Statement

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On

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

Presented to the

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

By

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June 7, 2016

Executive Summary: Testimony by Janis Orlowski, M.D., MACP, Chief Health Care Officer, Association of American Medical Colleges (AAMC)

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 conditions 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 recruitment 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 tremendous 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 increase 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:

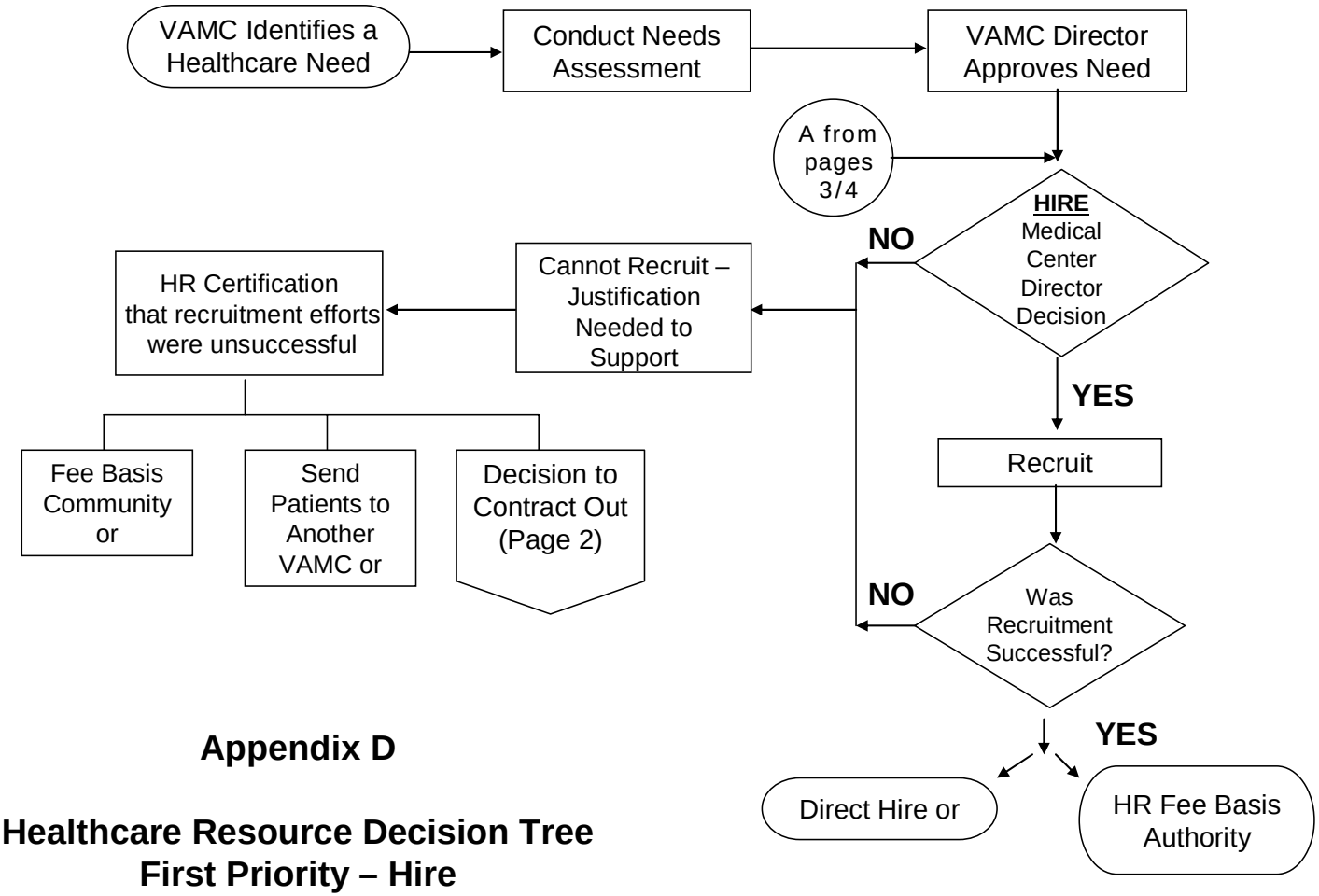
- The Delivering Opportunities for Care and Services (DOCs) for Veterans Act (S. 1676, H.R. 4011) and H.R. 3755;
- The Enhanced Veterans Health Care Act (H.R. 3879); and
- The Improving Veterans Access to Care in the Community Act (S.2633).

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

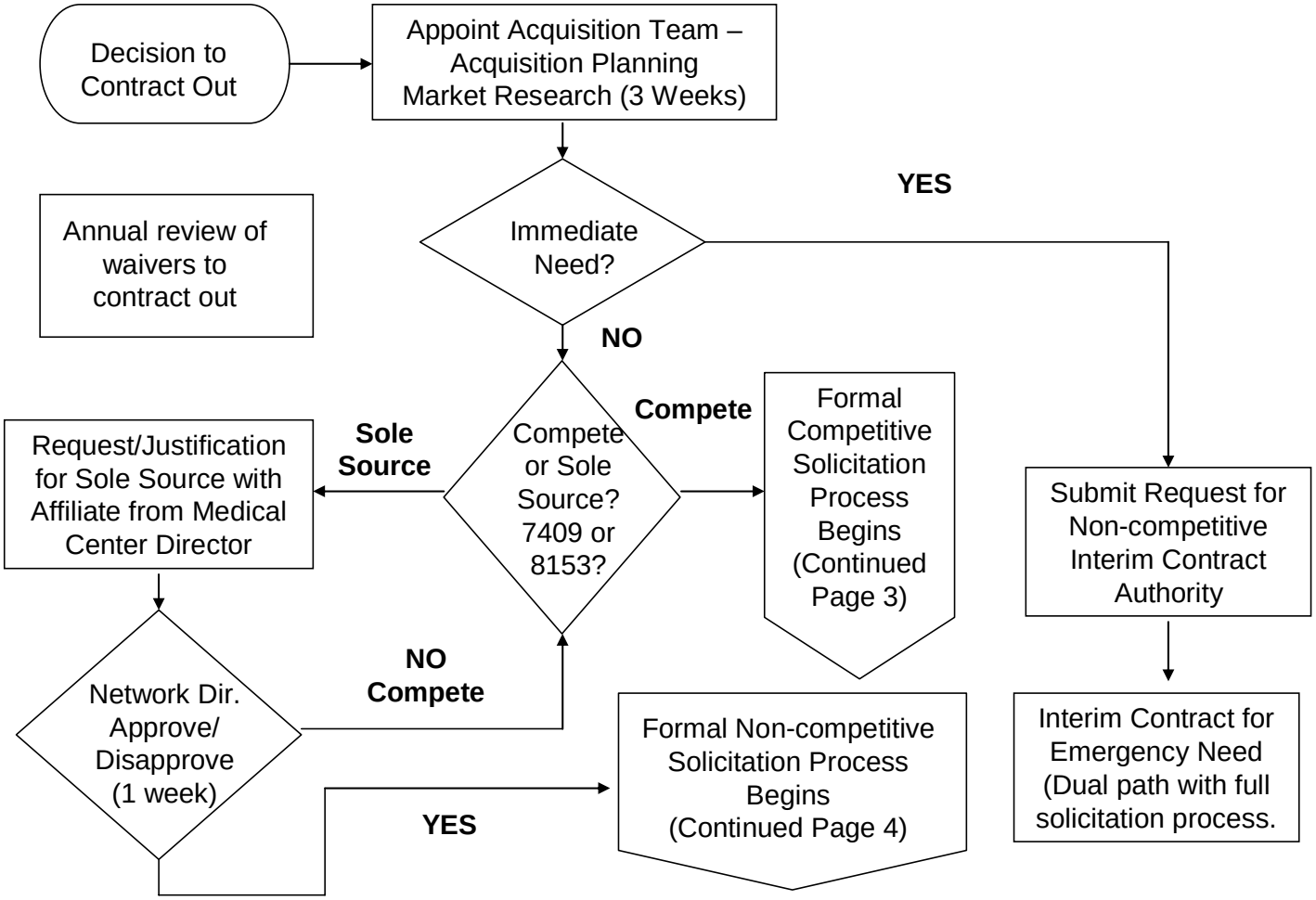
Biography of Janis Orlowski, M.D., MACP



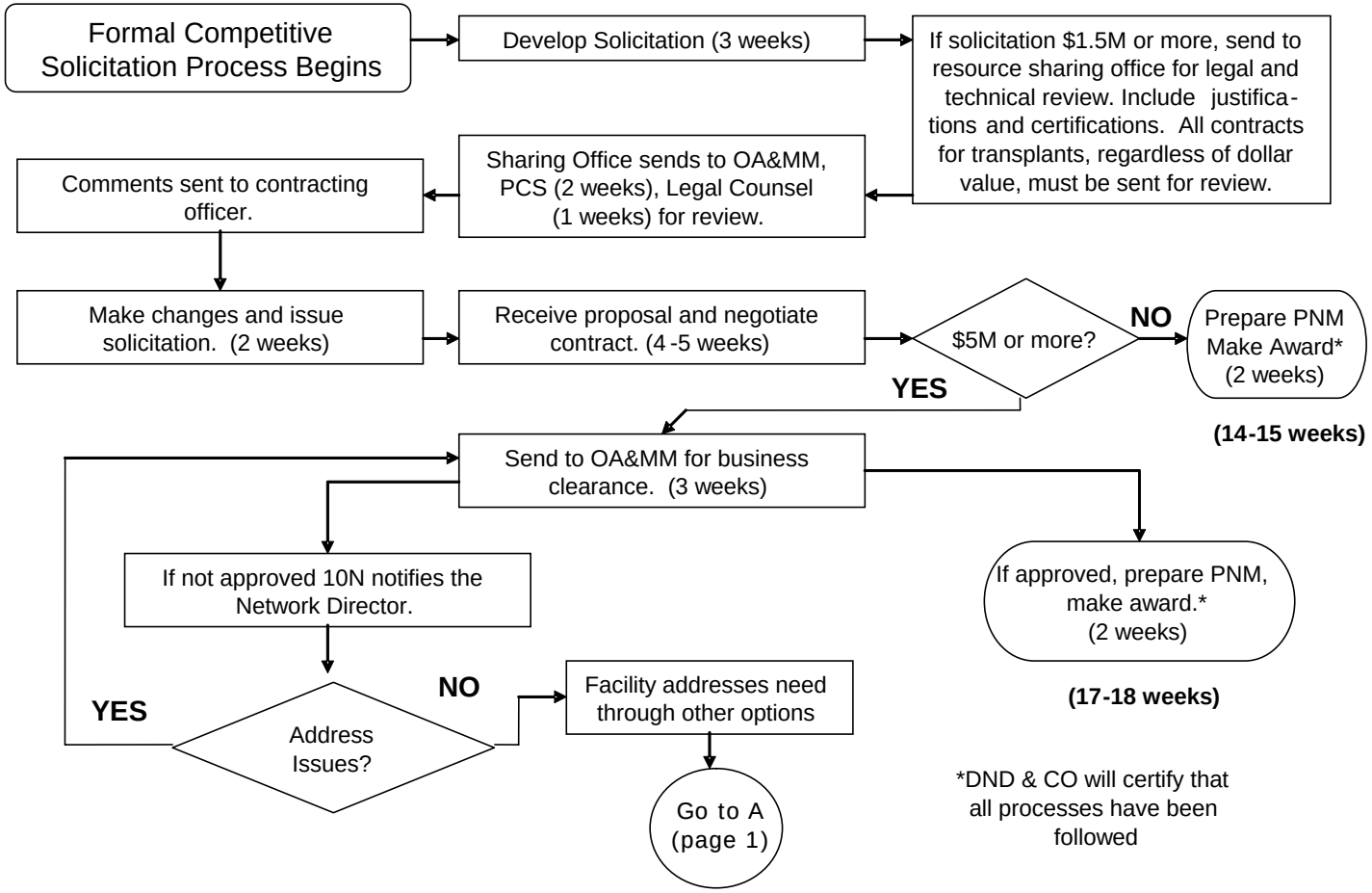
Appendix D

Healthcare Resource Decision Tree
First Priority – Hire
Page 1

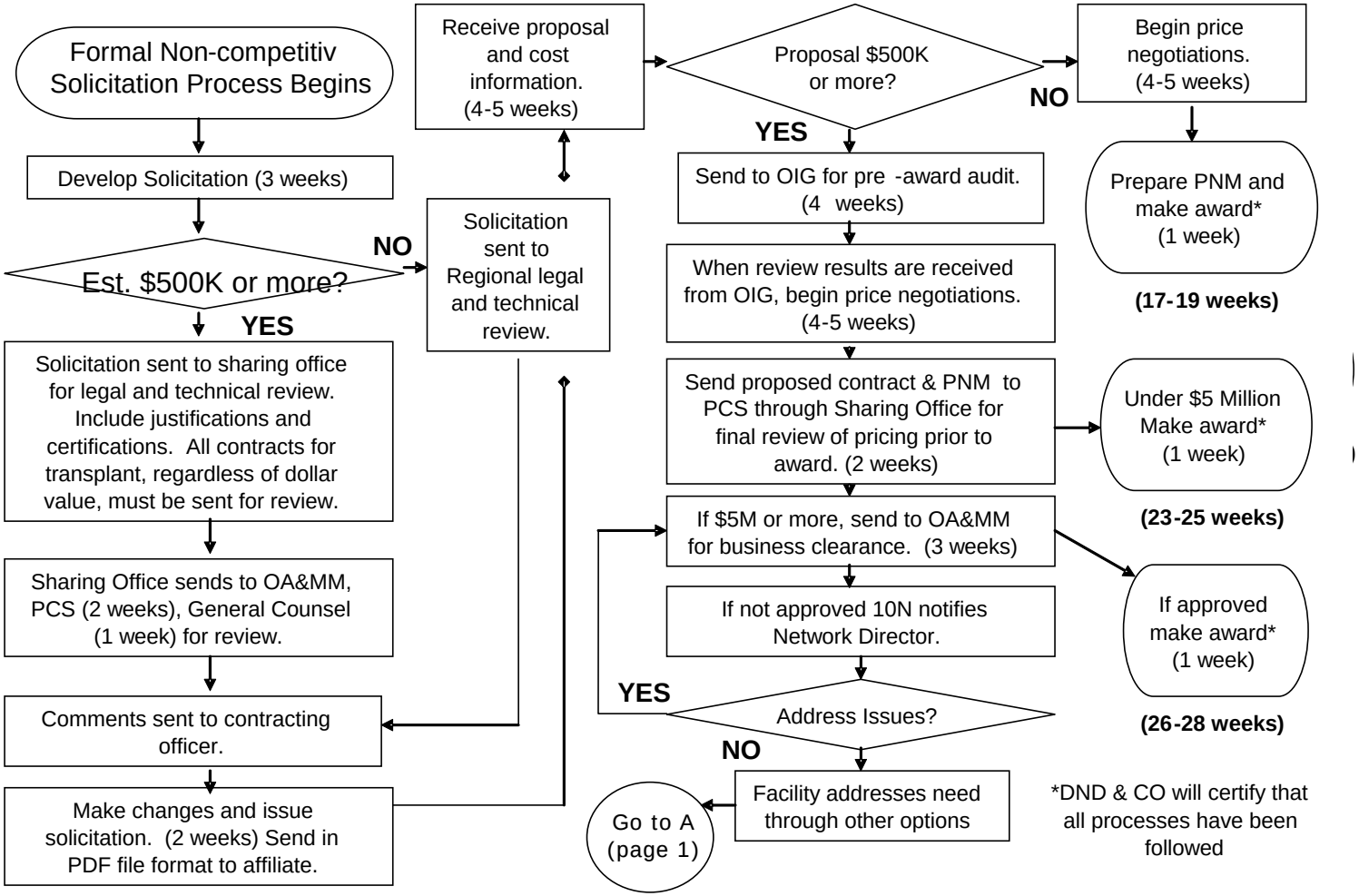
Appendix D, Page 2
Healthcare Resource Decision Tree – Decision to Contract Out



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



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



Janis M. Orlowski, MD, MACP

Dr. Janis M. Orlowski is the chief health care officer at the Association of American Medical Colleges where her focus is on the interface between the health care delivery system and academic medicine. Dr. Orlowski graduated from Marquette University's College of Engineering with a Bachelor of Science degree in biomedical engineering in 1978. She received her medical degree from the Medical College of Wisconsin in 1982.

Like the majority of physicians in the United States, Dr. Orlowski performed clinical rotations as a medical student in the VA at the Clement J. Zablocki VA Medical Center in Milwaukee. Her residency (1982–1985), her term as Chief Resident (1985–1986) and her Fellowship in Nephrology (1986–1988) were completed at Rush University Medical Center, Chicago.

Dr. Orlowski was the chief operating officer and chief medical officer of MedStar Washington Hospital Center, Washington, D.C., the largest hospital of the MedStar Health system. Dr. Orlowski oversaw the medical staff, clinical care, quality, patient safety, medical risk, perioperative services, ambulatory care and the medical education programs from 2004 to 2013.

Dr. Orlowski began her career at Rush as an intern. She left Rush as associate vice president and executive dean of the Rush University Medical School in Chicago.

Dr. Orlowski is board certified in both Internal Medicine and Nephrology. In her practice, she specializes in acute renal care and transplantation. She has been honored with teaching excellence awards, has participated in education and research in renal transplantation and has served on several national committees to oversee the quality of care in transplantation. Most recently, Dr. Orlowski chaired the national committee at UNOS (United Network for Organ Sharing) on transplant policy.

Dr. Orlowski has been the president of the Chicago Medical Society, and board member and chair of the Illinois State Medical Society. She served as editor of *Disease-A-Month*, and was on the editorial board of *Nephrology*.

In 2007 Dr. Orlowski was inducted as a Master in the American College of Physicians (ACP).

Dr. Orlowski currently serves as chair of D.C. Board of Medicine, Board of Trustees of Marquette University, Board of Montini Catholic High School and was recently appointed to the Board of Trustees of the Medical College of Wisconsin.