Association of American Medical Colleges

Statement for the Record on Pending Health Care Legislation

Senate Committee on Veterans Affairs

July 11, 2017

For more than 70 years, U.S. medical schools and teaching hospitals have supported the Department of Veterans Affairs to improve access and quality of care for our nation's veterans.

This partnership helps ensure veterans have access to specialized clinical services at academic medical centers that are scarcely available elsewhere, including trauma centers, burn care units, comprehensive stroke centers, and surgical transplant services. By working with the VA, medical schools and teaching hospitals help to promote veteran-specific clinical and cultural competencies while training the next generation of physicians. Additionally, veteran-centric research collaborations have advanced innovations in health care.

The discussion draft bills, "The Veterans Choice Act of 2017" and "Improving Veterans Access to Community Care Act of 2017," aim to address VA's workforce challenges by enhancing veterans' access to health care services in the community. While this is a laudable goal, if not structured properly, we believe there are potential unintended consequences that will adversely impact veterans. Mainly, we caution against reducing veterans' choice of clinical care settings by eliminating VA's authority to directly contract with academic medical centers and solely relying on fee-basis mechanisms that do not recognize the value of VA-academic affiliations.

We also urge the Committee to protect each of VA's statutory missions of 1) patient care; 2) health professions education and training; and 3) research, and that the current focus on patient care is not at the expense of VA's other missions to educate and train the U.S. clinical workforce and to advance veteran-specific research.

The Association of American Medical Colleges (AAMC)[1] recommends that the discussion draft bills preserve the VA's authority to directly contract with academic affiliates for specialized clinical services and to improve the process for sole-source contracting that puts veterans first in line for the best care in the world at academic medical centers.

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

Direct Contracting with Affiliates Ensures Services are Available for Veterans

Veterans require the entire spectrum of clinical care services: preventive services, primary care, and highly-specialized clinical treatment. When the VA is unable to provide those services,[2] VA medical centers are authorized under VA Directive 1663, in accordance with 38 U.S.C. § 8153, to enter into contracts with academic affiliates on a non-competitive or "sole-source" basis. Sole-source contracts help ensure that academic medical centers support the clinical service lines that are most important to veterans, but are scarcely available through other providers in the community.[3] Indeed, a 2016 Government Accountability Office (GAO) report found that "[Sole-source affiliate contracts] 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."[4]

The nation's medical schools and major teaching hospitals — frequently with regional campuses and co-located near or directly connected to VA medical centers — provide around-the-clock, onsite, and fully-staffed standby services for critically-ill and injured patients, in particular highly-specialized complex clinical care. For example, 5 percent of all U.S. hospitals are AAMC-member teaching hospitals, but they provide 23 percent of all clinical care and 37 percent of hospital charity care, including 100 percent of the nation's Comprehensive Cancer Centers, 68 percent of burn unit beds, and 79 percent of accredited level-one trauma centers.

The VA's ability to directly contract with academic affiliates allows for planning, staffing, and maintaining infrastructure for complex clinical care services. Without these service agreements, it is more difficult for academic medical centers to anticipate the unique clinical service needs of veterans, which are less-visible when veterans are aggregated with the broader patient population. Ultimately, sole-source contracts ensure academic medical centers and the advanced care they provide remain a choice for veterans.

Partnering with Academic Affiliates Improves Efficiency and Quality of Care

Sole-source contracting with academic affiliates improves coordination of care, providing immediate access to clinical services without the need of a third-party administrator or leaving veterans to manage their own care. These agreements also facilitate robust clinical information sharing and care coordination with VA facilitates. Additionally, nearly 70 percent of VA physicians have joint appointments with a medical school or teaching hospital, which facilitates integration of veteran patient care between the VA and its academic affiliates. These

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[2] "Prior to initiating a contract, the facility must ensure that a clinician could not be hired to fill the clinical requirements." VA Directive 1663

[3] "All health care resources contracts that do not require the acquisition of the Affiliated University faculty members' services to perform the contract services must be awarded competitively when two or more qualified providers (may include the Affiliate) of the health care resource are available that can fulfill the VA contract requirements." VA Directive 1663

[4] GAO-16-426: Published: May 6, 2016. Publicly Released: Jun 6, 2016.

appointments also serve as an important tool to recruit and retain the nation's best and brightest physicians.

Further, the high-volume and expertise at academic medical centers improves quality of care and reduces redundancies. For highly specialized complex clinical care, for example cardiac by-pass surgery, we know that academic medical centers that do high volumes of cardiac by-pass procedures have better outcomes than those who have less volumes. Academic medical centers around the country make tremendous investments in their cardiovascular service lines, including capital equipment, human capital investment and protocol management to ensure topflight care.

Many VA medical centers and community providers don't have the budgetary strength, patient volumes, or human capital to invest in these types of services in order to have comparable outcomes. Just as commercial and managed care organizations who preferentially contract with academic medical centers to ensure that their beneficiaries receive top line care, these same principles should be encouraged and embraced by the VA.

VA-Academic Affiliations Enhance Veteran Care through Education and Research

U.S. medical schools and teaching hospitals enjoy reputations as best in the world precisely because of their tripart missions: research, education, and patient care. Like a three-legged stool, these missions are fully integrated and dependent on one another — to separate them is to jeopardize the advancement of care that routinely originate in academic medical centers. VA's similar tripart missions are enhanced by close relationships with academic medical centers. As such, sole-source contracts with affiliates are critical to fostering veteran-centric research innovations and maintaining a well-prepared physician workforce to care for veterans. Conversely, eliminating VA sole-source contracting with affiliates weakens the relationships and puts all three missions at risk.

The VA is an irreplaceable component of the U.S. medical education system. Each year, the VA helps train more than 20,000 individual medical students and more than 40,000 individual medical residents within its walls. As a system, the VA represents the largest training site for physicians, and funds approximately 10 percent of national graduate medical education (GME) costs annually. The GME relationship between the VA and academic affiliates does more than benefit learners and training programs. Under the supervision of faculty, many of whom have been jointly recruited by the medical school and the VA, residents and fellows provide substantial and invaluable direct patient care.

VA Directive 1663 recognizes the immediate value added by sole-source contracts with affiliates, "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 services contracted). … The decision to compete contracts for services that overlap programs in which the facility has graduate medical education training in place must be weighted by additional factors beyond the contract costs. The decision must consider all implications to the business,

including the impact to the facility's training program, which is a direct contributor to the facility's productivity and may provide offsets."

Physicians who train with veteran patients are also better prepared to treat veterans in any future practice setting, whether at the VA, academic affiliates, or other community providers. The VA patient-learner dyad is a cultural anchor for many young physicians who have never served in the nation's armed forces. VA rotations and sole-source clinical contracts ensures with affiliates expands residents' empathic understanding of what it means to "serve and sacrifice" for the nation. Without this GME partnership, care for veterans inside and outside the VA system would be diminished.

Now is not the time to divest in veteran research. Young veterans are returning from recent engagements with polytrauma, mental health concerns, and complex clinical needs from injuries they may not have survived in the past. Aging veterans from previous wartime periods require additional care and resources to treat chronic conditions. VA's research mission improves the quality of care and the effectiveness of health systems that treat veterans.

Academic medical centers, in collaboration with VA medical centers, cultivate a culture of research curiosity and innovation. Medical faculty must be skilled in the latest clinical innovations to train the next generation physicians that will care for veterans. State-of-the-art technology and groundbreaking treatments jump quickly from the research bench to the bedside to the care delivery system. The VA's intramural research program serves as a recruitment tool and sponsors numerous projects in areas that specifically benefit veterans and the unique challenges they face — research that might otherwise be neglected in the private sector. Treatment at academic affiliates also increases veterans' access to a majority of National Institutes of Health (NIH)-funded clinical trials, while also increasing the opportunity for collaborative VA and academic affiliate clinical trials.

Without strong clinical ties to academic affiliates, VA's tripartite mission is put in jeopardy, and the substantial benefits of education and research are lost.

With Process Improvements, Direct Sole-source Contracts Can Reduce Bureaucracy

The AAMC supports streamlining and improving the efficiency of VA contracting with the nation's medical schools and teaching hospitals. Unwieldy and drawn-out clinical contracting process often hinders these relationships, despite their potential to greatly expand veterans' options for care. Many AAMC members report that they have the capacity to help address patient access issues, but are 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.

One of the most frequently identified barriers to improving veterans' access to care at academic medical centers through sole-source contracts is the additional review of contracts greater than $500,000 by the VA Office of Inspector General (OIG). VA must recognize the unique costs and circumstances associated with clinical contracting compared to other goods and services. 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

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 adjusting the $500,000 threshold in a manner that better reflect clinical costs and recognizes the value of long-term agreements with academic affiliates (e.g., at least $2.5 million for 5-year clinical contracts).

As referenced in the VA's 2015 consolidation plan, the AAMC appreciates VA's willingness to develop pre-approved template contracts that reimburse certain services with at least Medicare rates.[5] 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, as long as they don't have a specific role at the affiliate that would create a conflict.

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.

[5] Already, VA Directive 1663 states, "Contracts should be based on market prices as assessed by appropriate local and regional market analyses. Contracts should not exceed applicable Medicare rates unless there is adequate justification documented in the contract file."

Establishing Joint Ventures With Academic Affiliates

To better align the VA and the nation's medical schools and teaching hospitals, the AAMC supports the Enhanced Veterans Healthcare Act of 2017 (H.R. 2312). Our shared missions 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.

Conclusion

Mr. Chairman and Members of the Committee, thank you for the opportunity to submit this statement on these important issues. The VA is at a crossroads. Retaining and improving veterans' access to care at academic medical centers through sole-source contracting 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.