ISSUE BRIEF

Resolve Recruitment & Retention Issues within Veterans Health Administration (HR 1058/S 1871)

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).

The VA Provider Equity Act (HR 1058/S 1871) would boost recruitment and retention of doctors of podiatric medicine (DPMs) by recognizing them within the physician and dentist authority under VHA. Now House and Senate leaders must move swiftly to pass a VA bill with this 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 Association of Orthopedic Surgeons, the Academy of Orthopedic Foot and Ankle Surgeons, 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

- November 29, 2017 - US Sen. Bill Cassidy (R-LA) offered S 1871 as an amendment to the Caring for our Veterans Act (S 2193) which subsequently passed out of committee and was sent to the Senate floor for a vote.
- September 27, 2017 - US Sen. Bill Cassidy (R-LA) introduced S 1871, the VA Provider Equity Act.
- July 24, 2017 - Passed US House by voice vote..
- July 24, 2017 - CBO score released for HR 1058, estimated increase in direct spending of $106 million over the next decade.
- July 19, 2017 - AAOS and AOFAS endorse the bill.
- May 2, 2017 - APMA testified at US House Veterans' Affairs Subcommittee on Health about problems facing VA regarding recruitment and retention of podiatric physicians.
- February 14, 2017 - US Rep. Brad Wenstrup (R-OH), on behalf of himself and Reps. Ralph Abraham (R-LA), Julia Brownley (D-CA) and Raul Ruiz (D-CA), introduced HR 1058, the VA Provider Equity Act.

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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Department of Veterans Affairs
White Paper on Podiatry Pay
February 2017

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.

Modification of 38 USC 7431 is the most efficient way to address the pay deficiencies VA has for podiatrists as compared to their counterparts in the private sector. The VA podiatrist compensation package has remained unchanged since 1976, except for those changes that include adjustments for basic pay and locality rates. Meanwhile, clinical responsibilities of VA podiatrists have greatly expanded and podiatrists in the Veterans Health Administration (VHA) have assumed equivalent professional and administrative duties to other physician groups.

VA has identified podiatry as a profession that requires special attention in order to meet future patient care needs. There is a growing health care demand for primary and specialty podiatric services, especially among Veterans suffering from polytraumatic injuries, spinal cord injury, and limb amputation. This is in addition to the approximately 1.8 million Veterans (up 21% from 2015) who are receiving VHA care and are at risk for major foot wounds, infection and amputations.

All Amputation Risks As of Date: Apr 10, 2015	All Amputation Risks As of Date: November, 30, 2016	Increase/Decrease
1,509,771	1,828,565	+318,794 or 21%

The 41-year old law has significantly reduced VA's ability to provide Veterans with the most experienced providers, and instead forces the hire of younger and less experienced providers who tend to separate over pay issues just as they reach the pinnacle of their ability to provide the highest quality care to Veterans. The average delay in hiring new podiatric physicians is 14 months, with the majority (70% in FY 2016) without board certification. Additionally, 71 senior clinical podiatrists in over 40% of receiving locality pay have reached the legislatively capped rate of pay for the Level IV Executive Schedule limit of $160,300; this has significantly limited compensation over the past decade for these highly productive and experienced providers. Furthermore, this salary cap serves as a disincentive in attracting, recruiting and retaining even recent graduates. Many newly graduated residency-trained podiatrists have significant student loan debt that greatly impacts their future career practice options, with an average indebtedness of $194,000 excluding undergraduate debt.

The utilization of VA podiatric services is projected to increase 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, and traumatic brain injuries.

In 2005, a new pay system for Physicians and Dentists was enacted. This moved other physicians and dentists into a new pay structure from one which had been essentially the same as that for podiatry. This past year the House of Representatives passed HR 3016, which among other provisions called for including podiatrists in the definition of physician, consistent with CMS under Title 18. Placing podiatrists under the same definition as physicians and dentists and moving them to Title 38, U.S.C. Section 7431 pay tables would provide VA with the flexibility to competitively hire and compensate podiatrists, helping to ensure the highest quality of care for Veterans.

In conclusion, the following represent the major points supporting this change to 38 USC 7404 and 38 USC 7431.

- VA is having difficulty recruiting and retaining experienced providers due to low compensation.
- VA's limited ability to attract and retain experienced podiatric providers has affected access.
- With a projected increase in podiatry utilization, access challenges are likely to continue unless we are able to offer more competitive compensation for podiatric physicians.
- Experienced VA clinical podiatrists in over 40% of regions receiving locality pay have reached legislative caps.
- Podiatrists share the same inpatient, outpatient, OR, call, and rounding responsibilities as other physician professions.
- CMS defines podiatrists as physicians under Title 18.

Testimony of Dr. Seth A. Rubenstein

Member and Trustee, American Podiatric Medical Association

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

May 2, 2017

Chairman Wenstrup, 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.

I am Dr. Seth Rubenstein, member and trustee of the American Podiatric Medical Association (APMA). 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. I do not represent VA in my capacity today, though I bring with me 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 we serve.

Dr. Chairman, the Veterans Health Administration (VHA) qualification standards for podiatry were written and adopted in 1976. Podiatric education, training and practices in 1976 starkly contrasted with those of other physician providers of the time, and with podiatric medicine as it is today. Unlike 41 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 two, 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 613 standardized, comprehensive, three-year medicine and surgery residency positions to satisfy the full number of our graduates, with 64 positions (or 10 percent) of those residency position 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 who practiced when the statue was originally adopted. 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 in 2002 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)]. More than 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 data reflect that 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 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 nation's 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 the VA patient population. Patients who are statistically comorbid with psychosocial and socioeconomic issues, all of which play a role in the delivery of care and final outcome. The veteran population is far more complex to treat than patients in the private sector, as a whole. Greater than 90 percent of the veteran podiatric patient population is 44 years and older, with the majority of 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 the major missions as providers of lower extremity care is amputation prevention and limb salvage.

Dr. Chairman, the value of podiatric care is recognized in at-risk patient populations. Care provided by podiatrists, as part of an 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 these statistics for 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 peripheral vascular disease. We perform falls prevention and orthopedic surgery. As one of the top five busiest services in VA, podiatry provides a significant amount of care to 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, Chief of Podiatry and Residency Director, Department of Veterans Affairs – Northport Health Care System - Former 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 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.

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 less than 10 years of experience and are not board certified. As a result of the disparity the VA is attracting less experienced podiatric physicians. The majority of these new podiatrists hired into the VA will separate within the first five years.

Compounding the recruitment and retention issues, there exist 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. 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.

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 more than 10 years now. 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 former Under Secretary of Health, Robert Petzel, MD.

Seven 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, former Assistant Deputy Under Secretary for Health for Patient Care Services; Dr. Margaret Hammond, former Acting Chief Officer for Patient Care Services; and Dr. Jeffrey Robbins, Chief of Podiatry Service. We participated in several meetings with

members of the working group and 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 authority. 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. Dr. Chairman and members of the Subcommittee, thank you again for this opportunity. This concludes my testimony and I am available to answer your questions.

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12. Preventing Amputation in Veterans Everywhere (PAVE) Program

The VA Provider Equity Act

115th Congress

Cosponsors (33): HR 1058 (24) S 1871 (9)

*Original Sponsor

- **On November 29, 2017 the US Senate Committee on Veterans Affairs amended the Caring for Our Veterans Act (S 2193) to include S 1871.**
- **On July 19, 2017 the US House of Representatives PASSED HR 1058 by voice vote.**

CALIFORNIA
Rep Julia Brownley (D)*
Rep Raul Ruiz (D)*
Rep Adam Schiff (D)

CONNECTICUT
Sen. Richard Blumenthal (D)
Rep James Himes (D)

FLORIDA
Rep Carlos Curbelo (R)
Rep Daren Soto (R)

ILLINOIS
Rep Adam Kinzinger (R)

IOWA
Rep Rod Blum (R)
Sen. Chuck Grassley (R)
Rep Steve King (R)
Rep Dave Loebsack (D)
Rep David Young (R)

INDIANA
Rep Andre Carson (D)
Sen Joe Donnelly (D)

LOUISIANA
Rep Ralph Abraham (R)*
Sen Bill Cassidy, MD (R)*
Rep Clay Higgins (R)

MICHIGAN
Sen Gary Peters (D)
Sen Debbie Stabenow (D)
Rep David Trott (R)

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Rep Ann McLane Kuster (D)
Sen. Jeanne Shaheen (D)

NORTH DAKOTA
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OHIO
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Rep Brad Wenstrup (R)*

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Rep Earl Blumenauer (D)
Rep Suzanne Bonamici (D)
Rep Peter Defazio (D)

UTAH
Rep Mia Love (R)
Rep Chris Stewart (R)

WASHINGTON
Rep Denny Heck (D)

WISCONSIN
Sen. Tammy Baldwin (D)

Updated February 20, 2018

(R) – Republican (D) – Democrat (I) – Independent House Veterans Affairs Committee Armed Services Committee Senate Veterans Affairs Committee

The Department of Veterans Affairs Provider Equity Act

114th Congress

Cosponsors (26): **HR 3016 (16)** **S 2175 (10)**

*Original Sponsor

February 9, 2016 - HR 3016 was considered on the floor of the **US House of Representatives** under suspension of the rules and subsequently **passed by voice vote**. On February 10, 2016 HR 3016 was received in the US Senate, the legislation was read twice and was referred to the US Senate Committee on Veterans' Affairs.

AMERICAN SAMOA
Rep. Aumua Amata Coleman Radewagen (R)

ARKANSAS
Sen Tom Cotton (R)

CALIFORNIA
Rep Julia Brownley (D)*
Rep Grace Napolitano (D)
Rep Raul Ruiz (D)*
Rep Adam Schiff (D)

COLORADO
Rep Mike Coffman (R)

CONNECTICUT
Sen Chris Murphy (D)

ILLINOIS
Sen Richard Durbin (D)

IOWA
Rep David Young (R)
Sen Chuck Grassley (R)

LOUISIANA
Rep Ralph Abraham (R)*

MAINE
Sen Angus King (I)

MARYLAND
Sen Ben Cardin (D)

MICHIGAN
Rep Dan Benishek (R)*
Sen Debbie Stabenow (D)

MONTANA
Sen Jon Tester (D)*

NEW YORK
Rep Steve Israel (D)
Sen Charles Schumer (D)

OHIO
Rep Brad Wenstrup (R)*

OREGON
Rep Earl Blumenauer (D)

PENNSYLVANIA
Rep Ryan Costello (R)

SOUTH CAROLINA
Rep Joe Wilson (R)

TENNESSEE
Rep Phil Roe (R)*

TEXAS
Rep Lamar Smith (R)

WISCONSIN
Sen Tammy Baldwin (D)

Updated September 28, 2016

(R) – Republican (D) – Democrat (I) – Independent Veterans Affairs Committee Armed Services Committee Senate Veterans Affairs Committee

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

July 24, 2017

H.R. 1058
VA Provider Equity Act

As ordered reported by the House Committee on Veterans' Affairs
on July 19, 2017

H.R. 1058 would extend the current limitation on pension amounts that can be paid to certain veterans who receive benefits from Medicaid. The bill also would effectively increase the salary for podiatrists employed by the Department of Veterans Affairs (VA).

CBO estimates that enacting the bill would decrease direct spending by $552 million over the 2017-2027 period. CBO also estimates that implementing the bill would cost $53 million over the 2017-2022 period, assuming appropriation of the necessary amounts.

Because enacting the bill would affect direct spending, pay-as-you-go procedures apply. Enacting the bill would not affect revenues.

CBO estimates that enacting H.R. 1058 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2028.

H.R. 1058 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary effects of H.R. 1058 are shown in the following table. The costs of this legislation fall within budget functions 700 (veterans benefits and services) and 550 (health).

	By Fiscal Year, in Millions of Dollars						
	2017	2018	2019	2020	2021	2022	2017-2022
INCREASES IN SPENDING SUBJECT TO APPROPRIATION							
Estimated Authorization Level	0	9	10	10	12	13	54
Estimated Outlays	0	8	10	10	12	13	53

Note: In addition to the budgetary effects shown above, enacting H.R. 1058 would decrease net direct spending by a total of $552 million in 2025 and 2026.

BASIS OF ESTIMATE

For this estimate, CBO assumes that the bill will be enacted near the beginning of 2018, that the estimated amounts will be appropriated each year, and that outlays will follow historical spending patterns for the affected programs.

Spending Subject to Appropriation

Section 2 would add podiatrists to the pay schedule for physicians and dentists and thus increase their pay. Currently, VA employs about 400 podiatrists nationwide at an average annual salary of about $130,000. On the basis of information from VA about the average increase necessary for podiatrists to move to a pay schedule comparable to that of physicians and dentists, CBO estimates that the base salary for podiatrists would increase by about 15 percent to $150,000 in 2018. In addition, using data on hiring from VA, CBO estimates that VA would be able to hire an additional 30 podiatrists because the increased pay would make working at VA more attractive. After accounting for projected pay raises, CBO estimates that implementing the provision would cost $53 million over the 2017-2022 period, assuming appropriations of the necessary amounts.

Direct Spending

Section 3 would extend for two years (from September 30, 2024, to September 30, 2026) the expiration date of a provision that sets a $90 per month limit on pensions paid to any veteran who has no spouse or child and who is receiving Medicaid benefits in a Medicaid-approved nursing home; that provision also applies to any surviving spouse of a veteran who is receiving such coverage. Using data from VA, CBO estimates that about 13,000 veterans and 24,000 surviving spouses would be affected by this provision; the average monthly savings to VA would be about $1,900 per veteran and $1,200 per survivor. (Those estimates account for the effects of inflation, mortality rates, and growth

of the affected population.) On that basis, CBO estimates that enacting the provision would reduce VA spending by $1.4 billion over the 2025-2026 period. Because of the reduced pensions, Medicaid would need to make some payments to nursing homes that would otherwise be paid by the veterans and surviving spouses. Those higher Medicaid payments would offset some of the savings from the reduced pensions. CBO estimates that those Medicaid costs would total about $846 million over the two years, resulting in a net reduction in direct spending of $552 million over the 2025-2026 period, as shown in the pay-as-you-go table below.

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. 1058, the VA Provider Equity Act, as ordered reported by the House Committee on Veterans' Affairs on July 19, 2017

	By Fiscal Year, in Millions of Dollars												
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2017-2022	2017-2027
NET INCREASE OR DECREASE (-) IN THE DEFICIT													
Statutory Pay-As-You-Go Impact	0	0	0	0	0	0	0	0	-272	-280	0	0	-552

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2028.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 1058 contains no intergovernmental or private-sector mandates as defined in UMRA.

ESTIMATE PREPARED BY:

Federal Costs: Ann E. Futrell and Dwayne M. Wright
Impact on State, Local, and Tribal Governments: Jon Sperl
Impact on the Private Sector: Paige Piper/Bach

ESTIMATE APPROVED BY:

H. Samuel Papenfuss
Deputy Assistant Director for Budget Analysis

AMENDMENT TO THE AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 1058

OFFERED BY Dr. Wenstrup

Strike section 2 and insert the following:

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; clinical oversight standards

"(a) PODIATRISTS.—Except as provided by subsection (b), a doctor of podiatric medicine who is appointed as a podiatrist under section 7401(1) of this title is eligible for any supervisory position in the Veterans Health Administration to the same degree that a physician appointed under such section is eligible for the position.

"(b) ESTABLISHMENT OF CLINICAL OVERSIGHT STANDARDS.—The Secretary, in consultation with appropriate stakeholders, shall establish standards to ensure that specialists appointed in the Veterans Health Administration to supervisory positions do not provide direct clin-

ical oversight for purposes of peer review or practice evaluation for providers of other clinical specialties.".

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

"7413. Treatment of podiatrists; clinical oversight standards.".

(b) MODIFICATION AND CLARIFICATION OF PAY GRADE.—

(1) GRADE.—The list in section 7404(b) of such title is amended—

(A) by striking "PHYSICIAN AND DENTIST SCHEDULE" and inserting "PHYSICIAN AND SURGEON (MD/DO), PODIATRIC SURGEON (DPM), AND DENTIST AND ORAL SURGEON (DDS, DMD) SCHEDULE";

(B) by striking, "Physician grade" and inserting "Physician and surgeon grade"; and

(C) by striking "PODIATRIST, CHIROPRACTOR, AND," and inserting "CHIROPRACTOR AND".

(2) APPLICATION.—The amendment made by paragraph (1) shall apply with respect to a pay period of the Department of Veterans Affairs begin-

ning on or after the date that is 30 days after the date of the enactment of this Act.

II

115TH CONGRESS
1ST SESSION

S. 1871

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

SEPTEMBER 27, 2017

Mr. CASSIDY 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 ''VA 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:

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''(b) ESTABLISHMENT OF CLINICAL OVERSIGHT STANDARDS.—The Secretary, in consultation with appropriate stakeholders, shall establish standards to ensure that specialists appointed in the Veterans Health Administration to supervisory positions do not provide direct clinical oversight for purposes of peer review or practice evaluation for providers of other clinical specialties.''.

(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; clinical oversight standards.''.

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(B) by striking, ''Physician grade'' and inserting ''Physician and surgeon grade''; and

(C) by striking ''PODIATRIST, CHIROPRACTOR, AND'' and inserting ''CHIROPRACTOR AND''.

(2) APPLICATION.—The amendments made by paragraph (1) shall apply with respect to a 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.

○

AMERICAN ORTHOPAEDIC FOOT & ANKLE SOCIETY

AAOS
AMERICAN ASSOCIATION OF ORTHOPAEDIC SURGEONS

Representative Brad Wenstrup, Chairman
House Committee on Veterans' Affairs
Subcommittee on Health
335 Cannon House Office Building
Washington, D.C. 20515

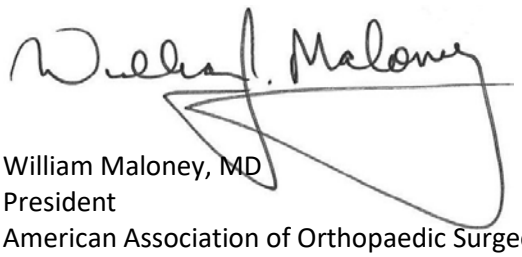
Chairman Wenstrup,

On behalf of the American Association of Orthopaedic Surgeons (AAOS), which represents over 18,000 board-certified orthopaedic surgeons, and the American Orthopaedic Foot and Ankle Society (AOFAS), which represents over 2,200 orthopaedic surgeons specializing in foot and ankle disorders, we would like to express support for your amendment to H.R. 1058, the VA Provider Equity Act.

The Wenstrup amendment will increase access to foot and ankle care for Veterans by improving recruitment and retention within the Department of Veterans Affairs (VA) of highly qualified podiatrists. The amendment accomplishes this by raising salaries for podiatrists and allowing podiatrists access to appropriate leadership positions at the VA. Podiatrists are an essential part of the care team at the VA and work alongside orthopaedic surgeons every day to provide excellent service to Veterans.

Thank you and your staff for your commitment to our veterans and for working with us throughout this process. We are happy to support the resulting legislation.

Sincerely,



William Maloney, MD
President
American Association of Orthopaedic Surgeons

Thomas Lee, MD
President
American Foot and Ankle Society