VA AND ACADEMIC AFFILIATES: WHO BENEFITS?

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BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

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U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT
AND INVESTIGATIONS,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 4:17 p.m., in Room 334, Cannon House Office Building, Hon. Mike Coffman [Chairman of the Subcommittee] presiding.

Present: Representatives Coffman, Lamborn, Roe, Huelskamp, Kuster, O'Rourke, and Walz.

OPENING STATEMENT OF MIKE COFFMAN, CHAIRMAN

Mr. COFFMAN. Good afternoon. This hearing will come to order.

I want to the welcome everyone to today's hearing, titled "VA and Academic Affiliates: Who Benefits?" This hearing will examine the relationship between the VA and the academic affiliates. The hearing will focus on issues and concerns related to sole-source contracting, billing issues, research funding, space, data and equipment.

VA has had a relationship with academic affiliates dating back to World War II. This relationship was developed and encouraged as a way to ensure that our Nation's veterans received the best care possible following their service to our country. We all agree our veterans deserve nothing less than the best care.

We have already witnessed many ways in which veterans are being denied high-quality health care, including excessive wait times, confusing scheduling processes, and the lack of access to non-VA care because of poor implementation of the Choice Act.

Now we are hearing that the relationship between VA and its affiliates may not be as beneficial as VA and veterans—I'm sorry—not be as beneficial to VA and veterans as was initially intended.

We are discovering that affiliates control the affiliate relationship and make decisions related to VA and the way it operates. Leadership positions at VA medical centers are held by employees who also have appointments at the academic affiliate.

This begs the question as to where the loyalties lay for these VA leaders. Are these VA leaders making decisions in the best interests of the veteran when they also have an allegiance to the affiliate? How can we be sure? What oversight is in place to ensure that veterans are benefiting from this relationship?

According to a recent OIG report from August 2015, VA medical centers are allowing physicians to come and go between VA and the affiliate with no true oversight of their time. There are no assurances that these physicians are in the VA performing their VA responsibilities when they are supposed to be, and the bills are being paid without questions about the services rendered.

Similarly, we are aware that VA leadership is allowing VA research projects to be conducted at the affiliate, VA equipment to be removed to the affiliate, and VA research data to be stored on university servers. These actions can greatly impact VA's ability to assert ownership rights in inventions made by VA employees who are using VA resources. We certainly do not want to see VA in a similar position to what it was regarding the hepatitis C drug.

We also know that VA nonprofit corporations are not being utilized to their fullest potential. Congress authorized these nonprofits in order to allow additional research dollars to be put back into VA research for the benefit of veterans, but much of this money is being administered by the affiliates instead, resulting in a loss of millions of dollars to VA.

Finally, according to the GAO report just issued yesterday, we know that VA is taking years to negotiate and enter into sole-source affiliate contracts, which results in gaps in patient care. This is most definitely not in the best interest of our veterans. Hopefully we can hear what VA is doing to improve this relationship with academic affiliates to better benefit veterans.

With that, I now yield to Ranking Member Kuster for any opening remarks she may have.

OPENING STATEMENT OF ANN M. KUSTER, RANKING MEMBER

Ms. KUSTER. Thank you, Chairman Coffman.

This afternoon, the Subcommittee on Oversight and Investigation will delve into issues involving VA and its academic affiliates.

The VA plays a vital role in our national health care delivery system. In 70 years of partnership with academic affiliates, the VA is the largest single provider of medical training in the United States. Today, over 70 percent of health care providers have received their training through the Veterans Administration.

While our overall health care system reaps the benefits of VA's education and training efforts, the 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 shortages in health care providers. In fact, it's estimated that there will be a nationwide shortage of between 46,000 to 90,000 physicians within the next decade.

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

We simply must improve the contracting process between the VA and its affiliates for medical services. How medicine is practiced in this country is undergoing a revolution, with more integration and more consolidation. VA's contracting process must recognize these changes and evolve with the practice of medicine.

It should not take 3 years for the VA to contract with its affiliates to provide medical services to our veterans. This cumbersome process meant that 161 academic affiliates who wanted to provide more doctors and services during the patient access crisis of 2014 were turned away because the contracting process was just too hard. It's unacceptable that a bureaucratic process stands in the way of our veterans accessing high-quality care.

Further, according to the GAO, who is with us today, the process for sole-source affiliate contracts is a mirror of what we often find on this Subcommittee when we look into VA's contracting processes in general—too little oversight, not enough data, and too many barriers to getting the job done. It's simply impossible to manage such a vital program if you do not have the information to make decisions, spot problems, and systemize and streamline the process.

I am hopeful that we have a conversation on how best to provide needed oversight and flexibility, and how best to recognize the changing nature of the health care industry in America, and to make sure that we leverage these changes to the benefit of our veterans.

I look forward to hearing from all of our witnesses invited to appear before us today.

And I yield back the balance of my time.

Mr. COFFMAN. Thank you, Ranking Member Kuster.

I ask all Members—I ask that all Members waive their opening remarks, as per this Committee's custom.

Hearing no objection, so ordered.

With that, I would like to introduce our panel. On the panel, we have Dr. Robert Jesse, Chief Academic Affiliations Officer for the Department of Veterans Affairs, who is accompanied by Dr. David Atkins, Acting Chief Research and Development Officer, and Ricky Lemmon, Acting Chief Procurement and Logistics Officer; Mr. Randall Williamson, Director of GAO's health care team; Dr. Janis Orlowski, Chief Health Care Officer, Association of American Medical Colleges; and Ms. Nancy Watterson-Diorio, Board Member of the National Association of Veterans' Research and Education Foundations.

I now ask that all witnesses stand and raise their right hands.

Do you solemnly swear under penalty of perjury that the testimony you are about to provide is the truth, the whole truth, and nothing but the truth?

Thank you. Please be seated.

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

Dr. Jesse, you are now recognized for 5 minutes.

STATEMENT OF ROBERT L. JESSE, M.D., PH.D.

Dr. JESSE. Good afternoon, Mr. Chairman, Ranking Member Kuster, and Members of the Committee, and thank you for this opportunity to discuss VA's relationship with its academic affiliates.

As you mentioned, I'm accompanied today by Mr. Rick Lemmon, the Acting Chief Procurement and Logistics Officer, and Dr. David Atkins, the Chief Research and Development Officer.

January 30th of this year, marked the 70th anniversary of Policy Memorandum 2. This established the visionary partnership be-

tween VA and America's medical schools. Strong academic relationships have proven to be a foundation for providing veterans access to high-quality health care and support for VHA to fill its statutory missions to educate for VA and for the Nation, and to carry out a program of medical research in connection with the provision of medical care and treatment of veterans.

Academic affiliates facilitate the recruitment of outstanding clinical staff to VA, and trainees working under their supervision serve as force multipliers. The opportunity to teach America's best and brightest attracts clinicians motivated by professional excellence, ensuring that VA can remain a leader in the knowledge and skills associated with the practice, teaching, research, and the building of the learning health care system.

The Office of Academic Affiliations manages the educational components of these relationships through affiliation agreements that address the health profession's educational activities and disbursements of funds for physician trainees. Research operations, including grant funding, as well as the arrangements for shared space, equipment, and personnel, are managed by the Office of Research and Development. And contracts for professional and clinic services are managed by the Office of Procurement and Logistics through sharing agreements and other contractual mechanisms.

VA is profoundly important to U.S. professional education, having affiliations with over 1,800 schools and programs. Nearly 124,000 trainees receive supervised clinical education in VA facilities each year, with about 70 percent of all U.S. physicians having some VA clinical experience in the course of their education. VA is the second-largest funder of graduate medical education after Health and Human Services.

VA research has contributed to transformational advances impacting virtually every aspect of health care as we know it today. VA research benefits from its position within a national integrated health care system, and from having a state-of-the-art electronic health record. It also benefits from dynamic collaborations with university partners, Federal agencies, nonprofit organizations, and industry, which bring in additional funding, and this was, I think, $287 million in 2015.

The Federal investment in VA research returns incredible value to veterans and to the taxpayer. Take, for example, the Million Veteran Program, which has already enrolled close to half a million veterans, who have donated samples and completed surveys to help unlock the genomic basis of health and disease, and is poised to be a cornerstone for precision medicine in the future.

Yesterday, GAO released its report entitled "Improvements Needed for Management and Oversight of Sole-Source Affiliate Contract Development." This report suggested eight Executive actions to ensure timely development of high-value, long-term sole-source affiliate contracts and effective development and use of short-term contracts, including the need to ensure better effective communication between VA and its affiliates.

VA has concurred with the GAO's recommendations and has developed an action plan to meet each of these. The goal is to more effectively and efficiently use VA's existing sole-source contracting authorities to meet the needs of veterans and to ensure compliance

that meets our fiscal responsibilities. VA appreciates the input from GAO and other adviser groups to identify root causes and develop long-term solutions.

Academic affiliations has brought great value to VA, to veterans, and to the American public for 70 years. However, U.S. health care has changed dramatically over this time. The organization of health systems now often involve multiple contracting entities. Health education is now rigidly prescriptive, research oversight is now intense, and payment models for health care are now rapidly evolving.

So, too, must VA change the way we do business with our partners in order to optimize the value of these relationships for veterans and the American taxpayer. Bold, innovative partnership models with affiliates structured around shared resources and accountability to optimize care for veterans are being explored.

As VA commits to improving existing processes, we hope to work with Congress to enhance the authorities under which partnership can be leveraged to improve the quality, safety, and timeliness of health care for all veterans, while also supporting the research mission and the training of the health care workforce for the Nation.

Mr. Chairman, this concludes my testimony. My colleagues and I are prepared to answer any questions you and Ranking Member Kuster may have—and the Committee. Thank you.

[THE PREPARED STATEMENT OF ROBERT L. JESSE APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you, Dr. Jesse.

Mr. Williamson, you are now recognized for 5 minutes.

STATEMENT OF RANDALL WILLIAMSON

Mr. WILLIAMSON. Thank you, Chairman Coffman and Ranking Member Kuster and Members of the Subcommittee. I am pleased to be here to discuss GAO's report, released yesterday, on VA's use of sole-source affiliate contracts.

VA partners with the university medical schools to provide learning opportunities for medical residents, while also increasing a pool of physicians available to treat our Nation's veterans. Over 40 percent of VA's total physician workforce is made up of residents and physicians supplied through academic affiliations.

VA has the unique authority to establish sole-source contracts with its university partners without competition. Today, I will address this very important aspect of VA's academic affiliations.

Sole-source affiliate contracts allow VA to obtain physician services needed to treat veterans and oversee residents working in VA medical centers. Our review covered VA's use and oversight of these contracts and compliance with existing VA procurement policies.

Most of these contracts are of two types: first, high-value, long-term contracts that are over $500,000 and more than 1 year in duration; second, short-term contracts that are less than $500,000 and less than 1 year duration. The value of the contract is an important factor to determine the amount of oversight it will receive. Short-term contracts under $500,000 are subject to much less oversight than high-value, long-term contracts.

We found that at four of the five VA medical centers we visited, they relied mainly on short-term sole-source affiliate contracts to obtain physician services from their affiliates, often avoiding high-level reviews and oversight that potentially could have reduced the contract prices and better ensured that VA was complying with procurement policy.

Contracting officials we interviewed attributed this over-reliance on short-term sole-source affiliate contracts to a number of factors. The most notable reason was that high-value, long-term contracts we reviewed took 3 years to process and finalize, on average, and this timeframe does not work for many medical centers that must seek quick solutions to physician shortages or add additional physicians in critical specialty areas. In contrast, short-term contracts can be finalized in 3 months or less.

The lengthy process to develop high-value, long-term sole-source affiliate contracts is due to incomplete and untimely information submitted by VA medical centers to contracting officers, rework to update paperwork to comply with revised forms or new policies, multiple reviews, and inexperienced contracting staff. Currently, VHA does not have performance standards to hold contracting staff accountable for timeliness, and does not have data to identify and resolve potential bottlenecks in the contracting process.

Relying on short-term sole-source affiliate contracts can have some significant downsides and risks for VA. For example, for short-term sole-source affiliate contracts, contracting officers aren't required to consult trained negotiators to help them establish contract price, as occurs for high-value, long-term contracts. Also, short-term sole-source affiliate contracts are not monitored by VHA's central office, and place VA at risk for overpaying the affiliate services provided through them.

Also, at one VAMC we visited, we found that all five short-term sole-source affiliate contracts we reviewed had serious violations of VHA policy and VA policy, including the absence of negotiations to address pricing issues before finalizing the contract.

More broadly, we found that nowhere in VA does anyone review the big-picture use of short-term sole-source affiliate contracts among medical centers to identify patterns of overreliance and detect potential noncompliance with VA policies and procedures.

Exacerbating the problems that I've outlined thus far is the relative inexperience and high turnover among medical sharing contracting staff. We found that one-quarter of the medical sharing staff leave each year, and two-thirds have less than 3 years of experience working with these types of contracts. It usually takes about 5 years to become proficient in developing these contracts, according to senior VA contracting staff. Moreover, VA has provided limited training to medical sharing contract staff, further aggravating an already difficult situation.

In short, VA needs to take bold steps now on many fronts to rectify its poor management of these contracts. In this regard, we made eight recommendations to improve VA's management of sole-source affiliate contracts, and VA concurred with all of them.

That concludes my opening remarks, Mr. Chairman.

[THE PREPARED STATEMENT OF RANDALL WILLIAMSON APPEARS IN THE APPENDIX]

Mr. COFFMAN. Well, thank you, Mr. Williamson.
Dr. Orlowski, you are now recognized for 5 minutes.

STATEMENT OF JANIS ORLOWSKI, M.D.

Dr. ORLOWSKI. Mr. Chairman, Members of the Subcommittee, thank you for the opportunity to testify on VA academic affiliations.

The Association of American Medical Colleges is a nonprofit institution comprised of all 145 accredited U.S. medical schools and nearly 400 major teaching hospitals, including 51 VA medical centers. As the chief health care officer at the association, my focus is on the interface between the health care delivery system and academic medicine.

The VA has over 500 academic affiliation agreements with our Nation's medical schools and teaching hospitals. As noted, 2016 is an important anniversary for the VA and academic medicine, as we celebrate our 70th anniversary in partnership.

The relationship, as you had noted, followed World War II, when the VA and the Nation faced very much the same situation we face today. At that time, the VA had a severe shortage of physicians as nearly 16 million men and women returned from overseas. Today, there's a combination of the VA's aging veteran population and an influx of veterans from recent engagements. There's an increasing need for more health care, resulting in access issues that are symptomatic of a broader trend, which is the physician shortage.

You ask who benefits from these relationships. Simply put, the veterans do. The AAMC projects a nationwide shortage of between 46,000 and 90,000 physicians by 2025. Though these shortfalls will affect all Americans, we note the most vulnerable populations, including veterans and those in underserved areas, will be the first to feel this impact as the VA is now.

What the VA and academic affiliations established was 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. The VA's education mission trains new physicians on cultural competency for treating veteran patients. Further, the VA has found that a physician is twice as likely to consider employment at the VA after training at a VA facility.

The VA's research mission creates advances in areas important to the veterans population, such as traumatic brain injury, PTSD, prostheses, respiratory exposure, not to mention the system reforms that improve care delivery within the VA systems.

Perhaps most importantly, VA academic affiliations put veterans first in line for the best health care in the world at the Nation's teaching hospitals. Our members take pride in being partners with the VA and providing care to veterans. They view this as an important part of their mission.

The AAMC believes VA's sole-source contracting, joint ventures, and the proposed core network of the Veterans Choice programs improve access for our Nation's veterans to the highest quality care by preserving the academic affiliates as a direct extension of VA care and a preferred provider.

Direct clinical care agreements, such as sole-source contracts, allow academic affiliates to plan, staff, and sustain infrastructure for certain complex clinical care services that are not available elsewhere, such as trauma centers, burn centers, comprehensive stroke centers, and surgical transplant centers. Solely relying on fee-based mechanisms has the potential to reduce veterans' access to care if teaching hospitals scale back services if they are faced with an uncertain patient load from the VA.

Both VA medical centers and their academic affiliates recognize the value of these relationships to improving veterans' health care access and quality. As with any partnership, there's always room for improvement, and the AAMC is working with the VA on contracting reform, including right-sizing the OIG review threshold to reflect clinical services, preapproved contract templates for selected services at Medicare reimbursement levels, and standardized overhead rates. These reforms will streamline agreements, reduce the negotiation times, help prevent delays in veterans' care, and shift reliance on short-term, temporary contracts in favor of the high-value, long-term contracts.

The VA is at a crossroads. Strengthening the 70-year history of the VA academic affiliation will prepare our country for the next chapter of VA health care. The AAMC and our member institutions will continue to work with Congress and the VA to address the challenges and opportunities to ultimately improve care for the veterans and all Americans.

Thank you very much for this opportunity to testify, and I look forward to answering your questions.

[THE PREPARED STATEMENT OF JANIS ORLOWSKI APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you.

The written statements of those who have just provided oral—oh, I'm sorry. Ms. Watterson-Diorio, you are now recognized for 5 minutes.

STATEMENT OF NANCY WATTERSON-DIORIO

Ms. WATTERSON-DIORIO. Good afternoon, Chairman Coffman, Ranking Member Kuster, and Members of the Subcommittee. Thank you for the opportunity to discuss the topic of "VA and Academic Affiliates: Who Benefits?"

My name is Nancy Watterson-Diorio. I am a board member of the National Association of Veterans' Research and Education Foundations, also known as NAVREF, and the CEO of the Boston VA Research Institute, known as BVARI.

As a witness, my topics include how the VA nonprofit corporations fulfill an important role at the VA, in addition to the academic affiliates, in administering this extramural research.

In 1988, Congress authorized the NPCs under title 38 to support VA research and, shortly thereafter, amended legislation to include educational activities. NAVREF represents the entire membership of 82 VA NPCs who are co-located within the VA medical centers across the country.

As reported in the 2014 annual NPC report to Congress, we raised over $260 million of annual extramural research and edu-

cational awards specifically targeted toward the VA's health care mission of supporting veterans' care. This represents approximately 15 percent of the total research portfolio supporting research at VA.

The founding legislation felt several areas of difficulty for the VA research and education programs. It discontinued handshake agreements with no contractual obligations, an acknowledgement of VA's research successes. It supplemented VA's intramural funding expertise with expert support for extramural pre- and post-award funding and unique compliance knowledge. It leveraged VA's ability to expand its research portfolio to support clinical trials and Federal funding, thus allowing more veterans to be supported with state-of-the-art research knowledge, and the opportunity to be treated with the newest therapies. And, finally, it fostered an innovative spirit of public-private sponsorship that we should continue to nurture and grow.

There are many advantages to using NPCs as envisioned by Congress. NPCs rigorously comply with Federal regulations and are subject to VA oversight that includes recurring VA audit requirements and inspections. Additional VA oversight includes statutory VA board members at each NPC, and a nonprofit oversight board at VA's central office. And NPCs operate transparently by providing an annual report to Congress detailing their accomplishments and successes in support of VA research.

There are also challenges that we must find ways to overcome. The VA NPCs are unable to pay investigators in the same manner as the academic affiliates. We have managed to be successful despite this inconsistency, but if we were given the opportunity to administer payments in the same way as the affiliates, it would further enhance our successes in completing our mission of improved veteran health outcomes.

Local practices are inconsistent on whether an NPC or an academic affiliate should be administering VA research projects. I recognize that not all 82 VA nonprofits have the current expertise to manage Federal grants. But without allowing them an opportunity to grow into this role, they will not be able to serve the veteran community to their potential.

And, finally, the decisionmaking process within VA regarding the administration of Federal grants varies from site to site. Frequently, principal investigators, who are duly appointed at the academic affiliates, or even local leadership make the determination on who will administer the research, which is a potential conflict of interest.

I believe that Congress created the NPCs for all the right reasons. However, I believe that the NPCs can contribute much more and be of even greater benefit to our veterans if the lingering barriers were removed.

To that end, I respectfully request that the Subcommittee consider updated directives that would allow NPCs to pay investigators to the same extent the academic affiliates, provide the VA NPC right of first refusal on administering all research awards supporting VA research, and reduce the level of variability from site to site by creating general guidelines and decision trees that remove or reduce conflicts of interest among decisionmakers.

Again, thank you for this opportunity to share the good work that is being done at the VA NPCs, and your support in allowing us this opportunity to participate in the important work that is being done in the VA's extramural research and education programs. NPCs offer great services and value, and I encourage congressional and VA leaders to look at expanding opportunities to use these great resources.

I look forward to your questions. Thank you.

[THE PREPARED STATEMENT OF NANCY WATTERSON-DIORIO APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you.

The written statements of those who have just provided oral testimony will be entered into the hearing record. We will now proceed to questioning.

Dr. Jesse, VA has been asking for noncompetitive contracting authority like what we see related to this hearing topic for other purposes, such as provider agreements. Its sole-source contracting with affiliates is such a mess, why should we believe that sole-sourcing other contracts would be any different?

Dr. JESSE. So I think there's two issues here. It's clear that the administration of the existing sole-source contracts that we have requires some work. And Mr. Lemmon can talk more about that. It certainly is the focus of the GAO report. But there are times when sole-source contracting provides the speed and agility one needs in order to provide care that veterans need in a timeframe that can be done.

And the issue here is primarily getting the proper care to veterans when they need it, and then ensuring that it's done in a fiscally responsible manner.

Mr. COFFMAN. Dr. Jesse or Mr. Lemmon, can you assure me that this affiliate contract situation is different from the purchase card abuse situation we have seen over the past few years, where VA has been making payments with purchase cards spread over many split transactions under false pretense that, actually, contracts existed?

Mr. LEMMON. Yes. There's no relationship to those issues with the purchase card program and what we're trying to do with affiliates.

The purchase card program is something that we're also working on. We didn't prepare statements for that. But we're working on establishing a lot of national-level contracts instead of more open-market procurements under the micro-purchase threshold of $2,500. And so the goal is to bring that in.

Right now, we have way too many people with purchase cards, way too many transactions. And we want to act more as an enterprise and buy off of nationally leveraged contracts that provide great value to VHA, and reduce the amount of open-market buying that's going on now that's created some of the problems that you identified.

Mr. COFFMAN. Well, can you assure me there aren't any handshake agreements here, that all this affiliate spending is done on bona fide contracts?

Mr. LEMMON. I believe we do have contracts in place for our affiliate agreements. It's hard to say that in no hospital at any place in the country there's something that I wouldn't know about, but there's been great effort to put contracts in place with affiliates.

GAO certainly found a number of challenges that we take ownership of and we're going to address, but I don't believe there's handshake agreements like there were in the past.

Mr. COFFMAN. Dr. Jesse, in a 2015 OIG report, it was found that the VA medical center in Pittsburgh had overpaid the University of Pittsburgh Physicians, Incorporated, by $44,082 for call-back service hours that should have been attributed to a VA physician as a five-eighths employee. Will this money be refunded to the VA?

Dr. JESSE. Well, I can't answer that question. I can take it for the record and get back to you.

But the question here is, when a five-eighths—when a part-time physician has already committed their hours to the VA and then are working for another agent, meaning the university, what are the responsibilities going back and forth there.

But I don't know the exact answer to your question. I will get back to you.

Mr. COFFMAN. Are you disputing the factual nature of the OIG report in terms of the overpayment?

Dr. JESSE. No. I agree the OIG report said that they were paid an additional $24,000. The question was, is it going to be returned, and I said I don't know the answer to that question, but we can find that out for you.

Mr. COFFMAN. It's $44,000.

Dr. JESSE. $44,000. I'm sorry.

Mr. COFFMAN. $44,000. And so are you going to try and get that money back? That's the question.

Dr. JESSE. Well, we have to make sure—and I would defer to Mr. Lemmon—do we have the authority to get that back. And that's what I don't know. But if we have the authority to get it back, we will try and get it back.

Mr. COFFMAN. Mr. Lemmon?

Mr. LEMMON. Yeah, the network contracting office involved is working with general counsel to determine if we can recover the funds. If they determine that legally we can do that, we will.

Mr. COFFMAN. Well, since we didn't get back—since we didn't attempt to get back any of the bonus money that was given during the appointment-wait-time scandal, I'm not all that surprised.

Ranking Member Kuster, you're now recognized for 5 minutes.

Ms. KUSTER. Thank you.

And these go to anyone who would like to answer.

So I want to get at: Knowing that the practices of the delivery of medicine is dramatically changing—we've got accountable care organizations, we have group practices, we have lots of different affiliations that are happening outside of the VA process, but just happening with academic affiliates across the country—how have these changes created issues with the development of these long-term sole-source affiliate contracts?

And if you can add to that, what is it that takes so long? Is this contributing to the length of time? Or are they issues within the VA that—because 3 years just sounds untenable to me.

Dr. JESSE. So let me take, sort of, the preamble to your question, and then I'll turn it over to Mr. Lemmon.

Actually, up in VISN 1, up in your area, there are a number of alternative relationships being explored with the affiliates in Burlington, Vermont, in Worcester, Mass., and in Maine, where we are looking more at a joint-venture model, which would share both care and accountability for care with the affiliate in shared space, actually, where the VA could provide care to the veteran under its authorities, the partner could provide care to their family under their authorities, and we would share in the other things like the social services that we know are required to engender good health and well-being.

And that model doesn't work well in a contracting venue that's really driven by a fee-for-service-type of model. And that was the comment I was alluding to about really relooking about how we can have the authorities to contract with partners to develop these types of models. So think about joint ACOs, for instance, as a potential, or other responsibilities, where we would have a shared capitation for caring for a group of patients rather than negotiating services for X number of cardiac surgeries, X number of transplants, X number of cholecystectomies or colonoscopies, but rather a much more holistic approach.

And, frankly, this is where CMS is really trying to drive with its alternative payment models, including both ACOs and the—

Ms. KUSTER. So do you think we're in a period of transition where the VA—I mean, as the country is transitioning over to the accountable care organizations, the VA is also following that process, and that we could get to a place of a better contracting and more effective and efficient and—

Dr. JESSE. So I'll speak on behalf of me and not the agency, because this is my opinion. And I think we have to. Because the current model—and as everybody on this panel has alluded to, the affiliation relationships that were established 70 years ago were done for a good reason, and they're here today, but the model of care in this country, how government functions in this country is very different than it was in the 1940s. So we need new structures that allow us to optimize the care for veterans consistently, where data moves back and forth smoothly, where there is no opportunity for people to get lost because of fractured care.

And as an example—

Ms. KUSTER. Do you think you need new—do you need new authority from Congress—

Dr. JESSE. Oh, I think we do. And I think—

Ms. KUSTER [continued].—to enter into those kinds of relationships?

Dr. JESSE [continued]. I think we do need new authorities from Congress, and we will be exploring them. We're just not prepared to say exactly what now.

But let me give you an example. This was just announced last month. In Palo Alto, they have now a relationship. The word went to CVS, to the MinuteClinics, where veterans out in the bay area, if they have a problem, they can call the nurse triage line. And if it's a problem that is in the purview of what MinuteClinics provide, they will be referred to a MinuteClinic, the closest one. They won't

have to travel into Palo Alto or go to the ER or urgent care or to their primary care provider. They get seen on the spot. VA pays; there's no pay for the veteran. But the information comes back over into the VA records so we get continuity of care.

Today, any veteran can go to any Walmart in the country and get a flu shot for free, and that information will come back in. And so these types of more extensive partnerships, I think, are the models we're going to be talking about in the future. Holistically—an ACO means certain things to certain people. I'm not sure it's exactly the right term. But more cohesive payment models will be key.

Ms. KUSTER. All right. Thank you.

My time is up. I yield back.

Mr. COFFMAN. Thank you, Ranking Member Kuster.

Congressman Lamborn, you're now recognized for 5 minutes.

Mr. LAMBORN. Thank you, Mr. Chairman. And thank you for having this hearing and for your leadership on investigative and oversight issues like this.

Dr. Atkins, you might be familiar with our recent Full Committee hearing regarding invention disclosure, which we held in February. What is VA doing to ensure that VA employees are disclosing inventions they develop to the VA?

Dr. ATKINS. Thank you. Yes, since that February hearing, we've instituted three steps.

With the specific example that was the subject of that hearing, regarding the hep C drug, we have an internal—an external review by our National Research Advisory Committee that will be reporting to us tomorrow. There is a criminal IG investigation of that case that has completed its interviews, but we have not received the report of that.

And I think, to your question specifically, we're revising our policies to ensure that we get more complete annual disclosure of inventions, so that the VA would be aware of intellectual property to which it may lay a legitimate claim.

Part of the problem has been the reporting process. We're going to try to make that easier for our researchers, so they can report it in the same way that they report it to the universities.

Mr. LAMBORN. Thank you for making some progress on that. I would like to ask that you provide the Committee copies of those reports as soon as you get them. You've referred to a couple of different—

Dr. ATKINS. Certainly.

Mr. LAMBORN [continued].—reports or updates and status reports. This is a big issue, and I hope there's nothing else out there of the magnitude of this hanging problem.

On the issue of disclosures, Dr. Jesse, changing gears slightly, we know that VA employees can have dual appointments with the affiliates and collect salary and benefits for both institutions. Does VA require financial disclosures from these employees?

Dr. JESSE. Of total salaries?

Mr. LAMBORN. Their dual status and—

Dr. JESSE. Oh, I don't think a dual status would be missed. The VA—

Mr. LAMBORN [continued]. And benefits.

Dr. JESSE [continued]. Yeah. So the VA maps clinicians' time, and it apportions that to clinical care, research, administrative, for the like. But if somebody's a part-time physician, then the rest of their time would be known to the university.

And, frankly, many of the clinicians are actually jointly recruited. So the recruitment includes a department chair, say, from the university working with a department chair, the counterpart at the VA, to bring a person in that would spend joint time. And this is particularly common in procedural-laden issues.

I think one of the challenges—and I want to be really clear about how I say this. But VA accounts for physicians' time as essentially an 80-hour pay period. And VA time and attendance—and I think you've heard the Secretary talk about problems with emergency physicians and hospitalists, that they don't fit normal hours that we ascribe physicians to work in. But we account for hours at a 40-hour week, 80-hour pay period.

Most universities account their physicians' time closer a 70-hour work week. And this is in part because of how they have to map and commit time on NIH grants and teaching and research. And clinical care is not a 9-to-5 operation. And so it is possible to have a full-time, 40-hour-a-week VA who also has a time commitment to the university above and beyond that.

And those arrangements are disclosed, as far as I'm aware. I don't think it could be missed. And this follows an NIH model that actually allows physicians to be paid for, actually, an additional 20 hours.

Mr. LAMBORN. Well, thank you for that. But I'm also wanting to make sure that we have disclosure in place that would lead to the revealing of conflicts of interest.

Dr. JESSE. Yeah. So I would hope that would be so. And I think you're driving at if there's shared development of intellectual property is probably the most important thing.

And, you know, a conflict of interest that—you know, we just talked about financial conflicts of interest, but there's also influence conflicts of interest too. And, you know, those have to be managed very carefully. Our lawyers, our general counsel, always advises people that we can clear you of certain levels of conflict of interest, but it does not absolve you, as the individual, from a criminal conflict of interest.

So the physicians themselves, you know, myself, always need to be aware of the rules and aware of those boundaries. But if there are issues, we will have counsel review them to make sure that the boundaries are clear. And this actually has happened recently with the chief of staff, for instance.

But they're very clear. If you cross—if you, as the individual, regardless of whatever clearance we've given you, cross certain boundaries, then you are liable for your actions.

Mr. LAMBORN. Okay.

Thank you for your answers, and thank you for being here today, all of you.

Dr. JESSE. Thank you.

Mr. COFFMAN. Mr. O'Rourke, you're now recognized for 5 minutes.

Mr. O'ROURKE. Thank you, Mr. Chairman.

Mr. Williamson, thank you for your work on this. The findings are serious, and I am glad to hear that the VA agrees with them, and has a course-correction plan in place. I'm going to ask Dr. Jesse about that in a minute.

But I wanted to ask you, Mr. Williamson, if there's any way to quantify the scope of these failings. There are anecdotes about overages that extend beyond the review threshold. Do we have an overall number? And do we know how much of this money you would characterize as wasted, where the taxpayer and the veteran did not receive value for the dollar spent over the threshold?

Mr. WILLIAMSON. No, unfortunately, we don't know that. And we certainly tried to look.

We do know that there are high risks through the use of short-term contracts when there's been poor management. At one VA facility where we looked at five short-term, low-value contracts, all five had procedural errors, including basically the affiliate getting the price they asked for with no negotiation.

So we know it's going on. We can't quantify that.

Mr. O'ROURKE. And just from human nature, we can surmise that that leaves the VA, the veteran, the taxpayer open to fraud potentially. We don't know that that, in fact, took place, but—

Mr. WILLIAMSON. Absolutely.

Mr. O'ROURKE. Yeah. So this is pretty serious.

I heard Dr. Jesse say that at some point in the future the VA will come to us requesting new authorities. Is it the GAO's position that any new restrictions or laws are necessary? Or are you satisfied with the VA implementing the recommendations that you made?

Mr. WILLIAMSON. Well, we're very happy that VA has concurred with our recommendations, and is apparently taking action. We'll see how that goes.

I think that this is a process that's going to take some time, because, just from the standpoint of the experience of the contracting officers who are working on medical sharing contracts, a third of them have less than a year of experience. Two-thirds have less than 3 years. That needs to be fixed very quickly, on a retention plan perhaps. One of our recommendations was that they have a retention plan.

So there are a number of things. There are duplicative processes in the—or duplicative functions within the process. Both, for example, the VA Office of Inspector General does a price analysis, and the Medical Sharing Office in Nashville also does one. You know, the question could be asked, why are two different organizations doing that.

Mr. O'ROURKE. Dr. Jesse, you said you agreed with the findings. Do you agree that employees of the VA purposefully avoided oversight? And if that is the case, can you outline the accountability—

Dr. JESSE. Well, I don't know that people purposely avoided oversight. I think people used contracts in order to get care for veterans, and when they know that—

Mr. O'ROURKE. The intentions may have been good, but, in the process of trying to get that care for veterans, did they know what the requirement was and exceed that requirement on purpose?

Dr. JESSE. I don't know that that's true or not true, and I really don't want to have to make a judgment there.

Mr. O'ROURKE. Okay.

Dr. JESSE. And I think part of the issue of—

Mr. O'ROURKE. How do we get VA employees to follow the rules and regulations within the VA? And it might concern people I represent that you don't seem to be concerned about that being the case. And so we can implement the reforms, but if you're not going to hold your employees accountable, I think, you know, that would be a concern for me.

Dr. JESSE. I don't want to appear unconcerned at all. We're very concerned about it. But I think it also speaks to Mr. Williamson's comments about the lack of seniority amongst this very crucial group of contracting staff. And it takes, what, 5 years to really get proficient at these contracts, so there is a very steep learning curve.

So, you know, people are trying to get their jobs done. I don't think they purposely lie, cheat, mislead. I think they try and provide solutions that can get veterans what they need.

Our job is to make that job easier and to make the process transparent so that we, all of us, can see what's going on and have the kinds of data flows we need to be able to have transparency into the process and know when issues arise. And we don't have that today. And that's one of the crucial things that needs to happen as part of the recommendations and the reforms.

Mr. O'ROURKE. I'm out of time, but I would agree with everything you just said. And I would add that we then also need to hold ourselves accountable. I mean, we can make countless excuses for failure to perform, but I don't think the people we represent, and I know you are not either, interested in hearing those excuses for failures within the VA.

So what I really want to hear—and perhaps you can follow-up for the record if you don't have it today—is the timeline to implement these recommendations, and an assurance that we're going to hold ourselves accountable for adhering to those new standards so that we get greater value for the taxpayer, we eliminate fraud and abuse, and we deliver care to veterans in a timely fashion, producing better outcomes than we see today. That's what I'm looking for.

Dr. JESSE. Okay. Absolutely. That's all laid out, and we can get that to you.

Mr. O'ROURKE. Great.

Dr. JESSE. Mr.—

Mr. O'ROURKE. I'm going to have to yield back to the chair. I'm out of time. Thank you.

Mr. COFFMAN. Dr. Roe, you're now recognized for 5 minutes.

Mr. ROE. Thank you, Chairman.

I'm probably going to take a little bit different vantage point on this. First of all, we know the VA is deeply involved in medical education. Forty percent, as Mr. Williamson, I think, pointed out, of the VA staff now are residents or faculty from the university. So that relationship, which has been there 70 years, helped train our physician workforce in the country, is absolutely paramount.

I think the Institute of Medicine back in the 1990s thought we had 25,000 too many doctors by 2010, and that's kind of like predicting who's going to win the next Super Bowl, but I think we do have—whatever the number is—a physician shortage. I don't think there's any question about that. The Committee recognized that with the Veterans Choice Act and put 1,500 residency slots in there, which the VA's trying to implement right now.

One of the things I think—and I may be wrong on this, but we had hearing after hearing when we found out all these wait times are going on. And so, if you're a contractor, you're a medical center director, you're going to try to find the quickest way you can to get additional manpower to see these patients. And that may end up being why there are so many short-term contracts.

That relationship between academia and the VA is absolutely paramount for medical education and for care in this country. And it's good for both parties. It's good for the veteran, it's good for the students, the doctors, like myself, who trained there. It's also very good for the academic institutions and for research. The VA carries on a very big research arm, and they have to have these collaborations with universities and the teaching hospitals. So I think this system has to work.

One of the questions I have, Mr. Williamson or Dr. Jesse, whoever wants to take it, how many of the contracts are short-term contracts? What percent I guess is what I'm asking.

Mr. WILLIAMSON. There are a total of 1,200 sole-source contracts. I'm blanking right now on how many of those are short-term. Many of them, perhaps most of them.

Mr. ROE. Most of them.

And the other question, I think everyone's going to ask, is, why does it take—why in the world does it take 3 years. I mean, that's unbelievable when I heard that. If it takes that long to have a long-term contract with an East Tennessee State University Quillen College of Medicine, the University of Pittsburgh, or whomever, you're going to have short-term contracts. Because the care's got to get delivered; I mean, there's no question. So that's got to get fixed, I think. And I think that would be paramount, to me, to fix—so you can go with these long-term contracts.

The other thing, the payment models, as you all have pointed out, the fee-for-service contract ought to be pretty simple. You're just paying somebody if it's a fee-for-service procedure done. That's been laid out by Blue Cross, by Medicare, by Medicaid. I mean, that's not a hard number to find.

I will agree with you, it's a lot tougher on the new models, with the ACO and with the capitated model. I don't know whether VA's put their toe in that water yet or not, but that's a little tougher one to—and you do need some very skilled people to do that.

And I don't know whether you have or not, Dr. Jesse.

Dr. JESSE. Well, that's why I parsed it by saying that's my opinion and not necessarily the agency's.

But we are an ACO. Fundamentally, we are a capitated system with social responsibilities. How one brings in external partners and pays them is actually the real challenge that we need to figure out. And, you know, that's—if it's a tenable model, then we'll come back to you. If it's not, we'll look at alternatives.

Mr. ROE. Well, the way the VA's capitated model works is it just creates waste. That's what happened in Arizona and others. When you can't get enough providers to get in, and you run to the end of your budget, you just put it off and—

Dr. JESSE. And that's not acceptable. There's no argument there.

Mr. ROE. And there's a much more efficient way, I think, to do it. I think we all agree with that.

And I think, again, I want to know—for the record, I'd like to know what percent of those contracts are short-term contracts versus long-term contracts.

Mr. ROE. If you fix that problem, I think you've gone a long way to fixing the other. The research arm, if you need some other help from us on that, let us know what that is, because that needs to be nurtured too, I think. We need to make sure that the VA and the other folks out there trying to do research—I think it's great. I think the VA does need to maintain that intellectual property.

For instance, in the hepatitis C, we've all heard that. We all know what a fiasco that was. We can't let that happen. But, again, the good news of that whole research was hepatitis C got cured. Whoever got the money, still, patients out there benefited from that. It was a slipup, there's no question about that, on the VA's part to turn that resource loose, but the fact is patients today, right now, are getting benefit from that research that's been done.

I yield back.

Mr. COFFMAN. Thank you, Dr. Roe.

Congressman Walz, you're now recognized for 5 minutes.

Mr. WALZ. Thank you, Chairman.

And thank you all for being here.

Mr. Williamson, and each of us have said this, it's hard to get people—and I'm going to focus on the contracting and the skill set of the employees—to get them there, to be able to do this, to get it right. But that employee skill training and execution, that's a personnel management issue. That is a personnel management issue.

And I don't know if I'm making—it seems to me this is a very similar situation, with lack of training, that went into some of the scheduling issues that we had.

So my question is this: Is there any discussion amongst VA to standardize the training, like a training center, and have the requirements clearly laid out, like the Foreign Service Initiative I'm familiar with and the military? When I go to a military school, there's a set of standards. When I come out of there, I'm skilled, I can do A, B, C, and D, and it is measured in there. Is there something similar in the VA for someone who is working on contracts, just to show level of competency?

Mr. LEMMON. Yes, there is. We have a VA Acquisition Academy in Frederick, Maryland, that provides all the training that's required to be certified as a contracting officer. In addition, our Medical Sharing Office has developed specific classes in health care contracting to deliver to our workforce. So we've got, really, two avenues that are good.

The turnover issue and the experience issue, there's a lot of reasons for it, but one of the big ones—and maybe I'm answering more than you asked, but we've got process issues we have to correct.

And it's been mentioned, 3 years. It's ridiculous that it takes that much time. So if you're an 1102 with a broken process, where you can't satisfy your customer in a reasonable amount of time, you're probably going to look for other work that would be more satisfying.

So, in my mind, we have to fix the process. And I'm committed to do that.

Mr. WALZ. Is it a case, you have to help me understand this, if I get all the training and I—say, I'm certified to teach, my first year in that classroom is arguably not going to be or shouldn't be as good as my 10th year in that classroom. So they have the skill set, but it's still a case of you have to execute, and there's something that comes with doing the job, is that the case, of not having enough experience no matter if they're trained or not?

Mr. LEMMON. Right. For warranted contracting officers, there's requirements both for education and length of time doing the work. So they have to have an experience requirement to be warranted to award contracts at certain levels.

So we have that in place. And we can talk about the issues with health care contracts, but they are much more complex than many of the other contracts we work on. We have to keep our workforce, and we have to have a process that makes sense so we can get these contracts done in a reasonable time period.

Mr. WALZ. And you think that's happening now? The process changes are happening, you're making the—

Mr. LEMMON. We're working on them right now.

Mr. WALZ. Okay. My next thing, we were just discussing up here the ability on these contracts on the useable data. And hard to—if we don't have all the useable data on them, if it's not collected useable, how are we—what are we doing about that? Can you fix that on your own or do we need to legislate it?

Mr. LEMMON. Well, it depends on what you're referring to as data. Certainly one of our plans to address the findings that GAO provided is we're going to create enterprise visibility on performance against new milestone plans for these contracts.

So leadership will know if there's a roadblock or something's not moving as fast as it needs to be. I believe we can do that without additional resources, quite frankly.

Mr. WALZ. And that was not happening before?

Mr. LEMMON. No.

Mr. WALZ. And it can be now?

Mr. LEMMON. It can be.

Mr. WALZ. And that should—I would think that would make a significant difference. Is that your take, that—

Mr. LEMMON. I think it will make a significant difference.

Mr. WALZ. Okay. I yield back, Mr. Chairman.

Dr. ORLOWSKI. Sir, if I can make a comment.

Mr. WALZ. Oh. Absolutely. I have 40 seconds, so—

Dr. ORLOWSKI. Thank you. About a year ago, one of the suggestions that the academic medical centers made to the VA is that we actually have some template agreements. They're very complex agreements, but there are certain standards that, rather than having each VA work on a specific language, that we'd like to see national templates. They could have some local changes to them as

needed, but that was one of the suggestions, because the academic affiliates actually have the same frustration with the fact that we're dealing with short-term contracts.

So that is one of the multiple suggestions that we've made as we've worked with the VA.

Mr. WALZ. Great.

Mr. LEMMON. I know there's just a few seconds left. But we do have 19 standardized performance work statements for various specialties now.

Mr. WALZ. Great. Thank you.

Thank you, Mr. Chairman.

Mr. COFFMAN. Thank you, Congressman Walz.

Congressman Huelskamp, you are now recognized for 5 minutes.

Mr. HUELSKAMP. Thank you, Mr. Chairman.

First a question for Dr. Jesse. The OIG reports in three contracts, the Pittsburgh VA entered with the University of Pittsburgh Physicians Incorporated, there was a total of nearly $850,000 administrative overhead expenses not supported or documented. What is VA doing to prevent this waste of taxpayer dollars?

Dr. JESSE. So Pittsburgh is already done. The issue is how do we prevent that from happening again, and this is why we have set up, for instance, the Office of Medical Sharing that reviews these contracts and negotiates with the universities. And, in fact, the history of that group and doing this in a relatively short period of time of a couple of years has saved, and Mr. Lemmon can give you the exact numbers, but it's, what, about 113?

Mr. LEMMON. Right. Even though the current process is horrible in terms of timeliness and we have to fix it, since October 2013 through April 2016, the VHA Medical Sharing Office has participated in the negotiation of 69 affiliate contracts and has achieved price reductions of over $113 million. That translates to well over $1 million per affiliate contract negotiated.

Mr. HUELSKAMP. Follow up to the GAO on this, trying to understand. Mr. Williamson, how widespread is it that the contracting officers accept the affiliate's proposed prices rather than negotiating or doing an independent price analysis?

Mr. WILLIAMSON. Why did that happen? Is that what you asked? Why—

Mr. HUELSKAMP [continued]. How widespread is the practice—

Mr. WILLIAMSON. Oh.

Mr. HUELSKAMP [continued].—of accepting the proposed prices?

Mr. WILLIAMSON. We don't know, but, you know, we only looked at 12 short-term contracts, and seven of those had problems like that. We can't project that, because, again, we only looked at 12, but it's a high incidence, and it's happened at more than one hospital.

Mr. HUELSKAMP. Okay. Second question I'd like to follow-up. In looking at the testimony, Dr. Atkins, in the VA testimony noted VA research has been involved in the CAT scan, the pacemaker, organ transplants, treatments for high blood pressure, and heart disease. You note Nobel Peace prize winners and other such honors. How many of these inventions does the VA own and how much money do they receive from these research projects?

Dr. ATKINS. I'll have to take that question for the record to get back the exact number. I know some of that was discussed at the hearing in February, and the feeling was that we could do better, but I'll get you the exact number.

Mr. HUELSKAMP. Okay. So since that hearing, you didn't look into it at all? You changed the policies or you're getting back to us?

Dr. ATKINS. So the policies on disclosure are being changed.

Mr. HUELSKAMP. Okay.

Dr. ATKINS. So—but we'll get back to you with the exact number.

Mr. HUELSKAMP. And disclosure. And what about policies on ownership with research affiliates and the researcher? Now we're talking about, I think, what, up to $400 million for just Hepatitis C. And so, yeah, I look forward to your response and follow-up with the Subcommittee.

I do have another question, Dr. Atkins, though. We've had reports of VA research data being stored on affiliate servers. Is this allowed?

Dr. ATKINS. That's not in compliance with policy. There are information security audits that actually look at where VA data is stored. It's supposed to be stored on VA servers. And so where that's found, we seek to correct that. That's not something we control, but the policy's pretty clear about that. And that would be—

Mr. HUELSKAMP. Policy is they cannot do that?

Dr. ATKINS. Correct.

Mr. HUELSKAMP. What are the penalties for violating that policy?

Dr. ATKINS. So we first try to go in and look and see—this is actually under the Information Security Office, their responsibility. And so they go and they find that, and they issue a corrective action, and then the facility's responsible for instituting that.

Mr. HUELSKAMP. And so what is the VA doing to protect veterans' information in these and other circumstances and their participation in VA research?

Dr. ATKINS. So, that's the reason we have the policy, to keep VA data stored on VA servers. And I think in some of those cases, those are maybe animal studies, there may be some cases of patient data being stored. But, again, we're seeking to make sure that those exceptions aren't happening. I can't tell you right now.

Mr. HUELSKAMP. So the policy is they can happen. You do know it's happening, and the only way we'll protect—

Dr. ATKINS. Actually, I don't know—

Mr. HUELSKAMP. Oh. I misunderstood.

Dr. ATKINS [continued].—it's happening, but you're telling me it is.

Mr. HUELSKAMP. Okay. Well, I was looking at reports. So you don't know if it's happening or not? I thought you said earlier you—it was—or you can't have the research data on affiliate servers. Is that correct?

Dr. ATKINS. VA data, involving VA patients, should be stored on VA servers. There are data use agreements that can allow sharing of data as long as other protection policies are in place. So it's—if stored on a secure server and it's part of an explicit data use agreement to collaborate with investigators outside of VA, that is permitted. It's not permitted for a university investigator to take the data from the VA, put it on his or her university server.

Mr. HUELSKAMP. Thank you, Mr. Chairman. I have one more question. If we're going to do another round, I do have an additional question.

Mr. COFFMAN. There will be one more round.

Ms. Watterson-Diorio, why are some NIH grants being administered through VA nonprofits while others are administered through the academic affiliate, with more than 51 percent of the research—when more than 51 percent of the research is being conducted at the VA?

Ms. WATTERSON-DIORIO. Mr. Chairman, that's an interesting question, and one that we have differing data on across the country. VA nonprofits on the East Coast versus the West Coast completely differ 100 percent, where the West Coast is actually administering NIH grants.

Decisions are made at a local level. These are done by VA leadership. They could even be done by a principal investigator. So decisions are being made because, in my opinion, there's not enough directives, regulatory directives that would allow the investigators to be told, you know, this is the equitable way in which we're arranging the administration of research.

Mr. COFFMAN. Now aren't they supposed to be administered by the VA?

Ms. WATTERSON-DIORIO. Well, Title 38 proclaims that we have the authority to administer this research. That's not, in fact, happening all across the country.

Mr. COFFMAN. Who does—who again, who decides where a grant is administered?

Ms. WATTERSON-DIORIO. It would be on the VA leadership side on—that would be, like, the board members of the VA nonprofits.

Mr. COFFMAN. So those are not uniform? It's not—it's not uniform?

Ms. WATTERSON-DIORIO. It's not uniform at all.

Mr. COFFMAN. It's not uniform? Can you estimate how much money VA is losing by having these grants administered through the affiliates instead of VA nonprofits?

Ms. WATTERSON-DIORIO. Well, again, I think that's a very hard number for me to be able to justify, because that's—

Mr. COFFMAN. We're in the millions. We're in the millions. Is that a fair assessment?

Ms. WATTERSON-DIORIO. Yeah.

Mr. COFFMAN. Okay.

Ms. WATTERSON-DIORIO. Yes. I would agree.

Mr. COFFMAN. Okay. Dr. Jesse, according to the GAO report, high value—quote, "high value long-term," unquote, affiliate contracts go through three different reviews. Why is that?

Dr. JESSE. I think Mr. Lemmon is in better shape to answer that than I am, but in—I do know that the IG does a preaudit review, and that's one of them. So—

Mr. LEMMON. Well, certainly the contract is looked at, at the local level. Then if it's over a half million dollars, our current process requires our university affiliates to provide cost data. Once we receive that cost data, there's a requirement that the IG review that data. And it's also reviewed at our Medical Sharing Office level, and at that level, they get concurrence from Patient Care

Services and the Office of General Counsel. So there is a number of levels of review.

We need to look at what pieces of this process we can streamline. We have to do these faster, no question.

Mr. COFFMAN. How long have you been in your position now?

Mr. LEMMON. Since October 15th, I've been acting in this position.

Mr. COFFMAN. We always have somebody—I love it when the VA always has somebody who's brand-new and who, you know, kind of washes their hands of the problem, but 3 years? I mean, that is unbelievable. I—you know, it—I don't know how you have a contracting negotiation process that lasts 3 years.

Mr. LEMMON. It's indefensible, but I would like to say that not all of—there are multiple parties involved. With some affiliates, getting cost data takes a long time. We do have situations with affiliates where we can't get a reasonable price. And I think what we have to do in those instances is make decisions quicker whether we're going to continue the relationship. It could involve—there are tough decisions. It could involve pulling out a residency program.

So it's not all the contracting process itself. Certainly there's plenty of opportunities to improve that, but some of it, there are legitimate problems that come up when negotiating these contracts.

Mr. COFFMAN. But this is supposedly done by experts who have all the training, am I correct in that, that have gone through—that Congressman Walz had mentioned that have gone through the appropriate certifications of the VA in terms of procurement?

Mr. LEMMON. They have. You have to have the requisite warrant level to sign and negotiate these contracts.

Dr. JESSE. So if I may, and this comes back to a comment that Ranking Member Kuster made in her opening remarks about how health care has been changing. And 70 years ago, virtually everything could be done on the signature of a dean of a medical school. Today when we have contracts with academic affiliates, as I mentioned, there are often multiple contracting entities. So in your report, I think, two of your agencies you were—the contracts were with the practice group as opposed to the university.

So we now have deans of medical schools, we have CEOs of hospitals, we have chairmen of practice groups, and they often have a vice-president for health sciences, and even in—there may be an office of managed care. And so it's not the—the time is not all on the part of the VA, it's often the going back and forth that requires multiple—multiple entities and—

Mr. COFFMAN. Let's just say it's a broken system.

Ranking Member Kuster, you're now recognized for 5 minutes.

Ms. KUSTER. Thank you, Mr. Chair.

And let me start right where we've left off and the changing nature of these practices and the complexity. For 25 years before I came here, I was an attorney in New Hampshire and I represented Dartmouth Medical School, and I'm very familiar with their relationships with the VA and White River Junction, Vermont.

You had mentioned in our previous dialogue about liabilities, you had used that word in passing, and sharing responsibility, but that entails liability. I want to focus in on the flip side of that, and

which are benefits that come from these contracts, and in particular, the benefits from discoveries of VA researchers.

In the best of all worlds, there are times when the VA is on the leading edge of treatment, of techniques, of protocols. I'm working with the VA now on the reduction of use of opiates and pain medication. I'm hoping that they'll be able to lead the country in that.

But can you talk to me in terms of these relationships and these contracts, how do you manage the benefits and the need to ensure that the VA and the veterans, most importantly, but preferably the veterans and the taxpayers, benefit from breakthroughs in—whether it's medical technology or new techniques?

Dr. JESSE. So I'm going to ask Dr. Atkins to answer most of that, but as a preamble, I'd like to say that we think this is really important. And the front end of a lot of the research we do is an institution, and article, I'm not sure of the right word, called a CRADA, which is an agreement of the sharing of intellectual property, and it actually—and sometimes it's quite frustrating to investigators, because it takes times to work that out because it's a lawyer-to-lawyer conversation, but that is a hard and fast thing that should be included in any research agreement that we do with an outside entity.

So do you want to expound on that?

Dr. ATKINS. Yeah. Well, thank you for your point, because I think we all feel that this is not a zero sum game, that all parties benefit. So the fact that our academic affiliates benefit is a good thing, because it makes them want to partner with us, and we benefit from that partnership.

And so, I want to comment a little bit on one of the questions Chairman Coffman asked about the NPCs in terms of whether all of our research should be administered through the NPCs. We don't lose any money by administering our research through the university. That actually builds a partnership that provides a lot of benefit. We owe a lot to our nonprofit corporations, they provide very good value, but they are independent entities. They are not the VA.

And so we leave the decision of which grants should be administered by the nonprofit corporation, which should be administered by the university to the VA Medical Center. There are some projects that solely recruit veterans, almost always are administered by the nonprofit corporation; but many of our research is relevant to veterans but may not involve patients, may be much more aligned with the grants that are being administered by the university, and the university certainly benefits from having those grants.

And I think the figures that were given show that roughly half of the non-VA research money that's brought in is administered through the nonprofit corporations, about half through the universities, but there's no—

Ms. KUSTER. So at the risk of sounding overly lawyerly, I want to follow the benefit, if I could, on behalf of the veterans and the taxpayers. Walk me through, and let's just make up an example about a breakthrough discovery in a new medication to treat pain that's not addictive and doesn't lead to substance use disorder.

Help me understand the value of that, and who controls it, and who owns it. If you get into a patent, does the VA pursue that, does

it then get turned over to some other entity in the Federal Government? Who owns the benefit of this?

Dr. ATKINS. So as Dr. Jesse mentioned, that's governed by these CRADAs, Cooperative Research and Development Agreements, where that shared ownership is worked out upfront, and that's the way the universities do it and the way that VA does it. It's a shared ownership of the intellectual property and the profits that flow from that.

Ms. KUSTER. So my time is up, but if I could ask for the record if there are examples maybe that would be beneficial for the Committee to understand, of technologies or breakthroughs in the past, and then how they've been adopted, and how they've been shared around the VA, and if there is a commercial value, how the dollars have flowed back to the taxpayers.

Dr. ATKINS. Thank you.

Ms. KUSTER. If that—thanks very much.

Dr. ATKINS. We'll do that.

Ms. KUSTER. I yield back.

Mr. COFFMAN. Congressman Huelskamp, you're recognized for 5 minutes.

Mr. HUELSKAMP. Thank you, Mr. Chairman. I appreciate the opportunity to follow-up on a couple more questions.

First one, Ms. Watterson-Diorio, since the time it became public that you would be testifying here today, have you received any pushback from anyone about testifying, or concerning what you might say?

Ms. WATTERSON-DIORIO. Nothing official at this time, sir.

Mr. HUELSKAMP. Nothing official. Anything unofficial?

Ms. WATTERSON-DIORIO. A few emails questioning where I was, what I was doing, yes.

Mr. HUELSKAMP. Okay. I would be interested in sharing that with the Committee. And I say this, obviously I know of the certain situation, but over the last 3 or 4 years, we have run into multiple situations where whistleblowers have received various levels of, I would say, penalties and punishments and displeasure from folks above them. And we rely heavily on folks from the inside sharing with us what does occur. So I—

Ms. WATTERSON-DIORIO. I certainly appreciate your concern, and I will share back. Thank you very much.

Mr. HUELSKAMP. And, Mr. Chairman, the second question I would have—I didn't get to last time, is in reference to research equipment.

Dr. Atkins, we have had reports of VA research equipment being transferred to the affiliates. Is that allowed?

Dr. ATKINS. The research equipment bought by the VA belongs to the VA. It is permissible for the research equipment to be stored offsite where that makes sense to the research. So we don't want to recreate a whole laboratory that exists on the university side in the VA.

And if we buy a piece of equipment that can augment what that laboratory can do, it makes sense for it to be over at the university. It doesn't make sense for it to stay over there after its use is expired. We have monitoring—tracking programs that track all of our medical equipment at the hospitals, and that's their responsibility.

Mr. HUELSKAMP. So the question wasn't about storage, it's whether it's transferred, whether before or after the contract, the research. Is it transferred to them? Is it given to them?

Dr. ATKINS. No.

Mr. HUELSKAMP. Is it shared?

Dr. ATKINS. No. It remains at the VA. It's just being used over at—offsite. We don't—we don't give up ownership of that.

Mr. HUELSKAMP. Okay. And then if the contract ends—or maybe they never end in this case. If they end, you collect the equipment back, or you transfer it or give it away? I'm just trying to follow-up what happens perhaps at the end of a contract.

Dr. ATKINS. If it's not being used at the—for research at the university site, and we have a use for it at the VA site, we would bring it back.

Mr. HUELSKAMP. Okay. Is it used by the research facility for other types of research outside the VA? Is that permitted?

Dr. ATKINS. Are you saying is it permissible for them to use it for non-VA research—

Mr. HUELSKAMP. No. Yes.

Dr. ATKINS [continued].—in the lab? I don't think there would be any prohibition against that.

Mr. HUELSKAMP. Okay. So what oversight measures have you—

Dr. ATKINS. It's a shared piece of equipment and it's governed—

Mr. HUELSKAMP. Shared, but VA owns it?

Dr. ATKINS. Right.

Mr. HUELSKAMP. So what oversight do you have to ensure that VA ownership that's used exclusively for VA, or you don't mind?

Dr. ATKINS. That's not a major concern of ours, in the sense that usually that research is being done to benefit—it's a partnership. And we buy the equipment where it seems to make sense, and the fact that our partners are using it to benefit research—

Mr. HUELSKAMP. That actually does bother me, Doctor. We just discussed a $400 million invention that was done by a VA researcher, probably using VA equipment, we don't know, and you all are looking into that. And that should be part of the agreement.

That should be part of the agreement of use of their time and equipment in order to capitalize. I mean, we talked about these tremendous advances through VA research. And we look forward to the response, but I think after months of expecting us to show, hey, this is what the VA got for all these investments, but the private sector, these individuals have taken that. So I just want to know what oversight measures you have in place to ensure VA equipment is accounted for, maintained, and used for the VA purpose, and if not, rented by the VA—by the research facility.

Dr. ATKINS. Yeah. I'm going to take that question for the record, because I may not be entirely right about the—how much of that is spelled upfront.

When there is an agreement to transfer the equipment for use, and I—in terms of whether that agreement specifies that it can only be used for certain uses and not for others, that may exist, and I—I will get back to you.

Mr. HUELSKAMP. Yeah. And I'm not lawyerly. I'm a farmer. I'd hate to be accused of that, but you mentioned storage.

Ms. KUSTER. Better to be accused of a farmer than a lawyer.

Mr. HUELSKAMP. I agree. I agree.

So we talked about storage, we talked about sharing, and we talked about transferring, and I think all those three terms have been mixed up in the response, at least I haven't followed that. So I appreciate the response and follow-up to the second question.

Dr. JESSE. If I may, if a VA researcher is using—has authority of a VA piece of equipment in a university lab, there is probably a much greater chance than—not that they are utilizing university assets in support of their VA research. And so it's—you know, it's a shared entity, it's a shared resource, and it's a partnership.

Mr. HUELSKAMP. No. I understand.

Dr. JESSE. It could go both ways, right.

Mr. HUELSKAMP. This question was about VA research equipment. Now, if that's the response that, well, we share their equipment, they share ours, then I would say there's not enough oversight measures in effect to say whether or not it's equal sharing, I mean, that's part of the question here, so I appreciate us digging into that and getting a close response—a better response to that.

I yield back, Mr. Chairman.

Mr. COFFMAN. Thank you, Congressman Huelskamp.

Congressman O'Rourke, you're now recognized for 5 minutes.

Mr. O'ROURKE. Yeah. Mr. Chairman, I just wanted to make the point that I think academic affiliations make a lot of sense, and I would like to better understand the authorities that Dr. Jesse and the VA are going to ask for, and these may be authorities that we want to support, and certainly, I'd like to see the process accelerated and shorten the amount of time it takes to enter into those agreements. We know from testimony earlier in the year from the VA that there are 43,000 authorized funded, but unfilled positions within VHA, and so this makes a world of sense to me to do this.

I just want to, you know, make the point that thanks to the GAO, I think there are some significant concerns that have been raised, and I'm very grateful that the VA has agreed with the recommendations and is going to implement them, and I'd love to see the detail of that, that addresses the lack of performance standards, this avoidance of oversight, intentional or not, and some of the other issues that are raised.

But I know, Dr. Jesse, when we came through the first round of questions, you were going to make an additional point, and I ran out of time, where you were going to refer to one of your colleagues. If you'd like to add anything to that, you're certainly welcome to.

Dr. JESSE. Well, thanks. And I guess I'm going to—Janis stole one of my lines in who benefits, being the question asked at the title of this hearing, and she said the veterans, and absolutely, but I would also add that it's you, me, and the American public, because if you have a good physician, if you have a good health care team, there is a great chance that it's the VA academic-affiliate relationship that was intimately involved in the training and skill building in those individuals. So we all benefit.

Mr. O'ROURKE. Yeah. You just want to make sure that there's absolute adherence to the standards—

Dr. JESSE. Oh, yes.

Mr. O'ROURKE [continued].—that you don't have fraud, because this is a little bit of a departure in some ways if we were to in-

crease the level of participation with academic affiliates to help staff and provide care for veterans like those in El Paso, which are historically underserved. So I don't want anything to jeopardize the program with some big scandal, hey, we were overbilled—

Dr. JESSE. Yeah.

Mr. O'ROURKE [continued].—X millions. Let's bring everything back in house and no longer do this again.

So I think the GAO's findings give us an opportunity to get this right so that we can expand it, accelerate it. You're asking perhaps for new flexibilities and authorities. We may want to do that. We just want to make sure that this thing's being run really well, so that we can expand it.

Dr. JESSE. Absolutely.

Mr. O'ROUKE. Yeah.

Dr. JESSE. Thank you.

Mr. O'ROURKE. Okay.

Mr. COFFMAN. You know, I have one question. And out of fairness to my colleagues, I'll let them ask another question if they do have one, but, Mr. Atkins, I think you said that there was really no—fundamentally no difference using the nonprofit—VA nonprofit, versus using a university, yet it seems to me that the issue with the Hep C drug totally contradicts your statement, where Emory University disproportionately benefited by whatever agreement was reached in terms of that Hep C drug, and so I don't understand what your rationale is.

The nonprofit, it would have flowed back into the VA versus it flowed to Emory University. Could you comment on that?

Dr. ATKINS. Well, as you know, that whole issue is under investigation and the facts as to what the research was done. I mean, I'm not sure that it flowing through the nonprofit would have changed the fact, depending on where—whether that—how that research was done and what—who had rights to the intellectual property.

Mr. COFFMAN. Ms. Diorio, can you comment on that?

Ms. WATTERSON-DIORIO. Well, I would say that, you know, as we all know, the sole purpose of the VA nonprofits is to serve the VA. We are under a lot of oversight to make sure that the tech transfer is upheld, the CRADA language is just perfect. A CRADA is a Federal document that allows the VA to enter and be bound by language to support research.

So when we do that, there are tech transfer laws, there are all of this documentation that is supporting the VA to own that property, but there are also some other regulations, and I can get that to you for the record, that allows the university an opportunity to enter into and help with tech transfer, because sometimes they are very expert in that field.

Mr. COFFMAN. Thank you.

Dr. ORLOWSKI. If I could add.

Mr. COFFMAN. Thank you very much. Yeah. Go ahead.

Dr. ORLOWSKI. Thank you, Congressman. The academic affiliates don't take a position as to which is the better—but I would say that there are specific reasons why the academic institution may in certain circumstances have more experience. There's complex regulations for human subject research, complex regulations for animal

research, and depending upon what is being studied, DNA sequencing changes, sometimes the local VA authorities will make a decision as to which institution has the better oversight.

Mr. COFFMAN. It just seems the problem is there's not oversight, and the problem is that some of these institutions get the better of the VA, which is not all that hard to do, given the lack of oversight.

Let me just conclude. Today we have had a chance to hear about the relationship between VA and its academic affiliates. As has been described, there are numerous issues, concerns, and problems surrounding this relationship that takes great advantage of VA and ultimately the veteran.

This hearing was necessary to accomplish a number of items: To highlight the conflicts when employees in leadership positions at VA also hold academic appointments at the affiliate; to highlight the potential for lost intellectual property rights when VA-approved research, VA equipment, and VA data are utilized by the academic affiliate; to highlight the potential lost revenue when Federal grants are administered by the affiliate, instead of the VA nonprofit corporations, when the majority of the research is being performed at VA; and to highlight the problems VA has in entering into fair and timely sole-source affiliate contracts. I hope that shedding light on these issues will lead to changes.

I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks, and include extraneous material. Without objection, so ordered.

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

With that, this hearing is adjourned.

[Whereupon, at 5:53 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Robert L. Jesse, M.D., Ph.D.

Good afternoon, Mr. Chairman, Ranking Member Kuster, and Members of the Committee. Thank you for the opportunity to discuss VA's relationship with its academic affiliates, specifically, the use of sole-source affiliate contracts, affiliate universities, billing issues, research funding, and use of research space. I am accompanied today by Mr. Rick Lemmon, Acting Chief Procurement and Logistics Officer, and Dr. David Atkins, Acting Chief Research and Development 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 close to half a million Veterans who have donated blood samples and completed surveys to help unlock the genomic basis of medical disease.

VA Research benefits from its position within an integrated health care system with 167 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- PTSD, traumatic brain injury, polytrauma, military sexual trauma. Second, 60% of our researchers are also practicing clinicians at VA medical centers (VAMC). As a result they are familiar with the Veteran experience and are able to seek knowledge and pursue research topics to help our patients. Additionally, unlike other Federal agencies, VA has no laboratories whose predominant function is research. Research studies are performed in parallel in the same space at VAMCs 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 mission is entirely supported by intramural funding. VA does not have authority to award grants to parties outside VA, and all VA Research funding is provided to VA-employed researchers.

VA researchers work at more than 100 VAMCs conducting research. In addition, 124 VAMCs have formal affiliations with academic institutions and hospitals, and many full-time and part-time VA employees also have academic appointments or are

employed at an affiliated academic institution or hospital - they are dually appointed personnel. Many clinicians/researchers have laboratory access at both VA and the academic affiliate. Because of these arrangements, many VA inventions could be jointly owned by VA and its academic affiliates.

VA Research fosters dynamic collaborations with its university partners, other federal agencies, nonprofit organizations, and private industry. Researchers are able to leverage $663 million in VA funding to bring in an additional $685M in external funding from industry and Federal agencies such as the National Institute of Health. 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 Affiliation (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 in VA's mission is just as relevant today: academic affiliations are invaluable to facilitate recruitment of outstanding clinical staff to VA, and the presence of supervised trainees often allows efficient leverage of effort for clinical staff because several trainees working under the careful eye of one supervisor can often treat many more patients than that senior clinician could treat if alone. Such academic activities are also vital for assuring that VA clinical staff remains at the leading edge of clinical knowledge and skill, and to attract clinicians motivated by professional excellence that is associated with practice, teaching, research, and system improvement activities that occur in academic settings. VA's health profession education activities have blossomed to include affiliations with over 1,800 schools of medicine, nursing, pharmacy, and nearly all other health professions. Through these affiliations, and VA's own sponsorship of selected programs, nearly 124,000 trainees in health professions receive supervised clinical education in VA facilities each year. The Veterans Health Administration (VHA) is profoundly important to overall health professions education in the US, with about 70% of US physicians having VA clinical experiences at some point in their education, VHA being the second largest funder of Graduate Medical Education (after the Centers for Medicare and Medicaid Services (CMS)), and VHA being a major source of both trainee and faculty funding and clinical experiences for professions including pharmacy, psychology, optometry, podiatry and many others.

The result is that VHA robustly fulfills statutory missions prescribed by 38 U.S. Code § 7303 "to carry out a program of medical research in connection with the provision of medical care and treatment to veterans." It is important to note that these many academic relationships and affiliation agreements address only educational activities and do not address contracts for provision of professional or clinical services for VHA's patient care services - those are addressed by VHA through other sharing agreement and contractual mechanisms.

Government Accountability Office (GAO) Report

GAO released its final report (GAO–16–426) titled "Improvements Needed for Management and Oversight of Sole-Source Affiliate Contract Development" on May 6, 2016 with a 30 day hold on public release. This report recommended eight executive actions to ensure timely development of high-value-long-term sole-source affiliate contracts (SSAC), effective development and use of short-term SSACs, develop and maintain medical sharing expertise within network contracting offices, and ensure effective communication between VHA and its affiliates regarding SSACs.

VA concurred with GAO's recommendations and developed an action plan to implement each of the recommendations. As part of this action plan, the Deputy Under Secretary for Health for Operations and Management will charter a workgroup to address several of the recommendations. The workgroup will be charged with tasks such as:

- Establishing performance standards for appropriate development time frames for high-value long-term SSACs;
- Establishing the oversight process for these standards;
- Developing requirements for VAMCs and network contracting offices to effectively engage in early acquisition planning for the replacement of expiring high-value long-term SSACs to reduce reliance on short-term SSACs as bridge contracts; and

- Developing standards for the minimum amount of time necessary to develop and award short-term SSACs to minimize cases of nonadherence to VA policy for these contracts.

The estimated timeframe for the workgroup to complete deliberations, finalize performance standards, and receive approval across all stakeholders, is one year. The estimated timeframe for nationwide implementation of new performance standards is one year, including pilot testing of any new technology and training of staff.

VA is strongly committed to developing long-term solutions that mitigate risks to the timeliness, cost-effectiveness, quality and safety of the VA health care system. VA is using the input from GAO and others to identify root causes and to develop critical actions. As we implement corrective measures, we will ensure our actions are meeting the intent of the recommendations. Our actions will serve to establish strong oversight on SSACs, improve current training offerings for VHA staff who work on SSACs, and seek increase prioritization of funding for training to appropriate department decision makers.

Since receiving the draft GAO report VA/VHA has initiated two short term initiatives and one long term initiative to improve outcomes of SSAC contracting. First, VA Directive 1663 which provides overall guidance for sole source academic affiliate contracts is being revised and updated to ensure more timely contract awards while still protecting VA financial interests. The 1663 revision is expected to be completed within the next 60 days. Second, enterprise capability to monitor the milestone adherence of sole-source affiliate contracts will be developed. This will enable senior management to take action when needed to overcome barriers to timely awards, with a targeted completion date of November 30, 2016. To meet the long-term goals of strong oversight and address all of the GAO recommendations, VHA is chartering an integrated workgroup.

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 Randall B. Williamson

VA HEALTH CARE

IMPROVEMENTS NEEDED FOR MANAGEMENT AND OVERSIGHT OF SOLE-SOURCE AFFILIATE CONTRACT DEVELOPMENT

Chairman Coffman, Ranking Member Kuster, and Members of the Subcommittee:

I am pleased to be here today to discuss our May 2016 report on the Department of Veterans Affairs' (VA) development and use of sole-source contracts with university-affiliated hospitals, medical schools, and practice groups.[1] Since 1946, VA has partnered with medical schools to provide educational opportunities for resident physicians and other types of students and to increase the availability of specialty physicians to treat veterans in VA medical facilities. This partnership has grown to include 124 of the 167 VA medical centers (VAMC) establishing affiliate relationships with at least one university medical school and its associated university hospital. As a part of these affiliate relationships, VA can obtain additional physician services to supplement available VAMC physician services from a university medical school, hospital, or affiliated physician practice group through expanded contracting authority- referred to as sole-source affiliate contracts (SSAC).[2] Through SSACs, which are available only to VAMCs and their affiliates, VAMCs can obtain physician services directly from the affiliate without competition if those services are necessary to support learning opportunities for physicians during their residency training in VAMCs.[3] SSACs serve an important role in helping to ensure that VAMCs can provide specialty health care services for our nation's veterans and support the residency training of a new cadre of physicians. From fiscal year 2011 through fiscal

[1] GAO. VA Health Care: Improvements Needed for Management and Oversight of Sole- Source Affiliate Contract Development, GAO–16–426 (Washington, D.C.: May 6, 2016).

[2] See 38 U.S.C. § 8153(a)(3)(A). For the purposes of this testimony, we use the term physician services to describe services provided by physicians and other highly-qualified professionals that are necessary for the operation of clinical departments that train resident physicians at VAMCs.

[3] See Department of Veterans Affairs, Health Care Resources Contracting-Buying, Title 38 U.S.C. 8153, VA Directive 1663 (Aug. 10, 2006). For the purposes of this testimony, we refer to this directive as VA Directive 1663.

year 2015, VA had nearly 1,200 SSACs valued at almost $724 million throughout its health care system.

SSACs can be used to fill short-term or long-term needs at the VAMCs and the level of VA oversight they require varies by their value. Specifically, high-value, long-term SSACs have a total initial value of $500,000 or more and provide affiliate services for more than 1 year.[4] Among all SSACs, high-value, long-term SSACs require the most review from the Veterans Health Administration (VHA) Central Office.[5] There are two types of low-value SSACs that are distinguished by the length of time the affiliate is providing services to the VAMC, and neither are required by VA policy to receive oversight from VHA Central Office. Low-value, long- term SSACs have a total initial value of less than $500,000 and provide affiliate services for more than 1 year. Short-term SSACs have a total initial value of less than $500,000 and provide affiliate services for less than 1 year.

Oversight of the VHA contracting workforce and the contracts they create is provided by the VHA Office of Procurement and Logistics. VHA created the Medical Sharing Office, a component of the VHA Office of Procurement and Logistics, to provide guidance to contracting officers and oversee the development and award of medical sharing contracts, which include SSACs. Both VHA contracting and clinical staff are to work together to plan, execute, and monitor medical sharing contracts. On the contracting side, contracting officers are responsible for developing, awarding, and administering contracts on behalf of the federal government. Each contracting officer works within 1 of the 21 network contracting offices and is overseen by a medical sharing team supervisor within their network contracting office.[6] Network contracting offices manage all the contracting activities of a single Veterans Integrated Service Network (VISN) that oversees the day-to-day functions of VAMCs that are within that VISN's network. On the clinical side, the VAMC seeking the SSAC is to designate a contracting officer's representative at the VAMC to assist in the development of the SSAC and monitor the affiliate's performance once the contract is awarded. Common tasks delegated to the VAMC-based contracting officer's representative include developing the initial information required to begin acquisition planning, referred to as the procurement package, which includes a definition of the services the VAMC needs the affiliate to provide and approvals from leadership officials.

My testimony today discusses the findings from our May 2016 report examining VA's use of SSACs. Accordingly, this testimony addresses (1) VHA's time frames for developing and awarding high-value, long-term SSACs; (2) VHA's use of short-term SSACs and how it oversees their development and use; (3) how much experience the workforce that develops SSACs has and what specialized training VHA provides; and (4) the challenges selected affiliates experienced with the development and use of SSACs. In addition, I will highlight the eight actions we recommended in our report that VA take to help ensure the timely and effective development of SSACs, the professional growth of the VHA contracting staff responsible for SSAC development and award, and effective communication between VHA and its affiliates. VA concurred with these eight recommended actions.

To conduct our work, among other things, we selected five VAMCs- located in Indianapolis, Indiana; Miami, Florida; Minneapolis, Minnesota; Palo Alto, California; and San Antonio, Texas-to visit along with the five network contracting offices responsible for developing and awarding SSACs for these VAMCs. We selected these VAMCs based on VHA reports on the number and value of SSACs. These five VAMCs are each located within different VISNs. At each of these VAMCs, we selected four to six SSACs and reviewed the terms of these contracts and supporting documents to determine the total elapsed time spent by VHA staff in developing and awarding each contract. We reviewed a total of 25 SSACs from these five VAMCs

[4] The total initial value of a SSAC refers to the combined value of the contract's base period and any option periods included in the contract. For example, a high-value, long- term SSAC may have a base period of 1 year valued at $1 million and four option periods that are 1 year each with a $1 million value for each option period. This high-value, long- term SSAC would have a total initial value of $5 million dollars.

[5] In this testimony, we use the term develop to describe a multistep process used to initiate, create, and review SSACs. This multistep process includes actions related to acquisition planning for a SSAC, development and issuance of a solicitation used to inform the affiliate of VA's needs, development and evaluation of the affiliate's proposal, and preparation for and negotiation between the affiliate and VA.

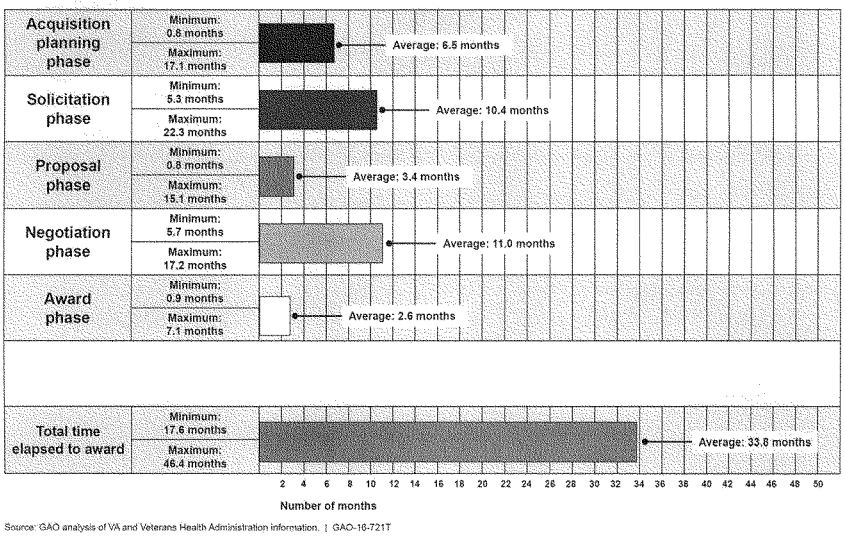
[6] There are 21 network contracting offices within VHA that report to the VHA Procurement and Logistics Office in VHA Central Office and manage all the contracting activities of a single Veterans Integrated Service Network (VISN) and all VAMCs assigned to that VISN. At the start of fiscal year 2016, there were 21 VISNs, but VHA is in the process of consolidating some VISNs so that by the end of fiscal year 2018, there will be 18 VISNs.

for services provided from fiscal year 2011 through fiscal year 2015.[7] In addition, we administered a data collection instrument to supervisors responsible for overseeing the development and award of SSACs in all 21 network contracting offices throughout VHA to capture information about various aspects of network contracting offices' experiences developing SSACs, including oversight by the Medical Sharing Office and contracting officer turnover. We also reviewed VA policy documents and interviewed officials from the VHA Medical Sharing Office and the VHA Procurement and Logistics Office, as well as officials from our selected VAMCs and their associated network contracting offices.[8] Further, we interviewed representatives of the five university affiliates that provided services to VAMCs under the 25 SSACS we selected for review and discussed their experiences with the development of SSACs. For each of our objectives, we reviewed relevant standards for internal control in the federal government.[9] Further details on our scope and methodology are included in our May 2016 report. The work this statement is based on was performed in accordance with generally accepted government auditing standards.

Selected VAMC's Time Frames for Developing High- Value SSACs Can Be Significant, But VHA Has Not Established Standards for Timeliness and Does Not Collect Data

We found that the 11 high-value, long-term SSACs we selected for review from three of the five VAMCs we visited took nearly 3 years (33.8 months) on average to develop and award.[10] (See fig. 1.) The total time required for the development and award of these 11 high-value, long-term SSACs ranged from 18 to 46 months and the longest contracting phases were the solicitation and negotiation phases.

Figure 1: Calculated Time Frames for the Development and Award of 11 Selected Department of Veterans Affairs (VA) High-Value, Long-Term Sole-Source Affiliate Contracts (SSAC), Awarded in Fiscal Years 2011 through 2015



Source: GAO analysis of VA and Veterans Health Administration information. | GAO-16-721T

[7] These 25 SSACs included 11 high-value, long-term SSACs from three VAMCs; 2 low- value, long-term SSACs from one VAMC; and 12 short-term SSACs from four VAMCs

[8] VA Directive 1663 outlines VA's policies and procedures for the establishment of medical sharing contracts, including SSACs.

[9] See GAO, Internal Control: Standards for Internal Control in the Federal Government, GAO/AIMD–00–21.3.1 (Washington, D.C.: November 1999). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

[10] One of our selected VAMCs acquired affiliate services exclusively through short-term SSACs and another of our selected VAMCs acquired affiliate services through low-value, long-term SSACs and short-term SSACs.

Note: Time frames for the development and award of 11 selected high-value, long-term SSACs from three VA medical centers (VAMC) are calculated using dates from available documentation in each contract's file; however, not all development actions are documented within contract files. As a result, this figure does not include calculations for actions that are not documented. The total time spent developing and awarding a high-value, long-term SSAC is calculated from the date the Veterans Integrated Service Network (VISN) approved the VAMC to acquire the service through a SSAC to the date the contract was awarded to the affiliate. VISNs are required to approve all SSACs before the formal solicitation process can officially begin. The duration of each contracting phase was calculated based on our analysis of selected contract files. Minimum and maximum values in this figure represent the shortest and longest time spent developing and awarding a single contract, as well as the shortest and longest time each phase took for a single contract. Average values in this figure represent the average time spent developing and awarding a high-value, long-term SSAC across all 11 of our selected contracts, as well as the average time each phase took across all 11 selected contracts.

According to leadership officials and contracting officers from all five of the network contracting offices we visited, establishing high-value, long- term SSACs in a timely manner has been challenging for several reasons, including (1) not always receiving a complete, actionable, and timely initial information package from the VAMC that contains information the contracting officer needs to begin acquisition planning; (2) lengthy review processes for high-value, long-term SSACs; (3) negotiation challenges with the affiliates on the price of high-value, long- term SSACs; and (4) VAMC resistance to developing and pursuing high- value, long-term SSACs. VAMC-based contracting officer's representatives and medical directors from all five of the VAMCs we visited also explained that establishing high-value, long-term SSACs has presented challenges for them. Specifically, 9 of the 14 contracting officer's representatives we spoke with noted that they are often asked to resubmit initial information packages to the contracting officer throughout the development of a SSAC due to form updates or policy changes that occurred since the time they created these documents. Moreover, VAMC officials from all five VAMCs we visited indicated that the length of time it takes to develop and award high-value, long-term SSACs presents many challenges for their VAMCs, including the potential for gaps in patient care and the need to repeatedly establish short-term solutions.

We also found that VHA has not developed standards that can be used to measure the timeliness of developing high-value, long-term SSACs. However, during fiscal year 2016, VHA developed estimates for the maximum duration of each contracting phase, referred to as procurement action lead times (PALT). Currently, the PALT goal for the development and award of a high-value, long-term SSAC is between 20 and 21 months; however, we found that 10 of the 11 high-value, long-term SSACs we reviewed exceeded these PALT goals by as little as 1.4 months and as many as 25.8 months. According to VHA officials we interviewed, PALT goals are not used as performance standards for VAMC, network contracting office, and Medical Sharing Office staff responsible for the development of high-value, long-term SSACs. These officials told us that VHA is currently developing and conducting validity tests of revised PALT goals for several types of contracts, including SSACs, but there is no planned end date for these tests and they do not expect to implement revised PALT goals across VHA until at least fiscal year 2017. These officials explained that the revised PALT goals will be used for setting expectations with VAMC officials for the length of time it should take to develop and award several types of contracts, including SSACs. Federal internal control standards recommend establishing and reviewing performance standards at all levels of an agency.[11] Absent such standards, VHA cannot ensure that its high-value, long-term SSACs are being developed in a timely manner.

Additionally, we found that VHA does not collect data on the length of time each contracting phase took to complete for any SSACs, including the 11 high-value, long-term and 12 short-term SSACs we selected for review. Federal internal control standards state that information should be recorded and communicated to management and others within the agency that need it in a format and time frame that enables them to carry out their responsibilities.[12] However, in contrast with these standards, VA is unable to analyze the time spent in each phase of SSAC development, and this inability has disadvantages in terms of management decisions and

[11] See GAO/AIMD–00–21.3.1.
[12] See GAO/AIMD–00–21.3.1.

accountability for SSAC development. The absence of real-time data on the amount of time being spent within each contracting phase limits VA's ability to make informed management decisions, including changes to the assignment of staff that are either overburdened by their workloads or in need of additional training to build their competency with a particular type of contract or contracting phase. This lack of information prevents VHA from effectively setting clear and consistent objectives for organizational performance and making improvements as needed.

Our report concluded that a lack of attention to the time spent to develop and award high-value, long-term SSACs has resulted in VHA's inability to ensure that contracts are being developed in a timely manner. To ensure the timely development of high-value, long-term SSACs, we recommended that VA (1) establish performance standards for appropriate development time frames for high-value, long-term SSACs and use these performance standards to routinely monitor VAMC, network contracting office, and Medical Sharing Office efforts to develop these contracts; and (2) collect performance data on the time spent in each phase of the development of high-value, long-term SSACs and periodically analyze these data to assess performance. VA concurred with these recommendations and said that it will take steps to address these weaknesses, including the creation of a workgroup that will establish performance standards for development time frames for high-value, long-term SSACs and the designation of an office within VHA to routinely monitor these performance standards. VA also said that it will assess its current data systems to determine whether a new or different system would be needed to capture all relevant data and that the Medical Sharing Office will collaborate with other stakeholders to determine the need for and the mechanism to collect additional data.

Short-Term SSACs Have Been Used to Overcome Lengthy High-Value, Long- Term SSAC Development Time Frames, but VHA Lacks Effective Oversight for Their Development and Use

We found that short-term SSACs are used to provide coverage to bridge the gap between an expired or expiring high-value, long-term SSAC and its replacement. Specifically, 6 of our 12 selected short-term SSACs were awarded as bridge contracts, which creates duplicative work for VAMC and contracting staff because they must simultaneously develop both the short-term SSAC bridge contract and the replacement high-value, long- term or low-value, long-term SSAC.[13] Of the remaining 6 short-term SSACs we reviewed, 5 were awarded to allow affiliate services to begin while new high-value, long-term SSACs were being developed for the same services and 1 was awarded to fill a short-term staffing need at a VAMC. In addition, we found that the use of these 12 short-term SSACs was consistent with reasons reported by from the majority of the medical sharing team supervisors from the 21 network contracting offices. Specifically, 12 medical sharing team supervisors from the 21 network contracting offices (57 percent) reported that the most prevalent reason that they opt to award short-term SSACs is to avoid any gaps in services due to the length of time it takes to develop and award high-value, long- term SSACs.

Federal internal control standards state an agency should provide for an assessment of the agency's risk associated with achieving its objectives, including identifying risks through forecasting and strategic planning.[14] However, in contrast with these standards, VHA does not have a policy that requires VAMCs and network contracting offices to engage in timely acquisition planning to ensure that expiring high-value, long-term SSACs are replaced without the need to use a short-term SSAC as a bridge contract. Moreover, VA's governing directive for the development of SSACs does not specify when VAMC and network contracting office staff should begin acquisition planning activities to replace an existing high- value, long-term SSAC.[15] As a result, VHA lacks assurance that its staff are performing and accountable for their roles in ensuring that replacement high-value, long-term SSACs are developed in time and that the agency is minimizing duplicative work when short-term SSACs are used as bridge contracts.

We also found that VHA was further exposed to potential risks associated with using short-term SSACs because the Medical Sharing Office, the VHA Central Office entity with oversight authority of SSACs, does not consistently review available data on all SSACs awarded throughout VHA; in particular, it does not review the level of reliance on short-term SSACs. While this office creates monthly reports for all VISNs and network contracting offices that provide information on the status of their medical sharing contracts, including all SSACs, they rely on network con-

[13] See GAO, Sole-Source Contracting: Defining and Tracking Bridge Contracts Would Help Agencies Manage Their Use, GAO–16–15 (Washington, D.C.: Oct. 14, 2015).
[14] See GAO/AIMD–00–21.3.1.
[15] VA Directive 1663.

tracting offices to determine if they are selecting the appropriate term for their contracts. This can potentially be problematic because 7 of the medical sharing supervisors from the 21 network contracting offices we contacted and leadership teams and contracting officers from 3 of the 5 network contracting offices we visited told us that at times they have purposefully developed short-term SSACs in lieu of high-value, long-term SSACs because the Medical Sharing Office does not review any short- term SSACs. In fact, we found 6 of the 12 short-term SSACs we selected for review were extended beyond their initial performance periods for up to 11 months resulting in total values for these 6 contracts that ranged from almost $686,000 to $1.4 million-well beyond the $500,000 Medical Sharing Office review threshold. Standards for internal control in the federal government state that control activities should occur at all levels of an agency to help ensure that management's directive are carried out by staff and that top-level reviews of actual performance by agency management are needed to track major agency achievements and compare these to plans, goals, and objectives that were previously established. [16]

In addition, we found that 7 of the 12 short-term SSACs we selected for review from two network contracting offices did not follow VA and VHA policy for the development of SSACs. Specifically, we found 5 short-term SSACs we reviewed from one network contracting office where (1) a solicitation was not issued to the affiliate, (2) the affiliate did not provide VHA a formal proposal outlining its services and instead submitted a price quote, and (3) negotiations were not conducted to address potential pricing issues before awarding the final contract. [17] The contracting officer responsible for these 5 short-term SSACs explained that he was often given as little as 10 business days to develop and award a short-term SSAC before the prior short-term SSAC expired and that he did not have the skills needed to conduct negotiations with the affiliate. We found that this contracting officer's supervisor had reviewed all 5 of these contracts prior to their award; however, the review process did not identify the areas that did not adhere to VA and VHA policy requirements for the development of SSACs. Federal internal control standards recommend that agencies establish processes to ensure the proper execution of transactions, including the provision of the proper amount of supervision. [18] However, without ensuring that contracting officers are adhering to VA and VHA policies and network contracting offices are effectively reviewing the development of short-term SSACs as required by VA and VHA policies, VHA may be at risk for overpaying for affiliate services provided through these contracts.

Our report concluded that the lack of attention to this overreliance on short-term SSACs as bridge contracts exposes VHA to risks. To ensure the effective development and use of short-term SSACs, we recommended VA (1) develop requirements for VAMCs and network contracting offices to effectively engage in early acquisition planning for the replacement of expiring high-value, long-term SSACs, (2) prioritize the review of SSAC contract data to identify patterns of overreliance on short-term SSACs that avoid appropriate Medical Sharing Office oversight, and (3) develop standards for the minimum amount of time necessary to develop and award short-term SSACs to minimize cases of nonadherence to VA policy for these contracts. VA concurred with these recommendations, and laid out plans to develop new requirements and standards while also charging the Medical Sharing Office with conducting data reviews of short-term SSACs.

High Turnover and Limited Training Opportunities Result in Inexperienced VHA Medical Sharing Contracting Officers and Impede the Development of SSACs

We found a high level of turnover among medical sharing contracting officers in all 21 network contracting offices that was exacerbated by a high level of inexperience among contracting officers responsible for developing SSACs. Network contracting office medical sharing teams experienced significant turnover in recent years, with 23 percent (49 of 217) of medical sharing contracting officer full-time employee equivalents (FTEE) in fiscal year 2014 and 27 percent (65 of 239) of FTEEs in fiscal year 2015 either resigning or transferring to another VHA contracting team.

Medical sharing supervisors offered several potential explanations for turnover on medical shar17ing teams, including job burnout, the complexity of medical sharing contracts, the workload associated with medical sharing teams, and frustration with the layers of review required for these contracts. Medical Sharing Office officials

[16] See GAO/AIMD–00–21.3.1

[17] The other two short-term SSACs that did not follow VA and VHA policy for the development of SSACs had similar policy adherence problems.

[18] See GAO/AIMD–00–21.3.1.

told us that this turnover hinders the SSAC development process because newer contracting officers have greater difficulty developing high-value, long-term SSACs due to a lack of experience and knowledge. They also told us that they believe it takes approximately 5 years for a contracting officer to become experienced in developing medical sharing contracts, including SSACs. We found, however, that more than half of medical sharing contracting officers had 2 years or less medical sharing contract experience and less than one-quarter had more than 4 years of experience developing medical sharing contracts. Federal internal control standards state that effective management of an organization's workforce, such as having the right personnel on board, is essential to achieving results.[19] However, in contrast to these standards, VHA does not have a plan to address medical sharing contracting officer turnover. As a result, VHA lacks assurance that network contracting offices can maintain and develop the contracting officers' skillsets that are necessary for developing complex medical sharing contracts, such as SSACs.

Moreover, we found that limited training opportunities for medical sharing contracting officers further erodes VA's knowledge base for developing high-quality and cost-effective SSACs. The Medical Sharing Office has developed and offered three in-person training courses designed to progressively build a contracting officer's competence in developing medical sharing contracts, including SSACs. Medical Sharing Office officials reported in February 2016 that over 90 percent of all participants for each of the training classes reported that the trainings increased their medical sharing competency and that the information presented would contribute to their job performance. Since fiscal year 2015, however, VHA has not consistently provided training for medical sharing teams in network contracting officers throughout VHA. VHA has canceled some of their course offerings due to budget constraints. In addition, VHA Central Office requested that the Medical Sharing Office cut the class size of each course offering by 25 percent. Federal internal control standards state that agencies should establish good human capital policies and practices, such as appropriate practices for training.[20] In contrast to these standards, VHA has not determined how to either provide the existing training courses or develop alternatives that do not require travel in response to a changing budgetary environment. As a result, VHA cannot build the skills of its medical sharing contracting officers and overcome the challenges associated with their inexperience.

Our report concluded that instability in the medical sharing workforce, due to high levels of turnover among medical sharing contracting officers, has limited VHA's ability to develop high-quality SSACs throughout VHA. To develop and maintain medical sharing expertise within the network contracting offices, we recommended that VA (1) create a plan to increase retention of contracting officers that work in medical sharing teams, and (2) develop mechanisms to either provide existing training courses or create training courses that do not require travel for contracting officers working within network contracting offices. VA concurred with both of these recommendations and summarized planned steps to address these recommendations, including the development of a retention plan and soliciting agency leadership for assistance in resource prioritization to fund VHA health care contracting training courses.

Selected Affiliates Reported Communication and Coordination Challenges with VHA Regarding SSACs

We found that representatives from the five affiliates that provide services through SSACs to our selected VAMCs noted challenges related to receiving information on changes to VA and VHA requirements for SSACs. These included communication from VHA about what services the VAMC needed from the affiliate, the documentation requirements affiliates needed to submit to support their physician salary pricing, and changes to VHA's approach to negotiations. The affiliate representatives also noted coordination challenges related to responding to SSAC solicitations. For example, representatives reported that it was challenging for them to provide services to VAMCs under short-term SSACs because the length of these contracts does not provide a commitment from VHA for the physicians hired by the affiliate to fulfill the contract. These affiliate representatives explained that it can take a year or longer to recruit a well-qualified academic physician and short-term SSACs do not provide the funding commitment needed by the affiliate to recruit these physicians. Federal internal control standards state that information should be communicated both internally and externally to enable the agency to carry out its responsibilities; for external communications, these standards state that management should ensure that there are adequate means of communicating with, and ob-

[19] See GAO/AIMD-00-21.3.1.
[20] See GAO/AIMD-00-21.3.1.

taining information from, external stakeholders that may have a significant impact on the agency achieving its goals.[21] In contrast to these standards, VHA's efforts to cultivate better communication and coordination with affiliates at the national level have been limited, consisting of three regional forums with all its affiliates in fiscal year 2012. Since 2012, VA has relied primarily on local coordination with affiliates in lieu of regional forums, due to travel restrictions associated with VA's recent budget shortfalls. As a result, VHA cannot ensure that it is effectively responding to the concerns of its affiliates.

Our report concluded that concerns about VA's communication and coordination with its affiliates, as voiced by representatives from the five affiliates we spoke with, demonstrate potentially ineffective communication streams with these critical partners. To ensure VHA effectively communicates with its affiliates regarding SSACs, we recommended that VA reach out to all its affiliates, identify any concerns, and determine the most effective method of communicating with affiliates regarding SSAC development. VA concurred with this recommendation and said that the VHA's Office of Academic Affiliations and Medical Sharing Office will re-engage with the American Association of Medical Colleges to determine the best ways to gather input from affiliates on their concerns and determine the most effective method of communication with them regarding SSAC development. Furthermore, VA added that these offices will evaluate VA's current partnerships with affiliates to identify both highly functional relationships that could be highlighted as best practices and partnerships that could benefit from targeted intervention.

Chairman Coffman, Ranking Member Kuster, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to answer any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact me at (202) 512–7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions to this testimony include Marcia A. Mann, Assistant Director; Cathleen Hamann; Katherine Nicole Laubacher; Dharani Ranganathan; and Said Sariolghalam.

[21] See GAO/AIMD-00-21.3.1.

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Prepared Statement of Janis Orlowski, M.D.

Fostering Department of Veterans Affairs Relationships with Academic Affiliates to Improve Health Care Access and Quality for Veterans

Executive Summary

As you finalize legislation to reform and improve health care for our nation's veterans, the AAMC respectfully asks that you recognize the importance of Department of Veterans Affairs (VA) academic affiliations and urges you not to undermine these important public-private partnerships. For 70 years, VA's shared research, education, and patient care missions with academic medicine have improved access and quality of care for veterans, both inside and outside the VA system.

The AAMC is a not-for-profit association comprised of all 145 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 VA medical centers; and more than 80 academic societies. The AAMC serves the leaders of America's medical schools and teaching hospitals and their 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

To better align the VA and the nation's medical schools and teaching hospitals, the AAMC supports the DOCs for Veterans Act (S. 1676, H.R. 3755, H.R. 4011); the Enhanced Veterans Health Care Act (H.R. 3879); and the Improving Veterans Access to Care in the Community Act (S.2633).

The AAMC believes VA graduate medical education, research, joint ventures, sole-source contracting, and the proposed Core Network of the Veterans Choice Program help ensure access for our nation's veterans to the highest quality care by preserving academic affiliates as a direct extension of VA care and a preferred provider. This relationship serves multiple purposes:

Access to Complex Clinical Care - Direct clinical care contracts allow academic affiliates to plan, staff, and sustain infrastructure for certain complex clinical care services that are scarcely available elsewhere, including trauma centers, burn care units, comprehensive stroke centers, and surgical transplant services. Solely relying on fee-basis mechanisms has the potential to reduce veterans' access to care if teaching hospitals scale back services when faced with an uncertain patient load from the VA.

Workforce Development - There is a pressing need for physicians to care for our nation's veterans now and in the future. VA physician shortages are symptomatic of a broader trend, the proverbial "canary in the coal mine." The AAMC projects a nationwide shortage of between 46,000–90,000 physicians by 2025. Though these shortfalls will affect all Americans, the most vulnerable populations, including veterans, in underserved areas will be the first to feel the impact.

Physician Recruitment - The VA is an irreplaceable component of the U.S. medical education system, training more than 40,000 medical residents annually, but academic partnerships also facilitate the joint recruitment of faculty to provide care at both institutions. VA GME programs also educate new physicians on cultural competencies for treating veteran patients (inside and outside the VA), and help recruit residents to the VA after they complete their training.

Innovation and Quality - The combination of education, research, and patient care at VA and academic medical centers cultivates a culture of curiosity and innovation. Under this tripartite mission, it is critical to expand VA research on chronic condi-

tions of aging veterans, emerging conditions prevalent among younger veterans, and the Million Veteran Program. 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, enhancing the quality of care provided to veterans.

Good evening and thank you for this opportunity to testify on behalf of the Association of American Medical Colleges (AAMC). As you consider reforms to improve health care for our nation's veterans, the AAMC respectfully asks that you recognize the importance of the Department of Veterans Affairs (VA) academic affiliations and urges you not to undermine these important partnerships. VA's shared patient care, research, and education missions with academic medicine 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 145 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 VA 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.

This year, the VA and academic medicine will celebrate their 70th anniversary. This relationship dates back 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 training with 135 of the 145 U.S. medical schools.

THE ROLE OF ACADEMIC AFFILIATES IN CARING FOR VETERANS

The AAMC believes VA sole-source contracting, joint ventures, and the proposed Core Network of the Veterans Choice Program help ensure access for our nation's veterans to the highest quality care by preserving academic affiliates as a direct extension of VA care and a preferred provider. This relationship serves multiple purposes:

Access to Complex Clinical Care

VA sole-source contracting allows academic affiliates to plan, staff, and sustain infrastructure for complex clinical care services that are scarcely available elsewhere. U.S. teaching hospitals provide around-the-clock, onsite, and fully-staffed standby services for critically-ill or injured patients, including trauma centers, burn care units, comprehensive stroke centers, and surgical transplant services. Solely relying on fee-basis mechanisms like the Veterans Choice Program has the potential to reduce veterans' access to care if teaching hospitals scale back services when faced with the inability to plan for a consistent patient load from the VA.

Medical Education

The VA is an irreplaceable component of the U.S. medical education system. The VA trains more than 40,000 medical residents within its walls annually. VA medical centers are the largest training sites for physicians, and fund approximately 10 percent of graduate medical education (GME). VA residency programs are sponsored by an affiliate medical school or teaching hospital. Without these affiliations, many VA programs would be unable to meet the requirements set by the Accreditation Council for Graduate Medical Education (ACGME). A provider referral preference for academic affiliates under clinical services contracts helps ensure an adequate and diverse patient load necessary for GME program accreditation.

Physician Recruitment

Academic partnerships between VA institutions and academic medical centers facilitate the joint recruitment of faculty to provide care at both sites. VA GME programs also educate new physicians on cultural competencies for treating veteran patients (inside and outside the VA), and help recruit residents to the VA after they complete their training. 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. The Veterans Choice Act recognizes the importance of this re-

cruitment to addressing Veterans Health Administration (VHA) health professional shortages by creating up to 1,500 new VA GME positions.

Innovation

The combination of education, research, and patient care that occurs because of the close relationships between VA institutions and academic medical centers cultivates a culture of 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, enhancing the quality of care provided to patients, including access to a majority of National Institutes of Health (NIH)-funded clinical trials. Without strong ties to academic affiliates, VA's tripartite mission is put in jeopardy.

AAMC SUPPORTS VA PLAN TO CONSOLIDATE COMMUNITY CARE PROGRAMS

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."

The AAMC applauds the VA for including academic providers in its proposed VA Core Network of preferred providers under its Plan to Consolidate Community Care Programs delivered to Congress last year. The plan, which outlines how the VA will purchase veteran health care at non-VA facilities, proposes a tiered network of providers and allows academic affiliates to continue contracting directly with local VA medical centers.

Current and Previous Challenges Hinder Clinical Relationships

The AAMC supports VA's goal of streamline and improve the efficiency of VA contracting with the nation's medical schools and teaching hospitals. Unwieldy and drawn-out clinical contracting has hinder these relationships, despite their potential to greatly expand the reach of the VHA. Several of these issues have been raised previously by the AAMC and academic affiliates but there has been no subsequent VA reforms to their contracting process. For example, as the VHA faced patient-access issues across the country, 161 of our member medical schools and teaching hospitals have told us they had the capacity to help, yet were often stymied due to contracting hurdles - delaying, and in some cases preventing, veterans' access to health care.

Fee-basis care through a predecessor to the Veterans Choice Program, the "Patient-Centered Community Care (PC3)" program, inserted a middleman between longtime partners, resulting in delayed and misdirected referrals due to skewed third party incentives, additional costs for the VA and affiliates directed to the third party, and unnecessary administrative burden for all. The AAMC appreciates that the VA has now recognized the inefficient processes for onboarding physicians/institutions through third party administrators, which further delayed veteran access to care.

The VA Plan to Consolidate Community Care Improves the Current System

There are many aspects of the proposed VA plan that will improve VA-academic affiliations and veterans' access to quality health care. The VA plan proposes a tiered network of providers. The 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, academic affiliates 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.

Recommendations

The AAMC recommends that the Veterans Choice Program continue a provider referral preference for academic affiliates. We support passage of the Improving Veterans Access to Care in the Community Act (S.2633) implement the VA plan to consolidate community care. This bill would allow VA to 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.

The Veterans Choice Program should also continue full Medicare reimbursement rates, including medical education costs. Additionally, we respectfully ask that the agency and Congress consult with representatives from the academic affiliate community as you implement the updated Veterans Choice Program. One important venue is the VA's National Academic Affiliations Council (NAAC) federal advisory committee, established by VA for the very purpose of advising the Secretary on these issues.

IMPROVING VA SOLE–SOURCE CONTRACTING WITH AFFILIATES

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 too 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 made 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. The contracting decision tree from VA Directive 1663 (attached as an Appendix) outlines the complexity and administrative burden embedded in the process. 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.

Further delaying action, the VA can require academic affiliates to submit documentation of all costs associated with physician employment. As an example, this might include faculty contracts, continuing education policies, time and effort reports, benefits costs, vacation policies, time and attendance policies, the distance and time it takes to walk from the hospital to the VA hospital, and even the monthly cost of parking. The VA reviews these items, in some cases for months. There are often a variety of questions about the data submitted, some substantive but many that seem to be of dubious value.

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.

Recommendations

Local VA medical centers and their academic affiliates see the benefits of these relationships, but are stymied by a process mired in misplaced oversight. 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.

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 overhead rates to eliminate unnecessary negotiations and contract administration.

Involving individuals with academic appointments in the contracting process should not be considered a conflict of interest, but rather recognized for the value they add to VA leaderships' ability to contract for clinical services. The AAMC recommends allowing VA officials with academic appointments to participate in contract negotiations with the academic affiliate.

VA must recognize the unique costs and circumstances associated with clinical contracting compared to other goods and services. The AAMC recommends increased training for VA contracting officers regarding clinical services contracting.

Academic affiliates also have a role to play in improving these negotiations. We have committed to working with our institutions to develop single points of contact instead of renegotiating the same contract with each program head.

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 Health Care Act (H.R. 3879). The VA and academic medicine have enjoyed 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.

The Enhanced Veterans Healthcare Act of 2015 would direct the VA to enter into sole-source 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.

INVESTING IN VA–CENTRIC RESEARCH FOR CLINICIAN RECRUITMENT

The VA Medical and Prosthetic Research and Development program is widely acknowledged as a success on many levels, all directly leading to improved care for veterans and an elevated standard of care for all Americans:

- Advancing Patient Care - 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 PTSD and other mental health challenges in veterans. These studies and their findings ultimately aid the health of all Americans.
- Recruitment and Retention - 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.
- High-Quality Research - 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.
- Investing Taxpayers' Dollars Wisely - Through a nationwide array of synergistic relationships with other federal agencies, academic affiliates, nonprofit organizations, and for-profit industries, the program leverages a current annual appropriation of $631 million into a $1.9 billion research enterprise.

Sustaining 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.

Despite documented success, since FY 2010 appropriated funding for VA research and development has lagged far behind biomedical research inflation, resulting in a net loss of nearly 5 percent 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 $17 million in FY 2017 (a 2.7 percent increase over the 2016 pending 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.

The AAMC believes an additional $17 million in FY 2017, beyond uncontrollable inflation, 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, VA research 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 one million veterans over the next five years. Additional funding will also help VA support emerging areas that remain critically underfunded, including:

- Post-deployment mental health concerns such as PTSD, 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 Million Veteran Program

The VA research program is uniquely positioned to advance genomic medicine through the MVP, an effort that seeks to collect genetic samples and general health information from 1 million veterans over the next five years. When completed, the MVP will constitute one of the largest genetic repositories in existence, offering tre-

mendous potential to study the health of veterans. To date, more than 450,000 veterans have enrolled in the MVP.

To support the President's Precision Medicine Initiative, AAMC recommends an additional $75 million to process the first 100,000 samples without reducing funding for other designated research areas.

VA Research Infrastructure

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 systemwide. 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.

Recommendations

The Administration and Congress should provide at least $740 million for the VA Medical and Prosthetic Research program for FY 2017 to support current research on the chronic conditions of aging veterans, emerging research on conditions prevalent among younger veterans, and the Million Veteran Program.

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.

TRAINING THE NEXT GENERATION OF PHYSICIANS TO CARE FOR VETERANS

To help VA address patient access and recruitment issues, the AAMC supports the Delivering Opportunities for Care and Services (DOCs) for Veterans Act (S. 1676, H.R. 4011) and H.R. 3755. VA physician shortages are symptomatic of a broader trend, the proverbial "canary in the coal mine" for the nation's health system. The AAMC projects a nationwide shortage of physicians between 61,700 and 94,700 physicians by 2025. Though these shortfalls will affect all Americans, the most vulnerable populations in underserved areas will be the first to feel the impact (e.g., the VA, Medicare and Medicaid patients, rural and urban community health centers, and the Indian Health Service).

The study, conducted by the Life Science division of the global information company IHS Inc., and prepared on behalf of the AAMC, and estimates a shortfall of between 14,900 and 35,600 primary care physicians and between 37,400 and 60,300 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.

To address this shortage, the nation's medical schools have done their part by expanding enrollment by 30 percent. 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. Thankfully, the DOCs for Veterans Act helps address this hurdle.

Just as Medicare GME supports Medicare's share of training costs at institutions that care for Medicare beneficiaries, VA GME supports residency training programs based at VA medical centers. 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. 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, without an in-

crease in Medicare GME support, there may not be enough affiliate residency positions to accommodate this VA expansion.

Most VA residency programs do not operate independently. They rely upon the existing administrative and training infrastructure maintained by the nation's medical schools and teaching hospitals. Nearly all VA residency programs are sponsored by an affiliate medical school or teaching hospital.

To assure that VA-based residents receive the highest quality training possible, they need diverse and supervised experiences in a variety of clinical settings. This includes training experiences at the nation's teaching hospitals and the multispecialty practices run by the nation's medical schools. While there is 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).

As such, simply increasing VA GME funding alone will not address the VA crisis. Without a corresponding increase in Medicare GME support, VA medical centers will be unable to capitalize fully on increases in VA GME funding. The DOCs for Veterans Act will allow affiliate teaching hospitals that are already at or above their 1997 Medicare GME cap to receive Medicare support for VACAA residents while they are training at a non-VA facility.

CONCLUSION

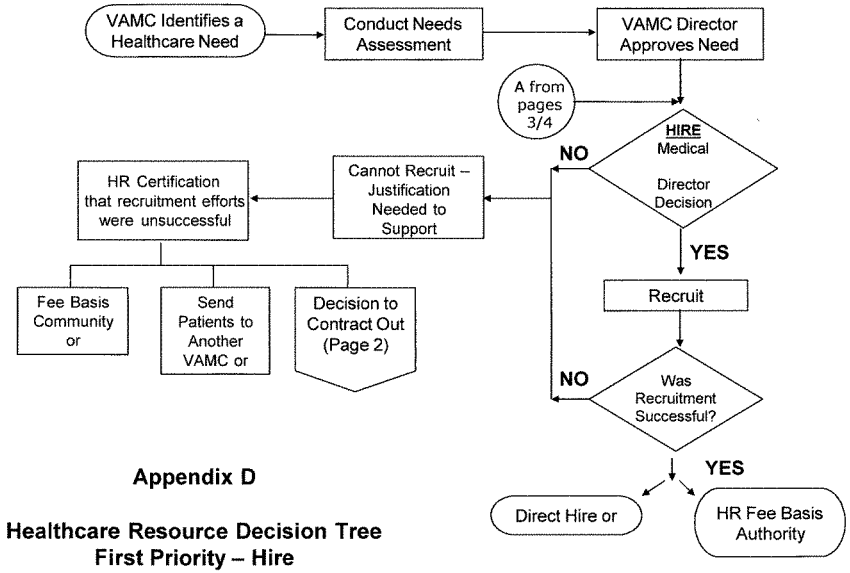
Mr. Chairman and Members of the Committee, thank you for the opportunity to testify on these important issues. To improve the relationships between the VA and the nation's medical schools and teaching hospitals, the AAMC reiterates its support the following bills:

- The Delivering Opportunities for Care and Services (DOCs) for Veterans Act (S. 1676, H.R. 4011) and H.R. 3755;
- The Enhanced Veterans Health Care Act (H.R. 3879); and
- The Improving Veterans Access to Care in the Community Act (S.2633).

The VA is at a crossroads. VA GME, joint ventures, sole-source contracting, 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.

APPENDICES

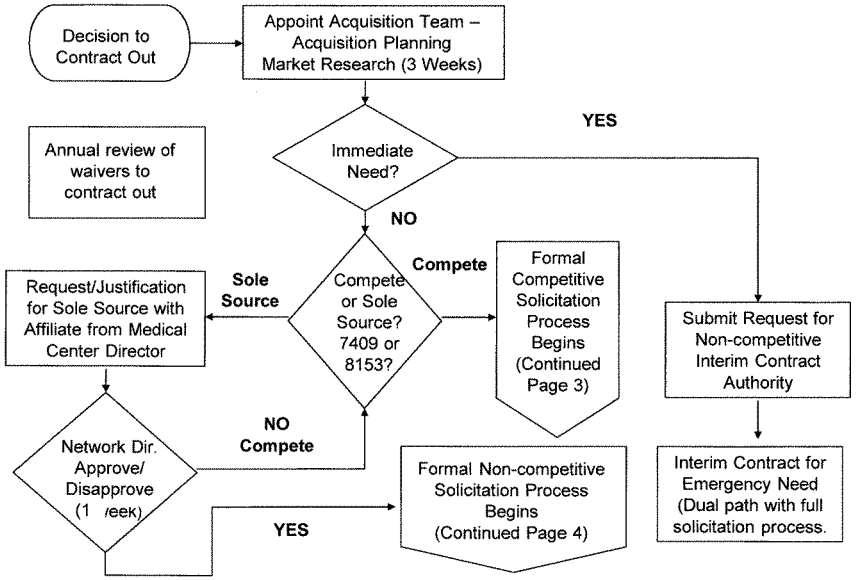
VA Directive 1663 Contracting Decision Tree
Biography of Janis Orlowski, M.D., MACP



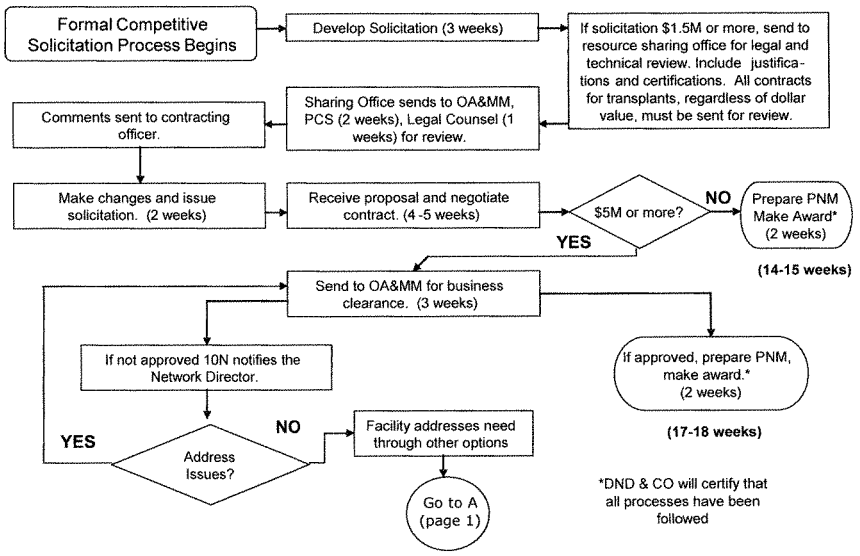
Appendix D

Healthcare Resource Decision Tree
First Priority – Hire
Page 1

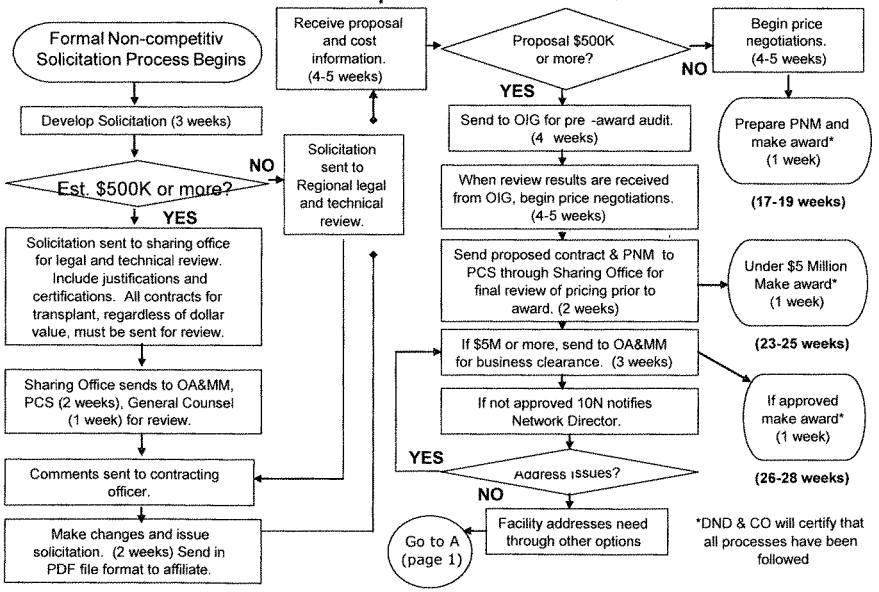
Appendix D, Page 2
Healthcare Resource Decision Tree – Decision to Contract Out



Appendix D, Page 3 – Healthcare Resource Decision Tree
Formal Competitive Solicitation Process



Appendix – Page 4 – Healthcare Resource Decision Tree
Formal Non-competitive Solicitation Process



Prepared Statement of Nancy Watterson-Diorio

EXECUTIVE SUMMARY

Testimony by Nancy Watterson-Diorio, board member of the National Association of Veterans' Research and Education Foundations (NAVREF) and CEO of the Boston VA Research Institute, Inc. (BVARI).

The VA Nonprofit Corporations (VA NPCs or NPCs) fulfill an important role at the VA, in addition to the academic affiliates (AAs), in administering extramural research. I believe the NPCs can contribute much more and be of greater benefit to our veterans if the lingering barriers surrounding consistent national practices were removed. To that end, I respectfully request consideration of the following recommendations: 1) Allow NPCs to pay investigators to the same extent as AAs. 2) Provide NPCs right-of-first-refusal on administering all awards supporting VA research. 3) Reduce the level of variability from site-to-site by creating general guidelines and decision trees that remove or reduce conflicts of interests among decision-makers.

The NAVREF network consists of 82 VA NPCs that are co-located within the VA medical centers (VAMCs or VAs) across the country. As reported in the 2014 Annual Report to Congress, the NPCs raised over $260M of annual extramural research and educational awards specifically targeted toward the VA's mission of supporting veterans' care. This represents approximately 15% of the total portfolio supporting research at the VA.

The NPCs' congressional founding legislation solved several areas of difficulty for VA research and education programs: 1) It discontinued handshake agreements with no contractual obligations and acknowledgement of the VA's research successes. 2) It supplemented VA's intramural funding expertise with expert support for extramural pre- and post-award funding and unique compliance knowledge. 3) It leveraged VA's ability to expand its research portfolio to support clinical trials and federal funding; thus, allowing more veterans to be supported with state-of-the-art research knowledge and the opportunity to be treated with the newest therapies. 4) It fostered an innovative spirit of public-private sponsorship.

There are many advantages to using NPCs as envisioned by Congress. First, NPCs rigorously comply with federal regulations and are subject to VA oversight that includes recurring VA audit inspections. Additional VA oversight includes statutory VA board members at each NPC and a Nonprofit Oversight Board at VA Central Office. In addition, NPCs operate transparently by providing an annual report to Congress detailing their accomplishments and successes in support of VA research.

There are also challenges that we must find ways to overcome in order to successfully carry out the mission and purpose of the congressional vision for NPCs: 1) The NPCs are unable to compete on a level playing field with the AAs because we are unable to pay investigators in the same manner. 2) The decision-making process within VA, regarding the administration of federal grants, varies from site-to-site. Frequently, Principal Investigators (PIs) who are dually-appointed at the AA, or local leadership, make the determination on who will administer the research, which is a potential conflict of interest.

By congressional design, the NPCs exist to advance veterans' health through innovative research and education programs, and I request that we remove all barriers and employ all available tools to accomplish that powerful mission.

WITNESS DISCLOSURE STATEMENT

Begins on following page.

DISCLOSURE OF FOREIGN PAYMENTS TO WITNESSES

I, Nancy Watterson-Diorio, attest that I am a nongovernmental witness and that I am not receiving foreign payments or contracts as a witness or a representative of the National Association of Veterans Research and Education Foundation or the Boston VA Research Institute, Inc. and have never received foreign payments.

Nancy Watterson-Diorio

CURRICULUM VITAE: NANCY WATTERSON-DIORIO

Begins on following page.

TESTIMONY

Chairman Coffman, Ranking Member Kuster, esteemed Subcommittee Members, I am Nancy Watterson-Diorio, and I am honored to be with you 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. As a board member of the National Association of Veterans' Research and Education Foundations (NAVREF) and CEO of the Boston VA Research Institute, Inc. (BVARI), I have over twenty years of experience in administering VA research through VA nonprofit corporations.

My career path has been exclusively spent engaged in medical research administration, first at the academic affiliate (15 years) and then at the Boston VA Research Institute, Inc. (BVARI), the VA nonprofit located at the VA Boston Healthcare System (20 years). I was told when I started at BVARI (and just 3 years from its inception) that "if you build it, they will come." BVARI's revenues were $100,000 in 1996 and only a few active investigators were interested. After 20 years, BVARI has increased its annual revenue to $14M, much of which is supported by the Department of Defense (DoD). Key areas of interest include posttraumatic stress disorder/syndrome (PTSD), traumatic brain injury (TBI), the Precision Medicine Initiative, and a newly developed clinical trials network supporting the northeast medical centers. I am proud of the work we have done at BVARI to support research that has positively impacted so many veterans and their families.

Veterans' Affairs Nonprofit Corporations (VA NPCs or NPCs) are congressionally authorized entities under US Public Law 111–163 Title 38 - Subchapter IV - Research and Education Corporations ("Title 38") sponsored by a great advocate for our nation's veterans, the late Congressman Sonny Montgomery. The mission and purpose of the VA NPCs is "to provide a flexible funding mechanism for the conduct of approved research and education" at an affiliated VA Medical Center (VAMC or VA) 1. Under Title 38, NPCs are allowed to "accept, administer, retain, and spend funds derived from gifts, contributions, grants, fees, reimbursements, and bequests from individuals and public and private entities.[and] enter into contracts and agreements with individuals and public and private entities"1. Recognizing that VA-appropriated funds are not the only source of revenue available to support US veterans' research and educational programs, Congress established VA NPCs to enable more avenues to support and add capacity to these programs. The mission of the NPCs is to advance veterans' health through innovative research and education programs by providing the technical support and the management expertise necessary to best enable their success. Over the past 28 years, since the establishment of the NPCs, the original concept has yielded great success; for the 10-year period from 2005–2014, NPCs expended over $2 billion in support of VA research activities, expending over $260M in 2014 alone in direct support of improving veterans' health. This represents over 4,000 research and education activities. Funds are predominantly federal (excluding VA appropriated dollars), at 72% of total, with the rest made up of private industry trials, foundation grants, donations, and other sources2.

The NPCs are accountable under congressional oversight, which requires a detailed annual report to the Committees on Veterans' Affairs of the Senate and House of Representatives, triennial Nonprofit Program Office (NPPO) audit and direct oversight under the federal Nonprofit Oversight Board (NPOB), as well as other regulatory requirements including federal, state, and local regulations governing their 501(c)(3) benefit status1. Those NPCs who are recipients of federal awards and meet certain financial threshold criteria are also subject to government's Single Audit requirements under the Uniform Guidance policy.

In addition to the NPCs, most VAs are affiliated with university academic affiliates (AAs). The affiliation supports healthcare, research, and medical education and training. The academic affiliation constitutes direct advantages to veterans' health research, most notably, it allows the VAs to recruit and retain the most highly qualified research Principal Investigators (PIs), who traditionally have an academic faculty appointment at the non-governmental academic medical centers (AMCs). At the VA, this faculty appointment exists in addition to their VA appointment, and thus they are dually appointed. Under this dual appointment, PIs may conduct research at the AA under their academic appointment, but in keeping with the intent of Title 38, their AA research must be clearly severable from their VA-approved research. With this option available to dual appointments, there are, however, notable inconsistencies around the nation about how this distinction is overseen and enforced. With the objective of achieving the maximum effectiveness of the affiliation in reference to the research aim, I am not aware of any specific definitions, metrics, or governance requirements guiding this partnership, which as noted may function differently at every local site.

Problem Statement and Recommended Action

Due to the inconsistencies of national practice on whether the NPCs or the AAs administer extramural research programs for the VA, the potential growth of NPCs and their ability to support veterans' research programs have yet to achieve their full potential that I believe was originally envisioned by Mr. Montgomery. A recommendation in the VA's 2009 Blue Ribbon Panel Final Report, conducted in partnership with the American Association of Medical Colleges (AAMC) stated (emphasis added):

"Transformative medical research requires investigators with disparate expertise. Moreover, many research questions are best addressed collaboratively. To enhance the translation of biomedical science into improved health care, the Panel recommends that VA and its academic partners redouble their efforts to develop new knowledge through collaborative research. The Panel endorses the need for a strong VA intramural research program, but cautions that policies limiting more dynamic collaboration with affiliated institutions [including the NPCs] may ultimately undermine the quality of the Nation's overall research enterprise."3

In this context, there are many areas to pursue in recognition of this recommendation. One such area I believe to be important is that the VA establish clear guidelines through its Office of Academic Affiliations governing policy for the administration of non-VA funded research activities that maximizes the benefits of the NPC and generally offers the NPC "right of first refusal" for all research efforts where the majority of effort occurs physically within the VA.

Background and NPC Qualifications

As statutorily established and governed entities, and due to their close relationship and direct knowledge of the VA system, NPCs are uniquely qualified to acquire funding and administer research awards supporting veterans' health priorities.

Additionally, NPC personnel and their volunteers are not paid federal employees and are therefore not restricted from fundraising activities like their federal colleagues, allowing them to directly solicit funds in support of their mission-an avenue that has improved veterans' health outcomes, as all funds raised are reinvested in the NPC's veteran research and educational programming in accordance with its statement of purpose.

The NPCs also provide a specialized role significant in securing research grant and contract funding opportunities. As specialists in veterans' health programs, the NPCs are highly qualified and have direct access to the resources and expertise necessary for successful programming. Some of the benefits of an NPC's internal expertise include access to government and non-government space; knowledge of and direct access to VA infrastructure, including the complexities of government information technology (IT); professional connections and recruitment channels to specialized research program staff; familiarity of the federal Without Compensation (WOC) process and direct relationships with VA HR personnel for processing WOCs; the direct ability to reimburse VA personnel for their work on a funded project; and direct understanding and knowledge of the unique effort-reporting and payment practices for VA PIs, including the "60-hour workweek" and effort disclosure Memorandum of Understanding (MoU), which are discussed in more detail below.

The NPCs are also recognized by the Department of Defense (DoD) as the direct conduit to the VA patient population, an important criterion on grant review and funding allocation due to the DoD's programmatic priorities. As of the 2014 NPC annual report to Congress, federal funding represented 87% of the top five NPCs' research portfolios2. The NPCs' role as specialized program experts can be compared to a disease-focused hospital that is seen as a national leader in that disease. There are, for example, numerous hospitals, AAs, and corporate entities pioneering advances in cancer research outcomes, but a few major dedicated cancer treatment and research institutes across the nation remain the most highly-renowned and receive very large annual funding allocations from research awards and donors. When comparing the NPCs' expertise and dedicated efforts, they serve in a comparable capacity for veterans' health advances.

NPCs also have significant expertise in negotiating and administering industry-funded clinical trial research agreements, by using the federally approved VA Cooperative Research and Development Agreement (CRADA) mechanism. Veterans represent a large patient population that encompasses some of the nation's most serious health concerns, which are priority areas for many pharmaceutical and device companies' research and development initiatives. More importantly, veteran patients deserve access to the most cutting-edge therapies and treatments, which frequently can only be found through industry-funded clinical trials. NPCs provide the VA with a mechanism to accept and administer these much-needed trials. The VA also maintains a robust inventory of patient data and bio-specimen samples, which

offers researchers rich insight into many diseases and their treatments. They have been leaders in major discoveries and treatment advances in over thirty disease areas, most significantly including PTSD and TBI, and in many cases, the NPCs enabled the research funding for these advances4.

A final area in which NPCs support veteran medical research is through the direct financial support of Veterans' Equitable Resource Allocation (VERA) under the Research Support weighting program. VERA Research funds are managed by the VA to "acknowledge the additional expense and provide an allocation of dollars for a facility to support and sustain a research mission"5. Revenue supporting VA-administered research programs, including NPC revenue, is weighted toward research support at 100%, whereas non-VA administered programs, including AA revenue, is weighted at 25%-75%5. According to the 2015 VERA Book, "by weighting VA-administered research at 100% and discounting non-VA administered research, there is an incentive to encourage VA administered research"5. NPC revenue, therefore, more directly supports veterans' research initiatives.

Significant Challenges Affecting NPCs and Impacting Research to Improve Veteran Health Outcomes

Among the most significant and pervasive issues for many NPCs are: 1) the inconsistent management of National Institutes of Health (NIH)-funded research award administration, and 2) PI salary payments on NIH (and other) awards.

The current practices surrounding NIH award administration varies greatly across the US. In some regions, AAs are administering the entire VA NIH-funded research portfolio; in others, NPCs maintain a productive relationship with the AAs and collaborate on NIH award administration; at still others, NIH award administration is considered by local VA officials on a case-by-case basis. Due to a lack of consistent policy interpretation, at this time, several VAs prohibit their NPCs from administering NIH awards, even though there is no formal regulation against doing so. As the NIH is the "largest public funder of biomedical research in the world"6, this represents a significant impairment to NPC growth and development. When AAs administer VA-approved research programs in lieu of the NPCs, there is often a significant increase in the amount of federal funding allocated to the program due to the often substantially higher F&A rates at the AAs in contrast to the NPCs. The biggest discrepancy in F&A rates between NPCs and AAs is seen in the small- to medium-sized NPCs, who typically do not have access to the NIH portfolio (data available upon request to NAVREF). These NPCs' growth trend has plateaued after their initial establishment, potentially due to the tendency at many VAMCs to allow all NIH awards to flow to the AA regardless of where the majority of effort is being exerted. Whether or not intentional, imposing barriers to NPCs' access to the largest source of US medical research funding is akin to cutting off the lifeblood of the NPCs, which in turn contributes to a reduction in veterans' research programs' ability to thrive.

Additionally, there are very specialized policies in the NIH Grants Policy Statement (NIHGPS or GPS) pertaining to jointly-affiliated VA–AA PIs, which are a major contributor to the inconsistencies in national understanding and practice surrounding federal award administration. In my conversations with numerous representatives on this issue, I have observed that many parties hold to historical interpretations and unilateral application of the NIH GPS language, which currently restricts the ability of entities to pay VA–AA joint-appointed PIs on NIH awards such that only a university AA may make those payments7. An NPC may be the recipient of NIH awards, but may not pay the PI's salary directly unless it is in the form of a reimbursement to the VA for the PI's official VA tour of duty7. Hence, if the PI is working on the project above-and-beyond his or her VA tour of duty (an allowable and recognized activity as long as total professional effort [TPE] remains within 60 hours per week across all employers ["the 60-hour workweek"]), the only functional mechanism for payment of that time is via a Joint Personnel Agreement (JPA), a convention that allows an AA to employ and issue salary payments when an NPC is the award recipient. The salary for PI effort is awarded to the NPC, but through a JPA agreement, the NPC agrees to send those awarded salary funds to the AA, who issues the PI's paycheck using those funds. After comprehensive research of the history and applicability of these practices, I have discovered that other agencies (federal and non-federal) accept the 60-hour workweek concept and have no objections to NPCs issuing PI salary payments directly, without using a JPA. However, local practices and a lack of understanding of the applicable policies have prevented many NPCs from making direct payments, which has resulted in direct financial loss to the NPCs due either to: 1) the need to forego the drawdown of budgeted award revenue covering PI project salary because there is no agreed-upon mechanism for issuing payment by the NPC, 2) the decision by the PI to forego

acceptance of the award because they are unable to be paid under the original contractual expectations and terms of the award, or 3) the direct loss of the entire award by the NPC under local directives to relinquish it to the AA in order to enable PI salary payments. These foregone payments have had a devastating impact on the ability of the NPCs to support veteran research programs.

In my research and discussions with national leaders on this issue, I have not found a significant regulatory basis behind the NIH policy language that restricts the flexibility of NPCs, and if left unaltered, the language will continue to raise concerns as it gives direct preferential treatment to the university AAs. NAVREF, with the approval of VA's Office of Research and Development (ORD), is discussing with NIH the possibility of modifying language in the GPS to allow NPCs to pay PIs directly for their NIH-funded project effort.

NIH has current policy language restricting VA PI "60-hour workweek" payments to the use of JPAs, but it is our finding that no other agency publishes such restrictions. Due to local policies and practices, many NPCs are utilizing "optional JPAs" (a JPA that is being practiced locally, but that is not officially sanctioned or governed by the funding agency). While optional JPAs are in some cases useful mechanisms for NPCs, there are several ways in which their local application can affect the NPCs financially: first, some AAs charge an administrative fee-on top of their federally negotiated fringe benefit (FB) rate and rolled into the award's FB budget-for processing these payments. The fee is treated as a Direct Cost (DC) expense on the award, and often costs the award more than the NPC FB rates would, thus taking funds away from the veterans' healthcare research project. In addition, several AAs do not currently allow JPAs due mostly to the inherent risk posed to the AA in taking accountability for the PI's effort without direct knowledge of the project. In many cases, the decision is being made locally to request that the AA directly administer the entire research award, simply as a means of enabling PI payment. This approach is in direct competition with the NPCs' mission and purpose, as defined in Title 38, to further veterans' health outcomes by administering VA-approved research and educational programs (when they are funded by non-VA-appropriated dollars).

I am concerned about the inherent conflict of interest posed by the PI and/or any organization's (e.g., VA, AA, NPC) direct leadership if they are given the option to choose the entity under which to submit grants, rather than following a vetted policy or directive. Whether or not intentional, a reasonable independent party could conclude that the person making the choice as to where the award is administered stands to personally gain from that decision, as they will either receive direct salary (and, potentially, benefits) from that entity (in the case of PIs) or financially benefit as an organization (in the case of organizational leadership being the decision-maker). The lack of consistent national practice has led to significant variation in which party administers the research project and/or pays the PI for project effort, and has resulted in consequential significant loss of potential revenue for veterans' medical research programs. Although the VHA Handbook 1200.17 allows NPCs to hire and pay VA employees (PIs)-and 18 U.S. Code § 209 provides NPCs with an exemption from salary supplementation concerns, as the employees serve in a "without compensation" (WOC) government capacity when working for an NPC on a portion of their 60-hour workweek-a lack of clear national guidance on conflict of interest vetting has resulted in paralysis of the ability of many NPCs to make payments8,9. I recommend a single national practice on NPC/VA conflict of interest vetting and a national directive explicitly allowing NPCs to make payments to PIs.

Summary, Impact, and Request for Action

The NPCs were created under Title 38 to serve as flexible funding mechanisms to enable advancements to veteran health outcomes. Because of inconsistent national practices, local decision-making, and a lack of clear and consistent policy language, the intent of the original legislation in Title 38 pertaining to the NPCs' missions has been diluted and redistributed across multiple parties (NPCs and AAs). Without any clear VA or congressional guidelines, each local medical center is afforded the ability to pick and choose the source of research award administration.

I recommend a comprehensive review of national practices and updated policies and directives to clarify the roles and responsibilities of the AAs and NPCs, and to give the NPCs the enhanced opportunity to participate in the important work that is being done in the VA's extramural research and education programs. I believe this is in keeping with the original intent of the NPCs and their statutory authorization, which was designed to directly benefit-without interpretation, dilution, or bias-the veterans.

Thank you for inviting me to discuss these important issues and thank you for your support of veterans. The VA's medical research program is a hidden jewel with

an enduring legacy of improving the care of veterans and citizens throughout the nation. The close collaboration and cooperation of VA medical centers, their academic affiliates, and the nonprofit corporations is absolutely essential to the continued success of this impactful research program.

TESTIMONY: NANCY WATTERSON–DIORIO

PROFESSIONAL BACKGROUND: My career has been focused on research administration for over 35 years. Of that, 15 years has been spent as an employee of the academic affiliate, Harvard Medical School, in several capacities. During that time I was directly employed by the affiliated teaching hospitals, Brigham and Women's Hospital and Beth Israel Hospital. My role involved many administrative aspects of research administration, which would often overlap with issues pertaining to the Department of Veterans Affairs (VA). In 1996 I became the Executive Director of two VA nonprofit organizations, the New England Medical Research Institute, Inc. (NEMRI) and the Boston VA Research Institute, Inc. (BVARI). Both organizations were in their very early stages of business development (less than five years). Annual revenue of both organizations was approximately $100,000. As the medical center underwent a merger, it was decided by VA leadership to merge both VA nonprofits into one. BVARI has just recently celebrated its 25th year of operations and its annual revenue for FY2015 totaled over $13M. BVARI directly supports 125 employees who play a key role in the organization from administration (12 employees) to research positions (113 employees). BVARI serves the faculty in both research and educational projects and programs from foundation grants to administering federal awards.

PERSONAL BACKGROUND: I am the granddaughter of a WWI veteran, the daughter of a WWII veteran, the niece of a vast array of service veterans, and the aunt of two nephews who most recently served. I've only known my family to be devoted Americans who felt it was their duty to serve in the military. I will mention that my Grandmother was a Gold Star Mother and my family most recently lost my nephew to suicide upon his successful completion of a tour as a submarine operator in the US Navy. And finally, my granddaughter graduated high school this week and her active military status in the U.S. Navy begins in July of 2016. Although not a veteran myself, I've had close family ties throughout my life. My service to the VA now makes me feel a part of this inclusive family bond.

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Statement For The Record

Dr. Christian Kreipke

To the Subcommittee on Oversight and Investigations of The House Committee on Veterans Affairs:

Nearly five years ago I was traveling the world sharing the results of my research which were touted in Neurology Today as the first real hope for a cure for head trauma. I was generously funded by both the National Institutes of Health (NIH) and the Veterans Administration (VA) to develop this research into a viable treatment for our Veterans and the public, at large, suffering the effects of brain injury. I was an assistant professor on tenure track, a VA investigator, a world-renowned expert in the field of traumatic brain injury (TBI), had a well-staffed laboratory, mentored students, the Chairman of the Board of Southfield Oncology Institute (IRB), and had a very successful and happy personal life-all the signs of success that can be achieved in America. However, this was all stripped away from me when I started to detect and brought to light chronic and systemic misappropriation of government monies. Now, I am an entry level line worker at an automotive plant without a home, swimming in debt, and involved in multiple litigations against the very entities I am trying to protect. In short, my payment for blowing the whistle on hundreds of millions of dollars of grant fraud is not protection but, rather, currently total destruction.

To explain how my life was ruined, in 2010 I was heavily immersed in my research which sought to develop a drug therapy to alleviate the signs and symptoms of head trauma. Additionally, I was selected by multiple government agencies (e.g., Department of Defense, VA, NIH) to review grants pertaining to TBI. Around the same time, large amounts of tax payers' dollars were being requested and reallocated to develop treatments for TBI which appears to be a national crisis affecting both our military personnel and the general public. At this same time I received funding from both NIH and VA to explore a novel therapy for TBI. The mechanism to allow me to explore further research to combat TBI was facilitated by a three way contract entered into between myself, VA and the affiliated educational institute for VA in Detroit, Wayne State University ("WSU") (Exhibit A).

While engaged in research at WSU, I began to detect irregularities in the grant procurement process-from how grants were being funded, who reaped the benefits of the money, to even how my salary was being determined. Specifically, I was asked by VA's educational affiliate, WSU, to sign off on an effort report which declares to government agencies how much time I was willing to allocate to a particular funded project in order for the University to be reimbursed from federal funds for my salary. I noted that I was being asked to sign off on a document that contained erroneous information. The University was claiming that I was allocating more time on my NIH grant than I was and, consequently, was asking the government to reimburse more of my salary than should be. I protested this and refused to sign off as it was not a true reflection of my effort and represented potential grant fraud. Two months after this I noted that grant funds from my grant were being syphoned off to pay for another faculty member's project. This, too, seemed blatantly wrong and I further protested this to the chair of my department. In December 2010, after discussing some of these issues with colleagues that sat on the policy committee at WSU I was recommended to serve on an internal committee designed to report to the Provost, Ronald T. Brown, any irregular policies that may be occurring at the University. I specifically was tasked to probe the research division. What I found was astonishing.

In the process of my review of Wayne State University's granting practices, I discovered that a chronic issue was manipulation of effort reports in order to obtain more money from the government to offset salary costs of faculty. I also discovered that often money allocated to particular projects was being used to fund different projects without reporting this to the funding agency. I detailed this in a report to the Provost and to the Vice President of Research, Hilary Ratner. It was at this time that I was severely retaliated against. I was charged with allegations of committing scientific misconduct in my own research. Ironically, my ultimate judges in this matter were both the Provost and the Vice President of Research who both promptly terminated my employment at WSU and reported to NIH that I was not a trustworthy individual.

In March of 2012, after being terminated from Wayne State on spurious charges of scientific misconduct after I blew the whistle regarding grant fraud, I moved my entire research project to John D. Dingell VAMC (JDDVAMC), again, Wayne State University's academic and financial partner. Unfortunately, the same type of retal-

iation continued, leading to my termination at VA, as well. After being exonerated twice of the same misconduct charges at VA, a third inquiry was undertaken that ultimately led to an Administrative Investigative Board (AIB) and pronouncement of my guilt at VA, too. It should be noted that WSU inserted its influence in that inquiry and AIB members wore two hats, being faculty or even Deans at WSU in addition to VA employees. Furthermore, the new Chief of Staff at the time, Scott Gruber, was also a Dean at WSU's medical school.

To now focus on, specifically, the VA involvement in this situation, through my own investigation of my grants and those that I had access to through grant review, I detected the following grant disparities which occur through partnering of VA medical centers with affiliated Universities:

1). Inappropriate sharing of funds between VA and the affiliate without proper oversight. Upon comparing my VA grant expenditures to my NIH grant expenditures I noticed that the vast majority of my VA grant was going directly to Wayne State University (Exhibit B), supposedly to pay for faculty and personnel at Wayne State that would contribute to my VA grant project. There were two fundamental problems, here. First, those same personnel were being paid by my NIH grant and/or University start-up funds and, second, many of these people never contributed to my VA project. In one case, there was a "ghost employee", or someone who I was not even sure who it was. Obviously, Wayne State should not have been receiving VA funds for these people as they were, essentially, "double-dipping".

2). Allegedly falsified effort reporting. I also noted that effort was being manipulated by several individuals in order to allow those individuals to compete for other grants without exceeding 100% effort or in some cases disregarding time and effort standards altogether. As recently as my pending trial in front of the Merit Systems Protection Board (MSPB), it was revealed through the course of testimony that the administration at JDDVAMC arbitrarily manipulated my effort on a currently funded grant in order to make the math work on me having two projects at once. In fact, through my grant reviewing efforts, I discovered that this is, in fact, common practice. As an example I have included a biosketch of a VA-funded researcher at University of Pittsburg, Edward Dixon, who is Principle Investigator on numerous grants which, conceivably, it is impossible that he could devote physical effort to all of these projects, yet he is receiving salary support for each (Exhibit C).

3). Inappropriate sharing of equipment and payments for this equipment between VA and the affiliate. Furthermore, Wayne State University in many cases charged VA for use of its space and equipment even when, in some cases, the very equipment being purchased is being purchased by VA funds. Thus, Wayne State not only benefits from receiving VA-funded equipment, but also receives direct funds from VA to utilize this equipment and/or the space that houses the equipment. It should also be noted that in many of the same cases this space and/or equipment, is also being charged to NIH and, thus, the government is paying twice for the same item while the University is reaping in the government funds.

4). "Improper influence"[1] of the Affiliate over VA. Also astonishing was what I discovered about oversight of VA grants. I discovered that Wayne State University provides research and monetary oversight over JDDVAMC using Wayne State personnel, many of which are both Wayne State and VA employees. Thus, the VA had little control over how research is conducted or how research money is being processed as the oversight is conducted by and through Wayne State University, the affiliated University, which receives a significant portion of the VA funds. It is through this affiliate oversight and influence over the VA that another chronic problem emerges. Contracts with individual faculty that share University and VA appointments are negotiated chiefly by University personnel or by those VA personnel that also have appointments with the University. In fact, as pointed to above, the Chief of Staff at JDDVAMC, Scott Gruber, is a Dean at WSU's medical school. This allows for a broad range of salaries to be paid via VA funds to supplement University salary (e.g., in excess of $155,000 per year for just the VA portion of an individual's salary), none of which conform to any VA policy, let alone to any general schedule (GS) standards. These potentially fraudulent practices are not limited to Wayne State University/JDDVAMC, but, rather, are ubiquitous throughout the nation.

What steps were taken to try to rectify these troubling grant practices? After discovering these allegedly illicit practices which not only waste tax payers' resources but also divert funds that are supposed to be used to help discover cures for disease and infirmity, I first reported to my superiors. At Wayne State I reported to first my chair and then to the Provost. At VA I reported many of these irregularities

[1] See Mithen v. Department of Veteran's Affairs. Of note, this case involves similar ″improper influence″ of Universities over VA.

through a series of administrative Grievances filed against the Medical Center Director, Pamela Reeves, and other VA personnel. What was the outcome? My report to the Provost at Wayne State was, in the words of the Provost's assistant, "deep-sixed." My Grievances were either ignored or summarily dismissed by Pam Reeves, the very person being grieved. I also brought my allegations to both administrators at HHS and the VA IG. They were largely ignored or referred back to the very people that ignored them initially. Even at the highest levels, my Grievances were ignored. Robert Petzel, former Undersecretary of Health, chose not to address the problems that I raised in the Grievances. Further, Douglas Bannerman, former Research Misconduct Officer for the VA, admitted, under oath, that he was aware of my Grievances yet did nothing. As what happened to me in WSU, I was likewise retaliated against and terminated by VA by a panel stacked with members that have clear conflicts as further discussed above.

To address my wrongful termination at WSU, I had no choice but to file lawsuit. Currently, my False Claims lawsuit against Wayne State is pending cert. from the Supreme Court of the United States of America. (By way of background, the current laws governing the False Claims action are interpreted differently across circuits as to whether or not Wayne State can be sued based on its status as a "State-Institution".). To address my wrongful termination by VA, I filed an appeal, which is currently being tried through the MSPB. I continue to be retaliated against even pending the outcome of this trial.

Despite heroic efforts by Congress to protect whistleblowers, does the VA still engage in retaliation for blowing the whistle? Yes. I feel it is important to also illustrate to you the level at which the VA continues to retaliate against those that blow the whistle, which is the subject of my MSPB claim. While at the VA, and after making my disclosures of grant fraud at Wayne State University, JDDVAMC's affiliate, I was charged and found guilty of scientific misconduct despite there being little to no evidence which suggests that I committed any misconduct. In fact, previous to VA being aware of my disclosures, I was found not guilty of misconduct. It was only after they were made aware of my disclosures of grant fraud that a third investigation against me was conducted which, again, was run by VA employees who had Wayne State appointments as stated above.

During the course of this investigation VA personnel took my computers (even though they admitted that no evidence was located on these computers) and accidentally erased all of my data which completely eradicated my ground-breaking research. I was subjected to being warehoused in a small office with two other individuals that often exceeded 90 degrees Fahrenheit. My phones were routinely monitored. My emails were routinely hacked. My due process rights were trampled on. My salary was reduced. I never received salary from a grant that I was on despite JDDVAMC receiving the funds to cover salary. I was stripped of my union representation. I was harassed by multiple VA personnel. I was taken out of the building by police escort in front of my colleagues and forced to go on paid leave (which further crippled my research mission). Further, my personnel, who supported me in testimony, were terminated despite my grant continuing to be funded. To meet their retaliatory end, VA personnel ultimately fired me and banned me from VA service for 10 years (which is outrageous even if I had committed misconduct, especially in light of the lack of punishment for so many VA administrators who did manipulate data with regards to wait times). Even the current MSPB trial has been met with great challenge at the hand of VA personnel. For example, VA agreed to mediation in settling this matter only to go on to show a lack of good faith by not proffering any reasonable offer. This added unnecessary time to the MSPB proceedings. Dennis McGuire, Chief Counsel to VA, taunted me after one of their witnesses stated that VA routinely changes effort in order to facilitate other grants, stating that he welcomes me to file a lawsuit against the VA for grant fraud. Furthermore even Robert McDonald, Secretary of the VA, attempted to strip me of my due process rights by, through his lawyers, submitting a motion to essentially attempt to block my ability to exercise my rights through the MSPB. So currently, instead of putting my talents to finding a cure for TBI I am sorting and balancing tires for pickup trucks twelve hours a day. To add insult to injury, during the course of my current trial, this matter was raised and Counsel for VA, Amy Slameka, objected stating that I should not complain since a line job is not a bad job. While I will not comment on the degree of satisfaction of my current job, certainly we can agree that I did not go through nearly twelve years of University coursework and training to work in an entry level position at a fraction of my previous salary.

To further illustrate the extent to which retaliation is the modus operandi of VA administrators, the retaliation against me is not limited to just me. My colleague and former student, Justin Graves, refused to condemn me when he was called to be a witness in the investigation into scientific misconduct. Further, he called into

question the Administrative Investigation Board's conduct (which included stripping him of his union rights) and within weeks he was fired. Now Mr. Graves is involved in a separate MSPB lawsuit which has languished on for over two years now. He too has been humiliated and stripped of his career trajectory. Thus, despite the efforts of Congress to establish laws that protect whistleblowers, regrettably these laws do not dissuade VA personnel from engaging in what appears a chronic culture of retaliation.

How does one fix this systemic problem?

Now that I have illustrated not only how University/hospital affiliates exert undue influence on the VA which often leads to waste and gross mismanagement in hundreds of millions of dollars of VA funds and after articulating my personal case of how the VA continues to engage in Kafkaesque retaliation to those that are compelled to blow the whistle on such schemes, I would be remiss in not acknowledging that this otherwise dismal situation can be fixed. First, the lines that University affiliates have so blurred need to made clear again. Proper policies that make clear the dissemination of resources need to be put into place to protect the VA mission and resources from being squandered. Second, oversight needs to be placed back into the central authority of the VA and not entrusted to Universities which often have self-interests that may conflict with the ethics and standards of VA. Third, proper oversight of all government granting agencies needs to be centralized such that redundancy and overlap in resources and effort are mitigated. With these and other measures, the ever-encroaching cancer that infects the otherwise beneficial mission of the VA can be excised. As for the whistleblower, VA administration must shed the current culture of treating whistleblowers as the enemy that needs to be crushed and try to understand that the vast majority of us are trying to help a broken system. Regrettably, currently even the Secretary of VA seems to want to live in a fantasy world where making excuses for what the nation sees as systemic problems is the way to fix the VA, while many of us are begging for the eyes to be open and to be transparent to systemic problems that CAN be fixed before the entire VA is reduced to mere ruins.

In closing, I discovered hundreds of millions of dollars of grant fraud (billions if one includes institutions in addition to Wayne State University and JDDVAMC) which deplete government funds, including those earmarked for the VA. Much of this fraud is related to the lack of oversight of grant funds to the VA and, more broadly, to the affiliated Universities. When I reported this I was met with extreme retaliation leading to my current dismal situation.

However, as I still have complete faith in my country, my government, and my government institutions, I do believe this tragedy is still capable of being fixed. I also believe that many of the aspects that make this Great Nation were accomplished through great personal sacrifice. Though I have made this sacrifice and have been annihilated by the VA, I am still committed to helping in any way that I can to fix this problem. With appropriate oversight, clear separation of duties between the VA and its affiliated University/Hospital, and proper provisions to assure accountability of those receiving government funds, VA's commitment to finding cures for diseases and injuries can be achieved. As our country faces ever increasing health problems, whether it be cancer or head trauma or new issues such as Zika virus, I still firmly believe that government-funded research holds the answer to cures to overcome the adversity associated with these medical issues.

I thank you for your due diligence in investigating this matter, I thank you for allowing me the opportunity to bear witness to my situation as being a representative of a more chronic dilemma, and I thank you for serving our country in its efforts to protect the American People. Once again, please feel free to call on me to assist in any way that I can in fixing this problem so that the VA and other government institutions can more efficiently and more effectively treat medical complications.

Respectfully Submitted,

Dr. Christian Kreipke

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