\$1	\$0	\$32	\$0	\$31	\$1	\$32	0.58	\$19
19 Denver	\$1	\$13	\$4	\$41	\$1	\$23	\$10	\$35	0.58	\$20
20 Portland	\$2	\$22	\$0	\$70	\$2	\$46	\$17	\$65	0.58	\$38
21 San Francisco	\$2	\$20	\$3	\$132	\$2	\$106	\$15	\$124	0.58	\$72
22 Long Beach	\$2	\$14	\$8	\$102	\$2	\$77	\$11	\$92	0.58	\$54
23 Minneapolis	\$1	\$45	\$9	\$85	\$1	\$29	\$34	\$67	0.58	\$39
VHA Totals	\$17	\$348	\$71	\$1,154	\$17	\$718	\$18	\$1,014	0.58	\$589

Formula for Research Support: B_{rs} = V_{rw} * N_{rs}

Budget for Research Support = Research Reported and Weighted * National Price for Research Support

Research which is Administered by the VA is Weighted at 100%

Research which is Peer Reviewed, but Not VA Administered is Weighted at 75%

Research which is Not Peer Reviewed and Not Administered by VA is Weighted at 25%

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

Note: Numbers may not add due to rounding.

Education Support: Back-Up Data

(\$ in millions)

Network	Volume Resident FTE for FY 1997 VERA	Volume Resident FTE for FY 2012 VERA	Volume Resident FTE for FY 2013 VERA	Volume Resident FTE for FY 2014 VERA	Volume Resident FTE (Ve) for FY 2015 VERA	National Price for Education Support (N _{es})	FY 2015 Budget for Education Support (B _{es})
01 Boston	542	565	569	595	590	\$80,901	\$48
02 Albany	276	252	256	249	259	\$80,901	\$21
03 Bronx	611	622	625	622	620	\$80,901	\$50
04 Pittsburgh	338	296	319	309	305	\$80,901	\$25
05 Baltimore	239	284	275	270	279	\$80,901	\$23
06 Durham	367	465	489	487	491	\$80,901	\$40
07 Atlanta	455	521	530	547	533	\$80,901	\$43
08 Bay Pines	563	751	747	767	782	\$80,901	\$63
09 Nashville	547	578	572	576	586	\$80,901	\$47
10 Cincinnati	265	345	338	355	355	\$80,901	\$29
11 Ann Arbor	315	382	382	391	394	\$80,901	\$32
12 Chicago	662	698	700	706	704	\$80,901	\$57
15 Kansas City	346	363	363	360	363	\$80,901	\$29
16 Jackson	713	851	884	887	920	\$80,901	\$74
17 Dallas	336	464	479	489	497	\$80,901	\$40
18 Phoenix	300	370	373	374	368	\$80,901	\$30
19 Denver	229	273	278	281	285	\$80,901	\$23
20 Portland	269	365	372	377	383	\$80,901	\$31
21 San Francisco	384	533	535	537	540	\$80,901	\$44
22 Long Beach	730	837	869	858	857	\$80,901	\$69
23 Minneapolis	408	438	437	426	409	\$80,901	\$33
VHA Totals	8,892	10,252	10,392	10,461	10,519	\$80,901	\$851

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

Note: Numbers may not add due to rounding.

Equipment Distribution: Back-Up Data

(\$ in millions)

Network	FY 1997 VERA Equipment Allocation	FY 2012 VERA Equipment Allocation	FY 2013 VERA Equipment Allocation	FY 2014 VERA Equipment Allocation	Volume Basic and Complex (V _{bc})	Price (N _{eq})	FY 2015 Total Equipment Budget (B _{eq})
01 Boston	\$18	\$44	\$33	\$38	275,741	\$65	\$18
02 Albany	\$10	\$24	\$18	\$21	148,703	\$65	\$10
03 Bronx	\$19	\$33	\$25	\$28	198,919	\$65	\$13
04 Pittsburgh	\$18	\$56	\$42	\$48	341,706	\$65	\$22
05 Baltimore	\$10	\$24	\$18	\$21	156,913	\$65	\$10
06 Durham	\$18	\$56	\$44	\$51	382,646	\$65	\$25
07 Atlanta	\$19	\$65	\$50	\$59	436,663	\$65	\$28
08 Bay Pines	\$24	\$95	\$72	\$83	602,463	\$65	\$39
09 Nashville	\$19	\$50	\$38	\$44	320,132	\$65	\$21
10 Cincinnati	\$13	\$39	\$29	\$34	248,801	\$65	\$16
11 Ann Arbor	\$14	\$48	\$36	\$42	311,921	\$65	\$20
12 Chicago	\$18	\$44	\$33	\$38	275,621	\$65	\$18
15 Kansas City	\$15	\$43	\$32	\$37	267,252	\$65	\$17
16 Jackson	\$32	\$87	\$65	\$75	548,388	\$65	\$36
17 Dallas	\$15	\$50	\$38	\$45	329,477	\$65	\$21
18 Phoenix	\$14	\$45	\$34	\$39	287,916	\$65	\$19
19 Denver	\$10	\$32	\$25	\$29	216,736	\$65	\$14
20 Portland	\$15	\$46	\$35	\$42	308,246	\$65	\$20
21 San Francisco	\$14	\$45	\$34	\$40	297,449	\$65	\$19
22 Long Beach	\$18	\$53	\$41	\$48	353,540	\$65	\$23
23 Minneapolis	\$19	\$55	\$42	\$49	355,174	\$65	\$23
VHA Totals	\$353	\$1,034	\$787	\$912	6,664,405	\$65	\$432

Formulas for Equipment Distribution: $B_{eq} = V_{bc} * N_{eq}$

V_{bc} = Volume Basic and Complex Care Patient

N_{eq} = National Price for Equipment = Budget for Equipment (Beq) divided by Basic and Complex Care Patients (V_{bc})

B_{eq} = Budget for Equipment

Note: Numbers may not add due to rounding.

Non-VA Care: Back-Up Data (\$ in millions)		
Network	Allocation	% of Allocation
01 Boston	(\$166)	3.5%
02 Albany	(\$72)	1.5%
03 Bronx	(\$63)	1.3%
04 Pittsburgh	(\$190)	4.0%
05 Baltimore	(\$81)	1.7%
06 Durham	(\$248)	5.2%
07 Atlanta	(\$272)	5.7%
08 Bay Pines	(\$458)	9.6%
09 Nashville	(\$211)	4.4%
10 Cincinnati	(\$189)	4.0%
11 Ann Arbor	(\$155)	3.3%
12 Chicago	(\$166)	3.5%
15 Kansas City	(\$207)	4.3%
16 Jackson	(\$380)	8.0%
17 Dallas	(\$212)	4.5%
18 Phoenix	(\$255)	5.3%
19 Denver	(\$253)	5.3%
20 Portland	(\$335)	7.0%
21 San Francisco	(\$301)	6.3%
22 Long Beach	(\$246)	5.2%
23 Minneapolis	(\$310)	6.5%
VHA Totals	(\$4,769)	100.0%

Note: Numbers may not add due to rounding.

CBO Staff: Back-Up Data (\$ in millions)		
Network	Allocation	% of Allocation
01 Boston	(\$4)	3.8%
02 Albany	(\$2)	1.9%
03 Bronx	(\$2)	1.7%
04 Pittsburgh	(\$5)	5.0%
05 Baltimore	(\$1)	1.2%
06 Durham	(\$8)	7.3%
07 Atlanta	(\$8)	7.6%
08 Bay Pines	(\$17)	15.3%
09 Nashville	(\$5)	4.2%
10 Cincinnati	(\$4)	3.4%
11 Ann Arbor	(\$5)	4.4%
12 Chicago	(\$4)	3.7%
15 Kansas City	(\$4)	3.9%
16 Jackson	(\$8)	7.3%
17 Dallas	(\$4)	4.0%
18 Phoenix	(\$3)	2.4%
19 Denver	(\$5)	4.2%
20 Portland	(\$5)	4.5%
21 San Francisco	(\$4)	3.8%
22 Long Beach	(\$6)	5.7%
23 Minneapolis	(\$5)	4.9%
VHA Totals	(\$108)	100.0%

Note: Numbers may not add due to rounding.

Labor Index: Back-Up Data

Network	Labor Index for FY 1997 VERA	Labor Index for FY 2012 VERA	Labor Index for FY 2013 VERA	Labor Index for FY 2014 VERA	Labor Index for FY 2015 VERA
	FY 1997 VERA	FY 2012 VERA	FY 2013 VERA	FY 2014 VERA	FY 2015 VERA
01 Boston	1.04070	1.06359	1.05732	1.05868	1.05824
02 Albany	0.96620	0.96045	0.95588	0.95766	0.95831
03 Bronx	1.08880	1.10380	1.09908	1.10036	1.09825
04 Pittsburgh	0.99300	0.98087	0.98382	0.98908	0.98860
05 Baltimore	1.03280	1.06043	1.06144	1.05993	1.05386
06 Durham	0.96370	0.97561	0.97746	0.97679	0.97547
07 Atlanta	0.96090	0.96294	0.95685	0.96034	0.95877
08 Bay Pines	0.94810	0.95004	0.95543	0.95405	0.95276
09 Nashville	0.95500	0.95485	0.95628	0.95302	0.95479
10 Cincinnati	0.99190	0.97366	0.97612	0.98269	0.98675
11 Ann Arbor	0.99870	0.97749	0.97913	0.97756	0.98386
12 Chicago	1.01040	1.01707	1.01673	1.01380	1.01361
15 Kansas City	0.97110	0.96061	0.95858	0.96472	0.96481
16 Jackson	0.97620	0.97994	0.98107	0.97663	0.97442
17 Dallas	0.96040	0.99367	0.99367	0.99095	0.99181
18 Phoenix	0.96370	0.96196	0.95274	0.96378	0.96904
19 Denver	0.97510	0.96857	0.97289	0.97064	0.97464
20 Portland	1.00420	1.01654	1.01588	1.01334	1.01560
21 San Francisco	1.12320	1.16077	1.15906	1.15227	1.15010
22 Long Beach	1.05760	1.07648	1.07410	1.06834	1.06871
23 Minneapolis	0.97710	0.97091	0.97630	0.97828	0.97885
VHA Totals	1.00000	1.00000	1.00000	1.00000	1.00000

Note: FY 1997 Values for VISN 23 are the average of the values for VISNs 13 and 14.

FY 2015 VERA Outcome

(\$ in millions)

Network	FY 2014 Total General Purpose	FY 2015 Total General Purpose	Decrease/Increase
01 Boston	\$1,995	\$1,793	(\$202)
02 Albany	\$935	\$859	(\$75)
03 Bronx	\$1,637	\$1,565	(\$72)
04 Pittsburgh	\$2,010	\$1,783	(\$226)
05 Baltimore	\$1,122	\$1,034	(\$88)
06 Durham	\$2,247	\$2,065	(\$182)
07 Atlanta	\$2,479	\$2,206	(\$273)
08 Bay Pines	\$3,567	\$3,178	(\$389)
09 Nashville	\$1,879	\$1,682	(\$198)
10 Cincinnati	\$1,660	\$1,501	(\$159)
11 Ann Arbor	\$1,756	\$1,645	(\$111)
12 Chicago	\$1,915	\$1,732	(\$183)
15 Kansas City	\$1,613	\$1,393	(\$220)
16 Jackson	\$3,197	\$2,828	(\$369)
17 Dallas	\$1,999	\$1,782	(\$217)
18 Phoenix	\$1,719	\$1,463	(\$256)
19 Denver	\$1,233	\$1,025	(\$208)
20 Portland	\$1,904	\$1,610	(\$294)
21 San Francisco	\$2,287	\$2,041	(\$246)
22 Long Beach	\$2,456	\$2,252	(\$204)
23 Minneapolis	\$2,106	\$1,805	(\$302)
VHA Totals	\$41,715	\$37,244	(\$4,472)

Note: Numbers may not add due to rounding.

FY 2015 Network Allocations

(\$ in millions)

Network	Basic Care Allocation	Complex Care Allocation	Long Stay Allocation	High Cost Patients Allocation	Geographic Price Adjustment	Research Support Allocation	Education Support Allocation	Equipment Allocation	Non-VA Care	CBO Staff	Total General Purpose Allocations
01 Boston	\$1,008	\$478	\$95	\$161	\$89	\$67	\$48	\$18	(\$166)	(\$4)	\$1,793
02 Albany	\$556	\$251	\$71	\$54	(\$33)	\$4	\$21	\$10	(\$72)	(\$2)	\$859
03 Bronx	\$711	\$397	\$120	\$205	\$118	\$16	\$50	\$13	(\$63)	(\$2)	\$1,565
04 Pittsburgh	\$1,205	\$444	\$137	\$140	(\$18)	\$23	\$25	\$22	(\$190)	(\$5)	\$1,783
05 Baltimore	\$576	\$254	\$93	\$86	\$48	\$27	\$23	\$10	(\$81)	(\$1)	\$1,034
06 Durham	\$1,456	\$583	\$99	\$138	(\$45)	\$25	\$40	\$25	(\$248)	(\$8)	\$2,065
07 Atlanta	\$1,641	\$598	\$108	\$125	(\$88)	\$30	\$43	\$28	(\$272)	(\$8)	\$2,206
08 Bay Pines	\$2,436	\$869	\$137	\$232	(\$140)	\$18	\$63	\$39	(\$458)	(\$17)	\$3,178
09 Nashville	\$1,277	\$443	\$45	\$114	(\$70)	\$20	\$47	\$21	(\$211)	(\$5)	\$1,682
10 Cincinnati	\$940	\$509	\$106	\$98	(\$17)	\$13	\$29	\$16	(\$189)	(\$4)	\$1,501
11 Ann Arbor	\$1,164	\$408	\$85	\$86	(\$23)	\$33	\$32	\$20	(\$155)	(\$5)	\$1,645
12 Chicago	\$1,015	\$495	\$109	\$162	\$22	\$24	\$57	\$18	(\$166)	(\$4)	\$1,732
15 Kansas City	\$1,026	\$445	\$43	\$83	(\$47)	\$8	\$29	\$17	(\$207)	(\$4)	\$1,393
16 Jackson	\$2,165	\$737	\$104	\$144	(\$65)	\$21	\$74	\$36	(\$380)	(\$8)	\$2,828
17 Dallas	\$1,263	\$470	\$93	\$103	(\$11)	\$19	\$40	\$21	(\$212)	(\$4)	\$1,782
18 Phoenix	\$1,107	\$445	\$61	\$83	(\$43)	\$19	\$30	\$19	(\$255)	(\$3)	\$1,463
19 Denver	\$815	\$336	\$39	\$62	(\$27)	\$20	\$23	\$14	(\$253)	(\$5)	\$1,025
20 Portland	\$1,244	\$433	\$48	\$110	\$26	\$38	\$31	\$20	(\$335)	(\$5)	\$1,610
21 San Francisco	\$1,183	\$449	\$129	\$213	\$235	\$72	\$44	\$19	(\$301)	(\$4)	\$2,041
22 Long Beach	\$1,408	\$556	\$61	\$209	\$125	\$54	\$69	\$23	(\$246)	(\$6)	\$2,252
23 Minneapolis	\$1,250	\$603	\$101	\$106	(\$35)	\$39	\$33	\$23	(\$310)	(\$5)	\$1,805
VHA Totals	\$25,445	\$10,205	\$1,883	\$2,716	\$0	\$589	\$851	\$432	(\$4,769)	(\$108)	\$37,244

Note: Numbers may not add due to rounding.

FY 2015 Calculation of Case-Mix Index for Basic and Complex Care

(Allocation \$ in millions)

Network	Basic Care Allocation	Basic Care Patients	Basic Care Average Price	Basic Care Case-Mix Index	Complex Care Allocation	Complex Care Patients	Complex Care Average Price	Complex Care Case-Mix Index	Total Funding (Basic Care Plus Complex Care Allocation)	Total Basic Care and Complex Care Patients	Total Average Price	Total Case-Mix Index
01 Boston	\$1,008	258,137	\$3,903	0.966	\$573	17,603	\$32,537	0.996	\$1,580	275,741	\$5,731	1.018
02 Albany	\$556	139,256	\$3,994	0.988	\$322	9,447	\$34,060	1.043	\$878	148,703	\$5,904	1.048
03 Bronx	\$711	183,121	\$3,881	0.960	\$517	15,798	\$32,744	1.002	\$1,228	198,919	\$6,173	1.096
04 Pittsburgh	\$1,205	325,106	\$3,706	0.917	\$581	16,600	\$35,023	1.072	\$1,786	341,706	\$5,228	0.928
05 Baltimore	\$576	147,142	\$3,913	0.968	\$347	9,771	\$35,527	1.087	\$923	156,913	\$5,882	1.044
06 Durham	\$1,456	362,377	\$4,019	0.994	\$681	20,269	\$33,622	1.029	\$2,138	382,646	\$5,587	0.992
07 Atlanta	\$1,641	414,543	\$3,958	0.979	\$707	22,121	\$31,946	0.978	\$2,348	436,663	\$5,376	0.955
08 Bay Pines	\$2,436	570,569	\$4,269	1.056	\$1,006	31,894	\$31,530	0.965	\$3,441	602,463	\$5,712	1.014
09 Nashville	\$1,277	303,817	\$4,203	1.040	\$487	16,315	\$29,867	0.914	\$1,764	320,132	\$5,511	0.978
10 Cincinnati	\$940	230,914	\$4,069	1.007	\$615	17,887	\$34,384	1.052	\$1,555	248,801	\$6,249	1.110
11 Ann Arbor	\$1,164	296,055	\$3,932	0.973	\$493	15,866	\$31,048	0.950	\$1,657	311,921	\$5,311	0.943
12 Chicago	\$1,015	258,037	\$3,932	0.973	\$604	17,584	\$34,323	1.051	\$1,618	275,621	\$5,871	1.042
15 Kansas City	\$1,026	251,304	\$4,082	1.010	\$488	15,948	\$30,594	0.936	\$1,514	267,252	\$5,664	1.006
16 Jackson	\$2,165	522,191	\$4,145	1.025	\$841	26,197	\$32,121	0.983	\$3,006	548,388	\$5,482	0.973
17 Dallas	\$1,263	313,149	\$4,035	0.998	\$564	16,329	\$34,511	1.056	\$1,827	329,477	\$5,545	0.985
18 Phoenix	\$1,107	272,446	\$4,065	1.006	\$506	15,469	\$32,729	1.002	\$1,614	287,916	\$5,605	0.995
19 Denver	\$815	203,581	\$4,003	0.990	\$375	13,155	\$28,512	0.873	\$1,190	216,736	\$5,491	0.975
20 Portland	\$1,244	292,964	\$4,246	1.050	\$481	15,282	\$31,473	0.963	\$1,725	308,246	\$5,596	0.994
21 San Francisco	\$1,183	281,372	\$4,205	1.040	\$579	16,076	\$36,012	1.102	\$1,762	297,449	\$5,924	1.052
22 Long Beach	\$1,408	334,156	\$4,214	1.042	\$617	19,384	\$31,821	0.974	\$2,025	353,540	\$5,728	1.017
23 Minneapolis	\$1,250	334,183	\$3,740	0.925	\$704	20,990	\$33,541	1.027	\$1,954	355,174	\$5,501	0.977
VHA Totals	\$25,445	6,294,421	\$4,042	1.000	\$12,088	369,984	\$32,671	1.000	\$37,532	6,664,405	\$5,632	1.000

Notes:

- Average Price = Total Funding divided by Patients.
- Case-Mix Index = Network Average Price divided by the National Average Price.
- A Case-Mix of 1.05, for example, indicates that the Network's patients in that price group, or in total, are on the average priced 5% above the national average; a case mix of 0.95 indicates that the Network's patients in that price group, or in total, are on the average, priced 5% lower than the national average.
- If a network has both Basic Care and Complex Care Case-Mix below the national average, but a Total Case-Mix above the national average, it means that while their Basic Care and Complex Care patients are priced below the national average, their proportion of Complex Care patients to Basic Care patients is higher than average.
- The numbers may not add due to rounding.

**Network Percent Variation From VERA National Average Price,
Including Floors and Adjustments, FY 1997, FY 2012 - FY 2015**

Network	FY 1997 VERA	FY 2012 VERA	FY 2013 VERA	FY 2014 VERA	FY 2015 VERA
01 Boston	11.1%	14.6%	12.7%	14.6%	16.3%
02 Albany	7.9%	-1.0%	-1.4%	-0.6%	3.4%
03 Bronx	24.1%	29.0%	28.5%	26.5%	40.8%
04 Pittsburgh	11.4%	-8.6%	-8.7%	-8.4%	-6.6%
05 Baltimore	1.4%	14.3%	14.6%	15.3%	17.9%
06 Durham	-6.5%	-3.3%	-4.0%	-4.5%	-3.4%
07 Atlanta	-3.4%	-6.7%	-7.3%	-8.2%	-9.6%
08 Bay Pines	-9.5%	-7.2%	-5.9%	-5.6%	-5.6%
09 Nashville	-3.8%	-5.1%	-5.7%	-6.6%	-6.0%
10 Cincinnati	-0.2%	7.4%	4.6%	6.0%	8.0%
11 Ann Arbor	-0.2%	-8.0%	-9.8%	-9.4%	-5.6%
12 Chicago	12.0%	12.7%	12.3%	10.1%	12.4%
15 Kansas City	-1.5%	-6.8%	-4.5%	-4.7%	-6.7%
16 Jackson	-13.7%	-9.0%	-8.1%	-7.3%	-7.7%
17 Dallas	-4.7%	-0.7%	-0.7%	-2.0%	-3.2%
18 Phoenix	-13.3%	-6.9%	-7.0%	-4.6%	-9.1%
19 Denver	-8.2%	-8.4%	-8.8%	-7.5%	-15.4%
20 Portland	0.2%	1.1%	1.2%	0.0%	-6.6%
21 San Francisco	13.7%	23.5%	25.0%	24.3%	22.8%
22 Long Beach	4.3%	13.4%	12.2%	12.1%	14.0%
23 Minneapolis	0.0%	-8.7%	-5.9%	-5.9%	-9.1%
VHA Totals	0.0%	0.0%	0.0%	0.0%	0.0%

FY 1996 - FY 2000 Final VERA

(\$ in millions)

Network	FY 1996 Pre-VERA		FY 1997 VERA 2		FY 1998 VERA 2		FY 1999 VERA 3		FY 2000 VERA 3			
	No Floor	Floor	No Floor	Floor	No Floor	Floor	No Floor	Floor	FY00 Actual distribution to networks including 0.38% rescission (equipment) (FY 2000 VERA Book figure)	FY00 Total GP reduced for Prosthetics (FY 2000 figure in Book, baseline for FY02 Allocations)	FY00 Total GP reduced for Prosthetics, including Adjustments \$ Diff	
01 Boston	\$854	\$845	\$803	\$845	\$799	\$809	\$780	\$785	\$828	\$821	\$821	\$0
02 Albany	\$437	\$434	\$407	\$434	\$405	\$416	\$411	\$411	\$465	\$460	\$460	\$0
03 Bronx	\$1,022	\$1,017	\$881	\$1,017	\$893	\$974	\$861	\$952	\$916	\$908	\$974	\$66
04 Pittsburgh	\$775	\$779	\$762	\$779	\$779	\$779	\$790	\$790	\$870	\$862	\$862	\$0
05 Baltimore	\$424	\$442	\$442	\$442	\$460	\$460	\$471	\$471	\$518	\$514	\$514	\$0
06 Durham	\$682	\$707	\$711	\$707	\$704	\$704	\$716	\$716	\$796	\$788	\$788	\$0
07 Atlanta	\$778	\$815	\$861	\$815	\$882	\$856	\$884	\$884	\$955	\$946	\$946	\$0
08 Bay Pines	\$960	\$1,018	\$1,054	\$1,018	\$1,077	\$1,071	\$1,126	\$1,114	\$1,303	\$1,290	\$1,290	\$0
09 Nashville	\$688	\$700	\$694	\$700	\$704	\$704	\$705	\$705	\$780	\$772	\$772	\$0
10 Cincinnati	\$511	\$530	\$534	\$530	\$535	\$535	\$558	\$555	\$627	\$621	\$621	\$0
11 Ann Arbor	\$655	\$657	\$643	\$657	\$632	\$632	\$656	\$656	\$702	\$695	\$695	\$0
12 Chicago	\$834	\$828	\$779	\$828	\$780	\$795	\$781	\$781	\$838	\$831	\$831	\$0
15 Kansas City	\$585	\$616	\$629	\$616	\$616	\$616	\$608	\$608	\$647	\$640	\$640	\$0
16 Jackson	\$1,074	\$1,135	\$1,201	\$1,135	\$1,225	\$1,194	\$1,247	\$1,238	\$1,397	\$1,384	\$1,384	\$0
17 Dallas	\$587	\$623	\$656	\$623	\$652	\$652	\$654	\$654	\$751	\$744	\$744	\$0
18 Phoenix	\$485	\$518	\$561	\$518	\$578	\$545	\$597	\$567	\$689	\$683	\$683	\$0
19 Denver	\$367	\$385	\$391	\$385	\$394	\$394	\$388	\$388	\$430	\$426	\$426	\$0
20 Portland	\$584	\$622	\$672	\$622	\$674	\$652	\$688	\$677	\$768	\$760	\$760	\$0
21 San Francisco	\$688	\$720	\$730	\$720	\$733	\$733	\$749	\$749	\$828	\$821	\$821	\$0
22 Long Beach	\$900	\$918	\$913	\$918	\$943	\$943	\$936	\$936	\$985	\$977	\$977	\$0
23 Minneapolis	\$708	\$714	\$697	\$714	\$692	\$692	\$713	\$712	\$736	\$730	\$754	\$25
VHA Totals	\$14,598	\$15,022	\$15,022	\$15,022	\$15,157	\$15,157	\$15,319	\$15,350	\$16,827	\$16,671	\$16,762	\$91

Notes:

1. FY99 Adjustments include \$20M for VISA 3 earmarked by Congressional Appropriations Committee, \$4.961 and \$5.537 for VISA 1, 3 for newly decentralized programs.
2. Numbers may not add due to rounding.

FY 2001 - FY 2002 Final VERA

(\$ in millions)

Network	FY 2001 VERA 3					FY 2002 VERA 3						
	Original Distribution to Networks in 2001 VERA Book	Supplementals Granted	Fund Rescission	Funding Supplementals*	Used as Baseline for FY02 VERA	\$ Net Impact of Supplemental Funding	Original in FY02 VERA Book to Networks	Before Adjustment Dec 01 to Networks	Supplemental, \$162M Supplemental and \$65M Reserve Distribution	VERA Adjustment plus WTC Plus Operational Shortfall	Used for FY03 Baseline	\$ VERA Adjustments
01 Boston	\$842	\$53	\$0	\$0	\$895	\$53	\$910	\$868	\$16	\$59	\$943	\$34
02 Albany	\$499	\$0	-\$1	-\$3	\$495	-\$3	\$497	\$497	\$10	\$0	\$507	\$10
03 Bronx	\$921	\$74	\$0	\$0	\$995	\$74	\$1,037	\$909	\$15	\$135	\$1,059	\$21
04 Pittsburgh	\$947	\$0	-\$3	-\$5	\$940	-\$5	\$936	\$936	\$20	\$0	\$956	\$20
05 Baltimore	\$563	\$0	-\$2	-\$4	\$557	-\$4	\$565	\$565	\$11	\$0	\$576	\$11
06 Durham	\$849	\$0	-\$2	-\$4	\$843	-\$4	\$861	\$861	\$20	\$0	\$882	\$20
07 Atlanta	\$1,021	\$0	-\$3	-\$7	\$1,011	-\$7	\$1,050	\$1,050	\$22	\$0	\$1,072	\$22
08 Bay Pines	\$1,365	\$0	-\$4	-\$7	\$1,354	-\$7	\$1,437	\$1,437	\$33	\$0	\$1,470	\$33
09 Nashville	\$811	\$0	-\$2	-\$4	\$805	-\$4	\$832	\$832	\$17	\$0	\$849	\$17
10 Cincinnati	\$662	\$0	-\$2	-\$3	\$657	-\$3	\$683	\$683	\$15	\$0	\$698	\$15
11 Ann Arbor	\$758	\$0	-\$2	-\$3	\$753	-\$3	\$750	\$750	\$16	\$0	\$766	\$16
12 Chicago	\$886	\$0	-\$3	-\$5	\$878	-\$5	\$883	\$863	\$15	\$21	\$899	\$15
15 Kansas City	\$681	\$0	-\$2	-\$4	\$676	-\$4	\$703	\$703	\$15	\$0	\$718	\$15
16 Jackson	\$1,447	\$0	-\$4	-\$12	\$1,431	-\$12	\$1,467	\$1,467	\$32	\$0	\$1,499	\$32
17 Dallas	\$799	\$0	-\$2	-\$5	\$792	-\$5	\$832	\$832	\$18	\$0	\$850	\$18
18 Phoenix	\$721	\$0	-\$2	-\$5	\$713	-\$5	\$715	\$715	\$16	\$0	\$732	\$16
19 Denver	\$462	\$0	-\$1	-\$2	\$458	-\$2	\$474	\$474	\$9	\$0	\$483	\$9
20 Portland	\$805	\$0	-\$2	-\$5	\$798	-\$5	\$825	\$825	\$15	\$0	\$840	\$15
21 San Francisco	\$900	\$0	-\$3	-\$4	\$893	-\$4	\$932	\$932	\$16	\$0	\$948	\$16
22 Long Beach	\$1,051	\$0	-\$3	-\$6	\$1,042	-\$6	\$1,062	\$1,062	\$21	\$0	\$1,083	\$21
23 Minneapolis	\$756	\$93	\$0	\$0	\$849	\$93	\$857	\$780	\$17	\$77	\$874	\$17
VHA Totals	\$17,746	\$220	-\$43	-\$88	\$17,835	\$132	\$18,309	\$18,042	\$369	\$292	\$18,702	\$393

Notes:

- * \$88M was withdrawn from GP for Supplemental of \$220M. An additional \$132M was withdrawn from SP.
- Numbers may not add due to rounding.

FY 2003 - FY 2005 Final VERA

(\$ in millions)

Network	FY 2003 VERA 10		FY 2004 VERA 10		FY 2005 VERA 10					
	No Floor	Floor	\$ Diff	VERA Allocations**	FY05 Total VERA Allocations including Travel and Floor	FY05 \$40M Supplemental, Non Recurring Needs, Distributed June 16, 2005	FY05 \$975M Supplemental (Option #5, 50% Capital, 50% Total VERA)	FY05 Actual IT expenditures, NON SALARY (Excludes BOCs: 1000, 2100, 2230, 2530, 2531, 2583, 2584)	FY05 VERA including Travel, Floor, Plus Supplemental, Less IT Allocations	\$ Diff
01 Boston	\$1,012	\$1,012	\$0	\$1,137	\$1,156	\$3	\$59	-\$30	\$1,193	\$31
02 Albany	\$556	\$556	\$0	\$602	\$602	\$1	\$20	-\$19	\$617	\$2
03 Bronx	\$1,073	\$1,112	\$38	\$1,195	\$1,183	\$3	\$56	-\$36	\$1,244	\$23
04 Pittsburgh	\$1,083	\$1,077	-\$6	\$1,186	\$1,201	\$2	\$47	-\$30	\$1,231	\$19
05 Baltimore	\$618	\$618	\$0	\$657	\$665	\$2	\$31	-\$13	\$691	\$20
06 Durham	\$991	\$991	\$0	\$1,089	\$1,130	\$1	\$41	-\$27	\$1,144	\$15
07 Atlanta	\$1,159	\$1,159	\$0	\$1,247	\$1,297	\$2	\$45	-\$33	\$1,306	\$13
08 Bay Pines	\$1,688	\$1,656	-\$33	\$1,939	\$2,028	\$3	\$91	-\$47	\$2,069	\$47
09 Nashville	\$927	\$927	\$0	\$1,019	\$1,063	\$2	\$48	-\$27	\$1,083	\$23
10 Cincinnati	\$771	\$771	\$0	\$857	\$903	\$1	\$36	-\$21	\$915	\$16
11 Ann Arbor	\$849	\$849	\$0	\$938	\$970	\$2	\$35	-\$24	\$984	\$13
12 Chicago	\$978	\$978	\$0	\$1,072	\$1,100	\$3	\$57	-\$22	\$1,139	\$37
15 Kansas City	\$761	\$761	\$0	\$847	\$897	\$1	\$35	-\$15	\$915	\$22
16 Jackson	\$1,689	\$1,689	-\$1	\$1,815	\$1,872	\$4	\$89	-\$30	\$1,939	\$64
17 Dallas	\$937	\$937	\$0	\$1,028	\$1,061	\$2	\$46	-\$22	\$1,088	\$26
18 Phoenix	\$803	\$803	\$0	\$890	\$948	\$1	\$26	-\$25	\$945	\$2
19 Denver	\$528	\$528	\$0	\$566	\$592	\$1	\$28	-\$13	\$606	\$16
20 Portland	\$903	\$903	\$0	\$965	\$1,005	\$0	\$41	-\$29	\$1,014	\$12
21 San Francisco	\$1,062	\$1,062	\$0	\$1,171	\$1,242	\$2	\$45	-\$37	\$1,246	\$10
22 Long Beach	\$1,232	\$1,220	-\$12	\$1,338	\$1,394	\$3	\$55	-\$44	\$1,404	\$14
23 Minneapolis	\$904	\$918	\$13	\$1,046	\$1,099	\$2	\$47	-\$24	\$1,120	\$25
VHA Totals	\$20,526	\$20,526	\$0	\$22,607	\$23,407	\$40	\$975	-\$568	\$23,895	\$447

Notes:

1. ** In FY 2004 there were no adjustments or floor.
2. Numbers may not add due to rounding.

FY 2006 - FY 2007 Final VERA

(\$ in millions)

Network	FY 2006 VERA 10			FY 2007 VERA 10		
	No Floor	Floor	\$ Diff	No Floor	Floor	\$ Diff
01 Boston	\$1,207	\$1,211	\$4	\$1,321	\$1,319	-\$2
02 Albany	\$613	\$627	\$14	\$656	\$655	\$0
03 Bronx	\$1,202	\$1,262	\$60	\$1,256	\$1,288	\$32
04 Pittsburgh	\$1,296	\$1,287	-\$9	\$1,402	\$1,401	-\$2
05 Baltimore	\$702	\$702	\$0	\$743	\$742	-\$1
06 Durham	\$1,225	\$1,214	-\$11	\$1,351	\$1,349	-\$2
07 Atlanta	\$1,384	\$1,373	-\$11	\$1,502	\$1,500	-\$2
08 Bay Pines	\$2,138	\$2,138	\$0	\$2,359	\$2,356	-\$3
09 Nashville	\$1,102	\$1,102	\$0	\$1,223	\$1,221	-\$2
10 Cincinnati	\$956	\$950	-\$6	\$1,048	\$1,047	-\$1
11 Ann Arbor	\$1,013	\$1,013	\$0	\$1,112	\$1,111	-\$1
12 Chicago	\$1,157	\$1,157	\$0	\$1,259	\$1,257	-\$2
15 Kansas City	\$946	\$946	\$0	\$1,057	\$1,055	-\$2
16 Jackson	\$2,009	\$2,004	-\$5	\$2,178	\$2,176	-\$2
17 Dallas	\$1,126	\$1,125	-\$1	\$1,230	\$1,229	-\$1
18 Phoenix	\$1,004	\$996	-\$8	\$1,090	\$1,089	-\$1
19 Denver	\$637	\$633	-\$4	\$714	\$713	-\$1
20 Portland	\$1,065	\$1,058	-\$7	\$1,149	\$1,147	-\$2
21 San Francisco	\$1,297	\$1,290	-\$7	\$1,419	\$1,417	-\$2
22 Long Beach	\$1,455	\$1,451	-\$4	\$1,605	\$1,603	-\$2
23 Minneapolis	\$1,164	\$1,158	-\$6	\$1,295	\$1,293	-\$2
VHA Totals	\$24,696	\$24,696	\$0	\$26,971	\$26,971	\$0

Note: Numbers may not add due to rounding.

FY 2008 - FY 2009 Final VERA

(\$ in millions)

	FY 2008 VERA 10		FY 2009 VERA 10		
Network	VERA Allocations	No Floor	Floor	\$ Diff	
01 Boston	\$1,468	\$1,541	\$1,540	-\$2	
02 Albany	\$741	\$760	\$770	\$10	
03 Bronx	\$1,383	\$1,430	\$1,439	\$8	
04 Pittsburgh	\$1,570	\$1,632	\$1,633	\$1	
05 Baltimore	\$833	\$859	\$866	\$7	
06 Durham	\$1,541	\$1,658	\$1,655	-\$3	
07 Atlanta	\$1,689	\$1,791	\$1,789	-\$2	
08 Bay Pines	\$2,684	\$2,804	\$2,802	-\$3	
09 Nashville	\$1,392	\$1,471	\$1,469	-\$2	
10 Cincinnati	\$1,219	\$1,283	\$1,282	-\$2	
11 Ann Arbor	\$1,252	\$1,328	\$1,326	-\$2	
12 Chicago	\$1,410	\$1,476	\$1,475	-\$2	
15 Kansas City	\$1,195	\$1,239	\$1,243	\$3	
16 Jackson	\$2,344	\$2,442	\$2,440	-\$2	
17 Dallas	\$1,374	\$1,459	\$1,457	-\$2	
18 Phoenix	\$1,235	\$1,292	\$1,290	-\$1	
19 Denver	\$801	\$853	\$852	-\$1	
20 Portland	\$1,283	\$1,354	\$1,352	-\$2	
21 San Francisco	\$1,591	\$1,692	\$1,690	-\$2	
22 Long Beach	\$1,801	\$1,890	\$1,888	-\$2	
23 Minneapolis	\$1,485	\$1,543	\$1,544	\$1	
VHA Totals	\$30,292	\$31,800	\$31,800	\$0	

Note: Numbers may not add due to rounding.

FY 2010 - FY 2011 Final VERA

(\$ in millions)

Network	FY 2010 VERA 10			FY 2011 VERA 10
	No Floor	Floor	\$ Diff	
01 Boston	\$1,681	\$1,681	\$0	\$1,816
02 Albany	\$854	\$864	\$10	\$888
03 Bronx	\$1,497	\$1,568	\$72	\$1,597
04 Pittsburgh	\$1,814	\$1,809	-\$4	\$1,924
05 Baltimore	\$992	\$990	-\$3	\$1,031
06 Durham	\$1,849	\$1,844	-\$5	\$1,995
07 Atlanta	\$1,997	\$1,991	-\$6	\$2,162
08 Bay Pines	\$3,068	\$3,063	-\$5	\$3,210
09 Nashville	\$1,660	\$1,655	-\$5	\$1,779
10 Cincinnati	\$1,405	\$1,402	-\$3	\$1,502
11 Ann Arbor	\$1,482	\$1,478	-\$4	\$1,594
12 Chicago	\$1,672	\$1,666	-\$6	\$1,819
15 Kansas City	\$1,387	\$1,384	-\$3	\$1,447
16 Jackson	\$2,695	\$2,689	-\$6	\$2,886
17 Dallas	\$1,660	\$1,655	-\$6	\$1,783
18 Phoenix	\$1,436	\$1,432	-\$4	\$1,545
19 Denver	\$997	\$992	-\$4	\$1,051
20 Portland	\$1,556	\$1,550	-\$6	\$1,660
21 San Francisco	\$1,886	\$1,881	-\$5	\$2,004
22 Long Beach	\$2,071	\$2,068	-\$4	\$2,203
23 Minneapolis	\$1,731	\$1,726	-\$5	\$1,873
VHA Totals	\$35,389	\$35,389	\$0	\$37,770

Note: Numbers may not add due to rounding.

FY 2012 - FY 2013 Final VERA		
(\$ in millions)		
Network	FY 2012 VERA 10	FY 2013 VERA 10
01 Boston	\$1,862	\$1,882
02 Albany	\$882	\$898
03 Bronx	\$1,599	\$1,614
04 Pittsburgh	\$1,918	\$1,954
05 Baltimore	\$1,028	\$1,070
06 Durham	\$2,022	\$2,122
07 Atlanta	\$2,252	\$2,369
08 Bay Pines	\$3,283	\$3,425
09 Nashville	\$1,777	\$1,824
10 Cincinnati	\$1,545	\$1,565
11 Ann Arbor	\$1,626	\$1,663
12 Chicago	\$1,852	\$1,888
15 Kansas City	\$1,493	\$1,562
16 Jackson	\$2,941	\$3,048
17 Dallas	\$1,846	\$1,927
18 Phoenix	\$1,546	\$1,603
19 Denver	\$1,084	\$1,148
20 Portland	\$1,711	\$1,812
21 San Francisco	\$2,051	\$2,182
22 Long Beach	\$2,252	\$2,330
23 Minneapolis	\$1,875	\$2,010
VHA Totals	\$38,446	\$39,897

Note: Numbers may not add due to rounding.

FY 2014 - FY 2015 Final VERA

(\$ in millions)

Network	FY 2014 VERA 10	FY 2015 VERA 10
01 Boston	\$1,995	\$1,793
02 Albany	\$935	\$859
03 Bronx	\$1,637	\$1,565
04 Pittsburgh	\$2,010	\$1,783
05 Baltimore	\$1,122	\$1,034
06 Durham	\$2,247	\$2,065
07 Atlanta	\$2,479	\$2,206
08 Bay Pines	\$3,567	\$3,178
09 Nashville	\$1,879	\$1,682
10 Cincinnati	\$1,660	\$1,501
11 Ann Arbor	\$1,756	\$1,645
12 Chicago	\$1,915	\$1,732
15 Kansas City	\$1,613	\$1,393
16 Jackson	\$3,197	\$2,828
17 Dallas	\$1,999	\$1,782
18 Phoenix	\$1,719	\$1,463
19 Denver	\$1,233	\$1,025
20 Portland	\$1,904	\$1,610
21 San Francisco	\$2,287	\$2,041
22 Long Beach	\$2,456	\$2,252
23 Minneapolis	\$2,106	\$1,805
VHA Totals	\$41,715	\$37,244

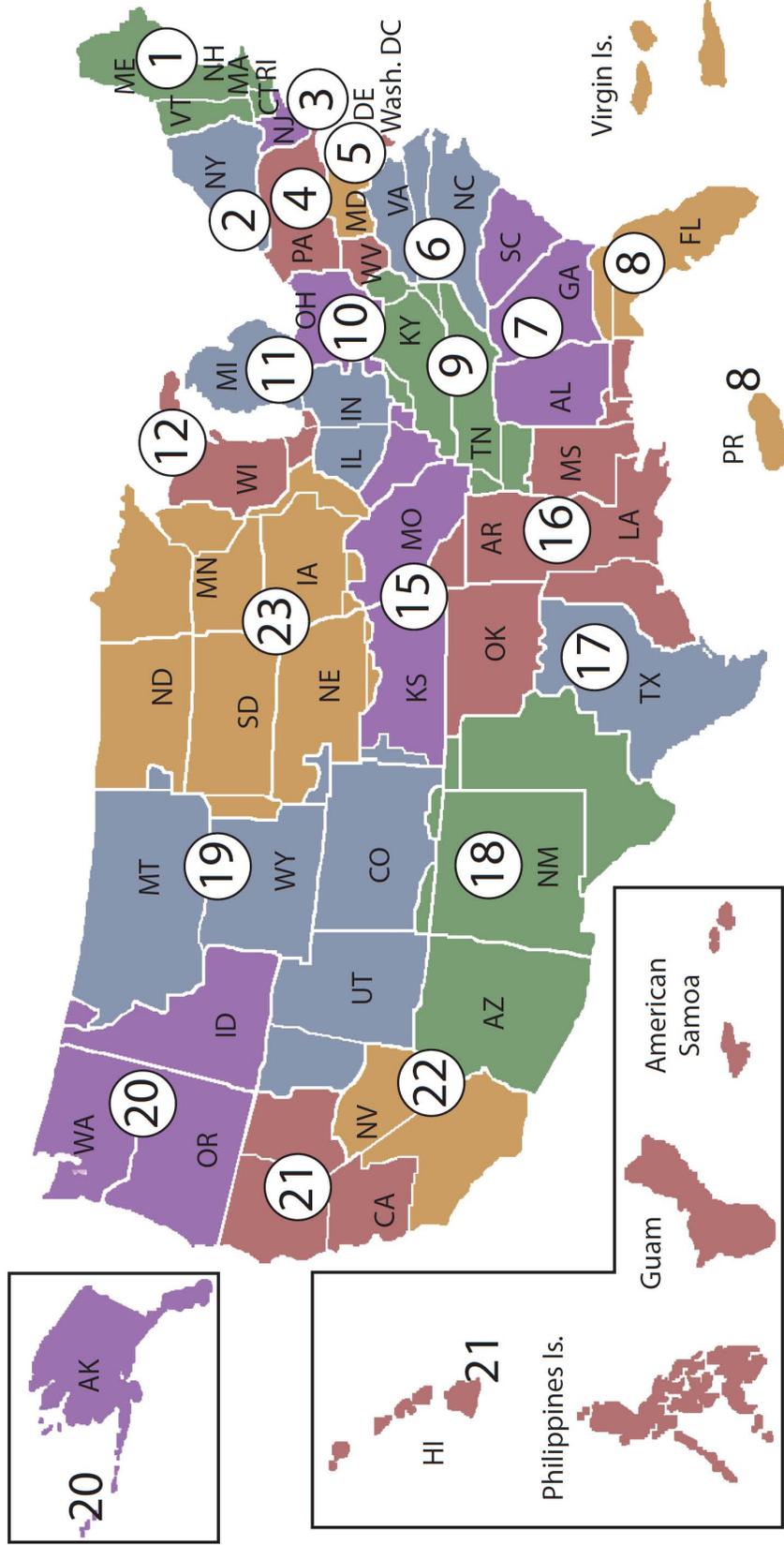
Note: Numbers may not add due to rounding.

Appendix 2

The Veterans Integrated Service Networks

Network	States
01 Boston	Massachusetts, Connecticut, Maine, New Hampshire, Rhode Island, Vermont
02 Albany	New York
03 Bronx	New York, New Jersey
04 Pittsburgh	Pennsylvania, Delaware, West Virginia
05 Baltimore	Maryland, District of Columbia, West Virginia
06 Durham	North Carolina, Virginia, West Virginia
07 Atlanta	Georgia, Alabama, South Carolina
08 Bay Pines	Florida, Puerto Rico
09 Nashville	Tennessee, Kentucky, West Virginia
10 Cincinnati	Ohio
11 Ann Arbor	Michigan, Illinois, Indiana
12 Chicago	Illinois, Michigan, Wisconsin
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
23 Minneapolis	Minnesota, North Dakota, South Dakota, Nebraska, Iowa

Veterans Health Administration 21 Veterans Integrated Service Networks



In January 2002
VISNs 13 and 14
were integrated and
renamed VISN 23

Appendix 3

**History: Previous Allocation Models, Changes to VERA and VERA
Supplemental Adjustments and Previous Assessments**

Previous Allocation Models

Since 1985, VA has used four funding allocation systems, including VERA. In general, the previous VA funding allocation systems (Resource Allocation Methodology, 1985-1990; Resource Planning and Management, 1990-1996; Blended Rates, 1996) 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.

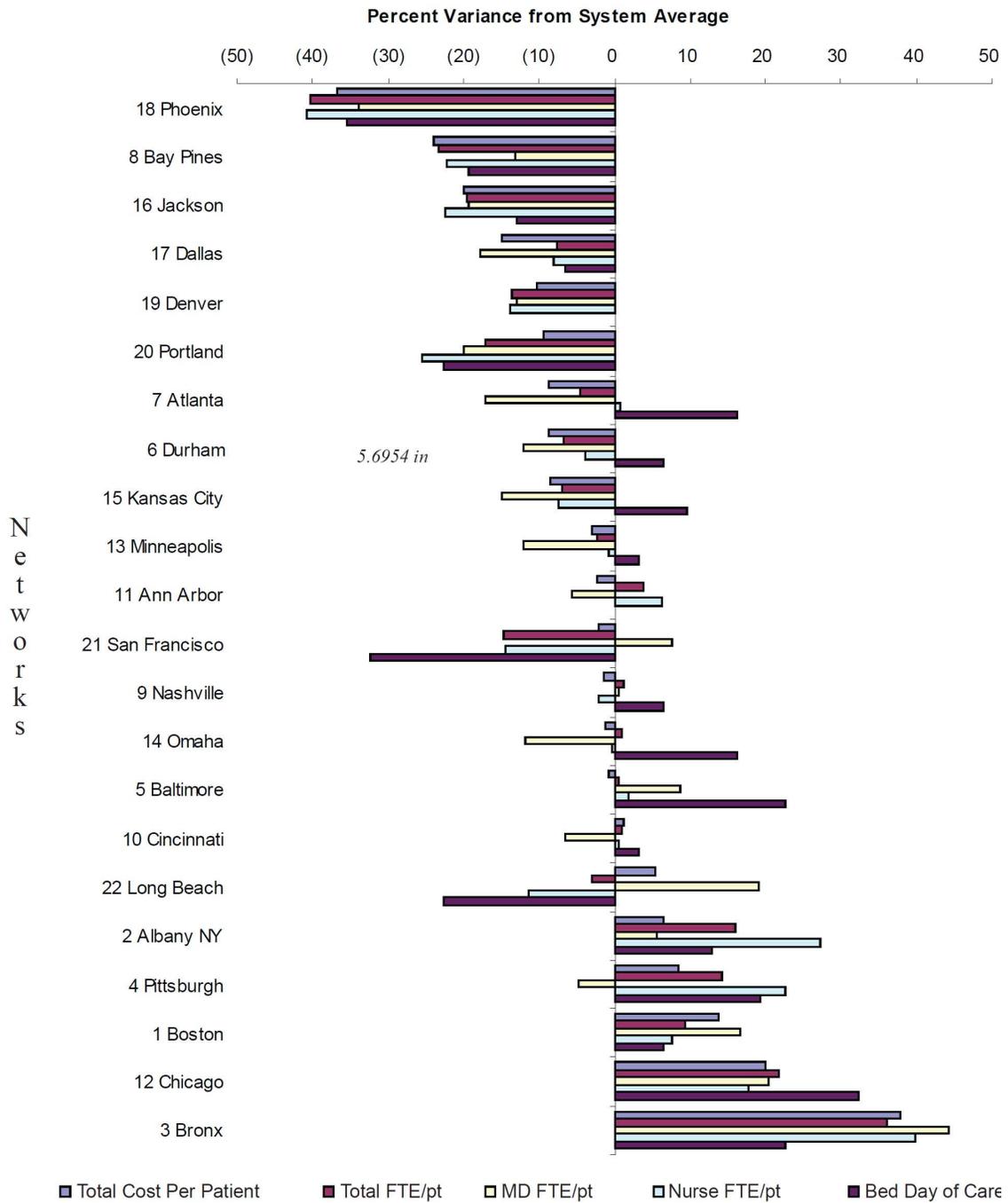
Measuring Funding Imbalances

In simple terms, “funding imbalances” or “funding inequities” occur when one network has more funding than another network, after adjusting for labor and other uncontrollable costs, and patient volume. 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 5 on page 80.

Figure 5 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. Networks 13 and 14 were not consolidated until FY 2002. 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 5: 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 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 patient 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.

Legislative Mandate for VERA

On September 26, 1996, under Public law 104-204, Section 429, Congress directed VA to implement a more equitable resource allocation system, as described in the language below:

SEC. 429 (a) PLAN.---(1) The Secretary of Veterans Affairs shall develop a plan for the allocation of healthcare resources (including personnel and funds) of the Department of Veterans Affairs among the healthcare Networks of the Department so as to ensure that Veterans who have similar economic status and eligibility priority and who are eligible for medical care have similar access to such care regardless of the region of the United States in which such Veterans reside. (2) The plan shall --(A) reflect, to the maximum extent possible, the Veterans Integrated Services Network developed by the Department to account for forecasts in expected workload and to ensure fairness to facilities that provide cost-efficient healthcare; and (B) include --(i) procedures to identify reasons for variations in operating costs among similar facilities where Network allocations are based on similar costs for similar services and workload; (ii) ways to improve the allocation of resources so as to promote efficient use of resources and provision of quality healthcare; (iii) adjustments to unit costs in subsection (a) to reflect factors which directly influence the cost of healthcare delivery within each

Network and where such factors are not under the control of Network or Department management; and (iv) include forecasts in expected workload and consideration of the demand for Veterans Administration healthcare that may not be reflected in current workload projections. (3) The Secretary shall prepare the plan in consultation with the Under Secretary of Health of the Department of Veterans Affairs. (b) PLAN ELEMENTS - The plan under subsection (a) shall set forth -- milestones for achieving the goal referred to in paragraph (1) of that subsection; and (2) a means of evaluating the success of the Secretary in meeting the goal. (c) SUBMITTAL TO CONGRESS -- The Secretary shall submit to Congress the plan developed under subsection (a) not later than 180 days after the date of enactment of this Act. (d)

IMPLEMENTATION -- The Secretary shall implement the plan developed under subsection (a) not later than 60 days after submitting the plan to Congress under subsection (c), unless within that time the Secretary notifies Congress that the plan will not be implemented in that time and includes with the notification an explanation why the plan will not be implemented in that time.

Phase-In Implementation of VERA

To assure the magnitude of the impact on each network was manageable; VA phased-in the implementation of VERA through FY 1999 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 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 1997 to Present

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 9. 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. The projected average price each network is paid under the VERA model in FY 2015 is found on page 3.

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 more than one network.

In addition to adjustments for labor, contracts, care in more than one network, and the highest cost patients, 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 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.

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.

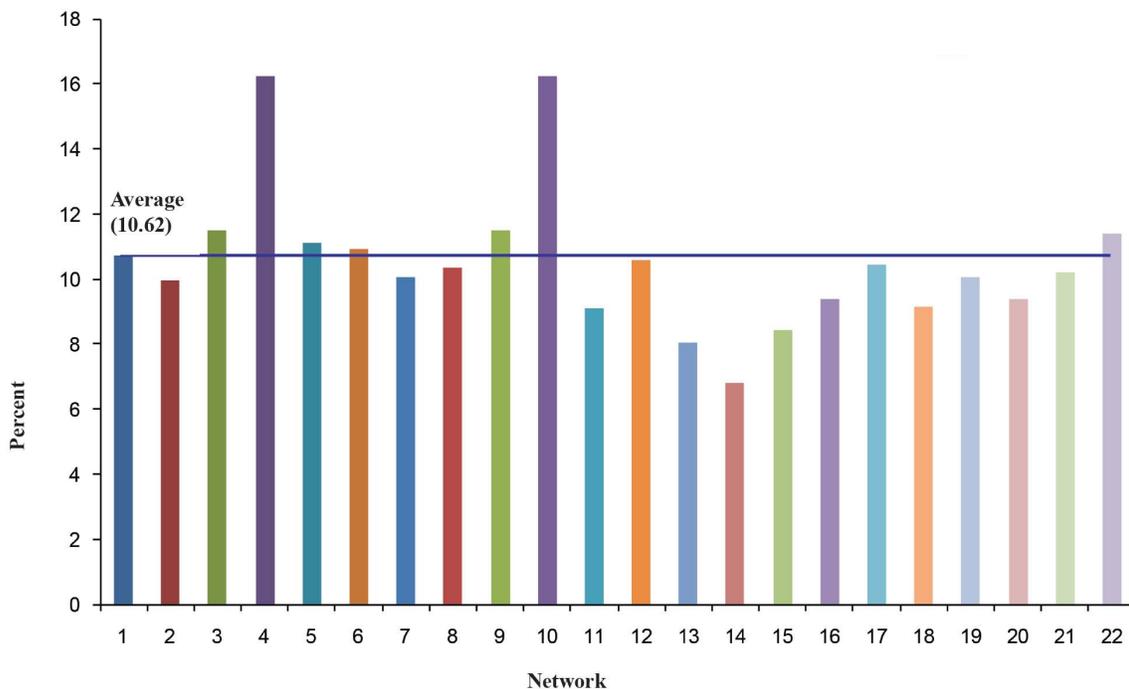
VERA achieves these objectives and, at the same time, strikes a balance between simplifying resource allocation and recognizing the complexities of the Veterans' health care system. For example, the VERA methodology recognizes that VA treats two general sets of patients - those with "routine" health 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.

VERA Changes - FY 1997 to FY 2014

There were no significant VERA changes from FY 1997 to 1998. In FY 1999, the following changes were made to the VERA Model. A second lower-cost Basic Care classification category for single outpatient visits was established. What was formerly known as Special Care was renamed "Complex" Care. Funding to support Research was based on a new formula that rewarded VA administered research. Equipment and NRM formulas began changing in a phased manner to more fully utilize patients (Basic and Complex Care) as the basis of those Models. The geographic price adjustment was changed to use the most recent and accurate data available to properly reflect the considerable efforts to manage their manpower expenditures. To that end, the labor index in the FY 1999 VERA Model was based on the most recent pay periods during FY 1998. Also in FY 1999, the geographic price adjustment did not include the effect of holiday, standby and overtime pay that reflected more truly the network's controllable labor costs.

History of Single Visit, Non-Vesting and Vesting in Basic Care: Figure 6 shows the Basic Single Outpatient Visit patients who used VA one time between FY 1995 and FY 1997, as a percentage of Basic Care patients during this period. Networks 13 and 14 were not consolidated until FY 2002. This is consistent with the Basic single outpatient visits and Basic Care patients presented in the FY 1999 VERA book. Figure 6 depicts that Networks 4 and 10 had 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 patients. 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. For the FY 2000 allocation, VHA established criteria for a vested patient even with one visit, and those patients are funded at the full Basic Vested Care price.

Figure 6: Basic Single Outpatient Visits as Percent of 3-Year Basic Workload, by Network, FY 1995 - FY 1997



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. 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 VA in the future, the Basic Care non-vested patients. A patient is considered vested in the Veterans' health care system if the patient 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.

FY 2000 Patient Classification Hierarchical Changes: In the spring of 1998, VHA CFO established the VERA Patient Classification Workgroup. The mission of this workgroup was 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 (in FY 2003 this changed to 21 Basic Care classes and 26 Complex Care classes and in FY 2005 changed to 27 Basic Care classes) in the VERA methodology. The workgroup recommended the following series of patient classification 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 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 costs 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 care 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 users. Now collateral visits do not qualify as VERA patients.
6. All patients associated with Home Care are 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 Hierarchical Changes: The following two patient classification refinements were approved for implementation in the FY 2001 allocation process.

Since the beginning of the VERA methodology, the number of Complex Care patients has been calculated in part by using a Veteran population factor, historical experience, and age. Because the Veteran population is declining, and VA market share is increasing, the forecast based on Veteran population trends predicts declines in patient numbers when in fact, users 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.

Geographic Price Adjustment and FY 2000 - FY 2002 Changes in the Adjustment: VERA also recognizes that the 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.

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 differed from the previous methodology in that it used 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 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 by weighting Complex Care patients based on their relative cost. 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.

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 account for expenses caused by geographic cost factors that are beyond a network's immediate control.

FY 2002 Patient Classification Hierarchical Changes: The following three patient classification 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 Residential Rehabilitation, 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 was established for patients actively participating in the Mental Health Intensive Case Management Program (MHICM), with a minimum of 41 visits recorded. Such patients are considered as Chronically Mentally Ill (CMI) patients for future recording and reporting.

Managerial Cost Accounting (MCA): (Formerly Decision Support System (DSS): The MCA was designated as VHA's patient cost assignment system. For this reason, VA uses MCA cost data as the basis for VERA allocations. To transition from the previous Cost Distribution Report to MCA, VHA Chief Financial Officer established a workgroup to analyze MCA outputs and VERA inputs to ensure an effective transition in the use of MCA to develop future VERA allocations. MCA cost data became the basis for VERA allocations beginning in FY 2002.

VERA Changes Not Approved for FY 2002: 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 Basic Care patient groups. The second change was to modify the funding allocation split between Basic Care and Complex Care from the FY 1995 split of 62% Basic Care and 38% Complex Care by two percent per year until the fund allocation split equaled the current base year actual cost split.

FY 2003 Change - Ten VERA Price Groups: This change expanded the VERA price groups from three to ten and recognized a differentiation in VA's "core mission" patients (Veterans with service-connected disabilities or those with incomes below the current threshold or special needs patients, e.g., the homeless) not present in the previous three VERA price groups. It follows the recommendation provided in the GAO and RAND reports and improved allocation equity among the 21 networks. This change also modified the funding allocation split between Basic Care and Complex Care to reflect the current cost experience between these groups rather than using a fixed ratio that reflected their FY 1995 relative costs.

FY 2003 Change - High and Low Funding Caps: VA's implementation in FY 2003 of a low cap and a high cap on network allocation increases provided that all networks received a minimum 5% increase and a maximum increase of 12.6% above the final amount received in FY 2002 (this included the initial FY 2002 VERA allocation with the VERA adjustments of \$267.3 million to Networks 1, 3, 12, and 23, an additional \$162 million from Specific Purpose Funds, \$6.8 million World Trade Center Funding adjustment to Network 3, \$142 million supplemental appropriation funding, and \$82 million from the National Reserve Fund, which included \$17.4

million for Network 1's operational shortfall). As a result, there was no VERA adjustment or supplemental allocation provided in FY 2003. This is in contrast to the VERA supplemental funding adjustments that were provided to certain networks from FY 1999 to FY 2002.

FY 2003 Change - Allocation for Top 1% High-Cost Patients: This change provided an additional allocation to networks with the highest cost patients by recognizing the impact on those networks with patients whose annual costs exceed \$70,000. These networks received an additional allocation equal to the amount that these costs exceeded \$70,000. This addressed not only the highest cost Complex Care patients, but also those in the Basic Care group.

VERA Changes Not Approved for FY 2003: There was one additional change recommended for FY 2003 implementation that the Under Secretary for Health did not approve. This was to include Basic Care Priority 7 Veterans not previously included in the VERA methodology. In recent years, this group of patients has grown significantly even though they were not included in VERA Basic Care. It was feared that the inclusion of these patients in the VERA methodology would provide added incentives to increase the number of these patients. If that did occur it would mean there would be less of VHA's appropriated budget for its "core mission" patients.

FY 2004 Change - Priority 7 Veterans in Basic Care: This change included non-service connected Priority 7 Basic Care patients in VERA. Because FY 2002 was the base year for the FY 2004 VERA model, VERA only included Veterans in Priority Groups 1 through 7 (Priority Group 8 was not created until October 1, 2002 and would not have an impact until the FY 2005 VERA methodology, which will use FY 2003 as the base year). Previously, only Priority 7 Veterans in Complex Care were included in the methodology. Including these patients in Basic Care was more consistent with VA's enrollment policy and better aligned the VERA patients with actual Veterans served. In conjunction with this change, the VERA price groups were modified and a separate price was created for Priority 7s in each of the ten price groups based on their relative cost to Priorities 1-6. Beginning in FY 2004, VERA had 20 prices, with two in each price group.

FY 2004 Change - Congress Separated VHA's Medical Care Funding: This changed into three appropriations: Medical Services, Medical Administrative, and Medical Facilities. This action was taken to provide greater oversight of the actual dollars spent for each program.

FY 2004 Change - Elimination of the Minimum Cap Adjustment: This change eliminated the adjustment that provided networks with a minimum percentage increase above the final amount received in the prior year.

FY 2004 Patient Classification Hierarchical Changes: These four adjustments corrected technical inconsistencies in order to properly align patient hierarchies that had arisen during transition from the VERA 3 to VERA 10 price group methodology. They are:

1. Expand the oncology definition by changing the range of ICD9 codes for outpatient oncology patient classification to be consistent with the broader inpatient definitions - this allows more outpatients to be classified as Oncology (price group 5) and some patients as Multiple Problem (price group 6). Under the previous application of the classification hierarchy these patients were not classified in price groups 5 and 6, but were in price groups 2-4 (Basic Medical, Mental Health, and Heart and Lung) because outpatient oncology patients were not recognized in price groups 5 and 6.
2. Eliminate the current application of the “no diagnosis” code - patients whose Outpatient file contains the “no diagnosis” code (MDC 0) as the only diagnosis code in combination with other valid treatment codes (i.e., ancillary services, etc. for other diagnosis but without the specific diagnosis code) are no longer assigned to price group 2 (Basic Medical) but are placed in the appropriate price group according to the valid treatment codes. Also, patients whose record contains the “non diagnosis” code (MDC 0) in combination with one other valid diagnosis code are no longer assigned to price group 6 (Multiple Problem) only because the “no diagnosis” code was treated in the past as a second diagnosis that classified the patient into price group 6 instead of one of the lower price groups. This reduces the number of patients in price group 2 and price group 6 and places these patients in price groups 3-5 (Mental Health, Heart and Lung, and Oncology) consistent with their diagnosis.
3. Change the effect of patients with more than one complex class/group - patients who qualify for two different Complex Care classes should be placed in the highest cost group for which they are qualified. In the FY 2002 patient classification hierarchy, the situation of a patient qualifying for more than one Complex Care class was not a factor. However, under VERA 10 there are now four complex care price groups. Because “AIDS or HIV+ with Anti Retro-Viral Therapy” is the second highest class in the hierarchy it would force patients with multiple complex diagnoses to be placed in price group 7 (Specialized Care) even though their other diagnosis with higher costs places them in either price groups 8, 9, or 10 (Supportive Care, Chronic Mental Illness, or Critically Ill). Under the three price VERA model, it made no difference because there was only one price for Complex Care.
4. Recognize the reality of institutionalized SCI (Spinal Cord Injury) patients by expanding the definition of SCI new injury to include institutionalized old injury patients who have more than 91 bed days of care (BDOC) in price group 10 (Critically Ill) rather than in price group 8 (Supportive Care) - under the old methodology, only patients in a Nursing Home were placed in Critically Ill. Patients are only allowed in the SCI New Patient class once in a lifetime. The SCI new injury class has been amended to include a new variable that identifies institutionalized patients. An SCI patient with 91 BDOC in an SCI bed (Treating Specialty 22) in a fiscal year is considered institutionalized and placed in the

New and Institutionalized SCI Patient Class and in price group 10 at the higher price. Also included as institutionalized are SCI patients with at least 31 BDOC in a long-term care (LTC) bed, including an intermediate or nursing home treating specialty. This definition includes SCI patients with multiple sclerosis residing in a LTC bed for at least 31 BDOC.

FY 2005 Change - Priority 8 Veterans in Basic Care: This change included Priority Group 8 Basic Care patients in VERA. Because FY 2003 is the base year for the FY 2005 VERA model, Priority Group 8 was not created until October 1, 2002 and thus FY 2005 was the first year they were included in the VERA methodology (Prior to FY 2003, these Veterans were in Priority Group 7). Including these patients in Basic Care is more consistent with VA's current enrollment policy and better aligns VERA patients with actual users. The VERA price groups will continue the separate prices for Priority Groups 7-8 based on their relative cost to Priority Groups 1-6, resulting in 20 prices, with two in each price group.

FY 2005 Change - Establish Minimum Cap (Floor) Adjustment: This change restored the adjustment that provides networks with a minimum percentage increase above the final amount received in the prior year. In order to pay for the increase, an adjustment is applied to the allocations of all networks with increases above the national average increase. Travel funds, which were previously funded separately, were included in VERA for FY 2005 and are not subject to this cap. For FY 2005, the minimum cap (floor) adjustment for network allocations was two percent.

FY 2005 Change - Increase Threshold for 1% High Cost Patients: This change increased the 1% high cost patient threshold from \$70,000 in FY 2004 to \$75,000 in FY 2005.

FY 2005 Patient Classification Hierarchical Changes: Eight patient classification changes were approved for the FY 2005 allocation process. These refinements expanded the patient care classification groups from 47 to 53, corrected technical inconsistencies arising from changes in utilization and funding, and properly aligned patient hierarchies. They are:

- A new Basic Care class has been established for legally blind patients and is in Price Group 4. This recognizes the higher cost of these patients.
- Basic Vested Care Homeless Seriously Mentally Ill (HSMI) patients in Price Group 2 were moved to Price Group 3 (Mental Health).
- A new Price Group 6 has been created in Basic Care called Significant Diagnoses that includes five new patient classes. Patients in this group have acute needs that are very expensive yet do not qualify for any of the Complex Care classes. They were formerly in other Basic Care price groups.
- The previous Price Group 6, Multiple Problem, is now Price Group 5.
- The previous Price Group 5, Oncology, is now Price Group 4.

- The previous Price Group 4 has been combined with Price Group 2 based on comparable costs.
- The Home Based Primary Care class has been moved from Price Group 7, Specialized Care, to Price Group 8, Supportive Care. This recognizes the higher cost of these patients.
- The Stroke class has been moved from Price Group 8 to Price Group 7. This aligns the price of these patients more appropriately with their costs.

FY 2006 Change - Establish Minimum Floor Adjustment: This change established a minimum 1.5 % increase on network allocations compared to the FY 2005 allocation. This change provided networks with a minimum percentage increase above the final amount received in the prior year. In order to pay for the increase, an adjustment was applied to the allocations of all networks with increases above the national average increase.

FY 2006 Change - Increase Threshold for 1% High Cost Patients: This change increased the 1% high cost patient threshold from \$75,000 in FY 2005 to \$80,000 in FY 2006.

FY 2007 Change - Establish Minimum Floor Adjustment: This change establishes a minimum 2.0% increase on network allocations compared to the FY 2006 allocation. This change provides networks with a minimum percentage increase above the final amount received in the prior year. In order to pay for the increase, an adjustment is applied to the allocations of all networks with increases above 2.0%.

FY 2007 Change - Increase Threshold for 1% High Cost Patients: This change increased the 1% high cost patient threshold from \$80,000 in FY 2007 to \$82,000 in FY 2007.

FY 2007 Patient Classification Hierarchical Changes: One patient classification change was approved for implementation in the VERA allocation process. This refinement established two new Basic Care classes for Multiple Sclerosis (MS) patients. This modification placed all Basic Vested MS patients in Price Groups 1-4, with high cost pharmaceuticals into VERA Price Group 5, and moved other Basic Vested MS patients in Price Groups 1-3 into VERA Price Group 4. This refinement corrected technical inconsistencies arising from changes in costs and utilization, and expanded the patient care classification groups from 53 to 55.

FY 2008 Change - Elimination of the Minimum Floor Adjustment: This change eliminates the adjustment that provided networks with a minimum percentage increase above the final amount received in the prior year.

FY 2008 Change - Increase Threshold for 1% High Cost Patients: This change increased the 1% high cost patient threshold from \$82,000 in FY 2007 to \$83,000 in FY 2008.

FY 2008 Patient Classification Hierarchical Changes: One patient classification change was approved for implementation in the VERA allocation process. This refinement changed the existing Transplant class to include patients with VA-sponsored transplants only in the year the transplant occurred (this class previously had two subsequent years of class protection if the patient receives VA care). This modification augments the Basic Vested Multiple Medical patient class (VERA Price Group 5) to include all patients in Price Groups 2-4 receiving post-transplant care (clinical services and pharmaceuticals) for qualified transplants in the years following the transplant procedures. This class should include all post-transplant patients, including patients receiving transplants outside VA. This refinement corrected technical inconsistencies arising from changes in cost and utilization.

FY 2009 Change - Increase Threshold for 1% High Cost Patients: This change increased the 1% high cost patient threshold from \$83,000 in FY 2008 to \$87,000 in FY 2009.

FY 2010 Change - Patient Classification Hierarchical Changes: The VERA 2010 Patient Classification system contains a series of changes from prior classification rules to better align the VERA Patient Classification process with VHA's ongoing clinical care initiatives. The VERA 2010 Model uses historical patient data up to and from fiscal year 2008. The actual classification changes include the following:

Complex Care:

- A new VERA Price Group (10a) and VERA patient class were added to categorize the Long Stay Patient population with greater than 90 bed days of care (BDOC) in a Community Living Centers (CLC). The resource needs and costs of this patient population are significantly higher than the vast majority of VHA patients due to extensive stays in VHA's CLC
- Price Group 10: Short Stay CLC Patient Class includes patients with 28 to 90 BDOC in a CLC;
- Price Group 8: Skilled Nursing and Rehabilitation Class. Includes patients with 7 to 27 CLC BDOC with the following Resource Utilization Groups (RUG III) groups including Extensive Services, Special Care, Rehabilitation and Rehabilitation and Extensive Services.
- Price Group 8: Legacy Long Term Care (LTC)/Intermediate class. Includes all patients in LTC treating specialties with BDOC over 30 and no RUG III score. Intermediate medicine patients are included in this class as are patients with combined intermediate or CLC BDOC that adds to 31 days.

- In addition to the new classes, the following Complex Care classes were modified as follows:
 - Telehealth Workload in the classification criteria for the Home Based Primary Care (HBPC) patient class and the Chronic Mental Illness (CMI) patient class Annual Retention Criteria.
 - HBPC Class: HBPC Patient Class requires 10 qualified visits. Of the required 10 visits, five of these visits may be completed by Telehealth, which is documented as DSS Clinic Stop 179 as a secondary clinic stop.
- The CMI Annual Retention Criteria identifies the minimum level of outpatient visits (individual or group visits) that a patient must receive to remain in the CMI patient class in the immediate subsequent year. Specifically, in the immediate subsequent year, a patient will be retained in a CMI class with:
 - 7 inpatient psychiatric BDOC, or
 - 6 Individual outpatient mental health visits, or
 - 11 Group or Telehealth by Real Time Video Care (DSS Clinic Stop 179) visits.
- Finally, the VERA 2010 CMI Retention Criteria does not require a minimum number of face-to-face visits during the fiscal year, and the old requirement that all CMI visits had to occur within the same VISN has been removed.
- Spinal Cord Injury New Injury/Institutionalize: Classification criteria requires 28 BDOC in LTC or Spinal Cord Injury unit. (These classes formerly required 31 and 91 BDOC respectively.)
- Note that Telehealth workload documented as a secondary clinic stop on the **same date of care will count as a CMI Retention Criteria visit**. (The primary clinic stop indicates whether the visit is individual or group.) The descriptions of the CS are as follows:
 - 690: General Telehealth Real Time: records data at the Patient's site, AND
 - 692: General Telehealth Real Time same station, or
 - 693: General Telehealth Real time NOT at same station as patient.

Basic Care:

- Create the History of Transplant in Multiple Problem Price Group 5. This will include post-organ transplant patients that are currently included in the Multiple Medical Patient Class when they receive anti-rejection drugs from VHA. In FY 2010, VERA also included post-bone marrow transplant patients for the immediate five years following VHA bone marrow transplant.

- The Multiple Problem Price Group Patient Classes will recognize “significant levels” of outpatient care. Seven (7) Resource Based Relative Value Units (RBRVUs) based on Work RVU will be considered significant. This value was previously 10 RBRVUs of “FAC” units, which did not sufficiently focus on the clinical component of the codes in former Patient Classification processes. In addition to changing to 7 Work RBRVUs, the Multiple Problem classes will include patients with both inpatient care and significant levels of outpatient care (7 Work RBRVS) in a second Major Diagnostic Category (MDC) for the Multiple Problem patient classes. In prior VERA Models, outpatient care was only used for these classes in the absence of inpatient care. This change removes the longstanding “inpatient/outpatient rule” and removes any disincentive (perceived or otherwise) associated with providing outpatient care. (Note: Based on analysis, the ARC has created imputed values for certain codes that do not have RBRVU.)
- Metastatic Cancer patient class will include the secondary diagnosis of Metastatic Cancer, when the patient has received treatment for a primary diagnosis of cancer in the same year.
- Legally Blind patient class will include several additional diagnosis codes that identify Legal Blindness. The qualifying codes for Legal Blindness include 369.01, 369.02, 369.03*, 369.04*, 369.05, 369.06*, 369.07*, 369.08*, 369.11, 369.12*, 369.13*, 369.14*, 369.22*, and 369.4. (New codes are designated with “*.”)

The following classes in Basic Care from preceding VERA models were removed:

- All Long Term Care (LTC) classes in Critically Ill Price Group 10 that required a minimum of 31 LTC BDOC and were differentiated by Resource Utilization Group (RUG) scores. These classes included: Specialized Care, Rehabilitation, Physical, Behavioral and Clinically Complex.
- The Low Activities of Daily Living (ADL) LTC Class in Price Group 8 is removed. The new LTC/Intermediate Class will capture most of the patients that qualified for this class due to BDOC in an intermediate treating specialty.

Establish Floor Adjustment - the FY 2010 floor adjustment is 3.5% compared to FY 2009 floor which was 4.0% of VERA allocations. An adjustment is applied to the allocations of all networks with results above 3.5% to fund the minimum floor adjustment.

Quality Enhancement Research Initiative (QUERI) - total funding dollars are incorporated into the base of research projects as 100% VA-Administered. This new process eliminates perceived disincentives associated with the QUERI initiative.

Tenant Support - moved from Specific Purpose to VERA General Purpose funding and will now be included in each VISN's VERA allocation.

Long Stay - the most costly patients fall under this price group. A geographic adjustment weighted higher in proportion to the patient costs. This enhances effect of the index in accounting for uncontrollable local costs within this price group.

Mental Health Initiative - metric is based on using the FY 2009 obligations to project for FY 2010, and was previously distributed through Specific Purpose funding is now included in each VISN's VERA allocation as a separate component.

Priority 8 Enrollees - funding for enrollment expansion of Priority 8 Veterans used the VA Healthcare model for newly eligible Veterans who may have been enrolled through the system. Now funding is included in each VISN's VERA allocation through the VERA General Purpose (GP) Allocation.

Increase Threshold for Top 1% High-Cost Patients - For FY 2010, the threshold for the additional allocation adjustment for the top 1% high-cost patients increased from \$87,000 to \$95,000 subject to an upper limit of ten standard deviations above the national average cost for providing that service, i.e., treating specialty and/or clinic costs. Networks will receive an additional allocation equal to the amount that these costs exceeded \$95,000. This addresses not only the highest cost Complex Care patients, but also those in the Basic Care group.

The Secretary approved the following changes in VERA for FY 2011:

- The VERA Patient Classification process was modified for the VERA 2011 process to include new patient classes to represent major initiatives in VHA patient workload. These new classes included:
- Basic Care: Care Coordination Home Telehealth (CCHT) Chronic Care Management (CCM), which captured patients receiving a minimum of three months of CCHT care.
- Basic Care: Homeless Multiple Medical. This class captured Homeless patients receiving significant outpatient care services.
- Complex Care: Care Coordination Home Telehealth (CCHT) Non-Institutional Care (NIC). This class identified patients eligible for non-institutional care receiving a minimum of three months of CCHT care.
- Complex Care: Homeless Chronic Mental Illness (CMI). This class requires a Homeless designation and a specified level of care for a Chronic Mental Illness diagnosis.

- Homeless Designation: The designation of homeless as a patient classification factor is new for the VERA 2011 Model. The process for establishing data sources to identify the homeless patient population is evolving and will ultimately be tracked and maintained in a Homeless Registry that will be established in fiscal year 2011. For the VERA 2011 Model, the designation of homelessness was based on either of the following a diagnosis code indicating homelessness at least once during fiscal year 2009.

In addition to a VERA Price per VERA-eligible patient, the VERA Model includes additional funding for patients whose annual cost exceeds an established threshold for the given year. For the VERA 2011 Model, two thresholds have been established for VERA-eligible patients whose fiscal year 2009 annual costs exceed the following thresholds: High Cost threshold for patients in the Long Stay CLC Price Group is \$222,000 while the standard threshold is \$107,000 for all other VERA-eligible patients. The VERA Model will fund dollar for dollar all costs in excess of the established threshold. The high cost payment is intended to compensate VISNs for extremely costly patients. Long Stay CLC patients who were previously precluded from receiving a high cost payment are now eligible when their fiscal year 2009 total costs exceed the high cost threshold of \$222,000. Analysis revealed that a cohort of patients in this price group have significant cost greater than the vast majority of VHA patients due to extensive inpatient stays in VHA's Community Living Centers (CLC's).

The Secretary approved the following changes in VERA for FY 2012:

For FY 2012, several technical refinements were made to more accurately reflect the costs and patients comparison of the patient class hierarchy. The FY 2012 VERA methodology increased the threshold for the additional allocation adjustment to networks for the top 1% high cost patients from \$107,000 to \$108,000 subject to an upper limit of ten standard deviations above the national average cost for providing that service. Networks received an additional allocation for these patients equal to the amount that these costs exceeded the \$108,000 threshold. The allocation adjustment threshold for Long Stay patients decreased from \$222,000 in FY 2011 to \$214,000 in FY 2012, which was designed to compensate VISNs for extremely costly patients. The VERA 2012 Patient Classification criteria included four changes from the previous year, including a new patient class, bringing the total number of patient classes in the Patient Classification hierarchy to 59 classes. The newly added class was titled Polytrauma (PT) and captures patients that received care in a VHA Polytrauma Center. The three remaining changes addressed modifications to the classification criteria for three Patient Classes. Each of the four class changes are explained below in greater detail.

Polytrauma (class 58): This was a new class beginning with the VERA 2012 Model. The Polytrauma Patient class is funded in the Critically Ill Price Group (#10). This class was designed to identify a costly cohort of patients that have received inpatient care in a designated VHA Polytrauma unit, which is identified as Treating Specialty 1N. A patient qualifies for the Polytrauma class with an inpatient admission to a VHA Polytrauma unit (at least one bed day of care (BDOC) in a fiscal year followed by confirmation of care by the Polytrauma Program Office. Additionally, unlike other Complex care patient classes, all Polytrauma patients, including patients with an eligibility status of TRICARE or Sharing Agreement, are VERA-funded. In the immediate three subsequent fiscal years following a discharge from a Polytrauma unit, a Polytrauma patient will fall no lower than the Traumatic Brain Injury (TBI)/Polytrauma patient class (class number 38 in Price Group 7) when the patient presents for either inpatient or outpatient care. In FY 2012 there were five (5) operational VHA Polytrauma units.

Blind Rehabilitation (class 40): The bed days of care (BDOC) requirement for this class was increased to three BDOC in a fiscal year from the previous requirement of one BDOC. Increasing the BDOC requirement more accurately identifies the patients that elected not to remain in the program for a reasonable period of time. In prior models, the BDOC requirement was one BDOC. Note the BDOC do not need to be consecutive but must occur in the same fiscal year in the Blind Rehabilitation bed section known as Treating Specialty “21.”

Hepatitis C (class 33): The Clinical Case Registry (CCR) is now the official data source for Hepatitis C patients receiving anti-viral drugs. Formerly, the diagnosis of Hepatitis C and anti-viral drugs were obtained from several different data sources. The transition to the CCR will improve the integrity of the data associated with patients receiving care for the condition of Hepatitis C.

Compensation and Pension Exam Class (class 3): All patients presenting for C&P exams have a purpose of visit (POV) code 01 for the encounter. The longstanding VERA funding rules allow for all patients presenting for C&P exams to be VERA funded, including non-veterans and active military personnel. The change to this class for VERA 2012 allows patients presenting for a C&P exam that meet the Vesting requirements to be placed in a Vested class and VERA funded at a Price no lower than Price Group 2. A Vesting visit ensures that the patient is receiving at a minimum primary care, signified by a Vesting CPT code by a provider authorized to complete a primary care visit. Vesting providers include physicians (includes residents), physician assistants, clinical nurse specialists and nurse practitioners. Prior to this change, all patients presenting for a C&P exam were retained in the C&P class regardless of the care provided. The impact of this change moves patients to a class that is no lower than the classes in Price Group 2 on the Patient Classification Hierarchy chart. The intent of the change was to improve the funding associated with C&P exams in a timely manner.

The VERA Model funds a rolling three-year cohort of Basic Care patients. To ensure appropriate funding of this population, the C&P patients that do not return to the VHA for care in the second and/or third year following their Vesting exam will be reassigned to the C&P class to ensure that they are not overfunded in subsequent VERA Models. Additional information on Vesting can be found at http://vaww.arc.med.va.gov/references/faqs/faqs/faq_ii.html http://vaww.arc.med.va.gov/references/faqs/faqs/faq_ii.html.

VERA Model Works at the VISN Level

The VERA Model is designed to fund patient care at the VISN level using a “capitated” funding methodology. Capitated funding is a process that results in a series of nationally computed prices designed to fund major groupings of patients at the VISN-level. The process utilizes similar groups of patients based on well-defined criteria outlined in the VERA Patient Classification system. The Patient Classification system is a risk-adjusted system used to categorize patients based on clinical complexity and resource utilization patterns. This system provides the national patient case-mix that is used to establish the VERA Model Prices.

The VERA 2012 Model consisted of 10 price groups that historically have distributed approximately 90% of the VERA dollars to VISNs. By design, a “capitated” funding methodology is an appropriate funding mechanism when the funding units are sufficiently population and clinically diverse. For this reason, the VERA funding methodology is appropriate at the VISN level because the VISN patient population is both large in terms of the number of patients and sufficiently diverse in terms of clinical case-mix. However, unlike VISNs, facilities within a VISN are often specialized or organized by major treating specialties, thereby lacking a representative case-mix of patients. This lack of patient diversity precludes the VERA methodology from serving as a reliable facility-level funding strategy.

VISN to Facility Funding Process

For the first time since the inception of VERA, a new patient workload measure was developed to represent patient workload at units below the VISN-level. The Patient Weighted Work (PWW) measure is a numeric value derived from the hierarchical VERA Patient Classification system; thereby creating a logical extension from the VERA Model to the facility allocation process. The intent of PWW was to provide a national workload measure that reflected facility-level workload differences in costs and patient case-mix. Once adjusted for local variations in costs and case-mix, PWW provides VISN management with a representative workload variable for distributing VERA funds within a VISN.

Patient Weighted Work (PWW) is expressed as a numeric value that inherently quantifies the resource intensity of the patient population. The building blocks of PWW are based on a longstanding workload measure known as FacWork, a risk-adjusted workload measure reported in financial unit cost reports. FacWork is calculated at a subclass level, representing diagnosis, standardized age groups and Enrollment Priority Group. The formula for developing PWW begins with FacWork and includes additional adjustments to:

1. Add additional workload credit for excessively expensive treatment identified as Resource Intensive Treatments (RITs);
2. Correct the patient workload for geographic differences in costs at the facility level, and
3. Correct patient workload for the facility's Complexity Group assignment, which is a categorization system assigned by VHA.

The formula is:

$$\text{PWW} = (\text{FacWork} + \text{RITs} + \text{Geographic Adjustment}) * \text{Facility Complexity Level Adjustment}$$

Incorporating PWW in the VISN-to-facility allocation process established a uniform workload measure to document the patient workload differences amongst facilities within a VISN. However, VISN management determined the VERA patient care dollars that were distributed using PWW.

Medical Center Allocation System

The VERA Model funds VISNs using capitated Price Groups for large patient care groupings. By design, capitated Price Groups are successful at the VISN-level due to the case-mix (large number and diversity) of the patient population within a VISN.

Conversely, capitated prices do not adequately fund patient care practices at the medical center level, primarily because the medical center case-mix is insufficiently diverse. For this and other reasons, the Medical Center Allocation System (MCAS) does not use the VERA Price Groups to distribute funds within the VISN. Instead, the redistribution of the patient care funds requires a greater granularity of patient care data to ensure that medical centers receive the appropriate distribution of VERA funds. As a result, the MCAS uses weighted patient data organized by Patient Classification subgroups known as Diagnostic (Dx) classes to distribute VERA funds within a VISN.

The Secretary approved the following changes in VERA for FY 2013:

For FY 2013, several technical refinements were made to more accurately reflect the costs and patients comparison of the patient class hierarchy. The FY 2013 VERA methodology threshold remained the same as FY 2012 for the additional allocation

adjustment to networks for the top 1% high cost patients of \$108,000 subject to an upper limit of ten standard deviations above the national average cost for providing that service. Networks will receive an additional allocation for these patients equal to the amount that these costs exceed the \$108,000 threshold. The allocation adjustment threshold for Long Stay patients increased from \$214,000 in FY 2012 to \$218,000 in FY 2013, which is designed to compensate VISNs for extremely costly patients. The VERA 2013 Patient Classification criteria includes a series of changes from the previous year, including a new patient class bringing the total number of patient classes in the Patient Classification hierarchy to 60. However, while only one new class is evident in the VERA Patient Class list, there were refinements to the classification criteria in all of the patient classes in Price Group 6, Significant Diagnoses. A series of sub-classes more commonly referred to as Diagnostic (DX) classes changed as well. In addition to the changes to the classification criteria, the hierarchical order of some of the classes also changed, particularly within Price Group 10.

New Patient Class

- The new class for VERA 2013 is the Epilepsy class which identifies patients with a principal inpatient diagnosis code of Epilepsy, ICD-9 345.XX or a primary outpatient diagnosis code. The Epilepsy class will be funded in Price Group 4.

New DX Class

- Class number 45, Skilled Nursing and Rehabilitation includes a new DX class known as Rehabilitation. This class includes patients that have been admitted to Rehabilitative Medical Services (RMS) bed sections, represented by Treating Specialties (TS) 20 and 82 **and** have received high levels of rehabilitation services that are documented in the Inpatient Encounter (IE) file or the National Patient Care Database (NPCD). These bed settings are accredited by the Commission on Accreditation for Rehabilitation Facilities (CARF), which is an accrediting body for facilities providing rehabilitative services. In addition to an inpatient admission, patients must receive at least 15 hours of rehabilitative services in the fiscal year, which must be documented in the IE file or the NPCD using qualifying CPT codes. Each encounter form will be assessed for up to one hour of care based on the precise CPT codes that range from 97010 to 97546. Each qualifying code is valued at 15 minutes per code and the encounter is limited to a maximum of 60 minutes per form. Non-VA care is not considered for this patient class.

Changes in Classification Criteria

- The Significant Diagnosis Price Group 6 had changes to all five patient classes.
 - Respiratory Failure, High Cost Pneumonia, High Cost Conditions patient classes: Inpatient care: This year, the patient classification criterion has been

modified to comply with coding rules that allow *secondary* diagnosis codes when other clinical conditions are evident. The precise diagnosis codes for the classes above can be listed as either primary or **secondary diagnosis codes** in the PTF 501 segment of the Patient Treatment File (PTF).

○ Outpatient: Exclusively outpatient care for corresponding diagnosis codes associated with Respiratory Failure, High Cost Pneumonia, High Cost Conditions and Acute MI that are not followed by an admission on the same day will no longer qualify for these classes. A patient receiving outpatient care for the qualifying diagnosis codes will qualify for this class only when a hospital admission occurs on the same calendar date of care. The admission date of a PTF (or a non-VA PTF) must be the same as the outpatient encounter date to qualify for this patient class. For example, the Acute Myocardial Infarction (MI) patient class requires a principal inpatient ICD-9 diagnosis code of 410.X1. Note that the matching of admission dates is necessary because the admitting diagnosis might not necessarily include the ICD-9 code 410.X1 as principal diagnosis code if the patient is admitted for cardiac surgery.

○ Metastatic Cancer: The diagnosis codes for metastatic cancer can be either primary or secondary and may occur as either inpatient or outpatient care. If the diagnosis code is outpatient, the patient must have received outpatient workload that equates to a minimum of 3.5 “CMS Work” relative value units (RVUs). In prior classification years, this class required a minimum of 7.0 CMS Work RVUs.

● All patients that have “class protection status”: Complex Care classes that exclusively received telephone care and/or Secure Messaging in the fiscal year with no other care would be placed in the most appropriate Basic Care class to account for this workload. This includes patients in classes such as SCI Old Injury, TBI/ Polytrauma Aftercare and Stroke; all of which are multi-year classes that afford class protection in subsequent years when care other than a telephone visit or secure messaging occurs. The telephone encounters are documented by specific DSS clinic stops and secure messaging includes encounters that have a secondary DSS clinic stop of 719. This process ensures that VISNs are not over-funded for workload that is exclusively telephone encounters and/or secure messaging as noted above.

● The classification criteria for the Basic care Hepatitis C patient class requires that all patients with Hepatitis C be registered in the Clinical Case Registry (CCR), in accordance with the VHA **Directive 2011-026**. This ensures that the VERA Patient Classification process complies with the VHA's policy and procedures for documenting Hepatitis C.

Summary of Transformation Initiatives

In FY 13, \$350M of Transformation (T21) funding was included in the VERA Allocation and was shown as a separate component. In FY 14, the \$350M transitioned into the General Purpose allocation to support the sustainment of transformation activities related to the Major Initiatives in the field:

Coordinated Health Care: PACT is the foundational hub of VA's health care delivery system. It is predicated on a team-based model that ensures timely, proactive, patient centered, comprehensive services. Prevention and wellness are major components of this model. Behavioral health coaching and motivational interviewing are critical competencies, necessary to realize this vision. Secure messaging, telephone care, and telehealth services are all important tools that should be utilized by PACT teams. The primary care team should be supported by other services to ensure they can provide truly integrated care to meet the needs of their patients, including integrated mental health (MH) services. These teams should be provided with the resources needed to coordinate care across the entire spectrum of services and to provide intensive case management for high-risk patients. Members from a variety of disciplines (e.g., pharmacy, psychology, social work, nutrition, and chaplain) may be included as part of the extended PACT team. The PACT model should be in place wherever a clinic intends to provide primary care services, such as Women's Health, Geriatrics, General Medicine, and some specialty clinics. Complete primary care for women Veterans, including gender specific care, must be available for women at all sites. Close collaboration and coordination with Specialty Care and long-term care, combined with initiatives to end homelessness among Veterans, are all vital to providing comprehensive, whole-person care in our PACT.

Improving Access: The improvement of access to care is one of the cornerstones of VHA's strategy. Safety, quality, patient satisfaction, and cost are all adversely impacted when appropriate and timely access to care is delayed. Access to outpatient, inpatient, long-term care, and procedure-based services can be improved by applying system redesign principles and by expanding alternatives to facility based care, such as secure messaging, clinical video telehealth (CVT), home telehealth (HT) and store and forward telehealth (SFT) services, eConsults, and Specialty Care Access Network-Extension for Community Healthcare Outcomes (SCAN-ECHO). Nationally, we are developing mobile applications, improving MyHealthVet functionality through online authentication and working on social networking tools.

To redefine what access means, VA will build a system of care without walls that, by 2015, will impact 50% of those using the VA system for their healthcare. Early data suggest that we can reduce visit rates, particularly for urgent care, and hospitalizations by improving access to care tele-technologies and secure messaging. This would not only improve our capacity to care for those who do need a physical visit or acute care, but it would give patients the opportunity to

spend their time in more productive ways. Today, we have surgical teams providing post-op care by CVT, virtual specialty care clinics where local clinicians can be an active part of the team, and we are delivering psychotherapy directly into the patients' homes by CVT webcam. However, VA has a lot to do to expand the use of these innovative systems of care.

Specialty Care: Leaders must ensure that specialty care services, including long-term care, are also timely, and are aligned with the PACT model of care in order to improve coordination and integration of care, and are designed to focus on patient's needs. These challenges are particularly difficult in rural and underserved areas. We must invest in specialty care, including MH, to develop and sustain these vital services. Specialty Care is a critical component of VHA's comprehensive medical benefits. We must ensure that all staffs are working at their highest level of competency. For example, advanced practice nurses incorporated into specialty care teams can improve access and ensure that physicians are providing care specific to their specialty. Additionally, mini-residencies and specialized training can develop new competencies allowing clinicians to fill critical needs, particularly in underserved areas. Training has also been made available for clinicians to gain additional specific skills and competencies in evidence-based psychotherapies and creative partnerships with community partners that have the potential to improve outcomes.

The vision for Specialty Care Service (SCS)/Specialty Care Transformation (SCT) is to transform specialty care services into a more Veteran-centric environment by improving access to care through leveraging Telehealth and other non-face-to-face modalities for delivering care. The Specialty Care Neighborhood will interface with PACTs to provide coordinated, team-based care in which all disciplines (e.g., nursing, pharmacy, social work, nutrition, and chaplains) are valued partners. This relationship will ensure that the delivery of services across VHA is patient-centered and the coordination is timely, accessible, and of high quality. The focus will be on the Veteran experience and on shared decision-making. Specialty Care Neighborhood will leverage the use of Telehealth and other technologies to deliver care without requiring a face-to-face visit, for example, by using SCAN-ECHO and Electronic and Phone Consults. Additionally, we will need to ensure that My HealthVet and secure messaging are fully adopted and utilized, including by MH and all specialty care services. Broad implementation of evidence-based specialty care will reduce readmissions and unnecessary clinic appointments, and decrease Veteran travel to tertiary medical centers and unscheduled visits to the emergency room. In FY 13, Innovations in Consult Management (Electronic and Phone Consults) and SCAN-ECHO will be expanded to additional specialties and sites. To be most effective, SCAN-ECHO clinics should be staffed with high performing interdisciplinary teams. FY 13 Phase II project expansion will be initiated for SCAN-ECHO, Specialty Care Mini-Residencies, and models of specialty care that incorporate comprehensive primary care services for special populations.

Non-institutional alternatives to traditional nursing homes for dependent Veterans of any age are preferable in terms of cost, outcomes, patient and family preferences, and satisfaction. The vision for non-institutional alternatives to extended care is to match up local site strengths with local Veteran preferences and needs, by offering a broadened set of options.

Approaches that have been validated in the professional literature and that have now been shown to be successful in pilots offered by VA include Dementia Case Management, Transition Care (including medication reconciliation and preventive rehabilitation approaches), Program for All-inclusive Care in the Elderly, a range of face to face and telehealth-based caregiver support models, Hospital at Home, and modifications to Home-Based Primary Care and Adult Day Health Care for highly rural settings.

Patient Centered Care: At the core of the PCC Culture Transformation is an entirely new approach to health care that is a radical shift from our current system. VA health care of tomorrow must build on our successful quality improvements (prevention and chronic disease management) to patient-centered health care that optimizes the health and well-being of our Veterans. This approach requires a process that is proactive rather than reactive and engages the patient at the center of their care. There are three key components to this approach to healthcare:

1) personalized health planning; 2) whole person, integrative strategies and 3) behavior change and skill building. The development of a recovery-oriented, patient centered model, moving from disability to ability, is one example of how this change is reflected in Veteran care today. This radical departure requires a rational strategy for change that is aligned and integrated with the resources, capacities, and ongoing initiatives throughout VHA. This can be achieved by building partnerships with Veterans, family members, family caregivers, providers, and other staff/team members. The “Voice of the Veteran” is a key component, which needs to be consistently elevated during all planning (i.e., enabling patient authorization of information sharing and enabling patient self-reported data to become visible to the health care team). In the end, we must develop patient care practices that support patient ownership of their health, well-being, and plan of care.

Eliminate Veteran Homelessness: The Department of Veterans Affairs is taking decisive action toward its goal of ending homelessness among our nation’s Veterans. To achieve this goal, VA has developed the Eliminate Veteran Homelessness Major Initiative that will assist every eligible homeless and at risk for homelessness Veteran. VA will help Veterans acquire safe housing, needed treatment services, opportunities to return to employment, and benefits assistance. Additionally, VA plans to end the cycle of homelessness by preventing Veterans and their families from entering homelessness and by assisting those who are homeless to exit as safely and as quickly as possible.

The initiative is built upon six strategies: 1) Outreach/Education, 2) Treatment, 3) Prevention, 4) Housing/Supportive Services, 5) Income/Employment/Benefits, and 6) Community Partnerships. These six strategies encompass a wide continuum of interventions and services to prevent and end homelessness among Veterans. Homeless Veterans will benefit from the expansion of existing program capacity and treatment services, as well as the implementation of new programs focused on homelessness prevention and increased access to permanent housing with supportive services. Programming will include MH stabilization, substance use disorder treatment services, enhancement of independent living skills, vocational and employment services, and assistance with permanent housing searches and placement.

There were no changes made to the VERA 2014 Patient Classification criteria. The number of Patient Classes and the Patient Class Price Group assignments remain the same as VERA 2013. There were, however, some changes made to the hierarchical order of some Patient Classes within certain Price Groups. For example, in the VERA 2014 hierarchy, Mental Health Intensive Case Management (MHICM) is class number 48, but was class 52 in the prior VERA Model. Note that the new order of classes within certain Price Groups does not affect VERA funding to VISNs because resource allocation is done by VERA Price Group, not by individual Patient Class.

Reason for Change in Class Order

In general, the hierarchical order of classes reflects the national resource intensity of the classes within each Price Group. The change in class order is attributed to the change in the resource intensity (national average costs) of the specific patient classes within each Price Group. While this change has no impact on VERA funding at the VISN-level, change in class order ensures that patients are accurately represented within the Classification system, and appropriately classified in the single highest class attained in the given fiscal year. Data at the patient class level is used to create weighted patient data used in the Medical Center Allocation System (MCAS) to distribute VERA funds within each VISN.

Medical Center Allocation System

The VERA Model funds VISNs using capitated Price Groups for large patient care groupings. By design, capitated Price Groups are successful at the VISN-level due to the case-mix (large number and diversity) of the patient population within a VISN. Conversely, capitated prices do not adequately fund patient care practices at the medical center level, primarily because the medical center case-mix is insufficiently diverse. For this and other reasons, the Medical Center Allocation System (MCAS) does not use the VERA Price Groups to distribute funds within the VISN. Instead, the redistribution of the patient care funds requires a greater granularity of patient care data to ensure that medical centers receive the appropriate distribution of VERA funds. As a result, the MCAS uses weighted patient data organized by Patient Classification subgroups known as Diagnostic (Dx) classes to distribute VERA funds within a VISN.

Organization of the VERA Patient Classification Hierarchy

The VERA Patient classification hierarchy consists of 60 Patient Classes. The first level below the 60 VERA Patient Classes consists of 129 subclasses known as Diagnostic (Dx) classes. These groupings were developed by the VHA ARC and are used for VHA analysis and resource allocation purposes. While the VERA Patient Classification system is inherently a VHA classification system, the underlying data is organized using the Centers for Medicare and Medicaid Services (CMS) classification system known as the Diagnosis Related Group (DRG) system. The DRG system organizes all ICD-9 diagnosis and procedure codes assigned to patients in health care settings into groups that are used for both analysis and private sector payment systems.

The actual data used to populate the VERA Patient Classification system is obtained from patient workload that is successfully transmitted to Austin. Each month, the ARC classifies all patient care and reports patient workload using the VERA Patient Classification classes. Patient workload can be displayed at the VERA Patient Class level or the Dx class level. The variables used to document patient workload include:

- Unique Patient counts: Document the number of unique patients.
- Pro-Rated Patient (PRP): A numeric variable that adjusts the proportionate distribution of care to all locations that provide care for a patient. Each patient equates to one (1.0) PRP that is distributed to all units that provide services to the patient.
- FacWork: A risk-adjusted workload measure that is computed at the Dx class level within the VERA Patient Classification system. This numeric variable is used in financial reports to account for the resource intensity of patient workload. (The higher the FacWork variable, the more costly the given category of patients.)
- Patient Weighted Work (PWW): A numeric variable used in the Medical Center Allocation System (MCAS) to distribute patient care funds. PWW is computed from FacWork that is normalized to account for the facility-specific differences within a VISN. The adjustments include: Geographic Adjustment , Complexity Group Adjustment and facility-specific Resource Intensive Treatments (RITs)

VERA Supplemental Adjustments

From FY 1999 to FY 2001, 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 two networks, 3 and 23. In FY 2001, an adjustment of \$220.1 million was required for three networks, 1, 3 and 23. The size of the FY 2001 adjustment combined with an unexpected 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 four networks, 1, 3, 12 and 23 should receive an adjustment of \$292 million to their initial VERA allocation. In FY 2003, VA refined VERA by implementing a low cap of 5% and a resulting high cap of 12.6% on allocation increases over FY 2002. The purpose of this cap was to eliminate the need for supplemental funding adjustments to networks in FY 2003. Appendix 1 displays the data and impact on networks due to these adjustments and capping.

Appendix 4

Previous VERA Assessments, GAO, PricewaterhouseCooper LLP, AMA System, Inc., RAND Corporation Phase I, RAND Corporation Phase II, and RAND Corporation Phase III

Previous VERA Assessments

GAO Evaluations

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 users relative to VERA funding allocations. This system compared FY 1996 patient levels to FY 1997 patient levels for all Complex Care classes, as defined in VERA. That analysis concluded that for the period in question, total Complex Care patients did not change significantly. VA continued to monitor Complex Care patient tracking on a quarterly basis in FY 1998-FY 2003. Also, VA conducted a review of three-year Basic Care patient single encounter users 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 users 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 patient 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 patients 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 FY 2000, 2001 and FY 2002, VA completed an analysis of the three-year Basic Non-Vested patients as a percent of the total three-year Basic patients.

VHA's Chief Financial Officer and Chief Information Officer continued their efforts to improve the manner in which VERA's underlying data are reported and retrieved. Additionally, VA had a contractor (Systems Flow Incorporated) 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 VHA should be guided by ten principles that move the organization toward accomplishing its system wide 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, the VERA methodology is not designed to allocate funds to the facility level. This is because there are 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 allocations below the network level for the period FY 1998 - FY 2011. 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 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 VA Headquarters' review process 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 - 7 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 2011 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.”

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 allocations below the network level for the period FY 1998 - FY 2011. These principles coupled with VA Headquarters' review process will continue to guide future network allocations.

Government Accountability Office Findings and Recommendations

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?

On February 28, 2002, GAO issued a report entitled VA Health Care: Allocation Changes Would Better Align Resources with Workload (GAO-02-338). GAO concluded that VERA is a reasonable approach to allocate resources, but identified weaknesses in its implementation. GAO recommended that VA correct these weaknesses to better allocate comparable resources for comparable workloads.

The five GAO recommendations are as follows:

1. Better align VERA measures of workload with actual workload served regardless of Veteran priority group.
2. Incorporate more categories into VERA's case-mix adjustment.
3. Update VERA's case-mix weights using the best available data on clinical appropriateness and efficiency.
4. Determine in the supplemental funding process the extent to which different factors cause networks to need supplemental resources and take action to address limitations in VERA or other factors that may cause budget shortfalls.
5. Establish a mechanism in the National Reserve Fund to partially offset the cost of networks' highest cost Complex Care patients.

VA concurred with GAO's recommendations and has addressed VERA case-mix and risk adjustment changes, among others. Some of the issues and actions involved with VA's addressing these recommendations are:

- Although inclusion of non-service-connected Priority 7 Veterans in the VERA Basic Care category would be a step toward better aligning the VERA allocation model with VA's actual enrollment experience, including these Veterans in the VERA model would create financial incentives to seek out more of these Veterans instead of Veterans with service connected disabilities or those with incomes below the current income threshold or special needs patients (e.g., the homeless), Veterans who comprise VA's core health care mission. Therefore, the Secretary decided not to include non-service-connected Priority 7 Veterans in the VERA Basic Care category. Subsequently, the Secretary decided to include these Veterans in Basic Care in FY 2004.
- VA identified and evaluated three potential case-mix approaches. The three potential approaches were:
 1. VERA with 47 case-mix categories, (GAO used 44 classes in its report based on FY 2001, in FY 2003 there were 47 classes),
 2. VERA with 10 case-mix categories, which is a higher grouping of the 47 case-mix categories; and

3. The Diagnostic Cost Groups (DCGs) with 25 case-mix categories (only 24 cost groups).

- The Secretary made a decision to implement the VERA-10 case-mix methodology in FY 2003. This includes 6 Basic Care price groups and 4 Complex Care price groups.
- By implementing the VERA-10 case-mix price groups in FY 2003, there is no longer a need to maintain the FY 1995 Complex Care/Basic Care artificial allocation split of 38% Complex and 62% Basic. This change updates the FY 1995 weights to reflect the current base year experience. It is not anticipated that this change will create a disincentive for the enrollment and treatment of Complex Care patients.
- VA implemented caps on the FY 2003 VERA allocation increase over adjusted FY 2002 allocations at the low end of + 5% and at the high end of +12.6%. As a result, there were no supplemental VERA adjustments in FY 2003.
- For FY 2003, VA provided an allocation for each network's top 1% high-cost patients. This change recognizes the impact of high-cost patients whose annual costs exceed an established threshold of \$70,000. Networks receive an additional allocation equal to the amount that their patient's costs exceed the \$70,000 threshold.

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? (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 the number of patients. 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 total patients.
 2. Non-recurring maintenance - Future allocations will be based on the number of patients 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 using VA DCGs (Diagnostic Cost Groups) was evaluated in comparison with the VERA 3-price group model and the VERA 10-price group model and the decision for FY 2004 and the immediate future is to continuing refining the VERA 10-price group model.
 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 was carefully reviewed before a change was made. This issue was examined within the context of the review of the entire patient classification system. This change was first considered for implementation in the FY 2002 allocation, but action was deferred pending further analysis.

In FY 2003, with the expansion of VERA price groups from three to ten, this change also modified the funding allocation split between Basic Care and Complex Care to reflect the current base year cost experience between these groups rather than using a fixed ratio that reflects their FY 1995 relative costs.

- 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. The following components of the VERA allocation process were reviewed for the FY 2011 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 VHA Data System in Austin, Texas. Matching allocated patient costs back to the Monthly Program Cost Report (MPCR) validates costs.
 - 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 patient assignment in cases where a patient has been treated in more than one network.
 - Research Support: Three types of research are identified for receiving research support funding allocations: research administered by VA; research not administered by VA but peer reviewed; and research not administered by VA and not peer reviewed. The Headquarters Research and Development Office record the three types of research, 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.
 - Non-recurring Maintenance (NRM): Beginning in FY 2001 and in each succeeding fiscal year, the entire NRM calculation is based on construction cost adjusted patient volume. 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 the number of patients, 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 first computed using actual salary dollars expended in FY 2006, weighted patient

volume, 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 2006 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. These network-level purchases are subject to regional price variations resulting from local cost of living factors. The VERA model now contains an 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 VHA labor index, which is derived from VHA staff salaries. 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.
- 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. Beginning in FY 1999 and in each succeeding fiscal year, this improved the 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 2009 planning allocations based on the President's budget were issued to the networks in August 2008.
 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 are 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. It was determined that VERA allocations based on enrollment may not be the most equitable distribution of resources because all of those enrolled may not use VA services.
 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.

- 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, three refinements for FY 2002, four refinements for FY 2004, eight refinements for the FY 2005, and two refinements for the FY 2008 allocation process.
2. In FY 2003, the VERA price groups expanded from three to ten to recognize a differentiation in VA's "core mission" patients (Veterans with service-connected disabilities or those with incomes below the current threshold or special needs patients, e.g., the homeless) not present in the three VERA price groups.
3. In FY 2004, Priority 7 Veterans in Basic Care were included in VERA. Priority 7 patients were always included in Complex Care, but most were not included in Basic Care. In conjunction with this change, the VERA price groups were modified and there is now a separate price for Priority 1-6 Veterans and Priority 7 Veterans in each of the ten price groups for a total of twenty prices. Priority 8 Veterans are included in VERA with Priority 7 Veterans in FY 2005.
4. VHA National Leadership Board Finance Committee 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 - This would require that both the VERA and the performance measurement systems are mature and stable enough to support a direct link to budget allocations. This would also involve significant policy issues regarding the purpose of VERA (to fund Veterans' health care needs) and, the purpose of performance measures. As of FY 2011, the VERA methodology and performance measures remain as separate systems.

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 indicated 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.

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

VHA 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 no further action was required.

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 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 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. As a result of this review, it was determined that no adjustments to the VERA model were required. 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.

The RAND Corporation Study

The Department of Veterans Affairs contracted with the RAND Corporation to conduct a three-phase study of the Veterans Equitable Resource Allocation (VERA) methodology, directed by the Senate Appropriations Committee (Public Law 106-377). VA transmitted these reports to Congress as follows: RAND Phase I VERA report in September 2001, the RAND Phase II report in November 2002, and the RAND Phase III report in November 2003. A brief summary of RAND's findings and conclusions follows, which address all three phases of the study.

RAND Phase I Study

The RAND Corporation's National Defense Research Institute (NDRI) initially conducted a short-term (Phase I) assessment of the following issues raised by Congress:

- The impact of the allocation of funds under the VERA formula on Veterans Integrated Service Networks (VISNs) and sub-regions with older than average medical facilities; with older or more disabled enrolled Veterans; undergoing major consolidation, and/or with appointment backlogs and waiting periods in rural and urban sub-regions.
- Issues associated with the maintenance of direct affiliations between VA medical centers and university teaching and research hospitals.
- Whether the VERA formula for allocating funds adequately accounts for differences in weather conditions when calculating the cost of construction and maintenance of health care facilities and whether VISNs that experience harsh weather conditions require more resources.

RAND Phase I Results

Findings from the Phase I study appear in a report entitled *An Analysis of the Veterans Equitable Resource Allocation (VERA) System (RAND MR-1419-DVA)*, and are summarized as follows:

- Overall, the study identified factors that may influence the costs of, and access to, care within the VA system and assessed how VERA adjusts for those effects. Among the findings of the report were that health care delivery costs might be affected by the age, physical condition, and historical significance of a VISN's facilities, factors for which VERA makes no adjustments.
- Another finding was that VERA's case-mix adjustment methodology might not account adequately for differences in the average health status of Veterans across VISNs. In contrast, the influence of such factors as weather extremes and rural versus urban location appeared less clear. Finally, the report concluded that a comprehensive evaluation of the current system, as well as the potential effects of modification to it, would require extensive, quantitative analysis.

RAND Phase II Study

RAND undertook a quantitative analysis of the VERA system (Phase II) to assess how a variety of patient, facility, and community characteristics affected costs of patient care; to create a model to assess the impact of a wide range of policy changes; and to simulate how such policy changes would affect VISN allocations. RAND's approach was to create multivariate regression models that included factors that might lead to differences in patient costs. One such model, the "All Variables" model (AVM), included all identifiable variables that might influence differences in patient costs. Another model, the "Selected Variables" model (SVM), included only variables that showed a significant effect in the first model, were consistent with VA mission, and were largely outside the control of VISN directors. Factors that were found to have a major influence on costs included patient case-mix measures, reliance on Medicare for coverage of health care, and a small number of facility variables.

RAND Phase II Results

RAND published the findings of the analysis of the Phase II VERA study in *An Analysis of Potential Adjustments to the Veterans Equitable Resource Allocation (VERA) System*, (MR-1629-DVA) in January 2003, and are summarized as follows:

- For the most part, facility infrastructure characteristics do not play an important role in explaining patient cost variation.
- Additional adjustments to VERA may be warranted:
 - VERA-10 or VA Diagnostic Cost Groups (DCGs) should be used to adjust for case-mix differences.
 - If more refined case-mix adjustment is made, educational support should be revised.
 - Medicare reliance should be taken into account.
- To make these adjustments, VA should consider adopting an allocation system that relies on a regression/simulation framework similar to the one used in the Phase II analysis. However, before making any modifications along these lines, during Phase III of the study, VA should:
 - Examine why gainers and losers are different under VERA-10 and VA DCGs.
 - Disaggregate simulated allocations to better understand the impact of different variables.
 - Update the models using FY 2001 VA data and FY 2000 Medicare data.
- A modeling approach may be used in the adjustment process and in making network to facility allocations.

Based on these findings, RAND recommended that VA should consider modifying VERA to take greater account of patient and facility characteristics than it did. According to RAND, this could be accomplished by adopting an allocation system that relies on a regression/simulation framework similar to the one used in the Phase II analysis. However, before implementing such an allocation system, RAND recommended conducting additional analyses to gain a better understanding of how particular variables influence VISN allocations.

As a result of the Phase II study and a February 2002 GAO report, *VA Health Care: Allocation Changes Would Better Align Resources with Workload* (GAO-02-338), VA expanded VERA from three to ten price groups to recognize a differentiation in VA's "core mission" patients (Veterans with service-connected disabilities or those with incomes below the means test income threshold or special needs patients) not present in the previous three price groups. This change also modified the initial funding split between Basic Care and Complex Care to reflect the current base year cost experience rather than continuing to use the fixed FY 1995 cost split ratio. In addition to the change from VERA-3 to VERA-10 in FY 2003, VERA also provided an additional allocation to networks with the highest cost patients by recognizing the impact on those networks with patients whose annual costs exceed \$70,000. These networks received an additional allocation equal to the amount that these costs exceeded \$70,000. VA also developed minimum and maximum caps on network allocation increases in FY 2003. After examining the results of the Phase II VERA study, Congress requested that VA have RAND's NDRI conduct a set of additional analyses in a Phase III study.

RAND Phase III Study

The RAND Corporation's Phase III VERA study, "*Understanding Potential Changes to VERA: A Regression-Based Approach.*" is a follow-up to the Phase I and Phase II VERA studies. The goals of RAND's Phase III VERA study were to determine how particular patient and facility characteristics influence allocations to VISNs and to simplify and refine the regression models created in Phase II to reflect policy changes and more recent data. One such policy change was the FY 2003 modification of VERA's case-mix adjustment mechanism from three price groups (VERA-3) to ten price groups (VERA-10). RAND's approach was similar to that of Phase II, with several important differences:

- More recent data sets were used to estimate costs and to simulate VISN allocations.
- The modeling approach was simplified substantially by collapsing the patient and facility-level equations into a single-equation model without sacrificing the power of RAND's original two-equation model to explain and predict costs.
- To generate additional insights into simulated VISN allocations, RAND disaggregated the results to show the influence of each variable included in the models on VISN allocations.

Using its regression equation, RAND constructed three types of models, with three distinct objectives. The first model, the “Base Regression Model (BRM),” demonstrates how a regression-based approach for calculating VISN allocations compares with the method that VA currently uses to arrive at its VERA allocations. The second model, the “All Variables Model (AVM),” accounts for all patient, facility, and community variables that had been shown to influence the costs of treating Veterans at VA health care facilities and that could be measured using readily available data sets. The third model, the “Selected Variables Model (SVM),” includes all of the variables found in the BRM, as well as some additional measures of patient and facility characteristics that were included in the AVM, that is, variables that were found to influence the costs of care and that might be appropriate to use for policy purposes. In addition, to further assess the effects of case-mix measure, RAND compared the effects of the models using the VERA-10 case-mix measure and VA DCGs case-mix measure.

RAND Phase III Report Findings

Regression Results:

Six patient-level variables played key roles in explaining an individual’s use of VA resources:

- Similar to the findings of the Phase II report, sex and age independently affected patient care costs, controlling for case-mix and other factors. However, patients older than 85 had lower costs.
- Health status played a significant role in determining health costs.
- Patients residing in urban areas incurred significantly higher health costs than those in rural areas.
- Patients who travel a greater distance to receive their health care have higher costs.
- Greater Medicare reliance was associated with lower VA health costs.

A number of facility-level characteristics also influenced individuals’ use of VA health care resources:

- VISN labor index, research costs per patient, food costs per bed day, and square feet of building space, both per patient and per acre of land had positive influences on costs, independent of the case-mix measure used.
- In contrast, for three variables in the SVM—number of residents per full-time physician, energy prices, and contract labor costs—the direction of the association with costs depended on which health status measure was included in the model. When the VERA-10 measure was used, the number of residents per full-time physician had a positive effect on patient costs, but with VA DCGs case-mix measure, there was a negative effect. Similarly, energy prices and contract labor costs were negatively associated with costs under the VERA-10 case-mix measure, but were positively associated with costs under VA DCGs.

Simulation Results:

RAND found that recent VERA policy changes-including the introduction of the VERA-10 case-mix adjustment and the manner in which high cost cases (i.e., those with costs of \$70,000 or more) are treated under VERA-have reduced differences in the ways funds are allocated under the current VERA system compared with the regression-based approach. For example, in FY 2002, applying the regression-based approach-in particular, the VERA-10 SVM-would have redistributed 2.9 percent of the total actual allocation. However, in FY 2003, the regression-based approach with VERA-10 would have redistributed only 1.2 percent of the funds. VA DCGs would lead to a slightly larger redistribution (i.e., 1.8 percent of the total allocation).

Disaggregation Results:

RAND's disaggregation analysis compared the simulated allocation when each patient was assigned the average value for each characteristic (the "unadjusted average allocation") to the simulated allocation that occurs when a characteristic of interest (e.g., health status) was allowed to take its true value. The results can be viewed in two ways: from the VISN perspective and from the national perspective.

Viewing the results from the VISN perspective shows how each variable helps to move a particular VISN from the unadjusted average or patient-based, allocation to the simulated allocations from the SVMs.

Viewing the results from the national perspective shows the factors that are most important in affecting allocations nationwide. In general, there was a great deal of correspondence across case-mix specifications in terms of which variables appeared to change the allocations. In fact, RAND found that the five variables that had the greatest impact on allocations were the same, regardless of which case-mix measure was included in the model, although the order differed slightly between measures: health status, research costs per unique patient, the VA labor index, Medicare reliance, and the square feet of building space per patient. In both case-mix specifications, the amount of money redistributed by the health status measure far exceeded the amount redistributed by any other variable. The current VA system already adjusts for the top three money movers: health status, research costs, and geographic differences in labor costs.

RAND Phase III Report - Conclusions and Policy Implications:

In general, the findings of this Phase III analysis were similar to those of Phase II. A key conclusion from both the results presented in the Phase III report and those of the Phase II analysis is that case mix is critical in explaining differences in patients' costs and that it varies across VISNs. In the Phase II report, RAND recommended that VA adopt a more refined case-mix adjustment methodology - either VERA-10

or VA DCGs - than the previous VERA 3 methodology. Subsequently, VA adopted the VERA-10 case-mix measure. RAND applauded this decision, as they believe it will lead to a more efficient and equitable allocation of health care resources. RAND describes that what is less clear, however, is whether VERA could be further improved by moving from VERA-10 to VA DCGs. On the one hand, VA DCGs better explain patient-level cost variation than does VERA-10. On the other hand, RAND observed that VA DCGs would shift a substantial amount of money across VISNs, and they know little about why such redistributions would occur.

Also, as RAND found in the Phase II analysis, Medicare reliance continues to have a statistically significant effect on the costs of treating Veterans at VA facilities. Specifically, as one might expect, the greater the degree to which individuals rely on Medicare, the lower their VA costs. Consequently, RAND believes that VA should consider modifying VISN allocations to adjust for differences in the degree to which VA patients rely on Medicare providers for the care they receive. Doing so would help make the VERA system more equitable and efficient. However, prior to implementing a Medicare reliance adjustment, RAND believes that VA should investigate the accuracy with which Medicare data, which necessarily lag VA data by one year, predict future Medicare expenditures.

Finally, in both this and the Phase II report, RAND used regression analysis to understand the extent to which a wide range of variables influence the costs of caring for VA patients. RAND asserts that regression analysis holds great potential for serving as a mechanism for VA to determine VISN-level allocations to their medical facilities. However, RAND does not believe that it is critical at this juncture for VA to shift to a regression-based allocation approach. The primary reason RAND advocates against such a transition at this point is that such a change would be difficult to implement, and the current allocation approach comes very close to the regression-based one, as evidenced by the percent of funds that the latter would redistribute. In the event that VA elects to adjust VISN allocations for a wider range of variables - including, for example, Medicare reliance and some of the other factors that the disaggregation analysis demonstrated were responsible for shifting funds across VISNs - then adopting a regression-based approach might prove to be advantageous.

The Phase III VERA report concludes that even if VA does not switch to a regression-based methodology, the use of regression analysis can provide a powerful management tool for VA headquarters staff and VISN directors. The single-equation, regression-based approach upon which this study relied is easy to use and interpret. The output from the regression model can be used to identify additional potential adjustments to VERA, to make informed decisions regarding requests for supplemental funds, and to provide guidance for VISN directors in determining how funds should be allocated to facilities within their networks.

Study Limitations:

In reviewing RAND's findings, the following study limitations should be considered:

First, although the analyses generated insight into factors that explain variation in patients' costs, RAND was unable to compare, for example, the average cost per patient to any sort of efficiency "gold standard." In other words, RAND had no way of knowing what the "right" costs should be for any given patient or group of patients. Rather, they were able to compare only how costs vary for patients with different patient, facility, and community characteristics. This problem is exacerbated by the fact that the necessary data are not available to adjust the cost data for differences in quality of care across facilities and VISNs.

Second, the validity of RAND's analyses ultimately depends to a great extent on the completeness and quality of data that were used to construct the patient and facility equations. In general, RAND found the patient-level data to be quite complete, with the exception of certain variables such as income. Although RAND did not attempt to validate a sample of the patient data drawn from patients' medical records, they conducted a variety of reliability and validation checks using data from multiple years on the same set of patients. From what RAND could determine, the patient level data appeared to be of very high quality, and in their view, the quality and completeness of the facility data could be improved. To some extent, the problems that were encountered in the facility data set were due to the large number of management consolidations that have occurred over the last half dozen years or so. RAND believes that if VA chooses to adopt an allocation methodology that accounts for facility-level characteristics, such as the regression-based approach, the quality of the facility data collection process should be improved. Specifically, the definition of what constitutes a facility should be developed (e.g., a management unit or physical location) and applied consistently throughout the data collection process.

VA has shared this study widely both internally and externally to include, Network Directors, VA and VHA Central Office Officials, VHA National Leadership Board Finance Committee, the Senate Appropriations Committee (Chairman and Ranking Member), and the House Appropriations Committee (Chairman and Ranking Member).

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“To Care for Him Who Shall Have Borne the
Battle and for His Widow, and His Orphan.”

-Abraham Lincoln, March 1865

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