

**VA AND ACADEMIC AFFILIATES: WHO'S
BENEFITING NOW**

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INVESTIGATIONS
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VA AND ACADEMIC AFFILIATES: WHO'S BENEFITING NOW

Thursday, June 8, 2017

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON DISABILITY ASSISTANCE
AND MEMORIAL AFFAIRS,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 10:08 a.m., in Room 334, Cannon House Office Building, Hon. Jack Bergman, [Chairman of the Subcommittee] presiding.

Present: Representatives Bergman, Roe, Poliquin, Arrington, Kuster, Takano, and Sablan.

OPENING STATEMENT OF JACK BERGMAN, CHAIRMAN

Mr. BERGMAN. Good morning. This hearing will come to order. I want to welcome everyone here today.

This hearing is a follow-up to the one held last year around this same time on the VA–Academic Affiliate relationship. Unfortunately, one year later, the same concerns persist and VA appears to have not done anything to improve its position with the affiliate and make itself more of an equal partner.

As I prepared for this hearing and reviewed the relevant information, the same two words kept popping into my head: oversight and accountability. Where are the oversight and the accountability? These are the two things constantly lacking with the VA and this issue is no different.

At the budget hearing held just two weeks ago, Secretary Shulkin was asked about the VA's research budget. His response was that VA research is very important and it needs to find ways to continue to invest in its research.

Well, VA has an avenue that it is not properly utilizing and that is the VA Non-Profit Corporations or NPCs. These NPCs were set up to facilitate VA and promote VA research. Any money they collect by administering grants or awards is put directly back into the local VA Medical Center. Last year, they brought in over \$250 million to VA research, but this number could be even greater.

Also last year, NPCs paid salaries for an institutional review board and R&D coordinators, purchased equipment, and paid bridge funding so that VA researchers could stay on at VA and continue their research while applying for other grants. By allowing researchers to stay on, VA could continue to receive the benefit of VA physician researchers seeing veteran patients.

Despite this, many Federal grants are being awarded and administered by academic affiliates even when all research is being conducted in VA. So I am curious why in so many cases the affiliate is being allowed to administer awards and collect fees instead of the NPC when doing so prevents this money from coming back to support VA.

Think of what VA could be doing with this additional money. Wouldn't this be investing in VA research, as the Secretary noted? But again, lack of oversight or accountability is letting this money slip through VA's fingers.

VA also spends \$731 million annually on the Graduate Medical Education or GME program. But again, this is a question about the level of oversight and accountability, particularly about whether VA is getting what it is paying for.

Numerous VA medical centers have no process in place for ensuring that residents and attendees are actually in the VA clinics and seeing patients. There is no mechanism for accounting for these doctors' time and attendance. Further, VA does not have a policy in place that mandates documentation from the affiliate so that each local facility is left to handle as it sees fit, but whether or not VA receives proof of time and attendance, VA still pays the affiliate. In no other business would payment be made without proof of service, yet VA seems to think nothing of ensuring this level of accountability.

I am interested to hear from VA today on how it is ensuring that it is not losing out on what it is entitled to and how VA is being fiscally responsible in these relationships. I am also interested in hearing from the NPCs and how they could be better utilized. Either way, it is painfully obvious that reassessing these relationships is one of the many ways in which VA could better fulfill its research needs and help ensure research remains a critical component of VA care now and in the future.

I now yield to Ranking Member Kuster for her opening remarks.

OPENING STATEMENT OF ANN KUSTER, RANKING MEMBER

Ms. KUSTER. Thank you, Mr. Chairman, and thank you to our panel for being with us.

This afternoon the Subcommittee will delve into issues involving VA and academic affiliates. VA plays a vital role in our national health care delivery system. In 70 years of partnerships with its academic affiliates, the VA is the largest single provider of medical training in the United States, the largest single provider of medical training. Today, over 70 percent of health care providers throughout our civilian health care delivery system have received training through the VA.

In partnership with its academic affiliates and VA non-profit corporations, VA has also been a pioneer in the field of biomedical research.

These are two very important topics and I hope my colleagues, and especially Chairman Bergman, will schedule future hearings on the subjects, because there are so many important issues that we are trying to cover today, involving the training of health care providers, recruitment of providers, and VA research, that this hearing alone simply will not be enough.

While our overall health care system reaps the benefits of the VA's education/training efforts, VA also benefits by being able to rely on additional providers and specialists who are on the leading edge of medical knowledge and leaders in their field of practice. This is especially important to the VA, which is facing a shortage of over 45,000 health care providers. In fact, it is estimated that there will be a nationwide shortage of between 40,000 and 105,000 physicians within the next decade.

VA's relationship to its academic affiliates is essential if VA is to provide the level of health care that we all expect for our veterans, and that is why Congress, the VA and the academic affiliates must work together to address areas that need improvement.

We must do everything we can to make sure VA is able to fill all 1500 graduate medical education slots that Congress authorized under the Choice Act. I want to understand what barriers exist to filling the slots and recruiting these future providers who are completing GME rotations in VA medical facilities.

I look forward to discussing whether scholarship programs, debt reduction in student loan forgiveness programs, and even incentives to foreign-trained providers completing residencies in the U.S. could be leveraged to fill the 45,000 provider vacancies at VA.

Last Congress, I introduced the Grow Our Own Directive, we call it the GOOD Act, which would provide scholarships to veterans with military health experience to become physician assistants at the VA. I believe that programs like this should be considered, because they can go a long way towards solving provider shortage and recruiting some of our best providers to care for veterans, military servicemembers who themselves have experience providing health care to their fellow servicemembers.

I plan to introduce it again this Congress and I would love to work with my colleagues on both sides of the aisle to find the funding to support this pilot program so we can get it passed into law.

I look forward to discussing some ways that the VA can improve its recruitment and retention of medical professionals completing GME and training at VA facilities. We need to find creative ways to incentivize providers to work at VA and provide care to veterans, particularly those who live in rural areas and medically underserved areas like my home state of New Hampshire. VA's GME program and legislation like the GOOD Act are types of the creative programming that we need.

Our medically served rural communities struggle to retain quality medical providers, which hurts the quality of care in these communities. Of course, many of our Nation's veterans call these under-served areas home, and that is particularly true in the northern and western parts of my state.

It is critical that VA's GME program are mobilized to the greatest extent possible to help these shortages, and the same could be said for under-served urban areas. However, I remain concerned that rural and under-served VA facilities that may not have the infrastructure to support GME rotations are not doing more to build capacity or prioritize training for other providers that can be trained at these facilities.

In New Hampshire, for example, we have a shortage of nursing assistants. These are providers who require less training than reg-

istered nurses, but are still critical for effective health care, especially palliative care, hospice and nursing care. VA facilities can and should be working with their non-profit research corporations and academic affiliates to train nursing assistants and other providers to serve rural communities.

I know that the White River Junction VA Medical Center worked with its non-profit research corporation to provide training to VA volunteers to provide palliative care services and I want to highlight this as a success story, but I know that in other rural New Hampshire communities and across the country VA facilities are struggling to fill provider vacancies and need to do more to use training resources and opportunities with our academic affiliates and non-profit research corporations.

I also wish to examine how we can better support VA research and research conducted by our academic affiliates and the VA non-profit research corporations mentioned by Chairman Bergman.

I am concerned about the proposed \$33 million cut in the Trump budget to the VA research programs and 18-percent cut in the National Institute of Health budget. If VA's current research budget is not keeping pace with inflation and if NIH awards 5,000 to 8,000 fewer research grants, this will have a negative effect on VA's ability to develop treatment for our veterans. If funding for VA research continues to be cut, I want to know if it is possible to leverage private investment and nonprofit funding through our non-profit research corporations, as suggested by Chairman Bergman, and through our academic affiliates.

Finally, I want to ensure that VA is properly overseeing its research program and the administration of NIH-funded research through the VA non-profit research corporations and academic affiliates. I want to better understand when is it appropriate for the VA non-profit corporations and academic affiliates to administer the NIH grants and ensure that VA is following current policy directives.

Last week, I participated in a symposium at the Dartmouth Geisel School of Medicine on addressing the New Hampshire opioid crisis. Clinicians and researchers from Dartmouth, the White River Junction VA Medical Center, NIH, and hospital systems throughout New Hampshire came together to discuss how we as a community can work together to address the opioid epidemic and effectively treat chronic pain, which affects so many of our veterans in communities across the country.

I know that we have clinician researchers at VA medical centers and medical schools and teaching hospitals interested in developing effective treatments for both opioid addiction and alternative treatment for pain management. This is one of the many areas where VA should be leading the country in research to develop cutting-edge treatments to address the opioid epidemic and effectively treat and manage chronic pain, but these researchers need funding. Whether through Federal research grants or private nonprofit sources, we need to come together to figure out the best way to ensure this vital research is funded, it is administered properly, and so that this funding results in treatments that improve and in many cases will literally save veterans' lives.

Educating our Nation's health care providers and developing medical breakthroughs to provide treatment to our veterans are all part of the VA's core mission and it is vital that we as Members of Congress continue to support this mission.

So thank you, Chairman Bergman, for scheduling this hearing. I yield back the balance of my time.

Mr. BERGMAN. Thank you, Ranking Member Kuster.

I ask that all Members waive their opening remarks as per this Committee's custom. With that, I welcome the first and only panel that is now at the witness table.

On the panel, we have—and by the way, if I mispronounce your name, when you introduce yourself, please give me the correct pronunciation, please. We have Dr. Carolyn Clancy, Deputy Under Secretary for Health for Organizational Excellence. She is accompanied by Dr. Rachel Ramoni, Chief of Research and Development Officer for VHA, and Dr. Karen Sanders, Deputy Chief of the Office of Academic Affiliations for VHA.

We also have Mr. Rick Starrs, Chief Executive Officer for the National Association of Veterans Research and Education Foundations. He is accompanied by Ms. Nancy Watterson-Diorio, Chief Executive Officer of the Boston VA Research Institute.

Finally, we have Dr. Christopher Colenda, President Emeritus of the West Virginia University Health System, who is here representing the Association of American Medical Colleges.

I ask the witnesses to please stand and raise your right hand. [Witnesses sworn.]

Mr. BERGMAN. Please be seated.

And let the record reflect that all witnesses have answered in the affirmative.

Dr. Clancy, you are now recognized for five minutes.

STATEMENT OF CAROLYN CLANCY, M.D.

Dr. CLANCY. Good morning, Mr. Chairman, Ranking Member Kuster, and Members of the Committee. Thank you for the opportunity to discuss VA's research program and our relationship with academic affiliates.

As you noted, I am accompanied by Drs. Ramoni and Sanders.

For more than 90 years, VA research has contributed too many of the medical treatments and diagnostic tools in use today, including the CAT scan, cardiac pacemakers, and state-of-the-art prosthetic limbs. These achievements have resulted in three Nobel Prizes, seven Lasker Awards, and numerous other honors. VA research continues to drive advances in veteran care in areas as diverse as diabetes, spinal cord injury, mental health, and of course our groundbreaking Million Veterans Program.

In establishing the VA research program, Congress recognized both the need to study the unique needs of veterans and the opportunity for research to support excellent clinical care.

VA research plays a unique role that cannot be filled by external funding sources. Sixty percent of our researchers are also practicing clinicians at our medical centers. Unlike other Federal agencies, VA has no laboratories whose predominant function is research; instead, research studies are performed in parallel and in close proximity to where patient care is provided. This leads to a

focus on research that benefits veterans conducted by employees who are dedicated to the mission of improving care for veterans.

Our close partnership with universities allows VA researchers to be part of a much larger network of scientists and to leverage laboratory space, equipment, and expertise that may be more readily available at the university affiliate. VA research fosters dynamic collaborations with its university partners, other Federal agencies, nonprofit organizations, and private industry.

In 2017, VA researchers were able to leverage \$673 million in VA funding to bring in an additional \$595 million in external funding from industry and Federal agencies such as the National Institutes of Health and Department of Defense. The Federal investment in VA research then returns incredible value to veterans and the taxpayers, which is reflected in veterans' positive attitudes about research and health outcomes in VA.

VA-affiliated research and education corporations, also known as NPCs or not-for-profit corporations, were established by the Congress in 1988. Currently, there are 84 NPCs located throughout the U.S. and Puerto Rico. After paying their own administrative expenses, they have collectively contributed \$2.2 billion to VA research over the past decade; they employ approximately 2800 people, serve 2300 researchers, and administer 3500 research projects.

NPCs are established at VA medical centers and are state-chartered nonprofit corporations governed by boards of directors, overseen by the VHA Non-Profit Program Oversight Board. Oversight is accomplished through routine triennial on-site reviews, follow-up of past reviews, for-cause audits and investigations, the NPC annual report to Congress, education and training sessions, and ad hoc consultations.

January 30th of 2016 marked the 70th anniversary of what we call VA Policy Memorandum No. 2, a document crafted by General Omar Bradley and other VA leaders establishing the visionary partnership between VA and America's medical schools. As the Ranking Member noted, approximately 70 percent of U.S. physicians have had some part of their training in a VA facility, which means that VA is really profoundly important to medical education in this country. Many of these doctors first learned how to use an electronic health record at VA.

VA is affiliated with well over 90 percent of Doctor of Medicine and Doctor of Osteopathy-granting medical schools, and our health profession education activities include affiliations with over 1800 other schools. So that means that over 127,000 trainees received supervised clinical education in VA facilities in 2016 alone.

The VA and its academic affiliates are partners striving together for excellence in delivering the best health care to our veterans. Under the authority of the 2014 Veterans Access Choice and Accountability Act graduate medical education expansion program, VA is bringing new doctors in training, targeting primary care and psychiatry, to the rural and under-served areas where many of our veterans reside. VA appreciates the support of Congress in authorizing this initiative for ten years precisely so that some of these facilities can build the capacity that the Ranking Member noted.

We appreciate Congress' support which allows us to train future medical researchers and clinicians to care for veterans in the Nation as a whole.

Mr. Chairman, this concludes my testimony, and my colleagues and I would be happy to answer your questions.

[THE PREPARED STATEMENT OF CAROLYN CLANCY APPEARS IN THE APPENDIX]

Mr. BERGMAN. Thank you, Dr. Clancy.

Mr. Starrs, you are now recognized for five minutes.

STATEMENT OF RICK STARRS

Mr. STARRS. Good morning, Chairman Bergman, Congresswoman Kuster, esteemed Subcommittee Members, thank you for the invitation to be here today to share with you our thoughts regarding the VA's medical research program and the role in that program of the congressionally-authorized, VA-affiliated Non-Profit Research and Education Corporations, NPCs.

My name is Rick Starrs and I have served as the Chief Executive Officer of the National Association of Veterans Research and Education Foundations, commonly known as NAVREF, since January 2016. I am a proud Army veteran, having served on active duty as a Medical Service Corps Officer for 26 years, culminating as the Chief of Staff of the U.S. Army Medical Research & Materiel Command.

I was honored to join NAVREF and transition from a career supporting the health needs of soldiers to one supporting the health needs of all veterans.

I am accompanied by Ms. Nancy Watterson-Diorio, a member of NAVREF's board of directors and the Chief Executive Officer of the Boston VA Research Institute, Incorporated, BVARI. Nancy has led BVARI for 21 years, building it from a \$100,000 startup organization in 1996 to a \$14 million research enterprise today. Her experience, expertise, and leadership have been invaluable to NAVREF and I am happy to have her at my side.

NAVREF is the 501(c) (3) nonprofit membership organization of research and education foundations affiliated with VA medical centers. These nonprofits were authorized by Congress under Title 38 to provide flexible funding mechanisms for the conduct of research and education at VA facilities nationwide.

Basically, our corporations enable VA medical centers and their researchers to leverage their programs with funds from foundations and companies that the VA could not otherwise accept. The VA does not control our nonprofits, but Title 38 and the VA handbooks give the VA responsibility for oversight of their activities.

NAVREF's mission is simple: we exist to advance the success of the nonprofits. I am here today on behalf of the NAVREF board and our membership to tell you about the great work of these nonprofits, our potential for greater contributions, and areas where we face challenges. NAVREF envisions a Nation in which veterans receive the finest care based on innovative research and education.

Over the last four years, the NPCs administered over \$1 billion in support of VA research and education activities. Our member foundations have recently administered and funded research and

education projects for veterans in the areas of PTSD, mental health, precision medicine, and palliative care, among many areas.

As flexible funding mechanisms, the NPCs offer a multitude of services and benefits to VA research and education programs. These include renovating and upgrading VA research infrastructure; providing funds, staffing, and training support to VA research and institutional review boards; paying expenses related to recruitment of research investigators to the VA system; providing seed grants to new investigators to aid them in establishing their VA research careers; underwriting bridge funding for VA investigators who are between research grant awards, and procuring personnel, equipment, and supplies for VA-approved research and education projects.

NAVREF is encouraged by the approach of the VA's new Chief Research and Development Officer, Dr. Rachel Ramoni. In the short time that she has been in her position, Dr. Ramoni has reached out to NAVREF and the NPC community on multiple occasions to share information and seek partnership opportunities. She has a strong interest in bringing more clinical trials to veterans and understands the key role the nonprofits play in fostering these relationships with pharmaceutical companies and the clinical trial industry.

Secretary Shulkin and other leaders at the VA speak often about the need to partner with private industry to tap into the great ideas and willing contributors in the private sector. This is the role that the NPCs were designed to play and where we offer so much potential to the VA.

NAVREF strongly believes the NPCs offer tremendous benefits to veterans, but they are not being used to their maximum potential. NAVREF offers three recommendations: first, VA should establish clear guidelines for the administration of extramural research activities that offer the NPC the right of first refusal for all research efforts where the majority of this work occurs physically within the VA. Included in these guidelines should be a common practice for vetting conflicts of interest and ensuring those involved in the decision-making process are not conflicted.

Second, VA should review the appropriate level of oversight required to ensure the nonprofit corporations are operating appropriately and effectively while retaining their independence as nonprofit entities legislated to be flexible mechanisms outside of the Federal bureaucracy.

Third, the National Institutes of Health should modify its grants policy statement to allow our NPCs to pay VA clinicians as principal investigators on the Institute's research grants for their off tour of duty effort.

Ultimately, NAVREF and the NPCs share the same goals as the VA: to improve the lives of veterans. We only exist to facilitate and support the VA's research and education programs. My fellow executive directors and board members, many of whom are here today in the audience, are honored to devote our personal and professional energies to facilitate scientific breakthroughs that can change the lives of veterans, their family members, and all Americans.

With your continued support, the NPCs will make even more powerful contributions to the VA research and education programs and the veterans they serve.

Thank you. I look forward to your questions.

[THE PREPARED STATEMENT OF RICK STARRS APPEARS IN THE APPENDIX]

Mr. BERGMAN. Thank you, Mr. Starrs.

Dr. Colenda, you are now recognized for five minutes.

STATEMENT OF CHRISTOPHER C. COLEND A, M.D., MPH

Dr. COLEND A. Thank you, Mr. Chairman and Ranking Member Kuster, and Members of the Subcommittee.

I am representing today the Association of American Medical Colleges, which is a nonprofit organization of the 147 accredited U.S. medical schools and nearly 400 teaching hospitals in this country, many of which are VA medical centers.

I am Dean Emeritus of Texas A&M College of Medicine and former Chancellor for Health Sciences at West Virginia University, and President Emeritus of the West Virginia University Health System. My specialty is geriatric psychiatry and public health.

My testimony today focuses on the specific question posed by the VA Subcommittee on Oversight and Investigation, "VA and Academic Affiliates: Who is Benefiting Now?"

Who benefits from these relationships? Simply put, veterans. Since the end of World War II, the VA and academic medicine have partnered to improve veterans' health through delivery of complex clinical care, medical and health professional education, and collaborating on veteran-centric research designed to positively impact veterans' health.

We firmly believe that without the synergistic 70-year partnership with academic medicine, the VA's ability to fulfill its three statutory missions of patient care, research, and education would be limited.

Residency training, also known as GME, as conducted within the VA is high quality and conforms to expectations and standards set forth by the Accreditation Council for Graduate Medical Education, or the ACGME. ACGME sets general institutional standards and residency-specific competencies that guide graduate medical education. ACGME insists upon multiple training experiences in order to ensure that future physicians possess clinical competencies to treat diverse patient populations. The VA training sites fall under the accreditation sponsorship of medical schools and teaching hospitals, and are an important clinical setting to acquire the technical and cultural competencies to treat veterans.

Through a variety of mechanisms, the VA and sponsoring institutions ensure accountability for the quality of residency training experiences. For example, the VA mandates that sponsoring institutions maintain accreditation with the ACGME; surveys of both residents and faculty are conducted annually to ensure program effectiveness; time and attendance reporting of the VA and CMS are well documented, and there are policies and procedures in place to remedy resident clinical performance and professionalism problems should they arise.

In response to the nationwide physician workforce shortages, the U.S. needs to train more doctors. The AAMC appreciates the additional 1500 GME slots that the VA has been authorized. However, most residents spend about a third of their time in the VA and the remaining two thirds of time throughout other rotations with their clinical affiliates. So the VA cannot go it alone.

Unfortunately, GME growth at academic affiliates has been stymied by caps on Medicare support by the Balanced Budget Act of 1997. To address this issue, the AAMC endorses the Resident Physician Shortage Reduction Act of 2017, which would allow Medicare to support 15,000 new slots over five years and to provide a preference for teaching 15,000 new slots over five years, which would allow teaching hospitals that are affiliated with VAs.

Additionally, the VA encourages Congress to establish a mechanism to provide VA and Medicare funding for the 1500 residents while they rotate through teaching hospitals that are already above the Medicare cap.

Beyond increasing GME, the VA can adopt existing Federal public service programs tied to medical school and residency training to help recruit and retain physicians and future VA leaders in their careers. Successful models that the VA could emulate include the DoD's Health Professionals Scholarship Program, the National Health Service Corps, the Conrad 30 Visa Waiver Program for immigrating physicians, and the Uniform Services University of Health Sciences partnership with the Public Health Service.

As you know, the history of research within the VA is a source of national pride that has focused on the needs of successive generations of veterans. We need to have sustainable funding for current and future needs for research addressing veterans' health care needs. Academic medical centers have been and continue to be a high-valued partner for VA research enterprise. Among the many benefits include expert peers, research libraries, IT support, grants management expertise, IRB and other animal oversight care committees, which may not be necessarily found within the VA.

We also support ways to overcome bureaucratic barriers that limit the effectiveness of the VA academic medical center collaboration. For example, to reduce duplicate of compliance training at both VA and AAMC affiliates; for example, human subject privacy, data security, and animal care training manuals.

Because NIH-award administration is dependent upon a variety of local factors, the AAMC believes that administration of NIH awards should be determined at the local level and VA should use the same time-and-effort reporting system for faculty researchers as NIH, other Federal agencies, and university-affiliated schools.

And last, the AAMC and its members are proud of our clinical affiliations and clinical services agreement with local and regional VA centers. The AAMC recommends several things to preserve and enhance these relationships.

First, retain academic affiliations as a part of the core network of VA care, streamline the processing for direct contracting with academic affiliates by eliminating or raising the \$500,000 review trigger to more aligned with current clinical cost; develop pre-approved and national templates, and also set standardized overhead rates to eliminate unnecessary negotiations and contract delays;

and, finally, the Enhanced Veterans Health Care Act of 2017 would improve joint ventures with academic affiliates for health care resources, including space and equipment.

We believe that the VA is at a crossroad. This is a time of great opportunity for the VA and academic medicine to reaffirm our commitment to serving those who have served this Nation. The AAMC and its member institutions will continue to work with Congress and the VA to find effective solutions moving forward.

Thank you and I look forward to your questions.

[THE PREPARED STATEMENT OF CHRISTOPHER C. COLEND A APPEARS IN THE APPENDIX]

Mr. BERGMAN. Thank you, Dr. Colenda.

The written statements of those who have just provided oral testimony will be entered into the hearing record.

We will now proceed with questioning and I would like to open the question.

Dr. Clancy, what is the role of your office as it relates to research and development and academic affiliations, and do either of these offices report directly to you?

Dr. CLANCY. So my office has a very important role under the heading of Organizational Excellence. That includes a great deal of oversight and assessing and improving the integrity of our operations throughout the health care system.

My closest working relationship on a day-to-day basis is with the Office of Research and Development, in part because our other strong function is actually developing and implementing strategies to improve care for veterans as rapidly as possible and a big part of the Office of Research has a very strong research partner, right? If you implement a program and it looks like things got better, you'd like to know that it will work every place that people try it and so forth. So that has been a very strong relationship.

In addition to that, I serve by virtue of my background in research, I ran a research agency at HHS before coming to VA, as the central office official for our institutional IRB, which actually reviews grants for multi-site studies, which is an increasingly big part of our research program and one we have had some very good conversations with NAVREF about.

Mr. BERGMAN. Okay. Do they report directly to you or not?

Dr. CLANCY. No, they do not.

Mr. BERGMAN. Okay. Dr. Ramoni, I understand you are new to your position and have done several site visits. In learning about VA research locally, do you think that the relationship with the academic affiliates is unbalanced with researchers favoring university and not the NPCs for administering research?

Dr. RAMONI. Thank you, Chairman Bergman, for your question.

I am new to my role. I have been here in this position for about five months, drawn to it by the mission to serve veterans and our country by serving veterans.

I have performed so far six site visits in my four and a half months and what I have learned is that there is an individual relationship at each one of those sites between the NPC, the academic affiliate, and the VA medical center. And I have heard anecdotes about one being preferred over the other and because of that we

are going to undertake an independent review of all of the different relationships at all of the different 84 sites where we have a non-profit and academic affiliate in a VA medical center to better get a handle on what is happening at each one of those sites, moving beyond anecdotes to data on the whole system.

Mr. BERGMAN. Thank you. Again, Dr. Ramoni, what are the benefits of having VA NPCs administer Federal funding to research studies?

Dr. RAMONI. So there are several benefits. So grants come in different types. Sometimes a grant is a total-cost grant, that means the money they give you, if they give you a hundred dollars, that has to include your overhead costs plus the money you are going to use for research. When you have lower overhead costs, it means you have more money for research. Because the nonprofits typically have lower operating expenses, that means it leaves more money for research when you put it through a nonprofit, when you have a total-cost grant.

Now, not all grants are total-cost grants. Some grants just give you a dollar for research and on top of it they give you your overhead costs. So that is one of the benefits.

Another benefit is that there is a really close working relationship with a nonprofit. Oftentimes, the nonprofits are on site at the VA. When I visited Pittsburgh and I visited Chicago, for instance, they are actually on site and have clinical research facilities on site.

In addition, the nonprofits also administer IPAs, which allow hiring of personnel that would be difficult at the VA very quickly through the nonprofit.

Mr. BERGMAN. Thank you.

Ms. Watterson-Diorio, what advantages do you see in having the NPCs administer the research awards conducted at the VA?

Ms. WATTERSON-DIORIO. Thank you for your question, Chairman Bergman.

I believe that the advantages of VA NPCs administering such awards are that the VA NPCs exist solely to support veterans research. We are there, as Dr. Ramoni said, most of us on site, available to answer and be available for pre-award and post-award counseling, expertise. The dollars that are available through our organizations are exclusively used for research and the missions that you were talking about in your opening, as well as what Dr. Clancy and Rick also mentioned about being able to support back to the VA. All of the dollars are there for the VA.

Mr. BERGMAN. Thank you. I see my time has expired.

Ranking Member Kuster is recognized for five minutes.

Ms. KUSTER. Thank you very much.

This is aimed for Dr. Colenda, but if anyone else has anything to add. I have been very involved with my colleagues on both sides of the aisle in a task force to combat the heroin epidemic and a lot of this, I think we have an opportunity to work with the VA and with the medical schools.

We had research at our task force recently from experts that medical education curricula lacks focus on pain management, substance use disorder, and complementary or alternative medicine, particularly with regard to chronic pain.

And first, if you know this information, could you describe those components of medical education? And then I would like to get into if the VA could help us lead the way to better research, but also actually changing the education of our medical professionals.

Dr. COLEND. Thank you, ma'am, for asking that question, because I think it does get to the heart of the current epidemic of opioid addiction in this country and the adaptation of medical school and graduate medical education curricula to address that issue.

I would say that because of the increased awareness of opioid addiction at the undergraduate medical education level, that is in the first four years of the school, there has been a rapid adoption of curriculum that addresses both the basic science and the clinical science of opiate addiction to help improve and give competencies to medical students to be able to understand the addiction problem that's found.

As we move into graduate medical education, there is increasing focus on appropriate prescribing practices for pain management in a peri-operative or post-operative period, as well as training for those of us who are in psychiatry and behavioral health, in order to better understand the treatment paradigms and the best practices available for reducing opiate dependence for those people who are already addicted.

As you move into continuing medical education, many states are now implementing program modules for continuing medical education which requires physicians to be able to document in their CME profile that they have had additional expertise in substance abuse and prescribing practices.

So it's a curriculum that builds upon itself. It is relatively new, because the awareness of the epidemic is new, but I believe that medical education across the continuum is beginning to address this in a more effective way.

Ms. KUSTER. Yeah, I would very much like to work with you going forward, because one of the things we are considering is more of a national standard to make sure that everybody gets up to speed quickly.

Dr. CLANCY. If I could just add briefly?

Ms. KUSTER. Sure.

Dr. CLANCY. Although Dr. Ramoni reminded us that the plural of anecdotes is not data—

Ms. KUSTER. Yes.

Dr. CLANCY [continued]. —I do know of a number of instances where some of our experts in VA facilities have been hugely helpful to academic counterparts, particularly confronting an acute situation. And frankly, thanks to the support that we have received from the Congress through the Care, Addiction and Recovery Act, I actually think this is a potentially very exciting landscape for even more collaboration between VA's and academic medical centers.

Ms. KUSTER. Excellent. Thank you, thank you very much.

Just to get to the meat of the matter, under the Choice Act you talked about the VA residency training program was increased by 1500 positions, and I think this actually probably goes to either Dr. Colenda or Dr. Clancy, my understanding is only 547 have been

awarded, and I am wondering what is impairing VA's ability to get the new positions out the door and do you need our help to make this happen?

Dr. CLANCY. Just before I hand this Dr. Sanders, who knows all the details very well, I will simply say that in your opening statement, Congresswoman, you actually referenced the need for the right infrastructure in rural and under-served areas, and that have been a very strong focus of the Office of Academic Affiliations.

So we share the excitement that created this opportunity and I will turn it to my esteemed colleague.

Dr. SANDERS. Thank you, Dr. Clancy.

So we agree that we have allocated 547 positions after three rounds of the VACAA GME expansion, that third round of residents will not start until July 1st of this year. So really we are still very early into this process. The legislation was only passed less than three years ago and we have had to build a process of going to rural and under-served VAs, finding academic partners, planning and then building residency programs that then get accredited, as Dr. Colenda mentioned; and then putting in place the capacity at those small VAs to have faculty, to have an education office, to have protected time, to have computers and team rooms, and all the things that make a program run.

So I believe actually that the 547 positions is very good news, but we do thank you for extending the initiative to ten years. Thank you.

Ms. KUSTER. Great. Well, we are happy to work with you going forward to make sure you have the resources.

And I yield back. Thank you, Mr. Chairman.

Mr. BERGMAN. Mr. Arrington is recognized for five minutes.

Mr. ARRINGTON. Thank you, Mr. Chairman.

Dr. Clancy, help me understand the research operation there. How much of the research done is contracted out or outsourced to an affiliate like a university versus internal? Is it a hundred percent or is it some mix?

Dr. CLANCY. So all of the research that we fund from VA, it is an intramural program, which means that it goes to VA investigators.

Now, many of our investigators, I mentioned that 60 percent are practicing clinicians in our system, in order to qualify for grant funding, physicians have to have a five-eighths appointment, that is to say a little over half their time dedicated to work at the VA. Many of them also have another appointment in a department at the university affiliate, a situation they find very, very rewarding, because they have great colleagues on both sides, if you will.

Mr. ARRINGTON. Would you change that construct, would you change it for more flexibility, or is there any changes to that mix that would help us in pursuit of better research opportunities and outcomes?

Dr. CLANCY. The one other thing I should have just mentioned was our investigators can and do apply to other Federal and private sources for external support, that is the \$595 million figure that I mentioned in the testimony where our investment was \$673 million, but that leveraged, if you will, an additional \$595 million from other sources.

Mr. ARRINGTON. Like in NIH, NSF, et cetera?

Dr. CLANCY. And Defense, yes.

Mr. ARRINGTON. The indirect costs versus direct research, are the indirect costs the same or similar to the NIH and other research programs within the Federal Government?

Dr. CLANCY. VA cannot return—get indirect costs directly, that is why the role of the not-for-profit corporations is very, very helpful. It is, as the Congress designed it, a very flexible funding vehicle and that way we can't actually accept the indirect costs for these grants directly to the VA.

The rate that we get tends to be lower than most university affiliates. So I believe that it's about 27 percent, as opposed to 50 percent or higher for most academic affiliates.

And, Dr. Colenda, if that is hyperbole at all, please let me know.

But, in general, the rate is lower for us.

Mr. ARRINGTON. In terms of research dollars, has it gone up, down, or flat over the last three to five years?

Dr. CLANCY. Dr. Ramoni?

Dr. RAMONI. Thank you, Congressman, for your question.

So it had been flat and then we had an increase in the 2017 budget, primarily due to funding given to the Million Veteran Program for sequencing, for genetic sequencing of individuals in the Million Veterans Program, and you have seen in the President's budget a decrease is proposed.

Mr. ARRINGTON. To whom do you report the outcomes of that research?

Dr. RAMONI. So the outcomes of the research are reported in several ways. Because they have different impacts to the scientific community, they are reported through scientific journals. To the health professions community, also reading the scientific journals, we add professional conferences. I was just in Chicago where they had the clinical oncology meeting. We also have connections to the VA itself, obviously. So—

Mr. ARRINGTON. Well, let me just, let me make it clear.

Dr. RAMONI. Please, yes.

Mr. ARRINGTON. As a fiduciary, do you report your outcomes to this Committee or to the VA Committee when you are justifying more investment in research because of the efforts, the success rates, the discoveries? Who do you justify it to as a fiduciary of the dollars that you have in research?

Dr. RAMONI. That's a very good question. I don't believe we currently formally report our outcomes, but I will take that for the record to confirm; I want to get you the right answer.

Mr. ARRINGTON. Thank you.

And then who sets the agenda, the research agenda?

Dr. RAMONI. So the agenda, like NIH, some of the agenda is set by the investigators. And I want to point out that the investigators, the people applying for the grants, 60 percent of them are clinicians. So they are people working with veterans who know the needs of the veterans firsthand. So they apply for awards and we fund them on the basis of their merit.

In addition, we have targeted grants. So for instance, our largest area of funding, some of our largest areas of funding are aging,

PTSD, traumatic brain injury, suicide prevention, areas that you would expect that are of great importance to veterans.

So some of the agenda is set centrally, but we allow the investigators to respond to needs that they are seeing on the ground, to apply for grants independent of that agenda.

Mr. ARRINGTON. Mr. Chairman, I know I'm out of time, but would you mind circulating the answer to the question about outcomes and the fiduciary accountability?

Mr. BERGMAN. Absolutely.

Mr. ARRINGTON. Thank you.

Dr. CLANCY. So if I could just make one friendly amendment? The fiduciary accountability in terms of did the money go to the researchers and was it actually spent on research, that gets reported through the budget process, and we would be happy to follow-up with you or anyone else on your staffs for briefing.

The actual outcomes may be some period of time downstream. You know, investments in genetics today I am probably not going to be able to tell you about in October when the new fiscal year starts, but it will have payoffs downstream. Similarly, the big successes that you might hear about on the news or newspaper, wherever, probably are the results of investments made a bit of time ago.

Mr. BERGMAN. Thank you.

Mr. Sablan is recognized next for five minutes.

Mr. SABLAN. Thank you very much, Mr. Chairman.

Good morning, everyone.

I am from the Northern Mariana Islands, which is designated as a health profession shortage area. Unfortunately, because we do not have a teaching university, our hospital, our only hospital actually does not even qualify for the J-1 program. We have tried looking into that. But what would have to be done to create an affiliation between our hospital and the VA and establish a GME program? One.

I also understand that the Veterans Administration offers planning grants and infrastructure grants to help with establishing affiliations and filling slots. Could those funds be available to help the Northern Mariana set up the program there?

Dr. SANDERS. Yes, sir. Thank you for that question.

In our Veterans Access, Choice and Accountability initiative we have three levels and types of funding, as you've said. The first level of funding is the planning grant where we pay the VA to protect the time of an individual, so they can go out and seek academic partners to begin to plan for GME. These planning grants usually are awarded three to five years before the first resident might ever start.

The second level of funding, as you have suggested, is the infrastructure component. That usually is awarded between zero and two years before a resident is supposed to start and that's the grant that actually builds capacity at the local VA. They already have an academic partner that is willing to send trainees and now we have to build up the faculty, protect their time, make sure the support staff are in place, and make sure the patient population and everything else is ready to go.

And then the third component of funding is the residency funding itself.

And, yes, we would be happy to work with you, sir.

Mr. SABLAN. And you are saying even if we don't have a teaching university, it is possible?

Dr. SANDERS. Right. I would say there are flexible mechanisms and we would look to find you a partner, sir.

Mr. SABLAN. Thank you. Thank you very much.

I yield back.

Mr. BERGMAN. Thank you.

Mr. POLIQUIN is now recognized for five minutes?

Mr. POLIQUIN. Thank you, Mr. Chairman, very much, and thank you all very much for being here.

Dr. Clancy, I would like to start my questioning with you, if I may, please. Walk me through an example, if you don't mind, of the great research that is done on behalf of our veterans both at the VA and at outside affiliates.

And I believe a type of outside affiliate that you have a relationship with or VA does are universities, correct?

Dr. CLANCY. Yes.

Mr. POLIQUIN. Okay. My alma mater is Harvard, so I'm not picking on Harvard, but we will use them as an example. Okay. So let's say there is a \$3 million grant that Harvard or somebody at Harvard, an employee there or a professor there says, we need a grant to do specific research on how to put in a pacemaker better than has been done in the past. They apply to the VA for a grant, correct?

Dr. CLANCY. If they have an investigator who has a five-eighths appointment, they can apply to VA, yes.

Mr. POLIQUIN. Okay. So there is some mechanism that I don't understand, but that's okay, there is some mechanism for Harvard to apply to the VA for a grant?

Dr. CLANCY. Yes.

Mr. POLIQUIN. Okay. Let's say the grant is \$3 million. Okay. And does all three million of that dollars, taxpayer dollars that are designed specifically to help our veterans, does that go to the research, 100 percent of it?

Dr. CLANCY. So our program, Congressman, is an intramural program and generally we are funding VA investigators. Many of those investigators in your example might have appointments at Harvard as well. So where the money flows, a lot of that is going to depend on how much it is done at Harvard or sites outside of VA.

Mr. POLIQUIN. Okay. So let's stop there for a minute, Dr. Clancy. I want to make sure I understand this, is that Harvard can get a \$3 million grant—

Dr. CLANCY. No.

Mr. POLIQUIN [continued]. Okay. Harvard can apply for a \$3 million grant?

Dr. CLANCY. No.

Mr. POLIQUIN. Keep going.

Dr. CLANCY. An individual investigator who has an appointment—

Mr. POLIQUIN. Well, does the investigator work for the VA?

Dr. CLANCY [continued]. Yes, has to work for the VA.

Mr. POLIQUIN. Okay, is an employee at the VA?

Dr. CLANCY. Yes.

Mr. POLIQUIN. And what do they investigate?

Dr. CLANCY. Say they are investigating, I'll use a landmark study, whether it makes a difference to treat moderately high—

Mr. POLIQUIN. Okay.

Dr. CLANCY [continued]. —blood pressure.

Mr. POLIQUIN. So there is someone at the VA that is responsible for placing these grants?

Dr. CLANCY. Yes.

Mr. POLIQUIN. Okay. So they decide that Harvard is worthy to receive a \$3 million grant for some reason?

Dr. CLANCY. No.

Mr. POLIQUIN. No.

Dr. CLANCY. We are not funding Harvard. All of our money goes to research done for veterans.

Mr. POLIQUIN. Okay. Okay, I understand that, but if the research is done—if Harvard is applying for the grant, then Harvard is not doing the research?

Dr. CLANCY. Harvard can't apply for a grant. We would tell them, we're sorry, we only fund investigators who work at VA.

Now, a researcher who has an appointment with us, works a little over half of his or her time with the VA and also has an appointment, say they are professor at Harvard—

Mr. POLIQUIN. Okay.

Dr. CLANCY [continued]. —can apply for a grant. Not only that, they may need some of the time of some people who only work at Harvard and that would be done through sort of a subcontract.

Mr. POLIQUIN. Okay. So however the work is dispensed from the VA to the people that do the research, how much is spent on the research, how much is spent on overhead and administrative costs?

Dr. CLANCY. How much overhead? We don't do overhead, do we? We actually don't provide overhead costs from the money that we invest in research.

Mr. POLIQUIN. Is there any of that \$3 million, as an example, Doctor, that is spent on administrative overhead?

Dr. CLANCY. No.

Mr. POLIQUIN. There is not?

Dr. CLANCY. No, no. In fact, our clinician investigators, their core salaries are paid by the facility they work for, that does not come out of the research grant.

Mr. POLIQUIN. Oh. So you're saying, you're saying, if I understand this correctly and I can't possibly understand the road map that goes from the taxpayer to the VA to getting the research done, you're saying right now that there is no overhead and the money dispensed from the VA to do this medical research is 100 percent spent on medical research; is that correct?

Dr. CLANCY. Yes. And in fact it is supplemented, because our facilities invest in the core salaries of the people who do the work and for many, many research investments, a huge investment is the time that people devote to the work.

Mr. POLIQUIN. Talk to me a little bit about the internal process in these investigators again, how does that work?

Dr. CLANCY. Like any other research institution like the National Institutes of Health and so forth, if I am an investigator and I have a brilliant idea, whether or not I have an appointment at Harvard, I write up a grant application and it is submitted through a formal process, and it is reviewed by scientific peers. That has been the longstanding standard of how we evaluate whether this application is promising and, frankly, whether a group of well-established and recognized scientists believe that I, the investigator, can actually accomplish the work that I have laid out.

Mr. POLIQUIN. Thank you, Mr. Chairman. I yield back. Are we going to have a second round of questioning?

Thank you, sir.

Mr. BERGMAN. Thank you.

Mr. Takano, you are recognized for five minutes.

Mr. TAKANO. Thank you, Mr. Chairman, and thank you, Ranking Member Kuster, for allowing me to be present on a Committee I do not formally serve on. And I just could not pass up the opportunity to hear more about graduate medical school education at the VA.

I was proud to have a part in championing the 1500 residencies in the Choice Act during the conference committee phase and I am thrilled that a dozen slots have been awarded to the Inland Empire region of Southern California and my community. In fact, I met last week with psychiatry residents and, as we know, psychiatrists are in short supply at the VA and also in the general population in many parts of our country.

I want to just reach out to my Republican friends on the Committee, especially from rural states. I really believe that the GME opportunities we have here are a part of a solution to our shortages in rural communities. In fact, I met last week with psychiatry residents at UC Riverside School of Medicine who will be getting part of their training thanks to the VA.

I want to continue along Ms. Kuster's line of questioning. Dr. Clancy, is the VA on track to filling all 1500 slots by 2024, or are we going to pass another extension?

Dr. SANDERS. Thank you for that question, sir.

We believe within the ten-year milestones that we will be able to fill the 1500 slots. The first round, if you remember, we awarded about 200 positions and we believe that was from pent-up demand for residency positions, especially in psychiatry and primary care. And in the second round we had a dip, about 168 or so—and don't quote those exact numbers—but now we are seeing an uptick. And in fact we have just opened the fourth round of awards and we are seeing over 250 applications for new positions.

So we have worked very hard in my office over the last two years to build this capacity out in the rural and under-served areas and at the small VAs, and we think it is bearing fruit already and we are seeing that in the number of applications.

Mr. TAKANO. I did not realize that it took such amount of time to—for the rural areas, the underserved areas, to actually gear up and ramp up to be able to take advantage of those. And in some ways I am glad that the bulk of these residencies didn't go to the preexisting strong areas. I mean, we really got to—that's my con-

cern is that we make sure the opportunities that we have here are spread around.

Dr. SANDERS. Right. So the goal was not to get to 1,500 as fast as we could, I totally agree with you. If that was the case, we probably could have spread them around very fast within five years. But the goal was really to meet the legislative intent which was to concentrate on primary care and mental health, which is what the country needs, and to also distribute GME into rural and underserved areas, and assist the VA and their communities around the VAs with the workforce pipeline that they need and deserve.

Mr. TAKANO. I represent an urbanizing area, but many of what we call red states and rural areas, they are in great need of these residencies, and many of our veterans move to rural areas because they prefer them—it is less stressful, less noisy—and we have got to find ways to get these medical professionals into these rural areas. And we know that residencies—where they do their residencies, you know, give a 60 percent chance that that resident will become a doctor in that community and stay in that community. And I think this is an amazing opportunity.

Apart from increasing the medical GME caps, which is outside of the jurisdiction of this Committee, what else can we do to fill these slots?

Dr. SANDERS. I think we have focused on the Medicare cap as a major barrier to expansion of VACAA; basically because of the lack of funding at our academic affiliates due to the Medicare cap they are unwilling to either start up or expand new residency programs. And I might turn it over to Dr. Colenda to comment more about that.

Dr. COLEND. Thank you for the question because it is an important question, it gets to the maldistribution of residency spots in the United States as well as the fundamental funding challenges that academic health systems and teaching hospitals have face since 1997. And most of the expansion of residency slots have been out of hospital operating revenues. So resident slots have increased since 1997 but it has been funded by the health systems. And so when the VA—

Mr. TAKANO. When you say “health system,” you are talking about hospitals themselves—

Dr. COLEND. Hospitals, right.

Mr. TAKANO [continued]. —because there has been a cap on the Medicare funding?

Dr. COLEND. A cap on the Medicare funding. So at West Virginia University Health System we were well over 110 or so slots above our GME cap that was set in 1997. We pay for those positions out our hospital operating revenue.

So when you have an influx of new resident slots, and because of the accreditation requirements for multiple training sites to round out our residents training expectations, sometimes it is very difficult to incorporate that infusion of money from one sector without having an appropriate amount of increased funding in the other side of the balance sheet, so to speak, for residency funding.

So it takes time for hospital systems to adjust in terms of raising their total number of positions available so that the residents who are principally getting their funding from the VA may also have

the opportunity to experience training in other sites that are necessary to meet the ACGME requirements for training and the residency review competencies.

Mr. TAKANO. I understand we will have a second round of questions.

Mr. Chairman, I am sorry I went over my time.

Mr. BERGMAN. Before I recognize Dr. Roe for questions, Mr. Takano brought up a good procedural point. Unless I hear an objection, I ask unanimous consent that Mr. Takano be allowed to continue participating in the hearing should he decide to do so.

Hearing none.

Welcome.

Mr. TAKANO. Thank you, Mr. Chairman. Sorry, I have to leave.

Mr. BERGMAN. No problem.

Dr. Roe, you are recognized for five minutes.

Mr. ROE. I am totally confused now. What just went on?

Mr. BERGMAN. We had an interloper.

Mr. ROE. Okay. Thank you, Mr. Chairman. I would like to thank the witnesses for being here today to address this very important topic.

And we have heard from many facilities that there may be undo pressure on VA by university affiliates. The leverage, of course, is that the affiliate provides personnel that are needed by the facility and the facilities are afraid of losing the trainees. On the flip side, however, without the VA facility, affiliates would lose essential educational opportunities. While I realize that VA/university relationship is crucial, VA's staff should not have to choose what is best for our veterans while being pressured by an affiliate.

Further, it appears that at many facilities no process exists for determining trainee presence or the affiliates are not cooperative with the faculty—with facility education service chiefs. For instance, during a site visit at one facility committee staff was told that the affiliate refused to provide documentation of resident attendance and that the facility was afraid of actions the affiliate might take if they pushed them. At other facilities the affiliate did not get paid unless there was proof of attendance.

So there appears to be a wide disparity in what should be a consistent process across all facilities. While I understand the educational mission of VA, we are mindful that GME programs are supported by tax dollars and these dollars, although they support education, should also support veteran care.

With that in mind, I have a couple of questions. And I also worked at our university and we have a very close relationship with the VA at our medical school there at East Tennessee State [indiscernible] College in Madison. Why, and anyone can take this, but why is there such a disparity in the approaches from one facility to another? Why isn't there consistency?

Dr. SANDERS. Thank you for that question, sir. There should not be inconsistencies. Our policies are very clear when it comes to the documentation that is necessary to support an invoice from an academic affiliate for resident time and attendance. Policies have been in existence for over ten years, to my knowledge, that are very detailed and require the VA to have independent records before they will pay an invoice.

Mr. ROE. But that is clearly not happening. We found that it wasn't. So what is the penalty when you, for instance, on resident—that's a pretty simple thing. I mean, if you are getting paid, the resident, you should be able to document that resident at the facility working.

Dr. SANDERS. And there is really no problem documenting a resident's working because they are usually seeing patients and writing notes in the electronic record. In fact, there are multiple oversight processes in the resident tracking processes. Some of the oversight processes are at the national level in my office, some of the oversight processes are at the local level. But I think the principal of resident education—

Mr. ROE. No, wait. Let's just stop.

Dr. SANDERS. Sorry.

Mr. ROE. I understand all the policies are there, but it is not happening. So what happens when it doesn't happen? And whose responsibility is it to see that it is happening? And what are the consequences when it doesn't? And that's what my question is. Not that the policies are there, I know they are there.

Dr. SANDERS. Right. So basic fiscal processes require that an invoice be matched up with some documentation of what you receive even if it is a piece of machinery or a service. So these are core fiscal processes that should be working, and I am sorry that there is an example that it didn't.

Mr. ROE. And if they don't, what happens?

Dr. SANDERS. Right. So ultimately these are fiscal processes that are enforced and overseen at the local fiscal medical center level.

Mr. ROE. Okay. But what happens?

Dr. SANDERS. So I—if I hear at the national level that there is a problem with resident activity tracking, we actually go in and do a site visit, and we look at their processes. We tell them the benchmarks, and the requirements, and the standards.

Mr. ROE. Where has that happened, Dr. Sanders?

Dr. SANDERS. Where has it happened?

Mr. ROE. Uh-huh.

Dr. SANDERS. Several sites or I can get the names to you. Yes.

Mr. ROE. Okay. Thank you. And, again, the second question just dovetail on all that. Can you assure us moving forward that there is a consistent accounting of resident time to ensure that GME dollars are being spent appropriately?

Dr. SANDERS. Yes. And that gets back to the answer before, which is that resident time is highly choreographed. And they have requirements that are usually monthly and they have to go through a sequence of experiences; outpatient, inpatient, procedures, ER, et cetera. When they don't show up we know about it.

And so across 11,000 resident positions and 44,000 people it is very obvious when a resident is not doing their duty and they run the risk of not successfully completing their residency program if they don't show up for these experiences. So there is every motivation on the resident's part, the program's part, and the VA's part to have them successfully complete—

Mr. ROE. Well, I have taught residents who didn't show up. And, so, probably—I mean, most will, but I have been there when people didn't show up. And so there needs to be, again—I think from the

VA's standpoint if we are paying, and they are there to take care of veterans, we should be able to document. And then the affiliate shouldn't get paid if the resident's not there.

Dr. SANDERS. And that is absolutely the policy, sir.

Mr. ROE. I mean, it is pretty simple. Has it ever happened?

Dr. SANDERS. Yes, sir.

Mr. ROE. You have not paid the affiliate?

Dr. SANDERS. Yes. Or we have recouped money because—

Mr. ROE. On the—okay.

Dr. SANDERS [continued]. —we could not document.

Mr. ROE. I am sorry, I have exceeded my time. I yield back.

Mr. BERGMAN. Thank you. Everybody okay with round two?

I am going to defer my questions until the end. And recognize the Ranking Member Kuster for five minutes.

Ms. KUSTER. Thank you, Chairman Bergman. I am going to go back to the education of our providers on opioid safety initiative, pain management, and clinical practice guidelines for chronic pain at the VA. So this is directed at Dr. Clancy. Could you just give me an update? Dr. Colenda says that there is a new wave in medical education to address these issues given the opioid epidemic across this country. Could you tie in what the VA has been doing with regard to training on these three issues? I am sorry, there is one more. Excuse me, the complementary and alternative medicines for opioids.

Dr. CLANCY. So in the last administration the President issued a memorandum similar to but not quite the same as an executive order about reducing unsafe and inappropriate use of opioids. So I can tell you with full confidence that 98.8 percent of our prescribers have received training consistent with our guidelines and those from the Centers for Disease Control.

At that time we were not required to include residents in that. In part because many institutions were saying, well, we will be stepping forward with this training. I think it is actually a great time now for us to follow through on that commitment to make sure that it is impossible to finish training either at the undergraduate or graduate level without having been exposed to this because it is a huge problem. Certainly in New Hampshire, but you are not alone.

Ms. KUSTER. No, I think it could make a breakthrough change given that 70 percent of our medical providers are—doctors are trained through the VA. I think this could be, literally, a single step that could make the greatest difference and save lives all across this country. So I would like follow-up with you, if we could, on that.

Next, I am going to turn to the issue. Dr. Colenda, you mentioned several programs, and I think they were all instructive for us. This is with regard to what the VA can do to recruit and retain new physicians. You talked about

J-1 Visa waivers, student loan repayment through the National Health Service Corps, and a partnership with Public Health Service to place medical officers in VA clinics.

Could some of these programs or other initiatives be used at the VA? And maybe, Dr. Clancy, if you want to weigh in. Are there pro-

grams currently in place—loan repayment, waivers, that type of thing—that we could be using to fill these 45,000 empty positions?

Dr. COLEND. Ma'am, let me—I will probably hand this off partly to Dr. Clancy. But I think that there is clear evidence that with scholarship programs, for example, the Health Professional Scholarship Program, the National Health Service Corps programs, and the Conrad 30 Visa Waiver programs, they have been successfully implemented to recruit and retain folks in the specific service areas designed for those programs. For example, Army/Navy scholarships, Air Force scholarships for physicians who have an obligation to serve after they have completed their training.

Ms. KUSTER. So within the VA or in the civilian?

Dr. COLEND. These are in the military, the VA currently does not have that type of program. So if the concern for the VA is to look at their workforce in the future, downstream, these are programs that can be developed to help assure that type of commitment post-training. It is also—

Ms. KUSTER. And that would require legislation to set those up? I mean, I would like to work in a bipartisan way—

Dr. COLEND. Yeah.

Ms. KUSTER [continued]. —to pursue that.

Dr. COLEND. I would imagine, yes.

Ms. KUSTER. Okay.

Dr. COLEND. Now in terms of the value proposition for that. I think that—medical students, as you probably know, incur a tremendous amount of debt, and the loan forgiveness programs that are available can also help with incentivizing folks to work on a—in public service, let me put it that way, in a way that could be better maximized moving forward. So you have the undergraduate approach and you have the post-graduate approach, and I think combined together you could see a long-term benefit for innovative ways of helping to—

Ms. KUSTER. I am just going to cut you off because my time is very short.

Dr. COLEND. Sure.

Ms. KUSTER. If Dr. Clancy has anything to add about the VA with this recruitment and retention, or I can follow-up off line.

Dr. CLANCY. I have good news, and I may want to follow-up with you on additional authority for the kind of route that Dr. Colenda just mentioned. Where instead of having people who go to the uniform services, the military medical school going into the services, that there would be a number of slots where people could come to VAs. So we will follow-up with you on that.

The really good news is a lot of these other programs that have supported the training of people through the National Health Service Corps and others, VA facilities are now going to be an opening opportunity for that's where people can do their payback.

Ms. KUSTER. Excellent.

Dr. CLANCY. So we think—and that's very recent, so we are excited about that.

Ms. KUSTER. Excellent. Thank you very much. I yield back.

Mr. BERGMAN. Thank you. Mr. Poliquin, you are recognized for five minutes.

Mr. POLIQUIN. Thank you very much, Mr. Chairman. We are going to try this again, Dr. Clancy. Okay. Here we go. All right.

There was research performed for our great veterans to make sure we keep them healthy, both at the VA and at organizations outside the VA that they use, like Harvard.

Dr. CLANCY. [Inaudible]

Mr. POLIQUIN. Okay. Great. Now, we talked about these investigators, I think I understand this a little bit better now. An investigator is an employee of the VA paid by the VA, correct?

Dr. CLANCY. Yes.

Mr. POLIQUIN. Might that investigator also have employment, or co-employment, at an outside institution?

Dr. CLANCY. Absolutely.

Mr. POLIQUIN. So this investigator could be an employee of Harvard?

Dr. CLANCY. Yes.

Mr. POLIQUIN. And is part of his or her compensation at Harvard in part dependent upon how much research grant money they get?

Dr. CLANCY. Yes.

Mr. POLIQUIN. Oh, okay. Now we are getting somewhere.

Dr. CLANCY. Yes.

Mr. POLIQUIN. All right. So let's see if I understand this correctly. An investigator who is an employee at the VA and an employee at Harvard applies to not the VA but to the National Institution of Health or the Department of Defense for \$3 million grant, right? Okay. And someone has to administer, not do the research but do the management, administer that grant; is that correct?

Dr. CLANCY. Yes.

Mr. POLIQUIN. Could that be Harvard?

Dr. CLANCY. It could be Harvard, it could be one of the not-for-profit corporate—

Mr. POLIQUIN. Okay. It could be Harvard, right?

Dr. CLANCY. Yes.

Mr. POLIQUIN. So this gentleman or this lady, who's employee of the VA, any employee of Harvard can apply for a grant from another taxpayer pot of money, this time coming from the NIH or the DoD, his or her employment could be a function at Harvard of how much grant money they bring in, and this individual's in the position of rewarding that administration fee back to Harvard; is that correct?

Dr. CLANCY. Yes.

Mr. POLIQUIN. It is? And what, roughly, is the administrative cost to do that? What would Harvard charge to administer a grant from the NIH?

Dr. CLANCY. Harvard and all other universities have a negotiated indirect rate with all Federal funders.

Mr. POLIQUIN. Could it be as much as 50 or 60 percent?

Dr. CLANCY. Yes.

Mr. POLIQUIN. Oh, it could. Could it—

Dr. CLANCY. Harvard's is—I am sure Harvard's is more like 70.

Mr. POLIQUIN. Oh, 70 percent?

Dr. CLANCY. Yes.

Mr. POLIQUIN. Okay. So let's just roughly say it is two-thirds. So a \$3 million grant from the NIH, which is another pot of taxpayer

money, supposed to be helping our veterans here can be redirected back to Harvard who charges about two-thirds the cost of the whole grant, so about \$2 million of the \$3 million can go for overhead back to Harvard where a million bucks is left to do the research?

Dr. CLANCY. No, no, no. The \$2 million comes on top of the \$3.

Mr. POLIQUIN. On top of the \$3?

Dr. CLANCY. Yes.

Mr. POLIQUIN. Oh, okay.

Dr. CLANCY. And that's been the subject of some debate here and other Committees.

Mr. POLIQUIN. Okay. Do you see this as a conflict of interest?

Dr. CLANCY. Well, before we get there, can I just make one caveat?

Mr. POLIQUIN. Quickly.

Dr. CLANCY. All right. Having not been clear enough before. Some part of that money would also have to come back to VA. So if this person getting a grant from Harvard, also a VA employee, is working with VA people and enrolling veterans who are served by our system in their study, then some of those indirect funds would come back to the VA.

Mr. POLIQUIN. Okay. Let me ask you this, Doctor. Why wouldn't the VA, who has a nonprofit, that I believe these nonprofits at the VA were specifically set up to administer this overhead in 1988; is that right?

Dr. CLANCY. I thought that as well, Congressman. They actually had a broader purpose which was to be a flexible funding—

Mr. POLIQUIN. Okay. Can the VA administer these grants coming from the NIH or DoD, yes or no?

Dr. CLANCY. No. No.

Mr. POLIQUIN. They can't?

Dr. CLANCY. Some of them just depend on the affiliate to do it directly.

Mr. POLIQUIN. Okay. So there is no entity—there is no nonprofit entity affiliated with the VA that can do this administrative work?

Dr. CLANCY. Eighty-three of our facilities that have university affiliates—eight-four, excuse me, also have a not-for-profit corporation.

Mr. POLIQUIN. Okay. So there is a VA type entity that can do this administration?

Dr. CLANCY. Yes.

Mr. POLIQUIN. Don't you do—

Dr. CLANCY. But not all of our VAs—

Mr. POLIQUIN [continued]. Let me—

Dr. CLANCY [continued]. —who do research—

Mr. POLIQUIN. Don't you do that, ma'am?

Dr. CLANCY [continued]. —do that.

Mr. POLIQUIN. Isn't that what your entity does?

Ms. WATTERSON-DIORIO. I am in Boston, I know full-well, and, yes.

Mr. POLIQUIN. So you could do this administration?

Ms. WATTERSON-DIORIO. Uh-huh, I can.

Mr. POLIQUIN. Okay. Are you an employee of the VA?

Ms. WATTERSON-DIORIO. No. I am an employee of the VA nonprofit.

Mr. POLIQUIN. Okay. But some of this money would recycle back to the VA. You are affiliated with the VA, correct?

Ms. WATTERSON-DIORIO. Hundred percent.

Mr. POLIQUIN. Okay. All right. Now, my question is the following. Will somebody tell me that this is not a conflict of interest? You have an employee of an outside entity and an employee of the VA at the same time where this individual is given the authority to apply for taxpayer funding from another outside entity taxpayer funding, in this case DoD or the NIH, they can redirect that money to the entity that they work for in addition to the VA? And, excuse me, and their tenure or their success at that university is in part dependent upon how much money they can direct back to that institution. Somebody tell me this is not a conflict of interest.

Dr. RAMONI. Thank you for your question, Congressman.

Mr. POLIQUIN. Yes.

Dr. RAMONI. Having been at Harvard for 20 years myself, this speaks directly to me.

Mr. POLIQUIN. Are you an investigator?

Dr. RAMONI. I was an investigator.

Mr. POLIQUIN. Great. Okay. Now I finally got an investigator. Okay.

Dr. RAMONI. So on both sides, there are incentives to put the grant through the VA, and there are incentives to put the grant through the VA nonprofit, and there are incentives to put it through the academic affiliate. At the VA, you get additional—so in addition to your grant funding, so let's say you bring in a buck of grant funding at the VA, the VA will supplement that with what is called VERA dollars; Veterans Equitable Resource Allocation dollars. And, in fact, I get more VERA dollars if I put it through the VA nonprofit.

Also, my promotions happen at the VA. I have just signed off on promotions. So there are a lot of factors that may, in fact, you know, you do get benefits at the VA for putting your grants through the VA, the nonprofit may get me somebody to work for me.

Academic affiliates. Academic affiliates also perform some of the overlapping functions of the nonprofits. Academic affiliates actually employ people who work at the VA as well. Academic affiliates also—

Mr. POLIQUIN. What does it cost to do this administrative work at the VA nonprofit as compared to what it costs at—and by the way—

Dr. RAMONI. Yep.

Mr. POLIQUIN [continued]. —I loved my four years at Harvard, I am not picking on my alma mater, I am just using it because they are the high-priced folks in the room, right.

Dr. RAMONI. I don't think they will take it personally.

Mr. POLIQUIN. Okay. So is it cheaper to have the administrative done at the VA nonprofit as compared to an unaffiliated nonprofit or a Harvard?

Dr. RAMONI. Well, so just like it is—

Mr. POLIQUIN. Yes or no?

Dr. RAMONI [continued]. —cheaper to eat at a cheap restaurant—

Mr. POLIQUIN. Yes—

Dr. RAMONI [continued]. —and more expensive to at—

Mr. POLIQUIN [continued]. Yes or no?

Dr. RAMONI. It is what you get for it.

Mr. POLIQUIN. Okay. So the administration is different, it is not the actual work that's going on, it is the overseeing of that work?

Dr. RAMONI. It is what you—at the academic affiliate you get access to libraries, additional laboratory space, that's what goes into overhead cost calculations. The nonprofits—

Mr. POLIQUIN. But isn't this research—

Dr. RAMONI [continued]. —don't have libraries.

Mr. POLIQUIN [continued]. Isn't this research being done at the VA in our own labs? Could it be done at the VA in our own labs at the VA?

Dr. RAMONI. So sometimes yes, sometimes no.

Mr. POLIQUIN. Right. The investigator might be doing the research at the VA even though that individual is still employed by Harvard, right?

Dr. RAMONI. Yes.

Mr. POLIQUIN. Okay. So does VA have a library?

Dr. RAMONI. The VA's library, typically, is not as good, for instance, as the Harvard library.

Mr. POLIQUIN. Oh, does it cost a lot of money to use Harvard's library? How about the library at Congress right here in town.

Dr. RAMONI. You do have to have a Harvard—you do have to have a Harvard ID to use the Harvard library.

Mr. POLIQUIN. Okay. Well, the investigators do, right?

Dr. RAMONI. Yes. But—

Mr. POLIQUIN. Did you have an ID when you were an investigator and you were working at the VA and at Harvard, did you have a Harvard ID?

Dr. RAMONI. I wasn't at the VA as well. But in order to sustain those services, Harvard sustains those services through indirect costs.

Mr. POLIQUIN. How much does it cost overhead at a VA, overhead operation, as compared to Harvard, ma'am?

Ms. WATTERSON-DIORIO. So that figure runs between 25 and 30 percent.

Mr. POLIQUIN. Oh, thank you. And we just found out at Harvard it is about 70, right? What am I—

Dr. RAMONI. That's correct.

Mr. POLIQUIN [continued]. —missing here? What am I missing here, Mr. Chairman? Is that we are spending two or three times as much to send money to an institution like Harvard when it could be done at the VA, and we have the folks that are working at both entities redirecting money back to the more expensive place. What the heck am I missing here?

The funding of the VA has gone from \$120 billion to \$180 or \$190 billion over six years, we are \$20 trillion in debt, we got our vets coming back from the Middle East that need help, and we are spending money like this? What am I missing here?

Mr. BERGMAN. Thank you.

Mr. POLIQUIN. How much more time could I have? Thank you. I yield back.

Mr. BERGMAN. Well, days, but the—well, thank you. Thank you, Mr. Poliquin.

Dr. Roe, you are recognized for five minutes.

Mr. ROE. Thank you, Mr. Chairman. Couple things that I want to go in first and then. Dr. Sanders, according to VA testimony, the VHA has the second largest funder of GME. And during the Committee site visits we learned that many medical centers are having difficulty tracking residents' rotations. In one location this resulted in overpayment of \$1.725 million. Do we have a plan to not only track the residents but to also collect the money that's owed to the VA?

Dr. SANDERS. Thank you, sir. Yes. When we find out there are difficulties at a particular site, as I said before, we do do site visits and we train the staff to do the right procedures according to our policies. Our policies are very specific and some of these are actually some very basic fiscal policies. Like when you get a bill, don't pay it until you know it is right, and things like that. So those are the standards we go by in OAA and those are the standards our fiscal colleagues go by as well.

I think that resident time and attendance is a responsibility of the VA ultimately because we are paying the invoice. And we disseminate best practices in every way we can. We train every education leader out there; we train their staff; we have regular conference calls; and we have an annual conference to try to teach them the right way to do these processes. But we are happy to go in and assist people if they are doing it wrong or we find out that—

Mr. ROE. Well, these are—I mean, these are not our—these are our partners in educating people, I mean, we are not an adversarial, and that's clearly not what this is intended to be. But the question is if the policies were all right, how do you explain a \$1.7 million overpayment?

Dr. SANDERS. Well, truthfully, \$1.7 million in a very large budget may be less than one percent.

Mr. ROE. Well, where I am, and where I live, \$1.7 million is still a lot of money.

Dr. SANDERS. It is.

Mr. ROE. And that's just one institution. And who knows what it is over a lot. And, again, these are academic affiliates at the VA, for the most part, has a great working relationship with, not an adversarial relationship—I want to be sure I get that on the record—it is not. But it looks to me like either the VA or the academic affiliate is dropping the ball somewhere if there is those kind of disparities out there. And we don't know the magnitude of it because, obviously, we have a lot of them, and I want to encourage them.

I mean, the medical school where I am and taught, was started there because of the VA. There were five in the country, they were started in the late '70s early '80s, that had to be affiliated with the VA, that was the specific bill that was passed, that's how it had to happen. So it is a real close relationship. As a matter of fact, the medical school is on the VA campus. So it is a positive relationship, the question is the accounting doesn't seem to be right in some of these.

Dr. SANDERS. Right. I actually agree with you, sir. A lot of this is the training of what we call—used to call the Associate Chief of

Staff for Education, now we call this the Designated Education Officer. They are the single responsible individual at every VA that oversees all clinical training education, and is responsible for the time and attendance procedures. When we have turnover in that role, procedures may suffer. But we are there to train and develop the proper procedures at each site.

Mr. ROE. Well, first of all, Dr. Colenda, thank you for the years that you have put in. I don't know whether you were at the AAMC meeting when I spoke the other day, but I appreciate your training residents at West Virginia University for all these years, and young physicians to go out and fill these spots. And, certainly, what I would like to work with the VA on is these—I think Mr. Takano was talking about it, are these 1,500 slots in primary care that are not fully implemented yet three years into it.

And that's not easy. I know finding teachers and time to do it takes a lot of time, and takes time away from your clinical obligations. And it is one of the reasons that I put a bill in, we haven't figured out how we are going to fund it yet, but to provide scribes for doctors so they will have more time to be with patients or even to teach. So I would like to work with you all.

I know I have talked to VA before about doing this. I really want to get this implemented because we have a shortage coming out there of not only doctors but nurses and other health care providers in this country. My local hospital system, I was driving in the other day to the office here and I heard this advertisement on FOX News, I was listening to it on the way in, and this is their national news about Mountain States Health Alliance advertising for nurses, and paying—and I am thinking, well, there are a lot of mountain states, then I realized it was hometown that was advertising nationally for nursing personnel. I think you are seeing the same thing in medicine.

And in our state of Tennessee, the last statistic I saw were 26 percent of doctors actively practicing in the state are over 65 years of age. So we have a manpower shortage that is huge coming up. So I think it is critical that the VA get this done, and sooner rather than later.

Dr. COLEND. Thank you for that commentary. I was actually one of the deans of one of those five VA medical schools—

Mr. ROE. Yeah, I know you were.

Dr. COLEND. [continued]. —out in Texas. I think the health professional shortage is going to be an increasing problem over the next 10 to 15 years because of the changing demographics of our country.

I think that—the other thing is I have said is that, to me, health care now is practiced in teams. And to be able to ensure that the health care team has physicians, and nurses, and other types of health professionals to deliver care to patients, whether it is VA patients, veterans, or the civilian population is an important concept, and educational concept, to have you take away because it is not just dumping money into medical education, it really needs to be a broader platform for health professions education.

I would also like to share with you and compliment Dr. Sanders for being able to take the specific questions about the billing and

the transactional nature between the VA and the academic institutions for GME.

On the sponsoring institution side of that equation, that is the universities and teaching hospitals where the program is accredited, we take accountability equally important because failure to do so not only runs problems with the VA but also can have problems with CMS in terms of Medicare support for graduate medical education. It also has challenges for, as a former CEO of a health system, for my board of directors, because they ask me—“help me understand this GME line that is now part of the operating budget for your health system.”

And so this whole issue of the transactional nature of funding residency training and the accountability of such is first and foremost part of the culture of the graduate medical education experiences today. Will there be errors? Will there be problems in that? And we should expect 100 percent precision but when there is not 100 percent precision the key element is how can we address those short changes to be able to fix the problem because none of us want to lose our accreditation for our residency training programs. And this can get tied back to accreditation.

Mr. ROE. Just one last thing. And I appreciate you letting me go over, Mr. Chairman. But I will make you a bet that when you were a dean or head of the medical school, you wanted the GME dollars run by the medical school, and when you were over the whole system you wanted it run through the hospital.

Dr. COLEND. Well, I was more worried about the size of the pot.

Mr. ROE. I bet you were wondering about who controlled the pot too. I yield back.

Mr. BERGMAN. Thank you. Ms. Watterson-Diorio, what type of oversight is there from VA for the NPCs?

Ms. WATTERSON-DIORIO. The oversight that we are affected by is the nonprofit program oversight that happens via a tri-annual review that is run out of the office of Research and Development under Dr. Rachel Ramoni.

Mr. BERGMAN. Okay. And what do you understand the actual role of the NPPO to be?

Ms. WATTERSON-DIORIO. The role of the NPPO, as we call it, has been established as a formal oversight for developing their handbook—sorry, I am—I thought you were going to a different level of question. But their role is to look at how the nonprofits are effectuated by the handbook and the Title 38.

Mr. BERGMAN. Okay. Could we assume possibly not only oversight but working liaison as well as oversight?

Ms. WATTERSON-DIORIO. The liaison piece is probably the most prominent of what we would like it to be.

Mr. BERGMAN. Okay. Is this office, this NPPO office, and we all love acronyms—

Ms. WATTERSON-DIORIO. I know.

Mr. BERGMAN [continued]. —is this helpful? Is the existence of that office helpful?

Ms. WATTERSON-DIORIO. At this time, I don't believe that the processes that are happening within NPPO are being predominantly helpful. But we have—now I have addressed this with Dr. Rachel Ramoni and we are hopeful that we can make changes, and

we have offered her, basically, some strategic plan initiatives for that. I independently did that with her directly.

Mr. BERGMAN. So you are working with her. What are some of the impediments this office places on the NPCs right now?

Ms. WATTERSON-DIORIO. Well, I think that one of the major issues that we are having right now is the fact that the type of recommendations that we are getting, especially in these tri-annual reviews, are inconsistent with that of our financial independent auditors. And we have many audit types of—you talk about the alphabet soup; IRS, GAO, OPM, DHHS, ONR. These are all people that I have to, as a VA nonprofit, address as an audit type of relationship.

The NPPO recommendations can be inconsistent with those that are given by all of these other auditing agencies. When that happens, there is not a formal appeal process at this point in time. And we find that that is a real impediment for us to go forward and be effective as VA nonprofits.

Mr. BERGMAN. So, just to repeat what you said, there is no formal appeals process in place?

Ms. WATTERSON-DIORIO. There is no formal appeals process at this time, yes.

Mr. BERGMAN. Okay. Dr. Ramoni, are you aware of the issues that we just talked about here? And if you are, what is being done to address them?

Dr. RAMONI. Chairman Bergman, thank you very much. The health of the nonprofit corporation is essential to the health of the VA. And so one of the earliest contacts I made was with Mr. Rick Starrs when I took this role as chief research and development officer. I was very troubled to hear of these stories, these complaints, from the nonprofits. I have, of course, heard of good reviews, stories where we have been supportive, but I have heard comments like those of Ms. Watterson-Diorio.

And so we have decided to pause the reviews of the nonprofit corporations for a period of a month so that we can conduct an internal review. We will be reaching out to the nonprofits and to the VA medical centers accompanying them in order to get their feedback on this process. And we look forward to establishing a truly collaborative relationship with the nonprofit corporations while maintaining our role to ensure that they have proper internal controls so that they can be healthy nonprofits.

Mr. BERGMAN. Okay. Thank you.

Dr. CLANCY. And we would be happy to keep you informed as this progresses.

Mr. BERGMAN. You were reading my mind. Save me from asking the question. Number one, thank you, to all of you serving as witnesses today. Your perspectives, your experience are going to provide us with insights to better work together with you to provide the oversight, if you will, that we are required as a Committee to do. And we are all in this together.

In case anybody hasn't realized it, we are in some very, interesting is not the right word, but tough, tough fiscal times. And there is going to be tough decisions that have to be made, and by partnering together we will be able to do that. But we will not sacrifice the quality or the advancement of care for our veterans. No

excuses will be offered, no excuses will be accepted. So you are now excused.

Budgets are tight in the current fiscal environment which is one reason why we conduct a thorough oversight over VA and encourage it to be a, not only a good steward, but a forward-thinking steward of taxpayer money. Yet, time and time again we find examples of VA doing just the opposite. We have had some interesting questions and responses here today. Not having enough, or any oversight, or accountability regarding money intended for veterans.

I hope that the VA has heard our concerns and will work to improve its oversight over the GME program. I hope that they will put processes in place to ensure that time and attendance of residents before paying the affiliates. I hope that VA will ensure that when research is being performed in a VA facility, that the VA NPCs are administering the funds so that VA does not pay excessive overhead costs without getting the benefit of reimbursement.

Today, VA has heard many of the great benefits that NPCs can provide, and I strongly encourage them to take full advantage of these benefits so that the research can thrive and the veteran will receive the benefits.

I ask unanimous consent that all Members have five legislative days to revise and extend their remarks and include extraneous material.

Without objection, so ordered.

Again, the witnesses are excused. I would like to once again thank all of you and the audience members for joining in today's conversation.

With that, this hearing is adjourned.

[Whereupon, at 11:49 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Carolyn Clancy, M.D.

Good morning, Mr. Chairman, Ranking Member Kuster, and Members of the Committee. Thank you for the opportunity to discuss VA's research program and our relationship with academic affiliates. I am accompanied today by Dr. Rachel Ramoni, Chief Research and Development Officer and Dr. Karen Sanders, Deputy Chief Academic Affiliations Officer.

Office of Research and Development (ORD)

For more than 90 years, VA has conducted research within its hospitals and health care system in accord with Congressional authority to advance scientific knowledge about critical issues facing Veterans. In establishing VA Research, Congress recognized both the need to study the unique problems of Veterans but also the opportunity for research to support excellent clinical care.

Since its inception, VA Research has contributed to groundbreaking advances such as the Computerized Axial Tomography scan, the pacemaker, and organ transplants; it has sponsored groundbreaking studies on the treatment of tuberculosis, high blood pressure, heart disease, and Posttraumatic Stress Disorder (PTSD). It has partnered with industry to demonstrate the value of vaccination to prevent shingles, and to develop state of the art prosthetic limbs. These achievements have resulted in three Nobel prizes, seven Lasker Awards, and numerous other national and international honors. VA Research continues to drive advances in Veteran care in issues as diverse as diabetes, spinal cord injury, and mental health. Its groundbreaking Million Veterans Program has already enrolled more than half a million Veterans who have donated blood samples and completed surveys to help unlock the genomic basis of medical disease. Additionally, VA is looking to improve its research to focus strategically on the areas where we will have the greatest impact.

VA Research benefits from its position within an integrated health care system with more than 150 medical centers and a state-of-the-art electronic health record. Our ability to recruit patients throughout the country, to draw on detailed clinical data over two decades on 8 million Veterans, and to implement research findings into clinical care makes VA a model for bench-to-bedside research. Partnerships with national and regional VA clinical leaders, new outreach to Veterans in the community, and a network of research Centers with specific areas of focus ensure that research reflects the current and future needs of Veterans.

The VA Research program plays a unique role that cannot be filled by external funding sources. First, VA Research prioritizes problems that are common or important to Veterans, such as PTSD, traumatic brain injury, polytrauma, and military sexual trauma. Second, 60 percent of our researchers are also practicing clinicians at VA medical centers (VAMCs). As a result, they are familiar with the Veteran experience and are able to seek knowledge and pursue research topics to help our patients. Unlike other Federal agencies, VA has no laboratories whose predominant function is research. Instead, research studies are performed in parallel in close proximity to where patient care is provided. This leads to a focus on research areas benefiting Veterans. Third, research is conducted by VA employees who are dedicated to the mission of improving care for Veterans. Finally, a research program planned and run within VA can adapt to the changing needs of the Veteran population. For example, the Office of Research and Development has dramatically increased the number of researchers and studies addressing the needs of women Veterans over the past decade to meet the growing population of women entering VA care.

VA's research program relies on principal investigators whose primary commitment is to VA Research. All VA Research funding is provided to VA-employed researchers. Research in the 21st Century, however, is a highly collaborative enterprise, building on the collective contribution of different specialized areas of exper-

tise. For example, our research on Traumatic Brain Injury requires the collaboration of cellular biologists, neurologists, psychologists, radiologists, physicists, engineers, and rehabilitation specialists and requires accessing state-of-the-art imaging equipment and laboratory techniques. VA's close partnership with universities, detailed later, allows VA scientists to be part of a larger national network of scientists and to leverage laboratory space, equipment, and expertise that may be more readily available at the university. VA investigators must apply for a waiver if they intend to conduct VA Research outside of VA-owned property.

VA researchers work at more than 100 VAMCs conducting research. The majority of VA researchers - whether full-time clinician scientists or part-time Ph.D. researchers - have dual appointments at their academic affiliate. Their university appointment supports their VA research by keeping them up to date on research outside of VA, allowing them to train future researchers and clinicians and enabling them to pursue additional sources of funding. Dually appointed investigators can leverage their VA funding to obtain funding from National Institutes of Health (NIH), foundations, Department of Defense (DoD), and industry to accelerate their research and its impacts. Many clinicians and researchers have laboratory access at both VA and their academic affiliate.

VA Research fosters dynamic collaborations with its university partners, other federal agencies, nonprofit organizations, and private industry. In 2017, VA researchers were able to leverage \$673 million in VA funding to bring in an additional \$595 million in external funding from industry and Federal agencies such as NIH and DoD. The Federal investment in VA Research returns incredible value to Veterans and the taxpayers, value that is reflected in Veterans positive attitudes about research and health care outcomes in VA.

Office of Academic Affiliations (OAA)

Strong academic relationships have been the foundation of improving quality care and patient access in VA health care since 1946. January 30, 2016, marked the 70th anniversary of VA "Policy memorandum #2," a document crafted by General Omar Bradley and other VA leaders which established the visionary partnership that VA has with America's medical schools. The initial motivation for integrating academic relationships into VA's mission is just as relevant today: improving the quality of care provided to Veterans and ensuring that they are cared for by America's best and brightest from academic institutions. Moreover, the partnership with our universities and medical schools gives VA access to cutting edge technology, expertise and national research networks that would be difficult to replicate in VA. VHA is profoundly important to U.S. health care; approximately 70 percent of U.S. physicians have had some part of their training in a VA facility.

VA is affiliated with well over 90 percent of Doctor of Medicine (MD) and Doctor of Osteopathy (DO)-granting medical schools; VA's health profession education activities also include affiliations with over 1,800 schools of nursing, pharmacy, psychology, and other health professions. Through these affiliations and VA's own sponsorship of selected programs, over 127,000 trainees in health professions received supervised clinical education in VA facilities last year. VHA is also the second largest funder of Graduate Medical Education (GME), after the Centers for Medicare and Medicaid Services (CMS).

The Office of Academic Affiliations (OAA) is responsible for overseeing the statutory education mission of VA, as authorized in 38 U.S.C. 7302. The Office of Research and Development is responsible for the statutory research mission of VA, as authorized in 38 U.S.C. 7303. Related to the authority for affiliation relationships, VA is authorized to execute sole source contracts with academic affiliates under 38 U.S.C. 8153. These contractual relationships are overseen by the Medical Sharing Office in VHA. Therefore, all three of these offices share oversight responsibilities for conduct of the various components of the academic relationships of VA.

OAA provides oversight and leadership for aligning the health professions education programs with VA's health care workforce needs. OAA facilitates the conduct of the education mission through extensive outreach, communication and dissemination of best practices across the enterprise, focusing especially on training programs and trainees. Under the authority of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA) GME expansion, OAA works with small VAMCs and community-based outpatient clinics to initiate new GME programs in rural and underserved areas.

Academic partnerships and the work of dually appointed researchers are managed locally by the local VA Research office and by the leadership of the local VAMC. With over 3,000 researchers at more than 100 VAMCs, local leadership is best positioned to ensure that VA employees are fulfilling their commitments to VA, whether they be clinical, research, teaching or administrative duties. For research, the pri-

mary focus is on ensuring that the individual projects are proceeding on schedule, are completed successfully, and have results that are shared with the scientific and clinical communities. VA monitors the progress of individual projects through annual reporting using the NIH's electronic Research Administration system, through annual reports of VA-funded research centers, and through oversight of VA multi-site clinical trials through our Data Safety and Monitoring Board.

In general, VAMCs are affiliated with geographically nearby medical schools and teaching hospitals. Medical Education is sub-divided into Under Graduate Medical Education, the period of time prior to awarding of the graduate MD or DO degree, and the GME component, which is also called "residency training." GME programs are accredited by two main accrediting bodies, which are the Accreditation Council for Graduate Medical Education and the American Osteopathic Association. These accreditors publish essential standards for the conduct of these training programs. With few exceptions, academic affiliates, not VA, are the "sponsors" of residency training programs, which means they bear the primary responsibility for meeting the standards and requirements of the accrediting body. VA collaborates with its academic affiliates in the execution of the residency training programs in order to meet the educational needs of trainees and the care needs of Veterans. This collaborative partnership has multiple oversight mechanisms to ensure a high quality educational experience for physician residents as well as safe and effective care for Veterans. While OAA allocates resident positions and provides stipend funding for residency education, training program execution resides at the local level and is a shared VA-affiliate endeavor.

It is important to note that OAA's mission is to provide a health professions workforce for VA and the nation. In this context, OAA has many types of training programs and ensures the alignment of training programs with VA's workforce needs. For example, in the last five years of OAA's Mental Health Education Expansion, 699 mental health trainee positions were allocated across important professions such as psychology, social work, and chaplaincy. Funding was also added for Licensed Professional Mental Health Counselors and Marriage and Family Therapists in the last three years. Mental health training for Nurse Practitioners and Physician Assistants also recently began. All states now have at least one VA mental health training program. These trainees assist in providing direct supervised care for Veterans, and also ensure a robust workforce pipeline into VA staff employment.

Section 301(b) of the VACAA authorized VA to increase the number of GME physician residency positions by up to 1,500. An innovative part of VACAA was the inclusion of GME expansion targeting primary care and psychiatry. While some VA facilities were too remote or small to handle GME in other specialties, many had strength in family medicine, internal medicine and psychiatry. This statute has allowed many of those facilities to start GME programs by forming affiliations with residency sponsors in their service areas. New allopathic and osteopathic medical schools found clinical rotations for their students and residents, such as the University of Texas Rio Grande Valley in Harlingen and Burrell College of Osteopathic Medicine in El Paso and Las Cruces. This statute has opened VA to family medicine which brings along its care for women and crucial procedural skills. In the original 50 facilities OAA identified as having low or no GME positions only four remain with no physician educational activity. This statute has influenced the distribution of physician training to underserved areas in an effective and positive manner.

VA appreciates the support of Congress in authorizing this initiative for 10 years. This initiative has been extremely successful in the 2 years since the first VACAA residents first came to VA in July 2015. To date, 547 positions have been awarded to VAMCs around the country, and over two-thirds of these positions are in primary care and psychiatry.

Non-Profit Corporations (NPCs)

VA-affiliated research and education corporations, also known as non-profit corporations (NPCs), were established by Congress in 1988 under 38 U.S.C. 7361-7366. Currently, there are 84 NPCs located throughout the U.S. and in Puerto Rico. After paying their own administrative expenses, they have collectively contributed \$2.2 billion to VA Research in the last decade. Annually, they manage \$272 million in assets, comprised principally of cash and cash equivalents. NPC revenues are from Federal granting agencies such as NIH and DoD (68 percent), industry (20 percent), private foundations (10 percent), interest earned, and other sources (2 percent). NPCs employ approximately 2,800 people, serve 2,300 researchers, and administer 3,500 research projects. NPCs are established at VAMCs and are state-chartered nonprofit corporations governed by boards of directors. There are four directors required by law ("statutory directors"). They are the Medical Center Director, the

Chief of Staff, the Associate Chief of Staff for Research, and the Associate Chief of Staff for Education. Two non-VA community members are also required.

VA has oversight responsibility and authority for the NPCs. The VHA Nonprofit Program Oversight Board meets quarterly and provides direction with input from the VHA Chief Financial Officer and the Office of Research and Development. The Nonprofit Program Office (NPPO) is the principal liaison between VA and the 84 NPCs. On-site audits and other oversight measures are employed by the NPPO. This oversight is accomplished through routine triennial on-site reviews, follow-up on past reviews, for cause audits and investigations, the NPC annual report to Congress, education and training sessions, and ad-hoc consultations.

External funding from industry and other Federal agencies may be administered by the affiliated NPC. Who administers these funds is dependent on a number of factors such as the location of the principal investigator and collaborators, conduct of the research, complexity of the research, and expertise required for the management of the grant. VA encourages the use of the NPCs when possible, but allows the local VAMC to manage these relationships.

VA appreciates Congress's support which allows us to train future medical researchers and clinicians to care for Veterans and the nation as a whole. Mr. Chairman, this concludes my testimony. My colleagues and I are prepared to answer any questions you, Ranking Member Kuster, or other Members of the Committee may have.

Prepared Statement of Richard P. Starrs

Chairman Bergman, Congresswoman Kuster, esteemed Committee Members, thank you for the invitation to be here today to share with you my experiences and insights regarding the Department of Veterans Affairs' medical research program and the role of the Congressionally authorized VA-affiliated nonprofit research and education corporations.

My name is Rick Starrs and I have served as the Chief Executive Officer of the National Association of Veterans Research and Education Foundations, commonly known as NAVREF, since January 2016. I am a proud Army Veteran, having served on active duty as a Medical Service Corps officer for 26 years, culminating my career as the Chief of Staff of the US Army Medical Research & Materiel Command in Frederick, Maryland. I was honored to join NAVREF and transition from a career supporting the health needs of Soldiers to one supporting the health needs of all Veterans.

I am accompanied by Ms. Nancy Watterson-Diorio, a member of NAVREF's Board of Directors and the Chief Executive Officer of the Boston VA Research Institute, Inc. (BVARI). Nancy has led BVARI for 21 years, building it from a \$100,000 start-up organization in 1996 to a \$14 million research enterprise today. Along the way she has invested incredible time, energy, and devotion mentoring, advising, and assisting others in our community on how to best administer research and support Veterans. Her experience, expertise, and leadership have been invaluable to NAVREF and I am happy to have her at my side.

Thank you for inviting us to participate in this important hearing. We appreciate this subcommittee's continuing interest in the VA's research program and the role of the nonprofit corporations. Your staff has visited many of our sites over the last 12-months and is becoming well-versed in our operations and our challenges.

The National Association of Veterans' Research and Education Foundations is the 501(c)(3) nonprofit membership organization of research and education foundations affiliated with Department of Veterans Affairs (VA) medical centers. These nonprofits, also known as the VA-affiliated nonprofit research and education corporations (NPCs), were authorized by Congress under 38 USC §§7361-7366 to provide flexible funding mechanisms for the conduct of research and education at VA facilities nationwide. Currently, NAVREF has 80 member corporations.

NAVREF's mission is simple—we exist to advance the success of the VA-affiliated research and education corporations. The NAVREF Board of Directors is comprised of seven NPC executive directors elected by the membership, four VA employees elected by the membership consisting of a VA Medical Center Director, Chief of Staff, Associate Chief of Staff for Research and Development, and Associate Chief of Staff for Education, and two community members appointed by the board. I am here today on behalf of the NAVREF Board and our membership to tell you about the great work of these nonprofits, our potential for greater contributions, and areas where we face challenges.

Ultimately, NAVREF envisions a nation in which Veterans receive the finest care based on innovative research and education. We believe that by working closely with Congress, the VA leadership, NPC boards and leaders, and the great researchers and scientists working in VA medical centers across the country that our lofty vision can be achieved. We serve not only the Veteran, but a team of VA research and educational experts.

NAVREF has been encouraged by the approach of the VA's new Chief Research & Development Officer, Dr. Rachel Ramoni. We look forward to continued collaboration with her and her team at the Office of Research and Development. In the short time she has been in her position, Dr. Ramoni has reached out to NAVREF and the NPC community on multiple occasions to share information and seek partnership opportunities. She has a strong interest in bringing more clinical trials to Veterans and understands the key role the nonprofits play in fostering these relationships with pharmaceutical companies and the clinical trial industry. We look forward to continued development of this relationship and the role of nonprofit corporations as partners invested in the success of VA research and education activities. Secretary Shulkin and other leaders at the VA speak often about the need to partner with private industry and about tapping into the great ideas and willing contributors in the private sector. This is the role that the NPCs were designed to play and where we offer so much potential to the VA.

NAVREF strongly believes that the VA-affiliated nonprofit corporations legislated by Congress in 1988 offer tremendous benefits to Veterans, but are not being used to their maximum potential. NAVREF offers three specific recommendations:

1.VA establish clear guidelines for the administration of extramural research activities that offer the NPC right of first refusal for all research efforts where the majority of this work occurs physically within the VA. Included in these guidelines should be a common practice for vetting conflicts of interest and ensuring those involved in the decision-making process are not conflicted.

2.VA review the appropriate level of oversight required to ensure the nonprofit corporations are operating appropriately and effectively while retaining their independence as non-profit entities legislated to be flexible mechanisms outside of the Federal bureaucracy.

3.The National Institutes of Health (NIH) modifies its Grants Policy Statement to allow our NPCs to pay VA clinicians as Principal Investigators on the Institutes' research grants for their off tour of duty effort.

WHO THE NPCs ARE

The 1988 legislation authorizing the establishment of VA-affiliated nonprofits (US Public Law 111-163 Title 38 - Subchapter IV - Research and Education Corporations) laid the foundation for the creation of unique partnerships to support VA-approved research and education. It allowed for the establishment of private, state-chartered, nonprofit entities to provide flexible funding mechanisms for the administration of extramural funds (all funds other than those appropriated to VA). Today, 29 years later, there are 83 NPCs nationwide; each is an independent 501(c)(3). NPCs are physically located at or near VA medical centers in 44 states, Puerto Rico, and the District of Columbia. As reported in the VA's most recent 2015 annual report to Congress, the NPCs managed \$271 million, a slight increase from the previous year. As a point of comparison, the appropriated budget for VA research in 2015 was \$589M, so the NPCs' contributions are significant. Of the \$271 million managed by NPCs in 2015, 70% derived from Federal sources such as the National Institutes for Health and the Department of Defense, while 30% derived from private industry, other nonprofit foundations, and individuals. These financial data points, however, can be deceiving. Seven nonprofits in California and one in Seattle combine to generate 45% of all NPC revenue and over 56% of all Federal revenue. We believe these nonprofits and the relationships they have with their academic affiliates are models that should be emulated across the country and should not be confined to the West Coast. Federal research awards offer greater stability and less risk than industry trials or foundation grants. Federal awards allow the research institutes to build an appropriate research corporation that grows capability and multiplies its ability to support the VA research program.

More than 10 years ago these eight West Coast nonprofits and their academic affiliates worked out simple agreements whereby Federal research awards would be administered by the VA-affiliated foundation when the majority of effort was performed at the VA medical center and by the university when the majority of effort was performed at the university. NAVREF believes this practice is consistent with congressional intent and is fair to all parties involved. Unfortunately, at many VA medical centers across the country, this practice is not being followed. At many locations, there are understandings or informal agreements that all NIH awards will

be administered by the university, regardless of where the majority of work is performed. At some locations this is broadened to include all Federal awards-the VA-affiliated foundations therefore handle only non-Federal research grants. Admittedly, not all NPCs have the manpower or capability to administer Federal awards. But without the prospect of a Federal award, these same research corporations have had little motivation to build the capability. When Dr. Jeffrey Moore became executive director of the Cleveland VA Medical Research & Education Foundation (CVAMREF) four years ago, the Cleveland NPC administered less than \$100,000 in Federal awards and had annual revenues of approximately \$700,000. He focused attention on Federal awards and successfully grew the operation to nearly \$2.5 million in 2016 on the strength of Federal awards. As a result of this increased infrastructure and administrative capacity, he has also been able to dramatically increase support for industry-funded clinical trials.

SUCCESS STORIES

As flexible funding mechanisms, the NPCs offer a multitude of services and benefits to VA research and education programs. This includes numerous benefits to the VAMC and the Veterans it serves, including the following 10 common support services:

- Renovate and upgrade VA research infrastructure
- Provide funds, staffing, and training support to VA Research and Institutional Review Boards
- Pay for expenses related to recruitment of research investigators to the VA system
- Fund seed grants to new investigators to aid them in establishing their VA research careers
- Fund training of VA personnel on a wide variety of topics
- Underwrite bridge funding for VA investigators who are between research grant awards
- Support travel and registration fees for VA personnel to attend scientific conferences
- Procure personnel, equipment, and supplies for VA-approved research or education projects
- Host local and national educational conferences for VA personnel
- Act as fiscal agent for philanthropic and other available research funds

As seen from this listing, the nonprofit corporations are making daily contributions to their VAMC's research and education programs. Some of the simplest actions have the most powerful impacts.

At the White River Junction VA Medical Center in Vermont in 2013, the Palliative Care Suite was not being used to its full potential to provide end-of-life care for Veterans. Due to staffing restrictions, Veterans admitted to the Palliative Care Suite were required to have either a family member or a person trained as an end-of-life companion to be present 24/7 during their stay in the suite. The VA nonprofit (VERANNE) worked with the Director of the Palliative Care Suite to obtain a \$3,000 grant from the Vermont Veterans Fund to train volunteers as end-of-life companions. In their first class, they trained over 85 volunteers, many of whom were either VA employees or local Veterans. Since then, the Palliative Care Suite has been fully utilized, and they've seldom had to turn away anyone from using the suite for end-of-life care. The local newspaper ran a major story about this education program, which resulted in very positive press for the White River Junction VA Medical Center.

At the Jesse Brown VA Medical Center in Chicago, the Westside Institute for Science and Education (WISE) served the VAMC by re-tiling the Veterinary Medical Unit prior to the Association for Assessment and Accreditation of Laboratory Animal Care (AAALAC) inspection to ensure continued certification as a pathogen-free barrier unit. The total investment for labor and supplies was only \$20,000, but it was something the VA was unable to execute in a timely manner, so the NPC stepped in.

Many NPCs also provide financial support for VAMC-hosted educational events that can total less than \$10,000 annually but can be the difference between a successful, well-attended event and a failure. At WISE in 2016, four educational events supported in this manner with food and refreshments exceeded expectations including the annual Mental Health Summit [160 attendees], a Recreation Therapy Open House [80 attendees], a Military Sexual Trauma Training [60 attendees], and Research Week activities [55 Veteran attendees; 80 attendees to Research Open House].

But our NPCs have the capability and potential to have even greater impact. Veterans are under-represented in clinical trials, and robust NPCs are a primary mechanism for correcting this shortfall.

As mentioned earlier, the Cleveland NPC has grown and developed capability over the last 4 years to have a much greater impact on the lives of Veterans. This year, CVAMREF is leading a multisite Phase 3, placebo-controlled, randomized, observer-blinded study to evaluate the efficacy, safety and tolerability of aluminum hydroxide containing *C difficile* vaccine administered in 3-dose regimen in adults 50 years and older. Subjects will be randomly assigned to receive *C difficile* vaccine or placebo. 16,000 people will be enrolled in 25 countries with potentially up to 3,000 veterans being enrolled in 18 VAs across the country (so far). Three years ago, CVMAREF did not have the capability to lead a study of this magnitude, but like several other NPCs, it has grown its operations and increased its capability to administer a wide variety of research efforts.

Down the road from Cleveland, the Veterans Research Foundation of Pittsburgh established a Clinical Trials Center (CTC) in 2007. Today the CTC is the single portal of resources, expertise, and best practices for investigators and research staff to facilitate efficient, compliant and ethical study conduct and management. The CTC provides a location and resources for investigators to participate in multi-therapeutic clinical drug & device trials in accordance with government and industry standards. The mission of the CTC includes increasing awareness of clinical trials in the community through education and community outreach activities and interfacing with institutional/industry partners to support clinical research practice. The CTC has worked with over 50 commercial study sponsors and 15 Contract Research Organizations while running 40–50 trials per year. This capability has provided immense benefits to Veterans who now have the opportunity to receive the latest, cutting-edge therapies offered throughout the country.

On the other side of the country at the Palo Alto Veterans Institute for Research (PAVIR) in Palo Alto, California, PAVIR is participating in a complicated study sponsored by a group of pharmaceutical companies that will help determine management guidelines and inform policies for opioid use. This is a particularly important and relevant study for Veterans given the high burden of pain and prevalence of opioid use within the Veterans Health Administration (VHA). Prescription opioid misuse continues to represent a public health crisis for the VHA. Recent evidence indicates high rates of mental health disorders (such as anxiety, depression, and post-traumatic stress disorder) and co-existing high-risk opioid use within Veteran patient populations. Higher levels of opioid use generally may be related to higher rates of overdose, death, suicide, addiction, and other adverse outcomes such as motor vehicle accidents and falls. The results of this study will help determine management guidelines and inform policies for opioid use for the many hundreds of thousands of VHA patients who take opioids daily.

These are just a handful of current examples demonstrating the powerful impact NPCs can have on the lives of Veterans. NPC administration of Federal and non-Federal research awards offers superior benefits to both the VA and Veterans. NPCs are on site, close to the clinicians, researchers and patients. They focus on Veterans exclusively and they are cognizant of and compliant with all VA policies and regulations.

We believe that several steps can be taken to further enable the NPCs to provide even greater support to Veterans and the VA's research and education programs. For the VA to realize the full potential of the NPCs, we propose three recommendations.

RECOMMENDATION #1

Our first recommendation is that VA establish clear guidelines for the administration of extramural research activities that offer the NPC right of first refusal for all research efforts where the majority of effort occurs physically within the VA.

Currently at many VA medical centers, Federal research grants are not being administered by the NPC even when the majority of effort research/study is occurring within VA. In many locations, these grants are being administered instead by the Academic Affiliate. We believe this practice contradicts the intent of Congress when the VA-affiliated nonprofits were established to provide such support. This practice also contradicts the recently updated VHA Directive 1200.02 "Research Business Operations" which states in regard to extramural research:

"Extramural funds are funds other than those specifically appropriated for VA research by Congress. These funds may be provided by other Federal agencies, state or local government agencies, non-profit corporations or foundations, other charitable organizations, corporations and other private sector business entities, or an individual contributor. Such funds are to be administered through the VA Nonprofit

Research and Education Corporation (NPC) or through the General Post Fund when possible.”

In order to effectively implement and enforce this clear Directive, we recommend VA issue reporting requirements for each VA medical center to track what research projects are being administered through the local nonprofit corporation, what research projects are being administered elsewhere, the associated funding amounts, and the reason for any deviation from VHA Directive 1200.02.

At most VA sites there is no clearly defined process for determining how research grant proposals are to be submitted and administered. Without a clearly structured process, the decision about where to submit the grant proposal is often left to the principal investigator. Leaving the decision to a person who has an appointment at both the VA and the academic affiliate places them in a conflict of interest situation with serious potential ramifications under 18 USC 208. We believe that due to conflicts of interest associated with being a dual-appointee at the academic affiliate, principal investigators should not be making these decisions. A PI's relationship to the academic affiliate should not enter the decision-making process and the only way to remove the conflict is to remove the PI from the decision loop.

Consider the following scenario, which is not uncommon: a VA investigator or PI is a 5/8 VA employee and 3/8 an employee of the affiliate; the affiliate has an interest in increasing its research activity; his/her Dean and department head are given performance objectives related to the annual volume of Federal research awards in their school or department; the more Federal awards a PI can generate for the university, the more stature a PI earns with the university; PIs can be compensated above the 40-hour work week if the university administers an NIH award, but not if the NPC administers the research award; PIs can accrue additional lab space and other benefits at the university based on the volume of research funding; and finally, the university is an attractive employer to PIs, particularly after earning a Federal retirement. In this scenario, a PI given the choice of where to administer a Federal research award has numerous personal and professional incentives to submit the award through the university, regardless where the majority of effort is being expended and despite what might be in the best interests of the VA. Under 18 USC 208, the VA has indicated that the PI clearly has conflicts of interest that would be difficult or impossible to mitigate without removing the PI from the decision process.

Therefore, as a corollary to our “right of first refusal” recommendation, we further recommend that the local VA medical center research & development committee serve as the decision-maker for the administration of extramural research awards and provide regular reports to VA Central Office and/or the congressional oversight committees detailing where awards are being administered and why.

RECOMMENDATION #2

Our second recommendation is that the VA initiate a review to determine the appropriate level of oversight required to ensure the nonprofit corporations are operating appropriately and effectively while retaining their independence as non-profit entities legislated to be flexible mechanisms outside of the Federal bureaucracy.

The VA-affiliated nonprofits were designed by Congress to be non-Federal entities so that they could provide flexible solutions to support research and education activities. The congressional authorizing language highlights the independence of NPCs in Title 38, § 7361 (d), the enabling legislation for VA NPCs, by explicitly stating that “(2) A corporation under this subchapter is not—(A) owned or controlled by the United States; or (B) an agency or instrumentality of the United States. Similarly, VHA Handbook 1200.17 § 2 (b) states that: “NPCs are not owned or controlled by the Federal government, nor are they an agency or instrumentality of the Federal government.”

The law further emphasizes this independence:

“Except as otherwise provided in this subchapter or under regulations prescribed by the Secretary, any corporation established under this subchapter, and its officers, directors and employees, shall be required to comply only with those Federal laws, regulations, and executive orders and directives that apply generally to private nonprofit corporations.”

While Congress made clear its intent to establish independent nonprofit corporations to serve as flexible funding mechanisms for the conduct of VA research and education programs, other elements of the legislation ensured strategic alignment of the nonprofits with their VA medical centers. Like all nonprofits, each NPC is governed by a board of directors. The original legislation included a requirement that the NPC board of directors include the local VA Medical Center Director, Chief of Staff, Associate Chief of Staff for Research and Development, Associate Chief of

Staff for Education, and a minimum of 2 Community Members (not federal employees). The requirement for these statutory positions ensures that the NPC remains aligned with the VA medical center or centers with which it is affiliated.

In addition to board composition as a method to ensure alignment with the VA, the conduct of research administered at each NPC is subject to all VA regulations and oversight. Every research grant or award administered by an NPC must have a VA principal investigator and must be approved by the supported VAMC research and development committee. Similarly, the administration of any education activities must be approved by the supported VAMC education committee or equivalent body.

Additionally, the VA established VHA Handbook 1200.17 with the stated reason to “provide procedures and instructions governing Nonprofit Research and Education Corporations (NPC) created pursuant to Title 38 United States Code (U.S.C.) 7361 through 7366.” VA’s oversight responsibility of the NPCs is formally performed by the Nonprofit Oversight Board (NPOB), the Nonprofit Program Office (NPPO), and the VHA Chief Financial Officer (CFO). From paragraph 4 of VHA Handbook 1200.17 dated April 26, 2016:

(1) Nonprofit Program Oversight Board (NPOB). The NPOB is VA’s senior management oversight body for NPCs, as outlined in the NPOB charter. The NPOB is responsible for reviewing NPC activities for consistency with VA policy and interests, and for making recommendations through the Under Secretary for Health to the Secretary of Veterans Affairs regarding VA policy pertaining to NPCs.

(2) Nonprofit Program Office (NPPO). The NPPO is a VHA program office that operates as a liaison between VHA and NPCs. The NPPO is responsible for coordinating policy regarding NPCs and provides oversight, guidance and education to ensure compliance with applicable regulations and VA policies affecting the operation and financial management of NPCs..

(3) Chief Financial Officer (CFO). The VHA CFO exercises financial oversight of NPCs by review of NPPO activities and review of any audit of an NPC by independent auditors, as necessary. Results of such CFO reviews must be made available to the NPPO and NPOB through the Chief Research and Development Officer.

Since their inception, the Nonprofit Oversight Board (NPOB) and the Nonprofit Program Office (NPPO) have served important roles and made significant contributions to the successes of the NPCs. However, NAVREF is concerned that over the years VA, with the best of intentions, has slowly exerted increasing levels of oversight (“mission creep”) that have led to reduced flexibility and threatens the independence of the nonprofits. Some examples of this reduced flexibility include allowing medical center directors to exercise individual hire/fire authority over nonprofit board members and executive directors; influencing compensation and work terms of executive directors; influencing staffing levels and office locations; directing how nonprofits file paperwork; dictating the frequency of budgetary reporting; directing the frequency of board meetings; and encouraging boards dominated by VA personnel, in contradiction to the legislative language cited above. These restrictive actions redirect attention and effort from the flexible roles the NPCs were intended to pursue. Our members believe that the VA should review its oversight framework and identify those essential aspects that must be continued and those non-essential aspects that should be modified or eliminated.

For example, the NPCs are required to undergo regular independent audits based on their annual revenues and state laws. VHA Handbook 1200.17 also directs, “Each NPC with revenues in excess of \$500,000 for any year must obtain an independent audit of the financial statements of the NPC for that year.” Furthermore, there is a federal requirement to conduct an independent audit if the nonprofit expends \$750,000 or more in federal funds in a single year. With these various requirements in place, is it essential for VA to conduct additional financial reviews or is it duplicative?

As a second example, the current VA triennial review procedure does not allow for a formal, well understood process to contest findings or resolve conflicts. Organizations like The Joint Commission, the Government Accountability Office, and the Internal Revenue Service employ well-documented and fair resolution procedures that we would like to see applied to VA reviews or audits. There should be a path by which the NPCs can safely voice concerns or objections and receive a fair and impartial hearing to reach a satisfactory resolution.

NAVREF leadership would be happy to contribute to this assessment to help VA strike the optimal balance between oversight, independence, and flexibility that will allow the NPCs to thrive and to make even greater contributions to VA research and education activities.

RECOMMENDATION #3

Our third recommendation is that the NIH modify its Grants Policy Statement to allow our NPCs to pay VA clinicians as Principal Investigators on the Institutes' research grants. NAVREF agrees that to stimulate and incentivize clinician/researchers it is appropriate to compensate them for the additional time and effort they invest in research beyond their VA clinical duties while off tour of duty. However, the NIH Grants Policy Statement specifically prohibits the NPCs from compensating PIs for this additional work, while academic affiliates are permitted to do so. We have not encountered this limitation when dealing with other Federal funding agencies such as the Department of Defense, Centers for Disease Control, and Department of Transportation. We believe the NIH limitation exacerbates the conflict of interest question that we previously addressed. NAVREF will continue to engage with policy officials at NIH to bring this situation to a favorable resolution.

CLOSING

In closing, I wish to thank the Committee for its attention to and support of the VA's medical research program and for holding this hearing. Ultimately, NAVREF and the NPCs share the same goals as the VA—to improve the lives of Veterans. We only exist to facilitate and support the VA's research and education programs. My fellow executive directors and board members are honored to devote our personal and professional energies to facilitate scientific breakthroughs that can change the lives of Veterans, their family members, and all Americans. With your continued support, the VA-affiliated nonprofits will make even more powerful contributions to the VA research and education programs and the Veterans they serve.

Prepared Statement of Christopher C. Colenda, MD, MPH

Good morning and thank you for this opportunity to testify on behalf of the Association of American Medical Colleges (AAMC) regarding Department of Veterans Affairs (VA) relationships with U.S. medical schools and teaching hospitals for the benefit of our nation's Veterans. The AAMC looks forward to working with Congress and the Administration to ensure that the long-standing and critical partnerships between VA and these academic affiliates are preserved and enhanced. We share the VA's commitment to caring for our nation's Veterans through our joint missions of patient care, research, and education to improve access and quality of care for Veterans, both inside and outside the VA system.

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members comprise all 147 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 VA medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their nearly 160,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

The unique relationship between the VA and academic medicine dates to the end of World War II when the VA faced a severe shortage of physicians as nearly 16 million men and women returned from overseas, many with injuries and illnesses that would require health care for the rest of their lives. At the same time, many physicians were returning from the war without having completed residency training.

The solution was VA-academic affiliations established under VA Policy Memorandum No. 2, making the VA an integral part of residency training for the nation's physicians. In return, the VA improved access and quality of care for our nation's Veterans. What started as a simple idea in a time of great need has developed into an unprecedented private-public partnership. Today, the VA has over 500 academic affiliations, and 127 VA facilities have affiliation agreements for physician education training with 135 U.S. medical schools. The AAMC encourages Congress and the Administration to build upon this past success to improve access and quality of care for the military service members who have bravely served our country.

THE ROLE OF ACADEMIC AFFILIATES IN CARING FOR VETERANS

Many Veterans who use VA services face complex health care conditions, ranging from chronic diseases associated with aging, treatment and rehabilitation from polytrauma injuries and complications, and neuropsychiatric and behavioral disorders associated with traumatic brain injuries, post-traumatic stress (PTS), depression and the tragic risk of suicide. These conditions not only affect individual Vet-

erans but they also impact their families and the communities in which they reside. It is heartbreaking to hear the stories of Veterans and their families who have suffered; who have not received responsive and timely care; and who appear to have been left behind as the nation continues to move forward. Our collective responsibility and moral obligation as a nation is to address these challenges directly and with empathic urgency.

U.S. medical schools and teaching hospitals are committed to mobilizing the resources necessary to partner with the VA to solve the 21st century problems of Veterans and their families. The AAMC as the membership organization for academic medicine would like to offer recommendations to ensure that we effectively partner with the VA to ensure that our nation's Veterans have access to the highest quality care, and to hold forth the promise that the next generation of physicians and health professionals will have the necessary competencies to care for Veterans, and all patients, across the care continuum.

Medical Education and Training

The VA is an irreplaceable component of the U.S. medical education system. Each year, the VA helps train more than 20,000 individual medical students and more than 40,000 individual medical residents within its walls. As a system, the VA represents the largest training site for physicians, and funds approximately 10 percent of national graduate medical education (GME) costs annually. The GME relationship between the VA and academic affiliates does more than benefit learners and training programs. Under the supervision of faculty, many of whom have been jointly recruited by the medical school and the VA, residents and fellows provide substantial and invaluable direct patient care. The VA patient-learner dyad is also a cultural anchor for many young physicians who have never served in the nation's armed forces. Thus, their VA rotations expand their empathic understanding of what it means to "serve and sacrifice" for the nation. Without this GME partnership, care for Veterans inside and outside the VA system would be diminished.

Innovation from Veteran-Centric Research

The combination of education, research, and patient care that occurs because of the close relationship and proximity among VA medical centers (VAMCs) and academic medical centers (AMCs) cultivates a culture of research curiosity and innovation. Medical faculty must be skilled in the latest clinical innovations to train the next generation physicians that will care for Veterans. State-of-the-art technology and groundbreaking treatments jump quickly from the research bench to the bedside to the care delivery system. The VA's intramural research program serves as a recruitment tool and sponsors numerous projects in areas that specifically benefit Veterans and the unique challenges they face - research that might otherwise be neglected in the private sector. Ultimately, we all benefit from breakthroughs at the VA, which have led to the cardiac pacemaker, CAT scans, kidney and liver transplantation, the nicotine patch, and numerous prosthetic developments.

Access to Complex Clinical Care

Veterans require the entire spectrum of clinical care services: preventive services, primary care, and highly-specialized clinical treatment. The VA's ability to directly contract with academic affiliates allows for planning, staffing, and maintaining infrastructure for complex clinical care services that are scarcely available elsewhere. In this way, the AAMC supports the proposed VA Core Network that retains academic affiliates as an immediate extension of VA. Further, when well-functioning contractual relationships exist between these institutions, there are better outcomes for Veterans and more efficient and cost effective use of health care resources.

TRAINING THE NEXT GENERATION OF PHYSICIANS TO CARE FOR VETERANS

Ensuring Quality and Accountability of VA GME

In the United States there are 792 institutional sponsors of 9,977 residency training programs. Most programs are sponsored by teaching hospitals and medical schools, and predominantly are accredited by the Accreditation Council for Medical Education (ACGME). The ACGME is a private, 501(c)(3), not-for-profit organization that sets standards for U.S. graduate medical education (residency and fellowship) programs and the institutions that sponsor them, and renders accreditation decisions based on compliance with these standards. ACGME accreditation provides assurance that a sponsoring institution or program meets the quality standards (institutional and program requirements) of the specialty or subspecialty practice(s) for which it prepares its graduates. ACGME accreditation uses residency review com-

mittees staffed by volunteer specialty physician experts from the field to set accreditation standards and provide peer evaluation of sponsoring institutions and specialty and subspecialty residency and fellowship programs.

ACGME standards expect diverse clinical training environments in order to expose future physicians to a wide variety of patients and clinical conditions. No single clinical training environment accomplishes that, thus residents rotate through multiple settings to gain clinical mastery. The VA is one of those important clinical settings to accomplish this core ACGME expectation and standard. With the exception of only a few programs, VA residency training is sponsored by an affiliated medical school or teaching hospital - an efficient arrangement that reduces administrative redundancy. Without these partnerships, most VA GME would be unable to meet the ACGME requirements as a stand-alone program. While there are considerable variability among VA medical centers, programs, and specialties, on average medical residents rotating through the VA spend approximately three months of a residency year at the VA (i.e., a quarter of their training).

VA Residency Training is Accredited by ACGME

The VA mandates that sponsoring institutions maintain accreditation by ACGME for residency programs. As a result, GME that is conducted within VAMCs are accredited by ACGME and thereby meet the educational and training standards that have been established for each specialty program. The sponsoring institution, e.g., the medical school or teaching hospital, however, is the accountable party to the ACGME, and the ACGME continuously monitors training programs to ensure compliance with its standards, including through data collection, evaluation, surveys and site visits.

Meeting ACGME Residency Training Standards for VA Rotations

To further clarify this relationship, when a resident rotates on a VAMC clinical rotation, that experience is part of the ACGME accredited program of the sponsoring institution and must meet the same ACGME standards as any other site. In this way, no matter where a resident rotates during training, the quality, the supervision, and all other standards will be met while the resident has the advantage of being educated in many different types of health care facilities. As one clear recognition that the VA will comply with ACGME standards, the VA requires that when a VAMC site participates in an ACGME accredited training program, it must evaluate the trainee's performance and conduct in mutual consultation with the program director and according to the guidelines outlined in the approved curriculum and accepted standards.

Resident/Faculty Survey Feedback

ACGME annually surveys residents and faculty members to collect critical evaluations of components of their programs to assist in their review for the purposes of accreditation. The surveys are only accessible by those participating during specific windows during the academic year. These participation windows are communicated directly to institutions and programs via email. All accredited programs are required to meet a minimum level of participation compliance with the ACGME surveys. Additionally, VA operates its own Learner's Perception Survey to audit training experiences at VAMCs, and these data are used by the sponsoring institution for quality control and feedback purposes. According to results from the VA's Learners Perception Survey, residents that rotate through the VA are nearly twice as likely to consider employment at the VA.

GME Funding Accountability to CMS and Time/Attendance Reporting

Teaching hospitals receive direct graduate medical education (DGME) payments from Medicare which are intended to pay Medicare's share of costs related to training residents in approved programs (including those accredited by ACGME), such as resident stipends and benefits, and faculty salaries. Among the requirements for hospitals to receive DGME, is that they submit to CMS, with their Medicare cost, report the Intern and Resident Information System (IRIS) report which tracks all rotations of all residents, whether they are training at the sponsoring institution, a VA facility, or elsewhere. These data allow the Medicare Administrative Contractors (MACs) to ensure that no resident is counted by multiple institutions for training during the same period of time. This ensures that when residents are rotating at VAMCs there is a record of their clinical rotation.

Physician Workforce Challenges Facing Both VA and Civilian Health Care Institutions: The Need to Increase GME to Address Provider Shortages

Current VA physician shortages are symptomatic of a broader trend for the nation's health system. The AAMC projects a nationwide shortage of physicians between 40,800 and 104,900 physicians by 2030. Though these shortfalls will affect all Americans, the most vulnerable populations in underserved areas will be the first to feel the impact (e.g., Veterans health, Medicare and Medicaid recipients, rural and urban community health center patients, and those served by the Indian Health Service).

The AAMC sponsored a study conducted by the Life Science division of the global information company IHS Inc. The study estimates a shortfall of between 7,300 and 43,100 primary care physicians and between 33,500 and 61,800 non-primary care specialties. Similarly, an AAMC review of physician vacancies advertised by the VHA found that approximately two thirds were for non-primary care specialists, and about one-third were for primary care providers.

At the undergraduate medical education (UGME) level U.S. medical schools have expanded enrollment by 30 percent since the mid-2000s. However, there has not been a commensurate increase in the number of GME residency training positions. The primary barrier to increasing residency training at teaching hospitals - and the U.S. physician workforce in turn - is the cap on Medicare GME financial support, which was established in 1997. To help VA address patient access and recruitment issues, the AAMC supports expanding U.S. graduate medical education.

Enhanced VA Funding for GME and Potential Funding Gaps for other Resident Training Sites

Funding graduate medical education in the U.S. healthcare system is complicated. Teaching hospitals receive direct graduate medical education (DGME) payments from Medicare which is intended to pay Medicare's share of costs related to training residents in approved programs (including those accredited by ACGME), such as resident stipends and benefits, and faculty salaries. The Budget Reconciliation Act of 1997, however, capped Medicare funding levels. Expansion of GME in U.S. teaching hospitals has occurred since 1997, but the sources of funding to support the additional residencies and residency slots have often come from hospital income, and these expansion slots have become a direct expense for AMCs. The nation's teaching hospitals recognize that this is an investment worth making for the future of health care in the United States. However, the GME expansion is also a tradeoff that these institutions make against other capital, clinical program advancement, other health professional educational investment, research and human resources. The AAMC endorses the Resident Physician Shortage Reduction Act of 2017 (H.R. 2267), which would allow Medicare to support 15,000 new slots over 5 years, and provides a preference for teaching hospitals that are affiliated with the VA.

VA Financial Support for GME

Just as Medicare GME funding supports Medicare's share of training costs at institutions that care for Medicare beneficiaries, VA GME supports residency training based at VA medical centers. The Veterans Access, Choice, and Accountability Act of 2014 (VACAA, P.L. 113-146) instructs VA to add 1,500 GME residency slots over five years at VA facilities that are experiencing shortages. However, VA is the only federal agency that has expanded support for residencies to help address physician workforce shortages. Without an increase in GME support outside the VA, there may not be enough affiliate residency positions to accommodate this VA expansion.

Recall that virtually all VA residency programs are sponsored by an affiliate medical school or teaching hospital and not by VAMCs. To successfully expand VA GME, VA estimates that affiliated teaching hospitals need two to three positions for every VA position to meet all ACGME program requirements. As such, increasing VA GME funding alone will not address the VA crisis, because many sponsoring institutions may not have the funding to accommodate the increased number of residents. Further, smaller training sites may have difficulty securing ACGME approval to increase the number of slots for a particular residency training program, and thereby not have the authority to expand the program to accommodate the added VA funding opportunity.

This illustrates the complexity of GME and the fact that without a corresponding increase in GME support for the teaching hospital affiliates, VA medical centers will be unable to capitalize fully on increases in VA GME funding. As a first step, the AAMC supported legislation introduced in the 114th Congress that would have exempted medical residents partially funded under VACAA from the Medicare GME cap.

Additional Models for Physician Recruitment and Retention

There are several federal programs that can serve as models for the VA to improve recruitment of physicians during residency training at the VA, including medical student loan repayment and immigration public service programs.

National Health Service Corps

While medical education remains an excellent investment, the average indebtedness of medical school graduates in 2017 was \$190,000. The National Health Service Corps (NHSC) offers scholarship and student loan repayment incentives in exchange for primary care practice in federally designated health professional shortage areas (HPSA). In FY 2012, the NHSC created the Students to Service (S2S) Loan Repayment Program, which provides a recruitment incentive as medical students choose their specialty and begin their careers in residency training. NHSC S2S provides up to \$120,000 for student loan repayment during medical residency, and in return physicians commit to a 3-year service obligation in a HPSA after they complete their training.

Conrad State 30 J-1 Visa Waiver Program

The U.S. relies on immigrating physicians for a significant portion of patient care, especially in medically underserved communities. To practice medicine in any state, U.S. residency training is required for professional licensure. In the 2017 medical residency Match, more than 3,800 positions were filled by non-U.S. citizen students. These immigrating physicians undergo rigorous screening by the Educational Commission for Foreign Medical Graduates as part of the visa process.

The J-1 “exchange visitor” visa is the most common pathway for medical students from other countries to attend residency training in the United States. To prevent international “brain drain” the J-1 visa requires participating physicians to practice for at least two years in their home country after completing their U.S. residency. The Conrad State 30 J-1 visa waiver program (“Conrad 30”) enables state agencies to recruit these physicians to underserved areas for three years in exchange for waiving the home country practice requirement. Each year, Conrad 30 directs approximately 1,000 new physicians to underserved communities in nearly every state.

Uniformed Services University of the Health Sciences and the Public Health Service

The development, recruitment, and retention of innovative clinical leaders is central to the success of the VA’s health care system. To better address leadership gaps at the VA during current and future physician workforce shortages, the VA can partner with the Uniformed Services University of the Health Sciences (USUHS) and the U.S. Public Health Service (PHS).

Currently, USUHS medical school graduates each year are assigned to shortage areas as PHS officers. With VA financial support, new participants in this program could be commissioned into the PHS, attend USUHS, and agree to serve seven years with VA post-GME residency. These trainees’ longitudinal exposure to VA presents a unique opportunity to create future physician leaders. As PHS commissioned officers, these physicians will be able to be deployed for national emergencies and, in turn, bring those skills and experiences back to the VA. It is our understanding that VA, USUHS, and PHS are already working on a draft memorandum of understanding, pending approval and funding. AAMC fully supports this innovative initiative and emphasizes the importance of similar leadership development programs.

Health Professions Scholarship Program

Since 1972, the Health Professions Scholarship Program (HPSP) has been a critical source of trained healthcare professionals entering the U.S. military. The HPSP offers prospective military physicians a paid medical education, from one to four years, in exchange for service as a commissioned medical department officer. Programs are available in the United States Army, the United States Navy, and the United States Air Force.

The incurred service obligation is generally one-for-one for every service-paid year of schooling, with a minimum of two years for physicians and three years for other specialties. Fulfillment of the obligation begins only after postgraduate training is completed. While in medical school, the recipient also earns a stipend in addition to paid education.

AAMC Recommendations

1. Nationwide GME Increases: AAMC encourages Congress and the Administration to develop a mechanism that will allow affiliate teaching hospitals that are already at or above their 1997 Medicare GME cap to receive federal financial support for VACAA residents while they are training at a non-VA facility.

2. Early Recruitment Increases: The AAMC recommends VA create public service programs tied to medical school and residency training similar to the HPSP, NHSC S2S, the Conrad 30, and the USUHS/PHS program to help recruit and retain physicians and future leaders earlier in their careers.

BOLSTERING VETERAN-CENTRIC RESEARCH TO IMPROVE CARE

The history of research within the VA is legion and is a source of national pride. VA research has made critical contributions to advancing standards of care for Veterans in areas ranging from tuberculosis in the 1940s to immunoassay in the 1950s to today's ongoing projects dealing with Alzheimer's disease, developing and perfecting the DEKA advanced prosthetic arm and other inventions to help the recovery of Veterans grievously injured in war, studies in genomics and in chronic pain, cardiology, diabetes, and improved treatments for PTS and other mental health challenges in Veterans. These studies and their findings ultimately aid the health of all Americans.

VA research is a completely intramural program that recruits clinicians to care for Veterans while conducting biomedical research. More than 70 percent of these clinicians are VA-funded researchers. VA also awards more than 500 career development grants each year designed to help retain its best and brightest researchers for long and productive careers in VA health care.

VA researchers are well published (between 8,000 and 10,000 refereed articles annually) and boast three Nobel laureates and seven awardees of the Lasker Award (the "American Nobel Prize"); this level of success translates effectively from the bench to the Veteran's bedside. And last, through a nationwide array of synergistic relationships with other federal agencies, academic affiliates, nonprofit organizations, and for-profit industries, the program leverages a FY 2017 annual appropriation of \$675 million into a \$1.8 billion research enterprise.

Sustaining VA Research Investment and Addressing Emerging Veteran Research Needs

The AAMC strongly believes funding for VA research must be steady and sustainable to meet current commitments while allowing for innovative scientific growth to address critical emerging needs. To that end, the AAMC endorses the Friends of VA Medical Care and Health Research (FOVA) and the Veterans Services Organizations' Independent Budget recommendation of \$713 million for VA Medical and Prosthetic Research in FY 2018, a \$38 million (5.6 percent) increase over the FY 2017 comparable level.

Despite documented success, since FY 2010 appropriated funding for VA research and development has lagged behind biomedical research inflation, resulting in a net loss of VA purchasing power. As estimated by the Department of Commerce Bureau of Economic Analysis and the National Institutes of Health (NIH), to maintain VA research at current service levels, the VA Medical and Prosthetic Research appropriation would require \$19 million more in FY 2018 (a 2.8 percent increase over the FY 2017 appropriation). Should the availability of research awards decline as a function of budgetary policy, VA risks terminating ongoing research projects and losing these clinician researchers who are integral to providing direct care for our nation's Veterans. Numerous meritorious proposals for new VA research cannot be awarded without a significant infusion of additional funding for this vital program.

Beyond inflation, the AAMC believes another \$19 million in FY 2018 is necessary for expanding research on conditions prevalent among newer Veterans as well as continuing inquiries into chronic conditions of aging Veterans from previous wartime periods, for example Alzheimer's disease, Parkinson's disease and other neurodegenerative illnesses that might have connection to wartime service.

Additional funding will also help VA support emerging areas that remain critically underfunded, including:

- Post-deployment mental health concerns such as PTS, depression, anxiety, and suicide;
- The gender-specific health care needs of the growing population of women Veterans;
- Engineering and technology to improve the lives of Veterans with prosthetic systems that replace lost limbs or activate paralyzed nerves, muscles, and limbs;
- Studies dedicated to understanding chronic multi-symptom illnesses among Gulf War Veterans and the long-term health effects of potentially hazardous substances to which they may have been exposed; and
- Innovative health services strategies, such as telehealth and self-directed care, relatively new concepts that can lead to accessible, high-quality, cost-effective

care for all Veterans, as VA works to address chronic patient backlogs and reduce wait times.

The VA research program is uniquely positioned to advance genomic medicine through the Million Veteran Program (MVP), an effort that seeks to collect genetic samples and general health information from 1 million Veterans over the next five years. To date, more than 500,000 Veterans have enrolled in MVP. When completed, the MVP will constitute one of the largest genetic repositories in existence, offering tremendous potential to study the health of Veterans. While AAMC supports \$65 million to support this transformative and innovative program, this program should not impede other critical VA research priorities.

State-of-the-art research also requires state-of-the-art technology, equipment, and facilities. For decades, VA construction and maintenance appropriations have failed to provide the resources VA needs to replace, maintain, or upgrade its aging research facilities. The impact of this funding shortage was observed in a congressionally-mandated report that found a clear need for research infrastructure improvements system-wide. Nearly 40 percent of the deficiencies found were designated “Priority 1: Immediate needs, including corrective action to return components to normal service or operation; stop accelerated deterioration; replace items that are at or beyond their useful life; and/or correct life safety hazards.”

The AAMC believes designating funds to specific VA research facilities is the only way to break this stalemate. In 2010, VA estimated that approximately \$774 million would be needed to correct all of the deficiencies found throughout the system; only a fraction of that funding has been appropriated since. A follow-up report is already underway and will guide VA and Congress in further investment in VA research infrastructure to recruit the next generation of clinicians to care for the nation’s next generation of Veterans. However, Congress needs to begin now to correct the most urgent of these known infrastructure deficiencies, especially those that concern life safety hazards for VA scientists and staff, and Veterans who volunteer as research subjects.

Stronger VA–Academic Relationships Through Joint Appointments

The AAMC strongly supports joint appointments for research faculty between medical schools and affiliated VAMCs. It advances both institutions as has been detailed throughout this testimony. Simply put, faculty are the glue that binds a medical school with its affiliated VA to achieve our collective desired research outcomes. Unfortunately, confusion and challenges continue to exist, especially surrounding effort reporting and dual compensation.

A 2010 Report by the Council on Government Relations (COGR) reviewed the considerable work that the VA and its affiliates have done to clarify the appointments and accountability process especially for research faculty. COGR’s report provides useful background information and best practices for affiliated medical schools and VA to follow. The COGR report delineates background issues that have caused conflicts between university/medical school and VAs over matters such as: how faculty work effort is defined differently between university/medical schools and the VA; the value of memoranda of understanding (MOUs) between the university/medical schools and VA, a faculty member’s Total Professional Activities; suggested approaches to for salary support from Federal grants, and approaches to establish a common language and approach to problem solving conflicts that inevitably arise among administrators from both the university/medical school and VA.

The good news is that there has been considerable work accomplished over the last several years to better understand the independence of faculty appointment from VA appointment, total professional activities, develop model template appointment letters and MOU certification formats to harmonize the challenges of joint university/medical school and VA appointments. We have heard from several of our AAMC medical schools officials that relationships are quite good between the school and VA. Others note challenges. The AAMC believes that the COGR template outlined in their 2010 document can serve as a model for such joint appointments of faculty. The document outlines the recommended appointment language and how to harmonize percent effort of the university/medical school appointment and the eighths appointment methods by the VA.

Administering National Institutes of Health (NIH) Grants

Like all federal agencies, the VA cannot be the recipient of a grant from another federal agency (such as the NIH). Likewise, the VA cannot receive facilities and administrative costs associated with grants from federal agencies. There are two common options for investigators with VA and academic affiliate appointments to conduct NIH funded research at the VA: administering the NIH grant through VA’s

academic affiliates or through VA Non-Profit Corporations (VA-NPC). Because NIH award administration is dependent on a variety of local factors, the VA Office of Research and Development allows the local VAMC to determine whether to use the academic affiliate or the VA-NPC. In many cases, the entity administering the grant is dictated by where the majority of the work takes place (i.e., the VA or the academic affiliate). Where the work is split between both sites, VAMCs can have the academic affiliate administering the grant subcontract with the VA-NPC, or vice versa.

In addition to supporting the aforementioned shared education and clinical missions, there are several reasons VAMC often choose to administer NIH grants through the academic affiliate. Sometimes there is no alternative: not all VAMCs have a VA-NPC and not all VA-NPCs are large enough to handle NIH grant administration. Academic affiliates are also able to offer high value resources, including medical libraries, core laboratory facilities at a reduced cost offered only to NIH funded investigators, university information technology resources, and oversight committees such as Institutional Review Board (IRB) or Animal Care and Use Committee (IACUC). These resources can be prohibitively expensive for VAMCs and VA-NPCs to support independently, and sharing with academic affiliates reduces unnecessary redundancies.

NIH provides additional funding for facilities and administrative costs to the entity that administers the grant. This rate is based on the expenses for supporting research and is negotiated at intervals with the NIH. For an academic institution, the rate is usually greater than 50 percent, whereas the rate for VA-NPCs is usually in the 25 percent range because they have fewer expenses. Some affiliates also set aside a portion the NIH facilities and administrative funding for the VAMC to support developmental activities, such as staff in the VAMC research office, bridge funding, and start up packages to recruit new faculty who will work at the VA.

Likewise, the VA provides additional Veterans Equitable Resource Allocation (VERA) funding to VAMCs to support administration of VA research, including salary for dedicated research time, utilities, security, and human resources. The VA balances the academic affiliates' high value resources and higher NIH facilities and administrative rate when calculating VERA-eligible research expenditures; NIH grants administered by VA-NPCs are counted at 100 percent whereas NIH grants administered by academic affiliates are counted at only 75 percent, favoring use of VA-NPC.

AAMC Recommendations

1.VA Medical and Prosthetic Research Funding Targets: The Administration and Congress should provide at least \$713 million for the VA Medical and Prosthetic Research program for FY 2018 to support current research on the chronic conditions of aging Veterans, emerging research on conditions prevalent among younger Veterans, and the Million Veteran Program.

2.Research Infrastructure Support: The Administration and Congress should provide funding for up to five major construction projects in VA research facilities in the amount of at least \$50 million and appropriate \$175 million in nonrecurring maintenance and for minor construction projects to address deficiencies identified in the independent VA research facilities review provided to Congress in 2012.

3.Reducing Regulatory Burden: To reduce training redundancy and burden, the VA should recognize and not require duplication of accredited human subjects research, information privacy and security, biosafety and biosecurity, and animal care and use training provided by the academic affiliate.

4.Maintaining Local Flexibility: Because NIH award administration is dependent on a variety of local factors (e.g., available research administration and support infrastructure) the AAMC believes that administration of NIH awards should be determined by the applicable VAMC in consultation with the VA-NPC and academic affiliate as appropriate.

5.AAMC encourages the use of COGR model templates for the joint appointment of faculty to university/medical schools and VAs in order to clarify Total Professional Effort and reporting efforts for Federal and non-federal grants applications. Standardizing the approach will greatly reduce administrative conflict and improved faculty awareness and understanding.

IMPROVING VETERANS' ACCESS TO CARE AT ACADEMIC AFFILIATES

The nation's major teaching hospitals - frequently with regional campuses and co-located near VAMCs - provide around-the-clock, onsite, and fully-staffed standby services for critically-ill and injured patients, including trauma centers, burn care

units, comprehensive stroke centers, and surgical transplant services. While on paper there may be appeal to increasing Veteran's access to civilian health care services through fee-basis mechanisms like the Veterans Choice Program, this also has the potential to dilute Veterans' access to the very best care available.

The rationale is quite simple. For highly specialized complex clinical care, for example cardiac by-pass surgery, we know that heart centers that do high volumes of cardiac by-pass procedures have better outcomes than those who have less volumes. AMCs around the country make tremendous investments in their cardiovascular service lines, including capital equipment, human capital investment and protocol management to ensure topflight care. Many regional VAMCs neither have the budgetary strength, patient volumes or human capital to invest in these types of services in order to have comparable outcomes observed in civilian programs. Like with commercial and managed care organizations who preferentially contract with AMCs to ensure that their beneficiaries receive top line care, these same principles should be encouraged and embraced by the VA.

The VA's 2015 Plan to Consolidate Community Care Improves the Current System

The Veterans Health Care Choice Improvement Act of 2015 (P.L. 114-41) required the VA to "develop a plan to consolidate all non-Department provider programs by establishing a new, single program to be known as the 'Veterans Choice Program' to furnish hospital care and medical services to Veterans enrolled in the system of patient enrollment established under section 1705(a) of title 38, United States Code, at non-Department facilities."

As proposed in the VA's 2015 plan, the AAMC supports a tiered network of providers in order to improve Veterans access to care at academic affiliates. The proposed VA Core Network would include federal and academic partners, and would be treated as a direct extension of VA care. The External Network would include a Standard Tier as well as a Preferred Tier for providers that demonstrate quality and value.

Under the plan, AMCs would be able to continue contracting directly with the local VA Medical Center to provide clinical services. This contracting would be streamlined with national templates, but allow for local flexibility. Importantly, medical schools and teaching hospitals would also be eligible for fee-basis care under the new External Network that is reimbursed at Medicare rates with customized fee schedules for selected areas and scarce specialty services.

The VA would be responsible for case management and referrals instead of third party administrators. Additionally, VA would accept academic affiliates' credentialing, with a new VA oversight committee to audit compliance with credentialing standards. The VA also plans to streamline referrals and health information sharing by automating these processes. The plan also calls for greater monitoring of outcomes and quality metrics for non-VA providers. VA is expected to utilize existing metrics, such as those under the Centers for Medicare and Medicaid (CMS) Hospital Value-Based Purchasing (VBP) program.

Improving VA Sole-Source Contracting with Affiliates

As was stated earlier, today's AMCs are sites where quaternary and complex clinical care can be best delivered to Veterans who are in need of those services. Improving the contractual processes between AMCs and regional VAs or VISNs would greatly relieve the administrative burdens for all parties, and thereby enhance the coordination and continuity of care for Veterans who require complex care.

While it is important to have performance standards and data, they will only confirm what we already know: the process for long-term, high value sole-source affiliate contracts (SSACs) is arduous, resulting in short-term SSACs as a fallback. In other words, the problem is the process itself, not the oversight of the process. The most frequently identified barrier is the additional review of contracts greater than \$500,000 by the VA Office of Inspector General (OIG). To apply similar review to short-term contracts under \$500,000 would only create the same problems we've seen with long-term, high-value SSACs.

Short-term agreements are executed as services are about to expire and leave Veterans in a lurch. AAMC members frequently report that short-term contracts are used as placeholders for long-term, high-value contracts. Both VA medical centers and their affiliates would prefer long-term, high-value SSACs, but the process and OIG oversight prevents or significantly delays agreements. As such, the focus should be on improving the process of long-term, high-value SSACs, rather than imposing similar arduous oversight on short-term SSACs.

In addition to improving turnaround for SSAC development and approval, the contracting rules for the VA are not designed with clinical services in mind. The size

of clinical services contracts varies greatly, but AAMC members report that virtually all 5-year contracts with the VA are between \$2 million and \$10 million, far exceeding the current \$500,000 threshold for additional review. As an example, the AAMC estimates that contracts for the following clinical services would surpass \$500,000 and trigger additional review:

- 10 uncomplicated cardiac surgeries
- 4 burn cases
- 5 intensive care unit cases
- 10 outpatient radiation cases
- 10 esophageal cancer surgery cases

The AAMC understands the need for federal oversight, but often the administrative bodies designed to review and enforce this oversight have a less than full understanding of the value in contracts with academic affiliates. This value is why VA Directive 1663 states, “Sole-source awards with affiliates must be considered the preferred option whenever education and supervision of graduate medical trainees is required (in the area of the service contracted). The contract cost cannot be the sole consideration in the decision on whether to sole source or to compete.”

However, by VA’s own estimation, once the decision to contract out care has been made, VA sole-source contracting with trusted academic affiliates takes longer than the formal competitive solicitation process - officially between 17–28 weeks compared to 14–18 weeks, respectively, according to VA Directive 1663. Sole-source contracts over \$500,000 go through an additional 10–11 weeks of review (23–25 weeks total) compared to contracts under \$500,000. Contracts over \$5 million require an additional 3 weeks (26–28 weeks total). AAMC members report additional delays of up to 18 months as a result of the VA OIG pre-award audit for sole-source contracts that exceed \$500,000.

As a result of approval delays, it is necessary to execute a series of extensions or short-term contracts to continue to be paid for services. This requires a great deal of time and effort on the part of both the VA and the academic affiliate. In some cases, payment is delayed as a result of this process. In the long term, it makes it difficult for departments to recruit faculty for the VA because there is no commitment for future funding.

Establishing Joint Ventures With Academic Affiliates

To better align the VA and the nation’s medical schools and teaching hospitals, the AAMC supports the Enhanced Veterans Healthcare Act of 2017 (H.R. 2312). The VA and academic medicine have enjoyed over a 70-year history of affiliations to help care for those who have served this nation.

This shared mission can be strengthened through joint ventures in research, education, and patient care. Already our institutions and medical faculty collaborate in these areas, but often VA lacks the administrative mechanisms to cooperatively increase medical personnel, services, equipment, infrastructure, and research capacity.

Current authority for VA to coordinate health care resources with affiliates has been narrowly interpreted by VA Office of General Counsel and the OIG. VA can occupy and use non-VA space for limited purposes, but only under 6-month sharing agreements, 6-month revocable licenses, or 5-year leasing agreements - all of which have failed in practice.

AAMC Recommendations

1.VA Core Network with Affiliates: AAMC supports implementation of the VA’s 2015 plan to consolidate community care and create a tiered network that facilitates provider participation, but importantly does not dictate how Veterans will use the network. For academic affiliates who do not yet participate in the VA Choice Program, the Core Network will enable VA to sustain and strengthen relationships with affiliates and allow Veterans access to the high quality, timely care these affiliates deliver.

2.Contracting Process Improvements: Sole-source contracting with trusted academic affiliates should not take longer than the competitive bid process. The AAMC recommends exempting sole-source contracting with academic affiliates from additional OIG review triggered by the \$500,000 threshold, or raising the trigger to at least \$2.5 million for 5-year contracts.

3.Pre-Approved Templates and Rates: As referenced in the VA’s consolidation plan, the AAMC appreciates VA’s willingness to develop pre-approved template contracts that reimburse certain services with at least Medicare rates. Additionally, we have discussed the development of standardized facilities and administrative rates to eliminate unnecessary negotiations and contract delays.

4. Joint Ventures with Academic Affiliates: The Enhanced Veterans Healthcare Act of 2017 (H.R.2312) would direct the VA to enter into agreements for health care resources (including space) with schools of medicine and dentistry, university health science centers, and teaching hospitals to deliver care to our Veterans to meet the growing demand for Veteran health care services.

CONCLUSION

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to testify on these important issues. The VA is at a crossroads. VA GME, research, joint ventures, and the proposed Core Network of the Veterans Choice Program can strengthen the 70-year history of VA-academic affiliations and prepare our country for the next chapter of VA health care. The AAMC and our member institutions will continue to work with the Congress and the VA to address the challenges and opportunities to ultimately improve care for Veterans and all Americans.

Statements For The Record

Letter from Christian Kreipke, Ph.D

To the Subcommittee on Investigations and Oversight, Department of Veteran's Affairs:

It has been nearly a year since I first provided testimony to you regarding my harrowing experience following my disclosure that VA facilities are allegedly defrauding the American people via their academic partners. Please allow me to update you as to the current disposition of this case.

By way of background, shortly after I made disclosures that Wayne State University (WSU) in Detroit, MI and John D. Dingell VAMC (JDDVAMC) were allegedly participating in wide-spread grant fraud I was terminated-first by WSU and then by JDDVAMC. However, they did not just terminate me. In an effort to reduce my credibility they accused me of committing scientific misconduct. When I first provided testimony to your committee I was in the middle of litigation against JDDVAMC through the Merit Systems Review Board brought on by VA's decision to terminate me, create a hostile work environment, and levy frivolous accusations of misconduct against me. Since this time, I received a verdict. The Judge ruled that, in fact, I was a whistleblower and that my disclosures were the source of the actions taken against me, including the misconduct proceedings. Of note to your committee, the Judge ruled that VA retaliated against me for exposing alleged corruption at WSU and that WSU coerced the VA to crush me. Specifically, the Judge stated in her decision,

"The record shows the strong academic relationship between the VA & WSU and the interplay among the VA, ORO [Office of Research Oversight, which provides oversight of VA research], ORI [Office of Research Integrity, which provides oversight over Universities and HHS], and WSU. An inference can clearly be made that Dr. Reeves [Director of JDDVAMC and Professor of Medicine at WSU] was attempting to appease WSU and protect their relationship by acquiescing in WSU's continued interference with the VA's employment of the appellant...I find the existence and motive to retaliate stemmed from the improper influence of WSU over the VA to take action against the appellant."

Thus, an independent arbiter of this situation concluded that Universities do exert undue influence over VA facilities with little scrutiny or accountability.

It appeared for a brief moment that I would receive relief from this situation as the Judge ordered,

"the agency to rescind its decisions to: (1) terminate the appellant's active Merit Review Award entitled "Poly-trauma following brain injury: towards a combinatorial therapy"; and (2) to rescind its decision to terminate the appellant's term appointment for VA research; and (3) to rescind its decisions to debar the appellant from receiving VA funds for a period of 10 years."

Regrettably the current VA administration refuses to comply with the Judge's order, thus leaving me, a whistleblower, still uncompensated, unable to continue my work and left with a horrific smear on my character-a 10 year ban from receiving government funding. Yet again I find the very government that I am trying to protect being my worst enemy. As a U.S. citizen I continue to be treated as an enemy of the state, despite having been victorious in the Court of Law.

My story does not end here. In the near future I will continue my nearly seven-year, extremely costly fight against corruption. I will be involved in yet another lawsuit-this time against the Department of Health and Human Services (HHS) which

has supported Wayne State University in their quest to destroy me. Regrettably, HHS tried to engage the VA in supporting Wayne State's claims against me, adding to the tangled web of falsities aimed at ruining my integrity. What is the connection between these entities? HHS provides millions of dollars to Wayne State to support not only grants but also the Institute of Perinatology which is located at Wayne State. Further, numerous VA grants are joint efforts between VA and HHS. It is patently clear that HHS has little oversight of the money that it is handing to WSU (and other Universities). My disclosures are surely a horrific embarrassment to HHS, exposing their lack of concern over the disbursement of billions of dollars nationwide. It appears that the improper influence of Universities extends to multiple agencies within our Government.

When I previously provided testimony to your committee I was also involved in a False Claims Act suit against WSU. Despite numerous witnesses corroborating my facts, the DOJ decided not to intervene. Thus, I was forced to litigate through my lawyer without the aid of the very government I was trying to protect. Though the Courts ruled that Universities are immune from any accountability, there was hope that the Supreme Court would analyze the current laws for whistleblowers in order to allow us to hold Universities accountable for defrauding the American people. Disappointingly, the Supreme Court decided to deny cert, thus allowing inconsistency across our Great Nation as to whether or not a University can be held accountable for fraud. Currently WSU and many other Universities are deemed to be immune from such accountability.

In summary, under current interpretation of the law, Universities can continue to exploit our hard-earned tax dollars at the expense of health care and medical discovery. The VA continues to retaliate against those that are trying to assist in correcting monumental problems that plague the beleaguered Agency. And grant money continues to be diverted away from advances to help our Veteran's cope with a myriad of health issues. Taken as a whole, the system is horrifically broken.

Is there hope? Despite having had my life ruined over a period of nearly seven years and now apparently having a system in which a Judge's opinion can be ignored, I still have hope in our Great Country and its Government Institutions. I believe in Democracy and I believe that it is this Democracy that will prove victorious in the end. It is in your hands, Members of Congress, to steer a flailing ship to calmer waters. I believe that you can make a difference by listening to us Whistleblowers, listening to what we are telling you, and allowing our testimonies to guide your decision making. By holding those that would defraud our fellow Americans accountable, we can stop this madness and allow for proper funding to guide medical discovery and better treatment for not only our Veterans but for each and every citizen.

In conclusion, while I still am battling horrific corruption within the VA and WSU, I am confident that we Americans can count on our Elected Officials in Congress to fix the problems that have been exposed. I am confident that in the near future confidence in the VA can be restored. I am confident that in the near future Universities can return to their mission of training our future generations. This cannot happen spontaneously, however. Careful scrutiny of current law is required to hold those that would threaten the veracity of our Great Institutions accountable. Either through modifications of current law or creation of new laws, accountability must be achieved.

As I have maintained throughout this horrific experience, I will continue to assist in any way that I can as I do believe that my sacrifices will not be in vain. I believe that these problems can and will be fixed. Thank you, in advance, for your continued efforts to try to implement improvements to the current System.

Respectfully Submitted,

Dr. Kreipke

