Statement

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On

VA and Academic Affiliates: Who's Benefiting Now

Presented to the

Subcommittee on Oversight and Investigations
Committee on Veterans Affairs
United States House of Representatives

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June 8, 2017

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 Veterans 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 committees 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 heath, 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/medial 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 rational 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.