ISSUE BRIEF

Resolve Recruitment & Retention Issues within Veterans Health Administration (HR 3016/S 2175)

Request

The American Podiatric Medicine Association (APMA) calls on Congress to pass legislation which would, at last, resolve ongoing recruitment and retention issues for podiatric physicians employed under the Veterans Health Administration (VHA).

In February, 2016 the US House of Representatives passed a bill (HR 3016 - the Veterans Employment, Education and Healthcare Improvement Act) which, among other things, would boost recruitment and retention of doctors of podiatric medicine (DPMs) by recognizing them as physicians within the VHA. Now House and Senate leaders must move swiftly to pass a compromise VA improvements bill with the same provision to ensure our nation's veterans have timely access to the best trained and most highly qualified foot and ankle specialists.

Background

The VHA podiatric compensation package has remained unchanged since 1976, except for those changes reflected in the Title 38, USC Section 7404 Clinical Podiatrist and Optometrist Salary Tables, that include basic pay and locality rate adjustments. The compensation package for VHA podiatric physicians has become less attractive than what is offered in other practice settings, especially the private sector, which has resulted in recruitment and retention problems within VHA.

A majority of the VHA podiatric physician workforce is composed of practitioners with less than 10 years experience (60%), and an even larger percentage of the podiatric physician workforce (70%) are not board certified.

To remain competitive, VHA needs to initiate appropriate recognition of podiatric physicians similar, if not identical, to what has been established for medicine and dentistry. Because this pool of podiatric physician providers is a very small percentage of the total physician workforce in VHA (less than five percent, or approximately 330 podiatrists system-wide), both the costs and the savings will have little impact on the overall budget. If VHA were to enact this legislation to include podiatric physicians under the Physician and Dentist Pay Schedule, it would give the individual VA facility directors the flexibility to help resolve retention and recruitment obstacles, and would result in an improvement to the quality of care being delivered to the nation's veteran population.

Strong Support

There is overwhelming support from VA chiefs of staff and chief medical officers for a legislative remedy to include DPMs in the Physician and Dentist Pay Authority. Additionally, the Veterans Health Adminstration, the American Legion, the Veterans of Foreign Wars, the Disabled Veterans of America, and the Paralyzed Veterans of America have all publically endorsed this common sense modernization of the VHA.

Status

- On May 14, 2015 APMA testified at the US House Veterans' Affairs Subcommittee on Health about problems facing the VA regarding recruitment and retnetion of podiatric physicians
- On July 9, 2015 US Rep. Brad Wenstrup (R-OH), on behalf of himself, all physician members of the Committee and its Ranking Member, introduced HR 3016, the VA Provider Equity Act.
- On September 17, 2015 the House Veterans' Affairs Committee combined the provisions of more than a dozen other bills into HR 3016, renamed the legislation the Veterans Employement, Education, and Healthcare Improvement Act, and reported it favorably.
- On October 8, 2015 US Senator Jon Tester (D-MT) Introduced compaion bill, S 2175.
- On November 19, 2015 the CBO released scoring analysis of HR 3016 and estimated that enacting the bill would reduce federal spending by $815 million over 10 years.
- On December 1, 2015 the House Veterans' Affairs Committee issued its report for HR 3016 (H. Rept. 114-358).
- On February 9, 2016 the US House of Representatives passed HR 3016 under suspension of the rules.

Prepared by the American Podiatric Medical Association,
9312 Old Georgetown Road, Bethesda, MD 20814, 301-581-9200,
www.apma.org. Contact advocacy@apma.org with questions.

APMA
American Podiatric Medical Association

ISSUE BRIEF

Podiatric Medicine:
Expertise in Foot and Ankle Care

Doctors of podiatric medicine are podiatric physicians and surgeons, qualified by their education, training, and experience to diagnose and treat conditions affecting the foot, ankle, and related structures of the leg.

- Podiatric medicine is a medical sub-specialty, focused on a specific part of the anatomy similar to other highly focused sub-specialties, such as ophthalmology, cardiology, and otolaryngology.
- Within the field of podiatric medicine and surgery, podiatrists can focus on specialty areas such as surgery, sports medicine, biomechanics, geriatrics, pediatrics, orthopedics, or primary care.

Doctors of podiatric medicine have the education, training, experience, and licensure to:

- perform comprehensive medical history and physical examinations;
- prescribe drugs and order and perform physical therapy;
- perform surgeries ranging from basic to complex reconstructive surgery;
- repair fractures and treat sports–related injuries;
- prescribe and fit orthotics, durable medical goods, and custom–made shoes; and
- perform and interpret X–rays and other imaging studies.

Podiatric Medical Education

Doctors of podiatric medicine receive basic and clinical science education and training comparable to that of medical doctors:

- Four years of undergraduate education focusing on life sciences
- Four years of graduate study in one of the nine podiatric medical colleges
- At least three years of postgraduate, hospital–based residency training

The education, training, and experience podiatrists receive in the care and treatment of the lower extremity is more sophisticated and specialized than that of broadly trained medical specialists.

Comparison of Physician Education, Training and Practice

Degree	4 Year Graduate Medical Education	Minimum 3 Year Residency	Independently Diagnose and Treat (Office)	Independently Diagnose and Treat (Hospital)	Surgical Privileges (Hospital)	Admitting (H&P) Privileges	Full Rx License
Doctor of Podiatric Medicine (DPM)	•	•	•	•	•	•	•
Medical Doctor (MD)	•	•	•	•	•	•	•
Doctor of Osteopathic Medicine (DO)	•	•	•	•	•	•	•

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ISSUE BRIEF

Fact Sheet: Studies Prove Podiatrists Prevent Complications, Provide Savings

According to the CDC, over 29 million Americans live with diabetes. Diabetes is the leading cause of non-traumatic lower-limb amputation; however, amputations can be prevented. Two peer-reviewed published studies evaluated care by podiatrists for patients with diabetes and demonstrated that compared to other health-care professionals, podiatrists are best equipped to treat lower extremity complications from diabetes, prevent amputations, reduce hospitalizations, and provide savings to our health-care delivery systems.

Access to a Podiatrist Can Lead to Savings for US Health-Care Delivery Systems

According to a study conducted by Thomson Reuters Healthcare (accessible at: www.tinyurl.com/trstudy) that compared outcomes of care for patients with diabetes treated by podiatrists versus care provided by other health-care professionals and physicians published in the *Journal of the American Podiatric Medical Association*[1]:

- Among patients with commercial insurance, a savings of $19,686 per patient with diabetes can be realized over a three-year period if there is at least one visit to a podiatrist in the year preceding a diabetic ulceration. Diabetic ulcerations are the primary factor leading to lower extremity amputations. Among patients with commercial insurance, each $1 invested in care by a podiatrist results in $27 to $51 of savings for the health-care delivery system.
- Among Medicare-eligible patients, a savings of $4,271 per patient with diabetes can be realized over a three-year period if there is at least one visit to a podiatrist in the year preceding ulceration. Among Medicare eligible patients, each $1 invested in care by a podiatrist results in $9 to $13 of savings.
- Conservatively projected, these per-patient numbers support an estimated $10.5 billion in savings over three years if every at-risk patient with diabetes sees a podiatrist at least one time in the year preceding the onset of an ulceration.

Care by a Podiatrist Can Reduce the Risks and Prevent Complications from Diabetes

According to an independent study conducted by Duke University published in *Health Services Research*[2]:

- Medicare-eligible patients with diabetes were less likely to experience a lower extremity amputation if a podiatrist was a member of the patient-care team.
- Patients with severe lower extremity complications who only saw a podiatrist experienced a lower risk of amputation compared with patients who did not see a podiatrist.
- A multidisciplinary team approach that includes podiatrists most effectively prevents complications from diabetes and reduces the risk of amputations.

[1] Ginger Carls et al., "The Economic Value of Specialized Lower-Extremity Medical Care by Podiatric Physicians in the Treatment of Diabetic Foot Ulcers," *Journal of the American Podiatric Medical Association* 101 (2011): 93-115, accessible at: www.tinyurl.com/trstudy.

[2] Sloan, F. A., Feinglos, M. N. and Grossman, D. S. , RESEARCH ARTICLE: Receipt of Care and Reduction of Lower Extremity Amputations in a Nationally Representative Sample of U.S. Elderly. Health Services Research, no. doi: 10.1111/j.1475-6773.2010.01157.x

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VHA Podiatry White Paper
May 2015

The Department of Veterans Affairs (VA) requests your support and assistance in proposing legislation to revise 38 USC 7404 and 38 USC 7431 to include Podiatrists in the Physician and Dentist pay system or establishment of a similar type compensation system.

Modification of 38 USC 7431 is the most efficient way to address any pay deficiencies VA may have for podiatrists as compared to counterparts in the private sector. The VA podiatrist pay schedule has remained unchanged since 1976, except for those changes that include Basic Pay and Locality Rates adjustments. The clinical responsibilities of VA podiatrists have greatly expanded since the respective VA Qualification Standards and pay scales were initially created in the 1970's. Within the Veterans Health Administration (VHA), VA podiatrists have assumed greater professional and administrative duties. Defining podiatrists under the same definition as physicians and dentists and moving podiatrists to Title 38, U.S.C. Section 7431 pay tables would provide VA with the flexibility to competitively compensate podiatrists, ensuring the highest quality of care for our Veterans.

Currently, 71 senior clinical VA podiatrists have reached the legislatively capped Rate of Pay for the Level IV Executive Schedule limit of $158,700, resulting in significant reduction in pay over the past decade for these highly productive and experienced providers. The current VA salary cap also serves as a disincentive in attracting, recruiting and retaining new VA optometrists and podiatrists. Newly graduated residency trained podiatrists have significant student loan indebtedness that greatly impacts their future career practice options. For Academic Year (AY) 2012-2013, the educational indebtedness for Doctor of Podiatric Medicine degree graduates it is $174,000 for graduate/professional school debt, but does not include undergraduate debt.

VA has identified podiatrists among several discipline-specific professions that require special attention in order to meet future patient care needs in VA. There is a growing health care demand for primary and specialty podiatric services, especially from Veterans suffering from polytraumatic injuries, spinal cord injury, and limb amputation. In that regard, we note that about 1.5 million Veterans receiving VHA care have diabetes and Veterans who served in Vietnam are service connected for diabetes. Additionally, diabetes is the major cause of foot wounds and amputations.

It is essential that modifications to the current pay schedules be made in order for VA to maintain the high degree of clinical expertise necessary to ensure eligible Veterans have timely access to VA's comprehensive array of preventive, optometric, podiatric, rehabilitation, and other health care benefits as detailed in the Veterans Benefits Package.

The utilization of VA podiatric services is projected to increase by an estimated 170,000 appointments in podiatry due to increasing enrollment and eligibility. This underscores the need to attract and retain podiatrists who have the advanced training and experience necessary to meet the special needs of an aging Veteran population as well as the unique rehabilitation requirements for Veterans with visual impairment, amputations, poly-traumatic injuries, traumatic brain injury, and blindness.

To remain competitive, VA must proactively initiate an appropriate pay system for podiatrists. Since this pool of providers is a very small percentage (~3%) of total provider population in VHA, both the costs and the savings should have little impact on the overall VA budget. Including podiatrists under 38 USC 7431 would provide VA with more flexibility to resolve recruitment and retention challenges in this specialty.

Testimony of Dr. Nichol L. Salvo

Member and employee, American Podiatric Medical Association

Before the Subcommittee on Health of the House Committee of Veterans' Affairs

May 15, 2015

Chairman Benishek, Ranking Member Brownley and members of the Subcommittee, I welcome and appreciate the opportunity to testify before you today on behalf of the American Podiatric Medical Association (APMA). I commend this Subcommittee for its focus to assist and direct the Veterans Administration (VA) to effectively and efficiently recruit and retain qualified medical professionals to treat veteran patients and improve access to quality health care in the VA system by addressing the lengthy and burdensome credentialing and privileging process.

I am Dr. Nichol Salvo, member and Director of Young Physicians' at the American Podiatric Medical Association (APMA). I am also a practicing VA physician, maintaining a Without Compensation (WOC) appointment status. I am before you today representing APMA and the podiatric medical profession, and specifically our members currently employed, and those seeking to be employed, by VA. While I do not represent VA in my capacity today, I do bring with me first-hand experience and knowledge of hiring practices within VA, as well as knowledge of the widespread disparity between podiatric physicians and other VA physicians.

APMA is the premier professional organization representing America's Doctors of Podiatric Medicine who provide the majority of lower extremity care, both to the public and veteran patient populations. APMA's mission is to advocate for the profession of podiatric medicine and surgery for the benefit of its members and the patients they serve.

Mr. Chairman, when the Veterans Health Administration (VHA) qualification standards for podiatry were written and adopted in 1976, I was not yet born. Podiatric education, training and practices in 1976 starkly contrasted with that of other physician providers of the time, and with podiatric medicine as it is today. Unlike thirty-nine years ago, the current podiatric medical school curriculum is vastly expanded in medicine, surgery and patient experiences and encounters, including whole body history and physical examinations. In 1976, residency training was not required by state scope of practice laws. Today, every state in the nation, with the exception of four, requires post-graduate residency training for podiatric physicians and surgeons. In 1976, podiatric residency programs were available for less than 40 percent of graduates. Today there are 597 standardized, comprehensive, three-year medicine and surgery

residency positions to satisfy the number of our graduates, with 77 positions (or 13 percent) housed within the VA. In contrast to 1976, today's residency programs mandate completion of a broad curriculum with a variety of experiences and offer a direct pathway to board certification with both the American Board of Podiatric Medicine (ABPM) and the American Board of Foot and Ankle Surgery (ABFAS). These certifying bodies are the only certifying organizations to be recognized by the Council on Podiatric Medical Education (CPME) and VA. These bodies not only issue time-limited certificates, but they participate in the Centers for Medicare and Medicaid Services (CMS) Maintenance of Certification (MOC) reimbursement incentive program. Unlike the residency curricula in 1976 (which were not standardized, nor comprehensive), today's residency curriculum is equitable to MD and DO residency training and includes general medicine, medical specialties such as rheumatology, dermatology and infectious disease, general surgery and surgical specialties such as orthopedic surgery, vascular surgery and plastic surgery. CPME-approved fellowship programs did not exist in 1976, but since their creation in 2000, they offer our graduates opportunities for additional training and sub-specialization. Today, podiatric physicians are appointed as medical staff at the vast majority of hospitals in the United States, and many serve in leadership roles within those institutions, including but not limited to chief of staff, chief of surgery, and state medical boards. Many of my colleagues have full admitting privileges and are responsible for emergency room call as trauma and emergency medicine are now also incorporated into post-graduate training. The competency, skill and scope of today's podiatric physicians are vastly expanded and truly differ from the podiatrist that practiced before I was born. Because of this, CMS recognizes today's podiatrists as physicians, and Tricare recognizes us as licensed, independent practitioners.

The total number of VA enrollees has increased from 6.8 million in2002 to 8.9 million in 2013 (1). While we are slowly losing our Vietnam veteran population, we are gaining a solid base of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) patients, returning from war with their unique lower extremity issues. The projected patient population of Gulf War Era veterans is expected to increase from 30 percent in 2013 to approximately 55 percent in 2043 (1). The number of service-connected disabled veterans has increased from approximately 2.2 million in 1986 to 3.7 million in 2013 (1). Over 90 percent of disabled veterans were enrolled in VHA in 2012 (1). The likelihood of service-connected disabled veterans seeking VA health care generally increases with the veteran's disability rating (1). The majority of male veterans who are currently seeking care from VA served during the Vietnam era (1).

As a matter of fact, veteran patients are ailing and have more comorbid disease processes than do age-matched Americans (2, 3, 4, 5, 6). This includes major amputation, where age-specific rates are greater in the VHA compared to the US rates of major amputation (7). Elderly enrolled veterans have substantial disease burden with disproportionately poor health status compared to the same age enrolled in Medicare (8). The prevalence of diabetes is substantially greater among veteran patients compared to the general population, and unfortunately, the prevalence is trending up (6). While diabetes affects 8 percent of the US population, 20 percent of veteran patients carry this diagnosis (9).The aging veteran population combined with these increased rates of diabetes has increased the burden of diabetic foot ulcers and amputations (10). Veteran patients with one or more chronic diseases account for 96.5 percent of total VHA health care (9). In addition to diabetes, some of the most common chronic

conditions documented in our veteran patients manifest in the lower extremity such as hyperlipidemia, coronary artery disease, chronic obstructive pulmonary disease, and heart failure.(9).

Socioeconomic and psychosocial issues often plague our veterans and further complicate disease management. Veteran patients statistically have lower household incomes than non-veteran patients (1). Sadly, many of our veterans are homeless and suffer from comorbid conditions such as diabetic foot ulcers, sometimes with a level of amputation, so management of this patient population can be extremely challenging. Health care expenses combined with disability and compensation coverage account for the majority of VA utilization and have demonstrated significant growth since 2005 (1).

This is my patient population, Mr. Chairman. I serve patients who are statistically comorbid with psychosocial and socioeconomic issues, all of which play a role in my delivery of care and final outcome. I know first-hand, with private practice experience and VA experience, that the veteran population is far more complex to treat than patients in the private sector, as a whole. Greater than 90% of the veteran podiatric patient population is 44 years and older, with the majority of our patients of the Vietnam era, who are plagued by the long-term effects of Agent Orange. Because of this and because of the increasing number of OEF, OIF, and Operation New Dawn (OND) veterans with lower extremity conditions, one of our major missions as providers of lower extremity care is amputation prevention and limb salvage. The value of podiatric care is recognized in at-risk patient populations. Podiatric medical care as part of the interdisciplinary team approach reduces the disease and economic burdens of diabetes. In a study of 316,527 patients with commercial insurance (64 years of age and younger) and 157,529 patients with Medicare and an employer sponsored secondary insurance, there was noted a savings of $19,686 per patient with commercial insurance and a savings of $4,271 per Medicare-insured patient, when the patients had at least one visit to a podiatric physician in the year preceding their ulceration (11). Nearly 45,000 veterans with major limb loss use VA services each year. Another 1.8 million veterans within the VA Healthcare Network are at-risk of amputation. These at-risk veterans include 1.5 million with diabetes, 400,000 with sensory neuropathy, and 70,000 with non-healing foot ulcers (12). Despite having a large at-risk patient population from the Vietnam era, VA podiatric physicians are seeing increasing numbers of OEF, OIF and OND patients who are at-risk for amputation. From FY 2001 to 2014, the number of foot ulcers increased in the OEF, OIF, and OND populations from 17 documented cases to 612 (12). Despite our statistics of at-risk patients, lower extremity amputation rates among all veteran patients decreased from approximately 11,600 to 4,300 between fiscal year 2000 and 2014 (12). Given the magnitude of amputation reductions, podiatric physicians not only provide a cost-savings to VA, but we also play an integral role in the veteran quality of life (12).

While limb salvage is a critical mission of the podiatry service in the VA, the care delivered by the podiatric physician is of much broader scope. As the specialist of the lower extremity, we diagnose and treat problems ranging from dermatological issues to falls prevention to orthopedic surgery. As one of the top five busiest services in VA, we provide a significant amount of care to our veteran patients and the bulk of foot and ankle care specifically. In fiscal year 2014, the foot and ankle surgical procedures rendered by the podiatry services totaled 4,794, while foot and ankle surgical procedures performed by the orthopedic surgery service was a sum total of 72.

The mission of VA health providers is to maintain patient independence and keep the patient mobile by managing disease processes and reducing amputation rates. Podiatric physicians employed by VA assume essentially the same clinical, surgical, and administrative responsibilities as any other unsupervised medical and surgical specialty. Podiatrists independently manage patients medically and

surgically within our respective state scope of practice, including examination, diagnosis, treatment plan and follow-up. In addition to their VA practice, many VA podiatrists assume uncompensated leadership positions such as residency director, committee positions, clinical manager, etc. Examples include:

- Steve Goldman, DPM, Site Director for Surgical Service, Department of Veterans Affairs - New York Harbor Health Care System;
- William Chagares, DPM, Research Institutional Review Board Co-Chair, Chair of Research Safety Committee and Research Integrity Officer and Chair of Medical Records Committee at the James A. Lovell Federal Heath Care Center;
- Aksone Nouvong, DPM, Research Institutional Review Board Co-Chair at the West Los Angeles VA;
- Lester Jones, DPM the former Associate Chief of Staff for Quality at the VA Greater Los Angeles Health Care System for eight years, and podiatric medical community representative while serving on the VA Special Medical Advisory Group; and
- Eugene Goldman, DPM formerly the Associate Chief of Staff for Education at Lebanon VA;

Despite this equality in work responsibility and expectations, there exists a marked disparity in recognition and pay of podiatrists as physicians in the VA. These discrepancies have directly resulted in a severe recruitment issue of experienced podiatrists into the VA, and unfortunately have also been the direct cause of retention issues. The majority of new podiatrists hired within the VA have stories just like mine. They have less than ten years of experience and they are not board certified. As a result of the disparity the VA is attracting less experienced podiatric physicians. After hiring, the majority of these new podiatrists that hire into the VA separate within the first 5 years. I am speaking from personal experience, Mr. Chairman. As stated earlier, I am one of the majority. I entered the VA with less than five years of experience and was not board certified at the time. I gained my experience, earned my board certification, and separated from the VA to take a leadership position with my parent organization. I will forever remain loyal to VA, which is why I still voluntarily treat patients at my local facility, without compensation. Having worked inside and outside the VA, I can truly attest to the disparity that exists.

Compounding the recruitment and retention issues, there exists lengthy employment vacancies when a podiatrist leaves a station. The gap between a staff departure to the time of filling the position is in excess of one year. I am personally aware that my position was assumed by a podiatric physician 14 months after my separation. Because of employment gaps as a consequence of the inherent and chronic recruitment and retention challenges, wait times within the VA for lower extremity care are unacceptably long. Since October 2014, 22,601 of the 191,501 (11.8 percent) established patients suffered a wait time of greater than 15 days, with some greater than 120 days. During this same time period, 23,543 of the 25,245 (93 percent) new patients suffered a wait time of the same magnitude. The prolonged vacancy exists partly because the VA is not capable of attracting experienced candidates, but also because the credentialing process is ineffectively burdensome. My credentialing process for my recent two without compensation (WOC) appointments was 11 months and 5 months, respectively. Those are 16 months of missed opportunity to treat patients, but instead, I was needlessly waiting, as were the patients

It is precisely because of the aforementioned issues that legislative proposals to amend Title 38 to include podiatric physicians and surgeons in the Physician and Dentist pay band, have been submitted by the Director of Podiatry Services annually for the last ten years. These proposals have been denied every single year. Additionally, several requests for an internal fix have been denied, despite written letters of support for this movement from the former Under Secretary of Health, Robert Petzel, MD.

Five years ago the APMA's House of Delegates passed a resolution making this issue a top priority. Since then we have alerted the VA to our knowledge of this issue. In response, former Under Secretary Petzel created a working group composed of Dr. Rajiv Jain, now Assistant Deputy Under Secretary for Health for Patient Care Services, Dr. Margaret Hammond, Acting Chief Officer for Patient Care Services, and Dr. Jeffrey Robbins, Chief of Podiatry Service. We have participated in several meetings with members of the working group and, most recently, we have received written support of Patient Care Services and Podiatry Service for a legislative solution to address this issue.

Occam's razor is a problem solving principle whereby the simplest solution is often the best. I come before this committee today to respectfully request that Congress help the VA and its patients by passing legislation to recognize podiatric physicians and surgeons as physicians in the physician and dentist pay band. We believe that simply changing the law to recognize podiatry, both for the advancements we have made to our profession and for the contributions we make in the delivery of lower extremity care for the veteran population, will resolve recruitment and retention problems for VA and for veterans. Mr. Chairman and members of the Subcommittee, thank you again for this opportunity. This concludes my testimony and I am available to answer your questions.

1. National Center for Veterans Analysis and Statistics, Department of Veterans Affairs http://www.va.gov/vetdata/index.asp

2. Singh JA. Accuracy of Veterans Affairs databases for diagnoses of chronic diseases. Prev Chronic Dis. 2009 Oct;6(4):A126.

3. Olson JM, Hogan MT, Pogach LM, Rajan M, Raugi GJ, Reiber GE. Foot care education and self management behaviors in diverse veterans with diabetes. Patient Prefer Adherence. 2009 Nov 3;3:45-50.

4. Powers BJ, Grambow SC, Crowley MJ, Edelman DE, Oddone EZ. Comparison of medicine resident diabetes care between Veterans Affairs and academic health care systems. J Gen Intern Med. 2009 Aug;24(8):950-5.

5. Agha Z, Lofgren RP, VanRuiswyk JV, Layde PM. Are patients at Veterans Affairs medical centers sicker? A comparative analysis of health status and medical resource use. Arch Intern Med. 2000 Nov 27;160(21):3252-7.

6. Miller DR, Safford MM, Pogach LM. Who has diabetes? Best estimates of diabetes prevalence in the Department of Veterans Affairs based on computerized patient data. Diabetes Care. 2004 May;27 Suppl 2:B10-21.

7. Mayfield JA, Reiber GE, Maynard C, Czerniecki JM, Caps MT, Sangeorzan BJ. Trends in lower limb amputation in the Veterans Health Administration, 1989-1998. J Rehabil Res Dev. 2000 Jan-Feb;37(1):23-30.

8. Selim AJ, Berlowitz DR, Fincke G, Cong Z, Rogers W, Haffer SC, Ren XS, Lee A, Qian SX, Miller DR, Spiro A 3rd, Selim BJ, Kazis LE. The health status of elderly veteran enrollees in the Veterans Health Administration. J Am Geriatr Soc. 2004 Aug;52(8):1271-6.

9. Neugaard BI, Priest JL, Burch SP, Cantrell CR, Foulis PR. Quality of care for veterans with chronic diseases: performance on quality indicators, medication use and adherence, and health care utilization. Popul Health Manag. 2011 Apr;14(2):99-106.

10. Johnston MV, Pogach L, Rajan M, Mitchinson A, Krein SL, Bonacker K, Reiber G. Personal and treatment factors associated with foot self-care among veterans with diabetes. J Rehabil Res Dev. 2006 Mar-Apr;43(2):227-38.

11. Carls GS, Gibson TB, Driver VR, Wrobel JS, Garoufalis MG, Defrancis RR, Wang S, Bagalman JE, Christina JR. The economic value of specialized lower-extremity medical care by podiatric physicians in the treatment of diabetic foot ulcers. J Am Podiatr Med Assoc. 2011 Mar-Apr;101(2):93-115.

12. Preventing Amputation in Veterans Everywhere (PAVE) Program

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October 13, 2015

Senator Jon Tester
311 Hart Senate Office Building
Washington, DC 20510-2604

Re: VA Provider Equity Act

Dear Sen. Tester:

The American Podiatric Medical Association (APMA) strongly supports the introduction of S 2175, the VA Provider Equity Act, to the US Senate. This vital legislation will ensure that our nation's 22 million veterans receive the highest quality care from the most highly trained and specialized foot and ankle specialists.

Montana currently employs four podiatrists to treat the more than 50,000 VA health-care system patients within the state, and has been challenged to fill past vacancies with some positions remaining open for up to two years. The successful passage of the VA Provider Equity Act would help to ensure that employment within the VA system is attractive to podiatric physicians, and would help keep America's veterans, such as Montana resident Michael Tolomeo-Atwood, active and mobile.

Tolomeo-Atwood joined the Navy at 17 and served for five years, and is now a disabled veteran reliant on care by a podiatrist. He works with the organization Communities for Veterans to address the needs of homeless vets by funding and constructing low-income housing units within the Fort Harrison campus. He currently travels three and a half hours to receive treatment from Keith Jones, DPM, at Fort Harrison because there is no VA facility employing a podiatrist closer to his home. It can take him up to two months to schedule a visit with Dr. Jones.

"I need my independence and to feel halfway normal and much of that has been through Dr. Jones," Tolomeo-Atwood said. "There are days that I feel suicidal and now I can go and enjoy God's country. I can now get out there and not worry about tripping and falling. Not having podiatric care would be a huge detriment to me. My ankles have gotten weaker. I have painful hips, my back is misaligned, and my nerves don't work correctly. Podiatric care makes a huge difference. Walking with my service dog and not having to rest as often and not worry about falling down makes me feel like a man again. I can walk through the grocery store without my legs buckling. My quality of life and independence—that's what it's all about. I am only 34 years old and I currently cannot provide for myself, I don't make enough on disability to get by, and am always going through more treatments. The use of my feet, legs, and mobility are extremely important to me. Would I serve all over again? YES, WITHOUT QUESTION!"

American Podiatric
Medical Association, Inc.

Another Montana vet, Mike Miller from Stevensville (143 miles from Helena), has been a patient at the VA Montana Health Care Center at Fort Harrison since 2007 and has been receiving podiatric care from Katie Kovacich-Smith, DPM, for the last two years.

"The reason it is important that I receive care by a podiatrist is because after serving in the Army for 22 years moving heavy equipment by myself and all of the parachute jumps and road marches, my feet just wore out," Miller said. "Dr. Smith has given me a quality of life that I haven't had before this time. Dr. Smith has reduced my pain, improved my walking, and fixed the problems I no longer have. The care given to me has been good. I am happy. I'm satisfied. The staff is lovely, personal, and professional, but there are not enough of them. Sometimes I can't get anyone on the phone. My wait time for an appointment with Dr. Smith is more than a month."

John Badovinac served in the Army during the Vietnam War and is also a patient of Dr. Kovacich-Smith.

"I'm a workout fanatic. I used to do the Stairmaster and I did it so much that I ruined the nerves or something else in my feet. I could only walk two or three blocks without it bothering me. I was a big runner and I had to stop running. Dr. Kovacich-Smith examined my feet and fitted me with orthotics. Now I can do just about anything including walking up to 10 miles. I view her like every other doctor, but with her I've had progress made and an improvement in the quality of life. If I didn't have a podiatrist I could see in the VA I would not be golfing or keeping up an exercise routine daily. I look forward to continue receiving excellent foot and ankle care from Dr. Kovacich-Smith in the future."

APMA applauds your effort to improve access to the very best care for America's heroes—like Michael Tolomeo-Atwood, Mike Miller, and John Badovinac. On behalf of podiatrists and patients nationwide, I extend our gratitude for your support.

Sincerely,

Phillip E. Ward, DPM
President

II

114TH CONGRESS
1ST SESSION

S. 2175

To amend title 38, United States Code, to clarify the role of podiatrists in the Department of Veterans Affairs, and for other purposes.

IN THE SENATE OF THE UNITED STATES

OCTOBER 8, 2015

Mr. TESTER introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to clarify the role of podiatrists in the Department of Veterans Affairs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Department of Veterans Affairs Provider Equity Act''.

SEC. 2. ROLE OF PODIATRISTS IN DEPARTMENT OF VETERANS AFFAIRS.

(a) INCLUSION AS PHYSICIAN.—

(1) IN GENERAL.—Subchapter I of chapter 74 of title 38, United States Code, is amended by adding at the end the following new section:

"§ 7413. Treatment of podiatrists

''For purposes of this chapter, the term 'physician' includes a podiatrist.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 74 of such title is amended by inserting after the item relating to section 7412 the following new item:

''7413. Treatment of podiatrists.''.

(3) CONFORMING AMENDMENT.—Section 7401(1) of such title is amended by striking ''Physicians, dentists, podiatrists,'' and inserting ''Physicians, dentists,''.

(b) QUALIFICATIONS.—Section 7402(b) of such title is amended—

(1) in paragraph (1)—

(A) in subparagraph (A), by striking ''or of doctor of osteopathy'' and inserting '', doctor of osteopathy, or doctor of podiatric medicine''; and

(B) in subparagraph (C), by inserting ''podiatry,'' after ''surgery,'';

(2) by striking paragraph (5); and

(3) by redesignating paragraphs (6) through (14) as paragraphs (5) through (13), respectively.

(c) PERIOD OF APPOINTMENT.—Section 7403(a)(2) of such title is amended—

(1) by striking subparagraph (C); and

(2) by redesignating subparagraphs (D) through (H) as subparagraphs (C) through (G), respectively.

(d) MODIFICATION OF PAY GRADE.—

(1) GRADE.—The list in section 7404(b) of such title is amended by striking ''PODIATRIST, CHIROPRACTOR,'' and inserting ''CHIROPRACTOR''.

(2) APPLICATION.—The amendment made by paragraph (1) shall apply with respect to any pay period of the Department of Veterans Affairs beginning on or after the date that is 30 days after the date of the enactment of this Act.

(e) CONTRACTS FOR SCARCE SERVICES.—Section 7409(a) of such title is amended by striking ''podiatrists,''.

(f) PERSONNEL ADMINISTRATION.—Section 7421(b) of such title is amended—

(1) by striking paragraph (3); and

(2) by redesignating paragraphs (4) through (8) as paragraphs (3) through (7), respectively.

(g) MEDICAL DIRECTORS.—Section 7306(a)(4) of such title is amended—

(1) by striking ''either''; and

(2) by inserting '', a qualified doctor of podiatric medicine,'' after ''doctor of medicine''.

(h) APPLICATION.—The amendments made by this section shall apply with respect to podiatrists who are employed by the Department of Veterans Affairs as of the date of the enactment of this Act or who are appointed on or after such date.

○

The VA Provider Equity Act

114th Congress

Cosponsors (18): HR 3016 (16) S 2175 (2)

*Original Sponsor

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Updated October 23, 2015

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

November 19, 2015

H.R. 3016
Veterans Employment, Education, and Healthcare Improvement Act

As ordered reported by the House Committee on Veterans' Affairs
on September 17, 2015

SUMMARY

H.R. 3016 would modify certain mandatory veterans' programs, including those that provide educational benefits and mortgage loan guarantees. On net, CBO estimates that enacting H.R. 3016 would decrease direct spending by $815 million over the 2016-2025 period.

In addition, H.R. 3016 would expand the types of medical care provided by the Department of Veterans Affairs (VA); reorganize the administration of several job training, readjustment benefits, and other benefit programs; transfer certain employment training and placement programs from the Department of Labor (DOL) to VA; and modify the processing of benefit claims. In total, CBO estimates that implementing the bill would cost $234 million over the 2016-2020 period, assuming appropriation of the necessary amounts.

Pay-as-you-go procedures apply because enacting the legislation would affect direct spending. Enacting the bill would not affect revenues.

CBO estimates that enacting H.R. 3016 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2026.

H.R. 3016 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would impose no costs on state, local, or tribal governments. State agencies that serve veterans would benefit from contact and service information about veterans provided electronically by VA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary effects of H.R. 3016 are shown in Table 1. The costs of this legislation fall within budget function 700 (veterans benefits and services).

TABLE 1. BUDGETARY EFFECTS OF H.R. 3016, THE VETERANS EMPLOYMENT, EDUCATION, AND HEALTH CARE IMPROVEMENT ACT

	By Fiscal Year, in Millions of Dollars					
	2016	2017	2018	2019	2020	2016-2020
CHANGES IN DIRECT SPENDING[a]						
Estimated Budget Authority	-7	-20	-44	-63	-80	-214
Estimated Outlays	-7	-20	-44	-63	-80	-214
SPENDING SUBJECT TO APPROPRIATION						
Estimated Authorization Level	76	54	33	36	38	237
Estimated Outlays	56	64	38	37	39	234

a. Enacting H.R. 3016 would have effects beyond 2020. CBO estimates that under H.R. 3016 direct spending would decrease by $815 million over the 2016-2025 period.

BASIS OF ESTIMATE

For this estimate, CBO assumes that H.R. 3016 will be enacted early in fiscal year 2016, the estimated amounts will be appropriated each year, and outlays will follow historical spending patterns for affected programs.

Direct Spending

CBO estimates that enacting H.R. 3016 would decrease net direct spending by $7 million in 2016 and $815 million over the 2016-2025 period (see Table 2). Most of that change arises from provisions that would modify the education benefits provided by VA. Changes to VA's authority to guarantee mortgages would increase direct spending by a smaller amount.

Changes to Education Benefits. H.R. 3016 would make several changes to education benefits provided under the Post-9/11 GI Bill. On net, those changes would decrease direct spending by $882 million over the 2016-2025 period.

Under the Post-9/11 GI Bill, VA pays for tuition and fees at institutions of higher learning and, with certain exceptions, provides monthly housing allowances to beneficiaries while they are in school. Payments for attending public schools cover the full cost of tuition and fees at rates charged to in-state students. Annual payments for education programs at private institutions are capped at about $21,000 for 2016. (That limit is adjusted annually for inflation.)

TABLE 2. ESTIMATED EFFECTS OF H.R. 3016 ON DIRECT SPENDING

	By Fiscal Year, in Millions of Dollars											
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016-2020	2016-2025
CHANGES IN DIRECT SPENDING												
Transferred Education Benefits												
Estimated Budget Authority	-10	-24	-41	-64	-79	-87	-98	-110	-123	-137	-218	-773
Estimated Outlays	-10	-24	-41	-64	-79	-87	-98	-110	-123	-137	-218	-773
Payments for Flight Training												
Estimated Budget Authority	-4	-8	-19	-20	-22	-23	-25	-26	-27	-29	-73	-203
Estimated Outlays	-4	-8	-19	-20	-22	-23	-25	-26	-27	-29	-73	-203
Fry Scholarships												
Estimated Budget Authority	2	4	7	11	11	3	3	3	3	3	35	50
Estimated Outlays	2	4	7	11	11	3	3	3	3	3	35	50
Credit for Time in Medical Care												
Estimated Budget Authority	1	2	3	4	4	5	5	5	5	6	14	40
Estimated Outlays	1	2	3	4	4	5	5	5	5	6	14	40
Work-Study Program												
Estimated Budget Authority	*	1	1	1	1	*	0	0	0	0	4	4
Estimated Outlays	*	1	1	1	1	*	0	0	0	0	4	4
Loan Guarantee Limit												
Estimated Budget Authority	4	5	5	5	5	6	7	7	8	15	24	67
Estimated Outlays	4	5	5	5	5	6	7	7	8	15	24	67
Total Changes in Direct Spending												
Estimated Budget Authority	-7	-20	-44	-63	-80	-96	-108	-121	-134	-142	-214	-815
Estimated Outlays	-7	-20	-44	-63	-80	-96	-108	-121	-134	-142	-214	-815

Note: * = between $0 and $500,000.

In addition, students who face tuition and fees above what VA will cover—students at certain private schools and out-of-state students attending public schools—may be eligible to have part or all of their remaining expenses covered under the Yellow Ribbon GI Education Enhancement Program (YRP). Institutions participating in the YRP agree to cover a portion of the difference between the tuition charged and the amount that VA would otherwise pay. VA then matches that financial assistance, thereby reducing or eliminating students' out-of-pocket expenses.

Service members and veterans can use those benefits themselves or transfer up to a total of 36 months of benefits to their spouses and children after serving at least six years in the military. Spouses can use the benefits as soon as they are transferred, but children must wait until the member has completed 10 years of service.

Transferred Education Benefits. Section 301 would modify the authorities under which service members may transfer education benefits to their dependents. On net, those changes would reduce direct spending by $773 million over the 2016-2025 period, CBO estimates.

Section 301 would reduce by half the monthly housing allowance paid to children who use transferred benefits. That reduction would apply to benefits that are transferred to children180 days or more after the bill is enacted. Based on current payment levels and adjusting for expected inflation, CBO estimates that the annual payment for the housing allowance under the Post-9/11 GI Bill will average about $7,000 in 2016 and $7,900 over the 2016-2025 period. (That annual payment may represent an academic years' worth of benefits for one student or portions of an academic year for two or more students.)

Based on data from the Department of Defense (DoD), CBO estimates that about 28,000 service members will transfer their education benefits to their children each year. Less than 10 percent of children who receive transferred benefits will be college-aged at the time of the transfer and only half will reach college age during the subsequent 10-year period. Most service members will have completed at least 10 years of service by the time their children are old enough to attend college. Thus, the reduction in the housing allowance would affect a small number of annual payments initially—about 2,000 in 2016. The number of reduced payments would increase over time to nearly 40,000 annual payments in 2025. CBO estimates that the number of annual payments that would be cut in half under section 301 would total roughly 220,000 over the 2016-2025 period, reducing direct spending by $900 million.

Section 301 also would change the terms under which service members may transfer Post-9/11 GI Bill benefits to their spouses and children. Under current law, members must serve at least six years and agree to serve another four years to transfer their benefits. Under section 301, members would have to serve at least 10 years, and agree to serve an additional two years in order to transfer benefits. Spouses and children would be allowed to begin using benefits as soon as they are transferred by the member.

CBO expects that those changes would cause some service members to leave the military and use their benefits themselves, rather than transfer them to their dependents. Because service members would have to wait four more years before committing to additional military service, they would have more opportunities to leave the armed forces. Also, spouses would have to wait an additional four years to use transferred benefits, somewhat reducing their value to the spouse. Finally, the length of service required from the member would increase from 10 years to 12 years.

Based on the rate at which personnel leave the military between their 6th and 10th years of service, CBO estimates that each year about 2,000 members who would have committed to additional service in order to transfer benefits under current law would, under this

provision, leave the military and retain those benefits for their own use. That change would have several offsetting effects that would increase net direct spending by about $130 million over the 2016-2025 period, CBO estimates. Those effects include:

- Increased costs of $560 million for an additional 20,000 service members who would separate and use additional benefits;

- Increased costs of $40 million for the roughly 2,000 additional recruits who would replace those separating service members, some of whom would later separate and use education benefits near the end of the budget window;

- Decreased costs of $270 million because spouses who do receive transferred benefits would have to wait an additional four years to receive them, reducing the total number of spouses who attend school over the next 10 years by about 6,500;

- Decreased costs of $100 million because about 4,700 fewer spouses would receive transferred benefits; and

- Decreased costs of $100 million because about 14,000 fewer children would receive transferred benefits, about 2,000 of whom would have reached college age during the next 10 years.

Payments for Flight Training. Section 306 would cap payments for tuition and fees for educational programs that involve flight training. Flight-training programs require significant expenditures for aircraft purchases, equipment maintenance, aviation fuel, and insurance. In 2014, VA paid an average of $42,000 in tuition and fees for all beneficiaries enrolled in flight-training programs at public institutions. The maximum benefit for tuition and fees for flight trainees at private institutions was $19,400 that year.

Section 306 would apply the limit for private institutions to all flight-training programs. (Students who are enrolled in flight-training programs before enactment of H.R. 3016 would not see their education benefits reduced for two years.) Payments for students whose tuition is below the new cap would not be affected. In 2014, the average cost for the 544 students whose tuition and fees exceeded the $19,400 limit applicable to private institutions for that year was about $62,000, a difference of $42,600. (That number excludes students at programs currently precluded from enrolling new students receiving VA education benefits.) In total, payments to schools would decline by $342 million over the 2016-2025 period as a result of the cap, CBO estimates.

Under the bill, the savings realized by capping tuition payments would be partially offset because some students may be eligible for additional assistance under the Yellow Ribbon Program.

Based on data from VA that reflects payments under the YRP, CBO expects that about 90 percent of the institutions affected by the new cap on flight-training costs would make qualifying contributions under the YRP, and those contributions would cover about 45 percent of the difference between the listed amount for tuition and fees and the limit on VA payments for those costs. Thus, reductions in benefit payments for flight training would be about 40 percent less than what they would be in the absence of the Yellow Ribbon Program. VA's matching payments under the YRP would total $139 million over the 2016-2025 period.

On that basis, CBO estimates that in most years about 600 individuals would be affected by the new limit on tuition and fees. The number of students affected would be smaller in 2016 and 2017 because payments for students who enrolled before H.R. 3016 was enacted would not be reduced in those years. In 2018, the first year that the cap would apply to payments for all students in flight training, payments for affected students would decline by about $30,000. That amount would increase annually because the gap between flight-training costs and the new cap would increase with inflation. CBO estimates that, in total, enacting section 306 would decrease direct spending by $203 million over the 2016-2025 period.

Fry Scholarships. The Marine Gunnery Sergeant John David Fry Scholarship provides 36 months of education benefits under the Post-9/11 GI Bill to spouses and children of service members who died on active duty at any time after September 11, 2001. Section 302 would enhance that benefit by allowing those individuals to receive payments under the Yellow Ribbon Program and by giving certain spouses more time to use the benefit. In total, section 302 would increase direct spending by $50 million over the 2016-2025 period, CBO estimates.

Under current law, service members must complete at least 36 months of active duty or be discharged from the military for a service-connected disability to earn YRP benefits. (Spouses and children who receive transferred benefits from members who were eligible for the YRP program can also receive that additional assistance.) Under the bill, recipients of the Fry Scholarship could receive additional education assistance through the Yellow Ribbon Program; thus, the roughly 6,000 dependents who use Fry Scholarship benefits each year also would become eligible for YRP assistance.

In 2014, VA made payments averaging $5,700 for 6 percent of the students who were eligible for the Yellow Ribbon Program. About 6,000 people with Fry Scholarships will attend school each year, CBO estimates. Assuming the same percentage of students with Fry Scholarships get similar YRP benefits (adjusted for inflation), those additional payments would increase direct spending by $25 million over the 2016-2025 period, CBO estimates.

Section 302 also would extend the time that certain spouses have to use Fry Scholarship benefits before they expire. On January 1, 2015, the Fry Scholarship was expanded to include spouses. Under current law, those spouses have 15 years after the service member's death to use their benefits; thus, some spouses have fewer than four years before their benefits will expire. Section 302 would allow spouses of service members who died between September 11, 2001, and December 31, 2005, up to 51 additional months to use their benefits. Approximately 2,000 service members with spouses died during that period, and their spouses would not have time to use any or all of their Fry Scholarship under current law. CBO estimates that direct spending on education benefits would increase by $25 million over the 2016-2025 period, because of the additional time for spouses to use their benefits.

Credit for Time in Medical Care. Section 307 would allow the time a reservist serves on active duty while receiving medical care or undergoing a medical evaluation, to count as qualifying active service for accruing education benefits under chapter 33. Based on historical data from the Department of Defense regarding such activations, CBO estimates that about 1,000 reservists will be called to active duty for those reasons annually, and spend an average of seven months in that status. For those individuals, that additional qualifying service could result in a roughly 15 percent increase in annual benefits under chapter 33—about $2,500 per person in 2016.

However, some activated reservists will already qualify for the maximum benefit as a result of other time on active duty; others would not use their benefits at all, even if the amount of the benefit were increased. Based on personnel data from DoD, CBO estimates that under section 307, about half of the reservists who are activated for medical care would receive and use additional benefits as a result of that service. Section 307 would apply to active-duty service after the date of enactment of the bill; thus, the initial budgetary effect would be small—about $1 million in 2016. As the population of veterans who would benefit from the provision grew over time, annual costs would increase to about $5 million. In total, the additional payments from VA for those benefits would increase direct spending by $40 million over the 2016-2025 period, CBO estimates.

Work-Study Program. Section 308 would renew for five years an expired authority to pay veterans to work in certain positions at VA while they are using educational assistance. Under the program, veterans could be paid the minimum wage for up to 25 hours per week for working in VA hospitals, nursing homes, retirement homes, and veterans' cemeteries, or for performing outreach services to other veterans. The authority to hire veterans in those positions expired on June 30, 2013. Section 308 would restart the program on June 30, 2016.

In 2012, the last full year before the authority expired, VA paid an average of $2,750 to about 400 veterans who performed such work. CBO expects that participation would be

similar under the renewed program; therefore, we estimate that enacting section 308 would increase direct spending by $4 million over the 2016-2021 period.

In-State Tuition for Dependents. For dependents who receive transferred benefits under chapter 33, section 408 would require public institutions of higher learning to set tuition and fees at rates that are no higher than those charged to state residents. Institutions that declined to do so would be disapproved for attendance by students using VA education benefits. To the extent that public institutions complied and lowered prices for such beneficiaries, the difference between the rate charged by the institution and the amount paid by VA would decline or disappear. Thus VA would not have to provide matching payments under the Yellow Ribbon Program for institutions that would have covered part of that difference, and spending for that program would decline.

Section 408 is similar to a requirement in current law that public institutions must offer in-state tuition rates to veterans who were discharged within the three-year period preceding their enrollment in the institution. That requirement should similarly reduce mandatory spending under the YRP. However, the Secretary of Veterans Affairs has waived the disapproval of institutions that do not offer in-state tuition to veterans, reducing the incentive for public institutions to offer that lower rate. The Secretary's waiver would similarly apply to dependents who would otherwise be affected by the enactment of section 408. CBO expects that VA will continue to waive the requirement in current law; therefore, enacting section 408 would not affect direct spending.

Loan Guarantee Limit. VA provides partial loan guarantees to lenders that make home loans to veterans. The guarantee payment from VA is capped at 25 percent of the initial loan balance, up to the maximum loan amount established by the Federal Home Loan Mortgage Corporation Act, currently $417,000. (Loans at or below that level are known as conforming loans; loans in excess are called jumbo loans. Exceptions are made to the conforming limit for certain high-cost areas like Hawaii and Alaska.)

Section 501 would eliminate the cap on the loan amount for which VA can provide a guarantee of 25 percent. As a result, VA would provide a larger guarantee amount for some jumbo loans that it will already cover under current law. Additionally, some veterans who would not have used the benefit because of the guarantee limit would do so if section 501 were enacted. From October 2008, to December 2014, the maximum loan amount for which VA could provide a full guarantee was temporarily increased to $729,750. Based on information about the jumbo loans VA guaranteed during that period, CBO estimates that if the loan limit were removed, VA would increase the guaranteed amount by about $100,000 on average for about 5,000 loans a year that it will otherwise guarantee for a lesser amount under current law. Also, VA would guarantee an additional 1,000 loans annually with an average loan amount of about $700,000. As a result, the annual loan volume that VA would guarantee would grow by an average of $1.2 billion. Because the subsidy costs of VA's loan guarantees are considered direct spending, increasing the loan

volume would increase direct spending.[1] Based on the experience from VA's loan guarantee program, CBO estimates that enacting section 501 would increase direct spending by $4 million in 2016 and $67 million over the 2016-2025 period.

Spending Subject to Appropriation

H.R. 3016 would expand the types of medical care provided by VA. It also would establish a new organization in VA to administer several job training, readjustment, and benefit programs, and would transfer certain job training and placement programs from the Department of Labor to VA. Finally, the bill would improve the systems and methods for processing benefit claims, and require VA to provide certain reports and studies. In total, CBO estimates that implementing the bill would cost $234 million over the 2016-2020 period, assuming appropriation of the necessary amounts (see Table 3).

Medical Care. The bill would expand neonatal care, increase the benefits paid to podiatrists at VA, establish a pilot program for certain veterans to train service dogs, and require periodic reviews of VA's budget for health care. In total, implementing those provisions would increase costs by $100 million, CBO estimates.

Care for Newborns. Section 103 would authorize VA to provide up to 42 days of health care to newborn children of female veterans who receive maternity care through the department. Under current law, VA may provide such care for no more than seven days after delivery.

Based on data from VA, CBO estimates that that 11 percent (or 240) of the roughly 2,200 eligible births that occur each year are complicated births that require neonatal care beyond seven days. Based on information from the Agency for Healthcare Research and Quality, and excluding the days over 42, the average length of stay for neonatal care for complicated births (for example, premature delivery, low birth weight, and fetal-growth retardation) is 15 days. Using information from VA, we estimate that the average daily cost for complicated births is about $4,000. As a result, and adjusting for anticipated inflation, CBO estimates that implementing this proposal would cost $50 million over the 2016-2020 period.

1. Under the Federal Credit Reform Act of 1990, the subsidy cost of a loan guarantee is the net present value of estimated payments by the government to cover defaults and delinquencies, interest subsidies, or other expenses, offset by any payments to the government, including origination fees, other fees, penalties, and recoveries on defaulted loans. Such subsidy costs are calculated by discounting those expected cash flows using the rate on Treasury securities of comparable maturity. The resulting estimated subsidy costs are recorded in the budget when the loans are disbursed.

TABLE 3. BUDGETARY EFFECTS OF H.R. 3016, THE VETERANS EMPLOYMENT, EDUCATION, AND HEALTH CARE IMPROVEMENT ACT

	By Fiscal Year, in Millions of Dollars					
	2016	2017	2018	2019	2020	2016-2020
SPENDING SUBJECT TO APPROPRIATION						
Care for Newborns						
Estimated Authorization Level	7	9	10	12	13	51
Estimated Outlays	6	9	10	12	13	50
Podiatrists						
Estimated Authorization Level	5	6	7	8	9	35
Estimated Outlays	4	6	7	8	9	34
Dog Training Therapy						
Estimated Authorization Level	2	2	2	2	2	10
Estimated Outlays	2	2	2	2	2	10
Outreach on Credit Protection						
Estimated Authorization Level	1	2	1	1	1	6
Estimated Outlays	1	2	1	1	1	6
Veterans Economic Opportunity and Transition Administration						
Estimated Authorization Level	*	30	10	10	10	60
Estimated Outlays	*	27	12	10	10	59
Transfer Labor Programs to VA						
Estimated Authorization Level	14	4	2	2	2	24
Estimated Outlays	10	7	3	2	2	24
Claims Processing						
Authorization Level	40	0	0	0	0	40
Estimated Outlays	27	9	2	1	1	40
Information on Benefit Entitlement						
Estimated Authorization Level	5	0	0	0	0	5
Estimated Outlays	4	1	0	0	0	5
Reports, Surveys, and Studies						
Estimated Authorization Level	2	1	1	1	1	6
Estimated Outlays	2	1	1	1	1	6
Total Spending Subject to Appropriation						
Estimated Authorization Level	76	54	33	36	38	237
Estimated Outlays	56	64	38	37	39	234

Note: VA = Department of Veterans Affairs; * = between $0 and $500,000.

Podiatrists. Section 101 would require VA to treat podiatrists as physicians for the purposes of pay, recruitment, and retention. Over the next five years, CBO expects that VA will employ, on average, about 400 podiatrists at an annual salary of $195,000. Based on pay data from VA, CBO estimates that this proposal would increase that compensation by 6 percent to an average of $210,000 over that period. In addition, CBO expects that the higher level of compensation would enable VA to be more successful in recruiting podiatrists. Accordingly, we estimate that over the 2016-2020 period, the number of podiatrists VA employs each year would increase to an average of 420. As a result, CBO estimates that implementing section 101 would increase personnel costs by $34 million over the 2016-2020 period.

Dog Training Therapy. Section 106 would require VA to establish a pilot program through which veterans diagnosed with post-traumatic stress disorder or other mental health conditions would train service dogs for use by other disabled veterans. The pilot program would operate in up to five medical centers over a five-year period. Based on the cost of a similar VA program in Palo Alto, California, CBO expects that each facility would train six service dogs every two years using one certified dog trainer. CBO estimates that implementing the provision would cost $10 million over the 2016-2020 period.

Outreach on Credit Protection. Section 105 would require VA to inform veterans about the negative effects on their credit score from overdue copayments to VA for emergency care provided at nondepartment facilities. VA also would be required to operate a toll-free line for veterans to report such credit issues to VA. CBO expects that implementing these requirements would require five additional employees at an annual cost of $1 million.

Section 105 would also require the Government Accountability Office to conduct an analysis on the timeliness of VA payments to non-VA providers of health care. Based on the resources necessary for previous studies, CBO estimates such a study would cost $1 million. In total, implementing section 105 would cost $6 million over the 2016-2020 period, CBO estimates.

Economic Opportunity and Transition Administration. Title II of the bill would create a new administration at VA to manage programs for readjustment benefits, home-loan guarantees, and small-business assistance. The title also would transfer the responsibilities for the veterans' employment programs administered by the Department of Labor to VA. In total, CBO estimates that implementing title II would increase costs by $83 million.

Veterans Economic Opportunity and Transition Administration. Beginning in fiscal year 2017, sections 201 and 202 would establish the Veterans Economic Opportunity and Transition Administration (VEOTA). The Veterans Benefits Administration (VBA) currently manages the following benefit programs for veterans and other eligible individuals:

- Disability compensation;
- Pension, dependency and indemnity compensation, burial, and fiduciary programs;
- Readjustment benefits (including education and vocational rehabilitation benefits);
- Home-loan guarantees;
- Small business programs; and
- Insurance.

This bill would transfer some programs that are currently administered by VBA to VEOTA. Under this new organizational structure, all readjustment benefit programs (including employment programs), the home-loan guarantee program, and veterans' small business programs would instead be managed by VEOTA. VBA and VEOTA each would be led by an Undersecretary. Section 201 would limit the total number of full-time equivalent (FTE) positions serving in both administrations to 22,118 in fiscal years 2017 and 2018.

Based on information from VA, there are currently about 4,400 VA employees who oversee and carry out the benefits programs that would transfer to VEOTA under this provision. CBO estimates that those personnel, and the records, property, and budgetary resources currently used by VBA to manage those programs also would be transferred. Using the current operating costs for VBA of $137 million, we estimate a 10 percent increase in 2017 to capture moving expenses, IT costs and other reorganization expenses, and about a 3 percent increase thereafter for ongoing operating expenses. Those estimated additional operating costs would total about $50 million over 2016-2020 period. In addition, CBO estimates that VEOTA would require an additional 20 FTE positions at an average annual cost of $180,000 to manage the daily operations of the new administration. As a result, CBO estimates costs of $9 million for additional staff.

CBO estimates that establishing VEOTA and transferring the programs, personnel, and accompanying assets and hiring the additional 20 personnel would cost $59 million over the 2016-2020 period.

Veterans Employment and Training Services. In 2014, DOL employed about 230 individuals and spent about $230 million to provide employment, job training, and reintegration services to veterans. Section 203 would transfer those veterans-related programs to VA, under VEOTA (as established in section 201). CBO estimates that implementing that provision would cost $24 million over the 2016-2020 period. Those costs primarily reflect building the necessary information technology (IT) systems for grant management and relocating staff.

Many of the transferred programs are grant programs that require grant management and data collection systems to analyze and evaluate the effectiveness of each program. Under current law, DOL relies on its customized IT systems to manage those programs. Those

systems are currently used throughout DOL and embedded in the department's greater IT infrastructure. CBO expects that VA would need to develop its own grant management system to distribute and manage the grants and collect the comprehensive data necessary to comply with the statutory reporting requirements of the transferred programs. Based on information from DOL, CBO estimates that it would cost $18 million over the 2016-2020 period to develop and maintain the IT systems.

Based on information from DOL, CBO estimates that about 140 of the 230 transferring employees work outside of the Washington, D.C. area. CBO assumes that those personnel would remain at their current locations after VA takes responsibility for their functions. The remaining individuals would relocate from DOL to a VA facility. Based on information from the General Services Administration (GSA), CBO estimates that it would cost about $20,000 to move each of those employees within the District of Columbia.

Because VA already leases space to accommodate some of their current employees, CBO expects that it would need to lease additional space to accommodate the 90 relocated employees. Based on GSA planning estimates, VA would need to lease about 18,000 square feet of office space at a cost of about $40 per square foot. Because those employees are intermingled with other DOL employees, CBO expects that DOL would not be able to consolidate space very quickly. Thus, any reduction in costs for DOL from the relocated employees would be less than the increase in costs for VA over the first few years. On net, CBO estimates that it would cost about $6 million to move 90 employees and lease office space over the 2016-2020 period.

Benefit Processing Improvements. H.R. 3016 would make several changes to the systems and methods used to process benefit claims. In total, those changes would increase costs by $45 million.

Claims Processing. Section 407 would require VA to maximize the use of automation and algorithms in systems used to process claims for educational assistance under the Post-9/11 GI Bill (Chapter 33) and would authorize the appropriation of $30 million in 2016 for that purpose.

Section 310 would require VA to reduce the number of IT systems used to process payments for vocational rehabilitation benefits and to ensure that such payments on behalf of a particular veteran are paid from only one system. It would authorize the appropriation of $10 million in 2016 for that purpose.

CBO estimates that implementing those provisions would cost $40 million over the 2016-2020 period, assuming appropriation of the specified amounts.

Information on Benefit Entitlement. Section 402 would require VA to allow institutions of higher learning to obtain information on the educational assistance to which a veteran is

entitled via a secure IT system. CBO expects that VA could accomplish that requirement by modifying systems that are currently used to provide other information to such institutions. Based on information from VA, CBO estimates that modifying those systems would cost $5 million over the 2016-2020 period, assuming appropriation of the estimated amounts.

Reports, Surveys, and Studies. The bill would require VA to produce a total of nine reports on matters such as medical care, benefit processing, and contract set-asides for veteran-owned business. It also would require a survey of veterans using educational benefits, and a multiyear study on job counseling and placement programs. Based on the costs of similar studies and reports, CBO estimates that meeting those requirements would cost a total of $6 million over the 2016-2020 period.

PAY-AS-YOU-GO CONSIDERATIONS

The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table.

CBO Estimate of Pay-As-You-Go Effects for H.R. 3016 as ordered reported by the House Committee on Veterans' Affairs on September 17, 2015

	By Fiscal Year, in Millions of Dollars											
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016-2020	2016-2025
NET INCREASE IN THE ON-BUDGET DEFICIT												
Statutory Pay-As-You-Go Impact	-7	-20	-44	-63	-80	-96	-108	-121	-134	-142	-214	-815

INCREASE IN LONG TERM DIRECT SPENDING AND DEFICITS

CBO estimates that enacting H.R. 3016 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2026.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 3016 contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments. State agencies that serve

veterans would benefit from contact and service information about veterans provided electronically by VA.

PREVIOUS COST ESTIMATES

On August 26, 2015, CBO transmitted a cost estimate for H.R. 475, the GI Bill Processing Improvement and Quality Enhancement Act of 2015, as ordered reported by the House Committee on Veterans' Affairs on May 21, 2015. Sections 102 and 103 of that bill are similar to sections 306 and 307 of H.R. 3016 and the estimated costs are the same. Section 104 of H.R. 475 is similar to section 501 of H.R. 3016. CBO estimates a smaller cost in fiscal year 2016 for section 501 than we estimated for the earlier provision because of the later expected date of enactment.

ESTIMATE PREPARED BY:

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