Written Testimony for Military Construction, Veterans Affairs, and Related Agencies Subcommittee

Hon. Ann McLane Kuster, New Hampshire's Second Congressional District
For April 17, 2018

Mr. Chairman and distinguished colleagues, thank you for providing me an opportunity to speak before your Subcommittee. I come before you today to testify on the state of Veterans benefits and services from my perspective as the Ranking Member of the House Veterans' Affairs Subcommittee on Oversight and Investigations *and* as the only congressional delegate to represent the veterans of the Granite State on either the Senate or House Committees on Veterans' Affairs. I will focus on three issues of importance for the Subcommittee:

1) Alignment of VA capital asset priorities with medical centers of greatest need,
2) The future of VA's community care programs,
3) Continued budgetary oversight of VA programs and projects.

VA Capital Assets

It is no secret that VA's capital assets are in serious need of repair. For Granite State Veterans, this reality was no more obvious than when the Manchester, NH Veterans Affairs medical center (VAMC) suffered a catastrophic water pipe breach. This breach allowed water to flow down multiple floors of the facility and immediately shutdown the Manchester VAMC's already limited surgical capacity. Emergency repairs have been ongoing since this episode and, as you know, this catastrophe occurred within days of the *Boston Globe* releasing a damning report developed in conjunction with a group of whistleblowers indicating severe patient access to care issues at the facility. That exposé brought to light serious issues around the utilization of the Choice program, which serves as a reminder of the need for robust reform of the VA's community care program, complete with effective mechanisms for congressional oversight.

As the only congressional delegate representing Veterans in the only state in the lower 48 to *not* have a full-service medical center, these issues mean something much more. My home state of New Hampshire lacks the same, robust VA capital assets that other Veterans across the country enjoy. As the Ranking Member of the O&I Subcommittee, it was my displeasure to learn about the gross misuse of funds in major construction projects like in Aurora, Colorado while Granite State veterans continue to see needed improvements deprioritized in the President's Budget (PB) Strategic Capital Infrastructure Planning (SCIP) rankings; the FY 2019 PB had the first Manchester VAMC project ranked 181st. It is clear that there is a need for greater focus on the prioritization of capital asset projects across the VA.

I am no stranger to the need for budgetary restraint; as proud, "frugal Yankees," New Hampshire veterans understand the realities of our current budgetary environment. From that perspective, I respectfully request the Subcommittee to seriously examine leveraging innovative concepts to deliver Veterans' healthcare economically and effectively. In my letter to the Subcommittee dated March 16, 2018, I requested the prioritization of ambulatory surgical centers as a solution that provides both quality healthcare while being fiscally responsible. The first ASC ranked in FY19 PB's SCIP priority list was 283rd.

As you know, ASCs have long been utilized by the private-sector to lower costs and improve health outcomes by concentrating ambulatory surgical procedures within a facility specially designed for outpatient procedures. These facilities are especially attractive in rural areas because they increase efficiencies of available providers. As a result, there are more than 6,000

ASCs that have reduced costs to Medicare by more than $2 billion a year, decreased wait-times, and improved health care outcomes across the United States. Rather than degrading Veterans' continuity of care by sending Veterans off-campus, ASCs would help resolve many of the long standing issues surrounding Veterans' healthcare today. With facilities like Manchester VAMC and Northampton, Massachusetts VAMC experiencing issues with effectively coordinating healthcare in the community, it is incumbent upon us to provide VA with the tools it needs to care for those who "borne the battle."

VA Community Care Programs

As we continue to deliberate on the future of VA's community care program, it is imperative that the Appropriations Committee continue to robustly fund the current iteration of the Choice Program to ensure its effective operation while a new and improved community care program is implemented. I remain concerned that the funding shortfalls put patients at risk. VA medical centers must not feel pressure to ration care to accommodate budgetary deficiencies. One of the most important lessons from the Manchester VAMC is the need for a program that values clinical input over budgetary issues; patients must come first always.

I request the Subcommittee consider two aspects of my bill, the *VA Community Care Enhancement Act*, introduced with Mr. Bilirakis of Florida. That bill would require VA to implement a demonstration program between VAMCs and Federally Qualified Health Centers (FQHCs). I respectfully request the Subcommittee recognize the importance of FQHCs for the future of VA community care, as it recognized years ago as part of its MyVA initiative. Unfortunately, VA has not directed enough of its resources to integrating FQHCs into the VA

community care network, despite FQHCs treating over 300,000 Veterans and existing precisely in parts of the nation where the lack of primary care providers acutely affect Veterans.

My bill also provides a mechanism to potentially resolve the persistent issue with improper payments. As you know, the majority of improper payments made by the VA through its contracting regime are to community care providers. In some cases, it appears these payments are made in excess of statutorily required rates because community providers will not see patients without those funds. The VA has requested Congress provide additional flexibility to pay providers rates that incentivize their continued participation with the VA. Here, too, FQHCs provide a novel solution that I believe resolves many of these issues. FQHCs received an "enhanced Medicaid" rate negotiated on a State by State basis to better cover their actual costs since FQHCs operate as "payers of last resort" and treat everyone regardless of their ability to pay. This special reimbursement rate is federally authorized under section 1902(bb) of the Social Security Act (42 U.S.C. 1396a). What makes this rate so effective is that is it tied to periodic audits by the Human Resources and Services Administration (HRSA) to ensure FQHCs are claim legitimate "costs" and are not defrauding the Federal government. VA currently lacks the flexibility to apply this rate to FQHCs and it has proven to be a significant disincentive for these facilities to participate in VA's community care network. I urge my colleagues on the Subcommittee to consider providing additional flexibilities for the VA to pay FQHCs these unique rates and thereby improve Veterans' access to quality healthcare.

Budgetary Oversight of VA Programs

I wish to take this opportunity to applaud the Subcommittee for separating funding for VA's modernization efforts for a new Electronic Health Record (EHR) from VA's general Information

Technology account. This move wisely recognizes the importance of enhanced oversight over VA's IT modernization efforts. History shows that the VA has proven incapable of effectively developing or implementing IT reforms, especially in replacing VA's aging VISTA system. As the Ranking Member of the Oversight and Investigations Subcommittee, I welcome continued coordination between our Subcommittees to ensure VA finalizes a contract for a commercial, off-the-shelf (COTS) EHR. The proposed reform is unprecedented in scope and will take bipartisan, cooperative oversight to ensure VA effectively implements the new system.

However, I urge my colleagues to heed these lessons and deny VA's proposed consolidation of the Medical Services account and the Community Care account. Consolidating these accounts would only serve to make VA's expenditures on community care more opaque and less accountable. The most generous reading of the Manchester VAMC issues provide an argument against consolidation of these accounts – faced with budgetary constraints, the VA made decisions that adversely affected patient care in order to save money. Increasing the opacity of these accounts will likely heighten these pressures and further dissuade medical centers from requesting additional funding that will trade-off with funding for other, VA-centric programs.

I remain encouraged by the work of this Subcommittee to ensure Veterans receive the best healthcare and services possible. It was my pleasure to testify before you today and offer my insights upon the state of the VA today. Thank you.