

**NHPF Issue Brief**  
No.796 / April 1, 2004

**NATIONAL  
HEALTH  
POLICY  
FORUM**

## Veterans' Health Care: Balancing Resources and Responsibilities

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**OVERVIEW** — *This paper looks at the health care benefits and services administered by the U.S. Department of Veterans Affairs. It examines management strategies adopted within the department to allocate resources, structure benefits, and improve quality. Some recommendations made by the General Accounting Office and the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans are reviewed, in particular the emphasis of the latter on increased collaboration with the Department of Defense. Long-term proposals to balance service commitments and financing also are considered.*

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## Veterans' Health Care: Balancing Resources and Responsibilities

Surely no government agency was ever charged with a mission at once so noble and concise: "To care for him who shall have borne the battle, and for his widow, and his orphan." These words, spoken by Abraham Lincoln in his second inaugural address, affirmed the government's obligation to care for those injured during the Civil War and to provide for the families of those who perished. Concise does not equate to simple, however, nor noble to noncontroversial. Several wars later, today's Department of Veterans Affairs (VA) bears the potential duty to "care for" the 70 million people—nearly one-fourth of the U.S. population—who are veterans or their family members and survivors. Benefits provided under the department's auspices include disability and death compensation, pensions, rehabilitation services, education and training, home loan assistance, life insurance, burial, and health care.

In 2003, the Veterans' Health Administration (VHA) within the VA provided medical services to some 4.5 million veterans of the 7.1 million total enrolled for VA health care. Those figures represent increases of 31 percent (from 3.4 million) and 70 percent (from 4.2 million) over fiscal year (FY) 1999. The numbers are substantial, but may not entirely convey the significance of the VA as a symbol of national obligation for service to the country. Congress has increased eligibility and benefits over the decades. A particularly notable spike occurred in 1996, when broad eligibility reform was enacted. The fact that an associated level of ongoing financial support could not be defined set the stage for intensified discussions about priorities and better matching of resources to needs. (See Figure 1 for enrollment and expenditures in recent years.)

In common with other public health care programs and with private-sector health plans as well, VHA management faces multiple challenges in improving quality, expanding access, and controlling costs. The health care system as a whole is adjusting to the growing burden of chronic illness and the increasing sophistication (and expense) of medical technology. The extent to which the VA should be assessed and evaluated on its own, as opposed to as part of a broader health policy concern, is not altogether clear. In some ways, being a federal agency is an advantage; for example, quality improvement programs may be implemented more smoothly when clinicians are salaried employees. In other ways, a public charter throttles flexibility—the VHA, unlike a commercial insurer, cannot elect to leave an unprofitable market. VHA managers are challenged to satisfy the varying demands and desires of patients, veterans'

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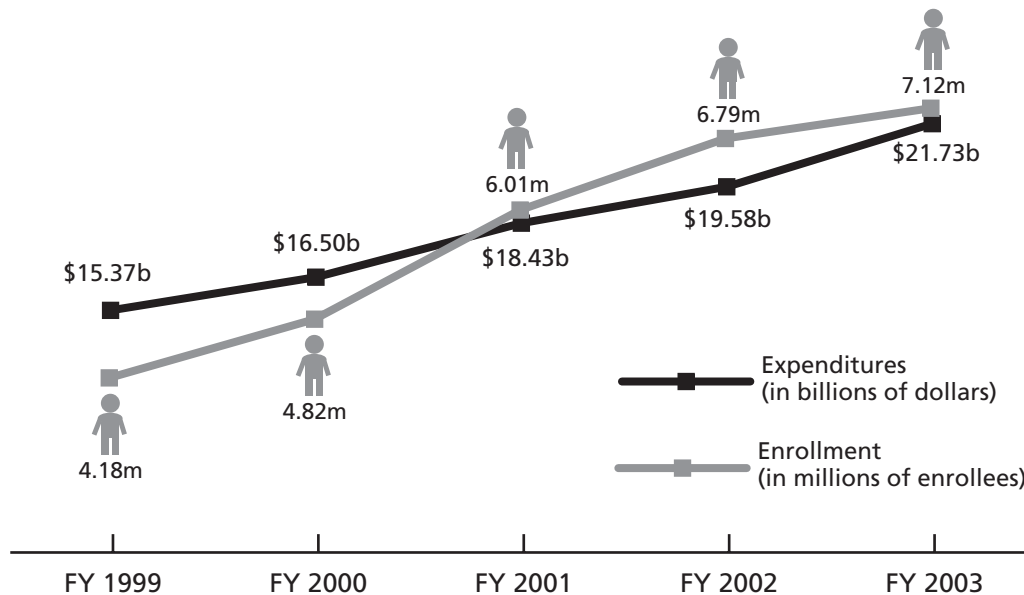
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**FIGURE 1**  
**VHA Health Care Expenditures Compared with Total Enrollment,**  
**FY 1999 through FY 2003**



Source: Veterans Health Administration.

groups, clinicians, and Congress. When resources available seem inadequate to promises made, policymakers must grapple with setting priorities for care delivery.

**TO SERVE THOSE WHO SERVED:  
 THE GROWTH OF THE VHA**

**Benefits**

Veterans’ benefits originally took the form of pensions (administered by the Bureau of Pensions of the Interior Department) and domiciliary care in facilities established by the states. Other types of benefits were added over time, such as disability compensation, insurance, and vocational rehabilitation, when the United States entered World War I, and education benefits under the Serviceman’s Readjustment Act (“the GI bill”), after World War II.

The traditional focus for VA health benefits has been those with service-connected injuries or illnesses and those with low income. Based on the extent of service-connected disability (that is, disability resulting from illness or injury incurred or aggravated during military service) and income status, veterans could qualify as eligible for specific categories of coverage,

such as inpatient, outpatient, and rehabilitation services. This piecemeal approach was remodeled in the Veterans' Health Care Eligibility Reform Act of 1996, which essentially charged the department with establishing a comprehensive, uniform health benefits package for all enrolled veterans. The act eliminated the distinction between inpatient and outpatient eligibility, mandated an annual enrollment system, and established seven priority classes for enrollment and care delivery. Priority 1 is veterans with service-connected disabilities rated 50 percent or more disabling. (For a full listing, see Appendix A). In 2002, Congress split Priority 7 in two (creating the new 7 and 8), distinguishing between higher- and lower-income levels in veterans without service-connected conditions. (See Figure 2 for the percentage of veterans in each priority group.)

The Veterans Millennium Health Care and Benefits Act of 2001, another congressional expansion of benefits, focused on long-term care. It required the VA to provide or pay for nursing home care for all veterans who are rated 70 percent or more disabled and those needing nursing home care because of a service-connected condition. Echoing a trend seen in other public programs following the *Olmstead* case,<sup>1</sup> the act also requires the VA to provide alternatives, such as adult day health care and home care, to institutional care for elderly and disabled veterans.

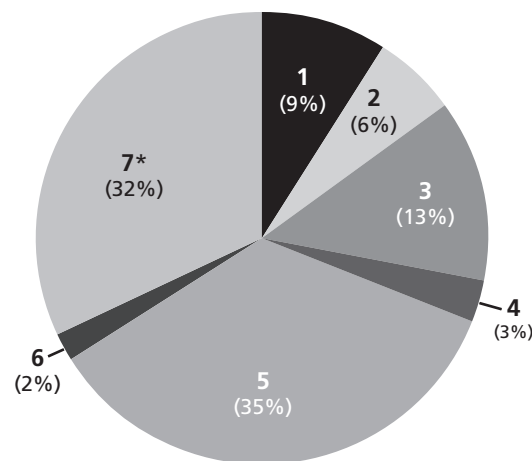
It was not legislation but economics that generated a narrowing of benefits in 2003. VA Secretary Anthony J. Principi announced early that year that the department was suspending enrollment for new Priority 8 veterans. In congressional testimony, he cited the tremendous growth in the number of veterans seeking VA care, noting that in Priority Groups 7 and 8 alone, the number of patients treated was about 11 times greater than in 1996.<sup>2</sup> Principi explained that his action was necessary in order to maintain the focus on "core" veterans: those with service-connected disabilities, the indigent, and those with special health care needs.

The VHA is widely known for its specialized programs for blindness, spinal cord injury, traumatic brain injury, serious mental illness, and post-traumatic stress disorder. In recent years, given veterans' high incidence of chronic diseases, the agency has established programs to measure quality of care and patient outcomes for high-prevalence and high-risk chronic diseases.

### Facilities and Staff

The VA health system grew from 54 hospitals in 1930 to the current complement of 158 hospitals. There are also now more than 800 outpatient clinics, 133 nursing homes, 42 residential rehabilitation treatment programs, and 206 readjustment counseling sessions spread across all 50 states, the District of Columbia, Puerto Rico, and the U.S. territories.<sup>3</sup>

**FIGURE 2**  
**Currently Enrolled Veterans**  
**as of September 30, 2002,**  
**by Percentage in Priority Groups 1-7**



\* Congress has since divided Priority 7 into Priorities 7 and 8 on the basis of income.

Note: The total number of current veteran enrollees as of September 30, 2002, was 6,467,985.

Source: Veterans Health Administration data.

More than 200,000 employees serve in the VA health system. In addition to employed physicians, nurses, and other health professionals, the medical ranks are augmented by some 20,000 medical students and 30,000 residents who rotate through VA facilities annually.<sup>4</sup> One hundred seven of the country's 126 medical schools maintain formal affiliation with a VA facility, making the VA an integral partner in training physicians.

VHA facilities and field operations are organized as 21 Veterans Integrated Service Networks (VISNs), described as "integrated networks of health care facilities that provide coordinated services to veterans to facilitate continuity through all phases of health care."<sup>5</sup> VISNs are all charged with making available a uniform package of benefits but are given the flexibility to determine where and how care will be delivered. The goal of the late-1990s reorganization that established the VISNs was to redefine the VHA from an inpatient model of care characterized by a limited number of specialized facilities and a provider focus to a patient-centered primary-care-based model with a much-expanded number of access sites.<sup>6</sup>

An increased emphasis on outpatient care is consistent with the growth of hospital outpatient services in the private sector. However, advocates for some veteran subpopulations wonder whether they are being short-changed in the process. The U.S. General Accounting Office (GAO) found that, since FY 1998, the VA has decreased the number of long-stay patients and increased the number of short-stay patients it treats in the nursing homes it owns and that it now pays for more veterans to receive care in state-run veterans' nursing homes.<sup>7</sup> Though the allocation of more resources to noninstitutional care, such as home health services, may delay the need for nursing home care, the department is likely to be challenged sooner or later to provide such care to a growing segment of its beneficiaries. Treatment programs for what the VA terms "substance use disorder patients" is another area of concern. While the number of such patients has increased 53 percent since FY 1998, the number receiving specialized treatment decreased 35 percent over the same period.<sup>8</sup>

### **Beneficiaries and Demand for Services**

With the attrition of the World War II generation, the total number of veterans in the population is decreasing. However, as noted, the number of veteran patients actually seeking and receiving care from the VA has increased, and this growth is expected to continue. Based on the VA's projection model, without any limitation on enrollment, the number of veterans served is forecast to peak at about 8.9 million enrollees in 2012.<sup>9</sup>

The largest cohort of today's veterans are from the Vietnam era, followed by those from World War II (Figure 3). The median age as of September 2003 was 58 years. The number of the oldest old, over 85 years, has more than quadrupled since 1990. VA analysts cite data showing that, on average, their beneficiaries are sicker than other Americans of the same age.

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As one VA official recently said with rueful humor, “We are the definition of adverse selection.”<sup>10</sup>

Beyond the simple growth in lower-priority enrollees, demand is spurred by a number of factors. One obvious draw is that the VA offers an outpatient pharmaceutical benefit, which Medicare does not (at least until relevant provisions of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 take effect in 2006—though even then the VA benefit may be more attractive). The VA’s efforts to multiply access sites and make more care available on an outpatient basis have proven attractive to veterans. The VA’s concentration on quality

improvement in recent years has garnered the department favorable publicity, possibly making some veterans more likely to seek care there. Patient satisfaction scores in recent years have compared favorably with those measured in other government programs and in the private sector.<sup>11</sup>

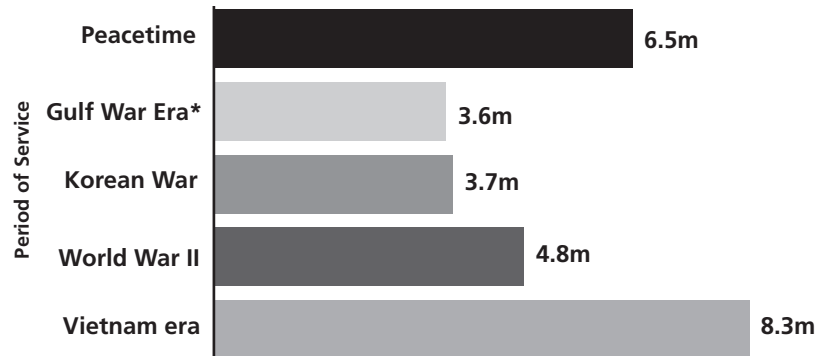
## ON THE INSIDE: VHA PLANNING AND MANAGEMENT INITIATIVES

### Safety and Quality

In 1997, a series of reports about adverse events and preventable deaths in VA hospitals in several newspapers (including the *St. Petersburg Times* and the *New York Times*) raised perennial questions about the quality of care provided by the VA. Sen. Jay Rockefeller (D-WV), then ranking minority member of the Senate Committee on Veterans’ Affairs, reproved the department for lacking the programs and systems to “adequately monitor, track, and analyze the quality of care provided.”<sup>12</sup>

As the 2000 Institute of Medicine report *To Err is Human* showed, a dearth of systemic quality analysis was by no means confined to the VA. In fact, even by the time of Rockefeller’s remarks, the VHA was working to implement the quality-focused culture change first proposed by then Under Secretary for Health Kenneth Kizer, MD, in 1995. Before *To Err is Human* was published, the VHA had established the National Patient Safety Registry, a database designed to collect information on adverse events and their root causes; set up an agency-wide patient safety improvement awards program; and founded the VHA National Center for Patient Safety

**Figure 2**  
**Veteran Population by Period of Service,**  
**as of September 30, 2002 (in millions)**



\* Includes service in Iraq.

Source: Office of Policy, Planning, and Preparedness, Veterans Administration, “VetPop 2001 Adjusted to Census 2000,” December 2002.

(NCPS) to lead and integrate patient safety efforts, incorporating human factors engineering and safety system approaches.<sup>13</sup>

In the years since, the VHA has been widely recognized as a safety and quality leader. *Leadership by Example*, a 2002 Institute of Medicine report focused on government roles in quality improvement, praised the VA's use of performance measures to improve quality in clinical disciplines and its integrated health information system. Also in 2002, NCPS received the John E. Eisenberg Award in Patient Safety from the National Forum for Healthcare Quality and Reporting and the Joint Commission on the Accreditation of Healthcare Organizations. VA networks participate in quality improvement projects at the local level; for example, in Pittsburgh, the VA system has collaborated with the Pittsburgh Regional Healthcare Initiative and the Centers for Disease Control and Prevention in an effort to reduce certain infections in surgical cases. The Cincinnati system administers a grant from the Agency for Healthcare Research and Quality to reduce the incidence of nosocomial (that is, hospital-acquired) infection in area hospitals.

A study by Ashish K. Jha, MD, and colleagues looked at patient quality-of-care indicators in the VHA before and after the mid-1990s reengineering, finding significant improvement in 12 of the 13 measures for which multiyear data were available. They also found that, on overlapping quality indicators, the VHA outperformed the Medicare fee-for-service system on 11 of 11 measures during the period 1997 to 1999 and on 12 of 13 in FY 2000.<sup>14</sup> The authors acknowledge structural differences between the programs (for example, the VHA's centralized decision-making capabilities and salaried physician workforce) but conclude that the VHA's quality-improvement initiatives are largely responsible for its superior results.

## Information Technology

Advances and investment in information technology (IT) support the VA's quality initiative and its vision of transition from visit-centered to patient-centered primary care. The Computerized Patient Record System (CPRS), accessible by all clinicians, offers images, reminders, and communications tools in addition to patient medical data. The CPRS provides for consolidation (in a "care management dashboard") of information on a panel of patients, such as those with diabetes. The recently launched *My Health@Vet* offers veterans health information, tools for measuring their own health status, and one-stop shopping for VA benefits. In future phases, it will give veterans access to key components of their own medical records and allow them to order prescriptions, make appointments, and maintain a personal health log.

The Performance Measurement System was designed to monitor and improve clinical performance and outcomes. Population data are assembled to track clinicians' adherence to evidence-based guidelines; results are fed

**Investment in information technology supports the VA's quality initiative and its transition to patient-centered primary care.**

back to individual clinicians and their management groups and are used to develop performance improvement plans.<sup>15</sup>

The VA pioneered the use of electronic bar codes in dispensing drugs, piloting its Barcode Medication Administration System in 1993 and rolling it out nationally in 2000.

### **Veterans Equitable Resource Allocation**

Until 1997, the VA's allocation to facilities of appropriated dollars was generally based on the facilities' historical expenditures. The aging of the veteran population and geographic migration to the South and Southwest created a level of demand in some areas that the VHA was hard-pressed to meet. The old strategy of undertaking new construction was no longer feasible when some regions were oversupplied and all were moving to an outpatient emphasis.<sup>16</sup> In FY 1997, the VA adopted a new approach, the Veterans Equitable Resource Allocation (VERA) system, designed to distribute resources among the VISNs primarily according to workload.

Since its implementation, VERA has shifted substantial resources among regions. Both GAO and RAND, asked to assess its effectiveness, endorsed its conceptual design. As GAO testified in 2002, "By receiving funding based on workload, the VA's health care networks have an incentive to focus on aligning facilities and programs to attract patients rather than focusing on maintaining existing operations and infrastructure regardless of the number of patients served."<sup>17</sup> GAO and RAND analysts also suggested improvements, such as refining the three-element case mix used in VERA calculations to more precisely reflect the range of case complexity, which the VA addressed by expanding to ten case mix categories.

### **Capital Assets Realignment for Enhanced Services**

Capital Assets Realignment for Enhanced Services, a national study known as CARES, was undertaken in October 2000 in response to a GAO recommendation that the VA develop a market-based plan for restructuring its delivery of health care in order to reduce funds spent on underutilized or outdated buildings. As GAO has noted in testimony, this infrastructure is no longer effectively aligned with a delivery model emphasizing outpatient care.<sup>18</sup>

CARES was intended to improve veterans' access to care and to assess how well the geographic deployment of VA resources matches the existing and projected needs of the veteran population. Following a pilot test in VISN 12 (Chicago), each network conducted extensive research and developed a market plan for its territory, laying out the relative merits of meeting future demand via contracting for care with non-VA providers; renovating available space; constructing new space; engaging in space sharing, joint ventures, or enhanced use of facilities; or acquiring new sites of care.

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Driving distance and waiting time are the types of indicators that CARES has homed in on. For example, one standard established for inpatient hospital care was that at least 65 percent of the veterans in a VISN should be within specified access parameters: 60 minutes in urban counties, 90 minutes in rural counties, and 120 minutes in highly rural counties. (Not all VISNs could meet this standard across their territories.)<sup>19</sup>

The VISN plans served as input to a draft National CARES Plan developed under the supervision of the under secretary for health. The secretary appointed an independent CARES Commission to review it and to hold hearings around the country at which stakeholders could air their views. Veterans also were invited to submit written comments. The commission had the power to choose to accept, modify, or reject the recommendations made in the draft. These included closing seven hospitals and building two new ones (in Las Vegas, Nevada, and Orlando, Florida), as well as expanding various specialty and outpatient programs. The commission's recommendations, released in February 2004, were to close only three hospitals (in Pittsburgh, Cleveland, and Gulfport, Mississippi), modify or realign services in several other locations, and build in Orlando and possibly Las Vegas. The final decision rests with the secretary.

CARES can be said to parallel VERA in its attempt to move resources to match workload. Money, of course, is more mobile than bricks and mortar. And VA facilities are not just sites of care administration; they are employers, partners with medical schools in training and residency programs, signs of attention focused on a place that may be losing population but still has pride. In this way, CARES recalls the Base Realignment and Closure Commission's process in the mid 1990s: there is a lot invested in the status quo.

For example, American Association of Medical Colleges president Jordan M. Cohen, MD, invoking the long association of the VA and the country's medical schools, testified to "underlying skepticism among the medical school deans about whether the education and research missions of the VA are being given adequate attention in the [CARES] process."<sup>20</sup> Labor unions have been reluctant to support plans that involve consolidation or relocation of services. Although veterans' services organizations (VSOs) have generally been supportive of the CARES process, they have also called for stepped-up communication by the VA to allay some veterans' fears that CARES could lead to "wholesale privatization and dismantlement of the VA health-care system."<sup>21</sup>

## **ON THE OUTSIDE: OTHER POLICY RECOMMENDATIONS**

In its role as advisor to Congress, GAO regularly examines and evaluates federal agencies, including the VA. In 2002 and 2003, assessment was also conducted by another entity, the President's Task Force to Improve Health

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Care Delivery for Our Nation's Veterans (PTF). Among the recommendations offered to the VA were the following.

### Increase Third-Party Payments

Many veterans are eligible for non-VA medical care, often through Medicare or the Department of Defense (DoD)—or both—as well as private insurance. When the VA treats such veterans for conditions that are not a result of injuries or illnesses incurred or aggravated during military service, it is allowed to bill some other health insurers. (Medicare, Medicaid, and HMOs that do not designate the VA as a participating provider are not among them.)

Although the VA has been authorized to collect third-party payments since 1986, it was not until the Balanced Budget Act of 1997 that it was permitted to use funds so collected to supplement (rather than offset) its medical care appropriations. Before that, it had little incentive to direct resources to aggressive collection.

In 2002, the VA collected \$687 million in such third-party payments, a 32 percent increase over the previous year. GAO attributes the increase to the VA's reducing billing backlogs and submitting more bills, as well as improving its documentation and collections processes.<sup>22</sup> However, GAO notes, staffing, training, and cooperation shortfalls still exist. In part because of these, the VA lacks a solid estimate of uncollected dollars (such as billable care missed in the coding process) and therefore cannot reliably predict the supplemental funds it will have to work with.

### Collaborate with Other Agencies

**Department of Defense** — The PTF was established in 2001 with a primary mission of identifying ways to improve services to those dually eligible for benefits from the VA as veterans and from DoD as military retirees through better coordination of the activities of the two departments.<sup>23</sup> Military retirees have at least 20 years' service and qualify for a pension upon retirement; they, along with those of shorter military tenure, are automatically classified as veterans upon separation from service.

The PTF organized its findings around several central principles:

■ *Committed leadership is essential to achieve collaboration between the VA and DoD to improve health care delivery to veterans.* Though this seems self-evident, the record has been patchy. Sharing authority for the two departments was first legislated in 1982, and Congress has steadily encouraged the practice.<sup>24</sup> In the early stages, sharing initiatives were scattered and focused at the local level, as either joint ventures or agreements to share specified resources. In May 1996, the departments established a joint Executive Council to work on sharing at the VISN and DoD Health Services Region level. Again, recommendations were spottily attended to. The "renewed sense of purpose and momentum"

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the PTF found in 2001 and 2002 may be at least partly explained as a response to the task force's own creation. A new Executive Council was constituted in 2002, under the joint leadership of the deputy secretary of veterans affairs and the under secretary of defense (personnel and readiness).

The PTF endorsed a joint strategic and budgeting process that builds in accountability for achieving targeted sharing. Its further recommendation that the departments jointly develop metrics to measure health care outcomes does not look beyond the VA and DoD to consider the outcomes development work taking place elsewhere in the government and in the private sector.

■ *To provide timely, high-quality care, it is important to have seamless transition of information across the full life cycle of health care for each veteran, especially at the point when he or she moves from military service to veteran or retiree status.* While in the military, service members and their families are covered under DoD's TRICARE program, which permits them to receive care in DoD facilities or from approved contractors, which may include VA facilities. Upon completion of service, members may choose to apply for VA benefits and learn to negotiate a system they may not have previously encountered. However, especially where no service-connected condition is involved, the member may not choose to participate in all available separation-from-service processes, and his or her first attempt to access VA services may occur years later.

One issue to resolve is the oft-criticized need for a retiring service member to have duplicative physical examinations. VA Deputy Undersecretary for Health Policy Coordination Frances Murphy, MD, has testified that the VA is "actively working with DoD to develop separation physical examinations that thoroughly document a veteran's health status at the time of separation from military service and that also meet the requirements of the physical examination needed by the VA in connection with a veteran's claim for compensation benefits."<sup>25</sup>

The PTF report observes that a process of seamless transition would include timely and straightforward access to information needed to determine eligibility for benefits and meet the health care requirements of veterans.<sup>26</sup> An important element in such access would be an interoperable electronic health record (EHR). Both departments have EHR systems, but they were designed separately and cannot readily share data. The VA and DoD are making strides toward compatibility, but there is still a long way to go. As of July 2003, a Federal Health Information Exchange (FHIE) is in operation. This is a one-way transfer of data on separated service members<sup>27</sup> from DoD's Military Health System Composite Health Care System to a VA repository, whence it can be accessed via the VA's CPRS. Data are available to clinicians at all VA medical centers about six weeks from the individual's separation

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from service.<sup>28</sup> A longer-term initiative, to be called HealthPeople (Federal) is premised on the departments' development of a common health information infrastructure and architecture. GAO regards its promised debut at the end of 2005 as a matter of some doubt.

One significant barrier to a mutual EHR system is the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which prohibit disclosure of personally identifiable health information to certain third parties without specific consent. An exception was written in to permit the one-way FHIE data transfer. However, DoD is not permitted to share postretirement data, and the VA is not permitted to share data with DoD at all. An FY 2002 request for a special exemption to permit collaboration for ongoing care was denied by the U.S. Department of Health and Human Services (DHHS). The PTF has called on the administration to declare the two departments to be a single health care system for HIPAA purposes.<sup>29</sup>

In addition to enhanced safety and timeliness and greater convenience for both providers and veterans, it is expected that an interoperable EHR system would further a research agenda. For example, better capture, tracking and reporting of occupational health data will lead to better understanding of service-related disorders and their manifestations over time.

■ *VA and DoD collaboration can improve quality, access, and efficiency of health care delivery by pooling resources, eliminating administrative barriers, and implementing change.* GAO reported in 2003 that the VA and DoD had made progress in working together to gain efficiency through the exchange of clinical and support services, joint facility construction, and joint purchasing ventures. However, GAO's last detailed review, in 1998, found that sharing activity was concentrated in a few locations and that, overall, direct sharing of services to beneficiaries constituted a fractional percentage of the departments' combined health care budget (\$60 million out of approximately \$40 billion).<sup>30</sup> PTF Chair Gail Wilensky noted in testimony that joint ventures were still regarded in the light of pilot programs and that the regular planning and personnel assignment programs of the two departments generally disregarded the needs of joint venture sites.<sup>31</sup>

Barriers to sharing are significant. The PTF report noted many differences between the two departments in personnel management, training programs, facilities, infrastructure, IT, and acquisition programs that "do not appear to be driven by their differing missions."<sup>32</sup> Geographic boundaries of VISNs and military treatment facility regions are differently defined, and policies are not necessarily consistent from one to the next. Management philosophies diverged when TRICARE began contracting with managed care companies to provide direct care to beneficiaries. As is so often the case in health care, a lack of incentives has retarded change. Although collaboration is now built into performance contracts for VISN directors, VISN leaders still have no means to

**Barriers to sharing are significant, and a lack of incentives has retarded change.**

provide incentives at the local level.<sup>33</sup> The PTF called upon senior management to provide “significantly enhanced authority, accountability, and incentives to health care managers at the local and regional level.”<sup>34</sup>

**Medicare** — For many years, VSOs and other advocates have seen Medicare subvention as a potential source of funding beyond appropriations. The dictionary definition of subvention is “providing of assistance or support, especially in the form of financial aid.” In this context, subvention would mean that the VA could bill Medicare for the services it provides to Medicare beneficiaries.

The Balanced Budget Act of 1997 authorized a three-year demonstration of Medicare subvention with DoD, which was closely watched as a model that the VA might learn from. The DoD subvention program took the form of a managed care plan, TRICARE Senior Prime, which allowed Medicare-eligible military retirees and their dependents to receive Medicare-reimbursed care in military facilities at six sites. At the end of the demonstration, GAO found that “although DoD satisfied enrollees and gave them good access to care, in doing so it incurred high costs...largely due to enrollees’ heavy use of services.”<sup>35</sup>

Attempts to authorize a similar demonstration for the VA were under way as the DoD demonstration was operating. In 1998, H.R. 3828 was reported by the House Committee on Ways and Means; the following year, the Senate Committee on Finance followed suit with S. 1928. The Centers for Medicare and Medicaid Services went so far as to enter into a memorandum of understanding with the VA in 1999 “in preparation for enactment of legislation that would...authorize implementation.”<sup>36</sup> But the forces necessary to make the desired demonstration a reality never aligned.

DHHS and the VA took action to address the VA-Medicare nexus, however, with the creation in 2003 of “VA+Choice” (later renamed VA Advantage to comport with the MMA). At the same time that Principi announced the suspension of Priority Group 8 enrollment, he and Health and Human Services Secretary Tommy Thompson announced an alternative for affected veterans. Under an agreement between the two departments, the VA would operate as a Medicare Advantage provider, allowing Medicare-eligible Priority Group 8 veterans for whom new enrollments were suspended access to VA care that Medicare would pay for. The program is expected to begin accepting enrollees in selected sites in September 2004.

Veterans who become eligible for the drug benefit under MMA in 2006 may well choose to remain with the VA drug benefit they already have. The department has been able to leverage the volume of its drug purchasing to obtain favorable pricing from manufacturing, a strategy MMA delegates to private entities rather than to DHHS. Out-of-pocket cost to beneficiaries is minimal under VA coverage as well; for example, the president’s 2005 budget proposes an increase in the per-prescription copay, but only from \$7 to \$15.

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## THE HEART OF THE MATTER: BALANCE FUNDING AND ENROLLMENT

The VHA faces a future wherein health care costs, beneficiary demand, and the drive toward quality and technological leadership may conceivably moderate, but are unlikely to reverse. Congressional commitment to (and vote-courting of) veterans is a staple. Budget deficits are more common than surpluses. Yet, as the PTF concluded, “the mismatch between funding for the VA health system and the demand for services from enrolled veterans affects the delivery of timely health care and impedes efforts to collaborate between VA and DoD.”<sup>37</sup> What options do department leaders have? Acting on advice to enter partnerships and to increase efficiency and collections in the near term would seem prudent. Ultimately, however, many stakeholders feel it comes down to a choice: secure funding adequate to discharge the mission or concentrate efforts on the core groups to the exclusion of veterans who are relatively better off and who have no service-connected injuries or illnesses.

Each approach has proponents. As described above, the Bush administration has chosen to limit enrollment by new Priority 8 veterans, who are generally those with higher incomes and without service-connected conditions. This finds some support among the core groups. As one service-connected disabled veteran put it, “Sure, they were in the service. But they didn’t get hurt. And why should a guy who hasn’t taken care of himself since he got out think the country owes him like they owe the guy who got his leg blown off?”

The VSOs, as membership organizations representing all sorts and conditions of veterans, want VA programs to be broadly inclusive. Their position is that VA health care funding should be moved from its current “discretionary” status to the “mandatory” column, where compensation benefits already reside. *The Independent Budget*, a budget and policy document jointly published by AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States, makes this case,

Because of their extraordinary sacrifices and contributions, veterans have earned the right to free health care as a continuing cost of national defense. Guaranteed health-care funding would not create an individual entitlement to health care, nor change VA’s current mission. Guaranteeing veterans health-care funding would, however, eliminate the year-to-year uncertainty about funding levels that [has] prevented VA from being able to adequately plan for and meet the growing needs of veterans seeking treatment.<sup>38</sup>

The VSOs’ pleas have not fallen on deaf ears; at different times, both the chair and the ranking member of the House Veterans’ Affairs Committee have introduced legislation to confer the “mandatory” designation. Chairman Christopher H. Smith (R-NJ) last year presented a more complex proposal: creating an independent board charged with forecasting the

**“The mismatch between funding for the VA health system and the demand for services from enrolled veterans affects the delivery of timely health care.”**

VHA's health-care budget needs and requiring the administration to use the board's numbers as the basis of its budget proposal.

## OUTLOOK

Legislation passed in 2003 was not of the fundamental-change variety. H.R. 1720/S. 1156 contained provisions that, for example, eliminate copayments for former prisoners of war and authorize the VA to hire chiropractors. This legislation also authorized funds for new construction and major medical projects and seemed (by requiring advance notice and enhanced reporting) to set up a warning system, should facility closings start to happen. The Veterans' Affairs Committees may feel strongly about increasing funding, but the necessary consensus does not exist Congress-wide.

The president's budget for 2005 requests \$29.5 billion for the VA's medical care, an increase of 4.1 percent over the 2004 level. This figure incorporates a projected \$2.4 billion in third-party collections and copayments from veterans, the latter including an annual user fee of \$250 for veterans in Priority Categories 7 and 8. In terms of benefit expansions, the request would eliminate some copayments and authorize the department to pay for emergency room care or urgent care for enrolled veterans in non-VA medical facilities. VSOs have judged the proposed funding insufficient.

Though strategies and processes may differ, the VA ultimately faces the same challenges as the rest of the American health care system: finding an equilibrium between demand and supply. Given an aging population subject to chronic disease and an ever-expanding technology, either a greater expenditure of resources or some way of rationalizing the distribution of lesser resources must be reached. Because resources to meet all demand for health care are not readily available and would have to be taken from the funding of other public goods, some form of tiering is the almost inevitable response. Preference may be granted on the basis of income (as already seen to some degree in the private sector), age, severity of condition, or (in the VA's case) percentage rating of service-connected disability.

The department's FY 2003–2008 Strategic Plan acknowledges reality in its key assumptions, among them that the "VA's budget will be consistent with the President's Government-Wide Budget Plan, and will change, as appropriate, to align with future initiatives."<sup>39</sup> Perhaps those charged with aligning veterans' health care needs with the VA's resources will find encouragement in another assumption—that the size of the veteran population will decrease from 25.2 million to 15.0 million between the years 2003 and 2030. Perhaps demand will moderate once prescription drugs are available through Medicare. On the other hand, it may not be wise to bank on an absence of future wars.

**The VA ultimately faces the same challenges as the rest of the American health care system.**

## ENDNOTES

1. On June 22, 1999, the United States Supreme Court held in *Olmstead v. L.C.* that the unnecessary segregation of individuals with disabilities in institutions may constitute discrimination based on disability. The court ruled that the Americans with Disabilities Act may require states to provide community-based services rather than institutional placement for persons with disabilities.
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**Appendix 1: VA Health Care Enrollment Priority Groups**

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**Enrollment Priority 1**

- Veterans with service-connected disabilities rated 50 percent or more disabling.

**Enrollment Priority 2**

- Veterans with service-connected disabilities rated 30 percent or 40 percent disabling.

**Enrollment Priority 3**

- Veterans who are former POWs.
- Veterans awarded the Purple Heart.
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty.
- Veterans with service-connected disabilities rated 10 percent or 20 percent disabling.
- Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation."

**Enrollment Priority 4**

- Veterans who are receiving aid and attendance or housebound benefits.
- Veterans who have been determined by VA to be catastrophically disabled.

**Enrollment Priority 5**

- Nonservice-connected veterans and noncompensable service-connected veterans rated 0 percent disabled whose annual income and net worth are below the established VA means test thresholds.
- Veterans receiving VA pension benefits.
- Veterans eligible for Medicaid benefits.

**Enrollment Priority 6**

- World War I veterans.
- Mexican Border War veterans.
- Compensable 0 percent service-connected veterans.
- Veterans solely seeking care for disorders associated with the following:
  - exposure to herbicides while serving in Vietnam, or
  - exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki, or

**Appendix 1 (cont.)**

- disorders associated with service in the Gulf War, or
- any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.

**Enrollment Priority 7**

■ Veterans who agree to pay specified copayments with income and/or net worth above the VA means test threshold and income below the U.S. Department of Housing and Urban Development (HUD) geographic index.

- Subpriority a: Noncompensable 0 percent service-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date.
- Subpriority c: Nonservice-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date.
- Subpriority e: Noncompensable 0 percent service-connected veterans not included in Subpriority a above.
- Subpriority g: Nonservice-connected veterans not included in Subpriority c above.

**Enrollment Priority 8**

■ Veterans who agree to pay specified copayments with income and/or net worth above the VA means test threshold and the HUD geographic index.

- Subpriority a: Noncompensable 0 percent service-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date.
- Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date.
- Subpriority e: Noncompensable 0 percent service-connected veterans applying for enrollment after January 16, 2003.
- Subpriority g: Nonservice-connected veterans applying for enrollment after January 16, 2003.

*Note: The term service-connected means, with respect to a condition or disability, that VA has determined that the condition or disability was incurred in or aggravated by military service. Some veterans may have to agree to pay copayments to be placed in certain priority groups. A disability rating of 0 percent is given where there are no residual symptoms of a condition, for example, a gunshot wound marked by a scar but no lingering pain. The rating can be altered if symptoms develop or recur later.*

*Source: U.S. Department of Veterans Affairs, "Enrollment Priority Groups Health Care: Fact Sheet," January 2003.*