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LEGISLATIVE HEARING ON H.R. 2787; H.R. 3696; H.R. 5521; H.R. 5693; H.R. 5864; H.R. 5938; H.R. 5974; AND H.R. 6066

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTEENTH CONGRESS

SECOND SESSION

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Wednesday, June 13, 2018

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

The Subcommittee met, pursuant to notice, at 3:00 p.m., in Room 334, Cannon House Office Building, Hon. Neal P. Dunn [Chairman of the Subcommittee] presiding.

Present: Representatives Dunn, Higgins, Gonzelez-Colon, Brownley, Kuster, and Correa.

Also Present: Representative Bost.

OPENING STATEMENT OF NEAL DUNN, CHAIRMAN

Mr. DUNN. The Subcommittee will come to order.

Before we begin I would like to ask unanimous consent for Congressman Mike Bost from Illinois to sit on the dais and participate in today's proceedings. Without objection, that is so ordered.

I want to thank you all for joining us.

This afternoon we will be discussing eight bills that have been referred to the Subcommittee on Health. These bills are sponsored by Committee Members and our non-committee colleagues alike from Members on both sides of the aisle.

I am grateful to each of the bills' sponsors for their interest in ensuring that the Department of Veterans Affairs is the best equipped to provide high quality care and services that our Nation's veterans have earned and certainly deserve.

The bills that we will be discussing this afternoon cover a wide variety of topics. For example, our agenda includes bills that pertain to noninstitutional long-term care and clinical productivity, efficiency, and medical waste management. Also, some of the bills on our agenda today address some aspects of recruitment and retention. The considerable challenges that VA has faced in recent years when it comes to hiring have been well documented in this Subcommittee.

Next Thursday we will be holding another hearing to evaluate what, if any, progress the VA has made with the additional authorities that this Congress has provided to improve the VA's abilities to recruit new hires, bring them on board, and retain them over the course of their careers.

I hope that that hearing reveals headway in meeting staffing needs across the VA health care system. However, as long as the staffing concerns remain a problem for the VA, this Subcommittee will continue to prioritize finding innovative ways to ensure that the VA is able to hire doctors and nurses and other providers that our veterans need.

Once again I want to thank the bill sponsors for introducing their thoughtful proposals and for their attendance here today.

I also want to thank the veterans service organizations who will be testifying or who have submitted statements for the record and for their willingness to lend their opinions and insights to us this afternoon.

Mr. DUNN. And finally, I am grateful to the witnesses from the VA for being here to provide the Department's perspective on these bills.

That said, I do want to note my disappointment that despite being provided with several weeks' notice of this hearing, VA's testimony did arrive late to the Committee staff.

We read your testimony carefully. We consider it seriously. And we would like to have more than 48 hours to study it. I found the testimony to be very useful once it was received, and I hope the next time we will be able to get that in a little more timely fashion.

I now yield to Ranking Member Brownley for any opening statement that she may have.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Well, thank you, Mr. Chairman, and I am looking forward to this hearing.

And I wanted to welcome back my friend, Dr. Wenstrup. We worked very closely together on this Subcommittee.

So welcome back.

And I, too, want to thank the VA and our veterans service organizations for being here today. We have some great legislation that we are considering, and your expertise and input is so valuable to us as we consider what changes need to be made to best help our veterans.

The bills before the Subcommittee today are practical solutions to issues affecting veteran's nation-wide. In particular, I am concerned about the persistent number of vacancies at the VA and feel that we must do more to bring qualified doctors, nurses, and other medical providers into the VA system.

Hiring and retention within the VA has long been problematic, and today a number of the bills seek to assist VA in attracting qualified health care providers to treat our veterans.

While we know VA offers a high quality of care, it is often a lack of access that can be frustrating for our veteran patients. By focusing on VA's HR department and premedical school training programs, we can ensure VA has a pipeline of providers entering the VA and the staff to ensure they are on board in a timely manner.

I look forward to further discussions of these bills and welcome any suggestions on how we can improve upon them. I thank all of our colleagues for being here and for their work supporting veterans.

Thank you, Mr. Chairman, and I yield back.

Mr. DUNN. Thank you very much, Ms. Brownley.

I will now introduce our first panel. It is a pleasure to be joined today by several of our bills' sponsors. With us are Congresswoman Vicky Hartzler from Missouri and Congressman Brad Wenstrup from Ohio. And he is former Chairman of this Committee, Dr. Wenstrup. I will introduce the other witnesses.

Actually, we also have Congressman Mike Bost from Illinois is going to be a witness on the panel, and also Congressman Clay Higgins from Louisiana.

I appreciate all of you taking time out from your afternoon here to discuss your legislation.

Mrs. Hartzler, you are now recognized for 5 minutes.

STATEMENT OF THE HONORABLE VICKY HARTZLER

Mrs. HARTZLER. Well, thank you, Chairman Dunn and Ranking Member Brownley and distinguished Members of the Subcommittee. I appreciate you allowing me time to testify on H.R. 5521, the VA Hiring Enhancement Act.

Our veterans deserve the best. Unfortunately, top notch care is often hampered by a shortage of doctors at the VA.

I believe that this bill, which I introduced along with Congressman Correa and Congressman Bost, will help the VA to fill some of these vacancies.

Our bill has three main provisions.

First, it would allow physicians to be released from noncompete agreements only for the purpose of serving in the VA for at least 1 year. Noncompete agreements are supposed to prevent a physician from building up a patient base and then taking those patients with them as they set up their own practice. A physician moving to the VA simply does not fit this description.

This proven provision would ensure that a noncompete agreement is never used to keep a physician from serving veterans at a VA facility and only applies to such a circumstance.

Second, our bill updates the minimum training requirement for VA physicians. Completion of a medical residency is widely accepted as standard comprehensive training for clinical physicians in the United States; however, current law only requires that a physician be licensed in order to treat veterans. In the case of some medical specialties, the difference between licensing and completing residency can represent 6 years of training.

Some have suggested this provision would exacerbate the shortage of physicians at the VA by shrinking the pool from which the VA can hire; however, the VA currently hires almost exclusively those physicians which have completed residency training, so this provision would not result in such an impact.

Others have rightly submitted that veterans are largely satisfied with the quality of care they receive at the VA. They, therefore, submit that we do not need a legislative fix to a higher standard. I contend that as long as Congress sees fit to impose any standard on the VA regarding those caring for veterans, we have a duty to ensure that that standard is appropriate.

Completion of residency training is the accepted standard in this Nation, and we should never expect veterans to accept anything

less. This is a commonsense update to something Federal law already addresses and ensures that only fully trained physicians care for those who served our Nation.

Finally, our bill would place veterans' hospitals on a level playing field with the private sector when it comes to recruiting timelines. Often, private sector health care providers begin recruiting medical residents as they begin their final year of residency, sometimes even earlier. Most residents have school debt they need to start paying off, an average of $190,000. During residency they treat patients and work upwards of 80 hours a week, sometimes with single shifts up to 28 hours.

These residents, rightfully motivated to secure a post-residency job with better pay and better hours, often accept a solid job offer from the private sector before VA recruiters are able to get their recruiting process even started.

Our bill authorizes VA recruiters to make job offers to physicians up to 2 years prior to fulfilling all of the VA's requirements contingent on meeting all requirements before they begin treating veterans. It offers job security to medical residents who want to work at the VA when they complete their training. And it allows VA facilities and recruiters to shore up appointments further in advance, helping them to plan and forecast medical workforce needs.

VA recruiters are already pitching a great opportunity for physicians, and we owe them policies that make them as competitive as possible with private sector recruiters. I believe that advancement of this legislation will help begin to fill the VA's many vacant health care position needs.

We have worked closely with this Committee's staff, VA recruiters, and VSOs on this bill, and I am pleased to report that it has garnered wide support, including formal endorsement from the American Legion and Paralyzed Veterans of America. It is my hope we can work together to move this bill to the House floor soon.

Thank you again for allowing me this time, and I yield back.

[THE PREPARED STATEMENT OF VICKY HARTZLER APPEARS IN THE APPENDIX]

Mr. DUNN. Thank you very much Representative Hartzler.

We now recognize Dr. Wenstrup for 5 minutes.

STATEMENT OF THE HONORABLE BRAD R. WENSTRUP

Mr. WENSTRUP. Thank you very much, Mr. Chairman, Ranking Member Brownley. It is good to be with you all again. I appreciate the opportunity to be with you today.

As a Member of the House Veterans Affairs Committee for many years, one of my frustrations was the inability to use metric-driven standards to comprehensively examine and improve how the VA was using its resources to deliver health care.

We often hear, "When you have seen one VA, you have seen one VA," and that stands to reason in many ways. But every time I sat where you sit now and ask VHA's past leadership if they were able to provide metrics on health care delivered for resources expended, I wasn't able to get an answer. I was told the numbers existed, but they never seemed to materialize. And some would say, "Well, it costs more to do this, it costs more to do that," but they really had no metric of explaining how.

The goal, I think, for our VA health care system should be to deliver quality care efficiently in a timely fashion. If you are determined to deliver health care to all of those veterans that are eligible for care in a timely fashion, you want to make sure that you can be the most efficient.

So my legislation, H.R. 6066, seeks to ensure that actual data, based on the measure of relative value units, will ensure we can best serve our veterans.

What is a relative value unit? It is something assigned. CMS uses it. And it gives us a value to what procedure you have just performed or what function you just performed. There are more RVUs for an open heart surgery than there is for an incision and drainage of an abscess, as you might imagine.

So recently the VA began tracking productivity metrics across more than 30 specialties, but significant gaps still exist and persist in the effectiveness and completeness of the current reporting.

Last year a GAO report that is cited in my written testimony found that current VA productivity metrics, including RVUs, called RVUs, are not complete and may not be accurate. Clinical specialties are siloed, certain patient work is not measured, and contract providers go unmeasured. So the data that we have is not really useful because it is not complete.

And recording an RVU and scoring an RVU when you perform a procedure is very simple. You have certain procedures in your specialty that you do every day, and you document it in your note, and you can just simply point out, "I did this and I did that." And then that can be scored.

So this is legislation to tackle the GAO's recommendations by tracking RVUs across all providers and providing more comprehensive and systematic review to put the data to work, and by doing this accurately we can figure some things out. In the private sector, obviously, the more RVUs you produce, the more you get paid. It is different in the VA. You are paid the same anyway.

But what we want to do is measure productivity. If you have two practitioners operating at the same time, doing the same type of work, and one is producing twice as much as the other, you can evaluate that by knowing how many RVUs you produced.

So what do you do with that? In our practice if we saw it we would say, you know, well, this doctor has a physician assistant or two medical assistants as opposed to your one, and if we do that we can increase the productivity. That doesn't decrease doctor time. It actually will increase doctor time with patients.

So these are things that I want to bring to light. It also can affect how you are scheduling. You can learn so much. You may need to know that you need one more treatment room to be more efficient.

So this is an adequate way of really determining how productive someone is or a clinic is or a hospital is and can guide us on where we may need to make changes to be more effective.

Last year, working with the Committee, we drafted the language found in the bill in response to the May 2017 GAO report and recommendations and from years of observation from the dais where you now sit. This language was included in H.R. 4242 when it passed out of this very Committee last November, though it did not

make it into the final VA MISSION Act. That is why I am introducing this language as a standalone bill.

The VA, like all government agencies, is operating in a resource-constrained environment. It is our obligation to make sure that the resources we do have are directed at the veterans that need care. If we can't measure this we can't improve it.

None of us can claim to have a monopoly on good ideas. So I stand ready work with all interested parties to make sure that every dollar we spend within the Veterans Health Administration is being used to effectively deliver care to our veterans.

Thank you, and I yield back.

[THE PREPARED STATEMENT OF BRAD R. WENSTRUP APPEARS IN THE APPENDIX]

Mr. DUNN. Thank you very much, Dr. Wenstrup.

I now recognize Captain Clay Higgins from Louisiana for 5 minutes.

STATEMENT OF THE HONORABLE CLAY HIGGINS

Mr. HIGGINS. Thank you, sir.

Chairman Dunn, Ranking Member Brownley, thank you for considering H.R. 5693, the Long-Term Care Veterans Choice Act.

My bill, H.R. 5693, authorizes the Department of Veterans Affairs for 3 years to cover the cost of long-term care at medical foster homes for up to 900 veterans otherwise eligible for nursing home care through the VA.

Medical foster homes are private homes in which a caregiver provides services to a small group of individuals who are unable to live without day-to-day assistance, and are an alternative to nursing homes for those who require nursing home care but prefer a non-institutional setting with fewer residents.

For many young veterans in need of round-the-clock care, medical foster homes can provide a more age-appropriate, independent setting than traditional nursing homes.

The U.S. Department of Veterans Affairs has run its medical foster home initiative since the year 2000, and today VHA oversees more than 700 licensed caregivers caring for nearly 1,000 veterans in 42 States.

To be eligible to provide care for veterans, a VA medical foster home provider must provide a background check, complete 80 hours of initial training and 20 hours annually afterwards, and cannot work outside of the home.

Unfortunately, while the VA will cover the cost of home-based primary care for eligible veterans living in medical foster homes, the VA does not cover the cost of medical foster home living arrangements for veterans otherwise eligible for nursing home care through the VA. Instead, these veterans must pay for medical foster home services out of pocket or through private insurance.

Costs associated with medical foster home services range between $1,500 and $3,000 a month, which is significantly lower than the nearly $7,000 per month the VA might otherwise pay per patient at a State VA nursing home.

In my home State of Louisiana, the VA operates state-of-the-art veterans' homes that provide residents a high quality of care in an understanding, supportive environment. This is understood. In my

district I have toured and visited the Southwest Louisiana Veterans Home in Jennings, Louisiana, and I can personally attest to the high quality of care and sense of well-being among veterans there.

But much like in the civilian world, there is no one-size-fits-all standard of care for veterans. Veterans should be afforded flexibility to use the benefits they righteously earned and that best suits their own individual needs. H.R. 5693, the Long-Term Care Veterans Choice Act, gives much-needed choice and personal dignity back to these brave men and women who have selflessly sacrificed for our Nation.

I look forward to the support of my colleagues on this bill.

Mr. Chairman, Madam Ranking Member, thank you for allowing me to speak on this bill, and I yield the balance of my time.

[THE PREPARED STATEMENT OF CLAY HIGGINS APPEARS IN THE APPENDIX]

Mr. DUNN. Thank you very much, Representative Higgins.

I now recognize former U.S. Marine Representative Mike Bost from Illinois for 5 minutes.

STATEMENT OF THE HONORABLE MIKE BOST

Mr. BOST. Thank you, Chairman Dunn and Ranking Member Brownley, for providing me the opportunity to testify before the Subcommittee on Health on my legislation, H.R. 5864, the VA Hospitals Establishing Leadership Performance Act, or VA HELP Act.

The mission of the Department of Veterans Affairs is to care for those who shall have borne the battle. When our heroes transition from the military they deserve to have access to quality health care and service.

Unfortunately, the VA continues to fall short on that promise due in part to failures in human resource management and operations. VA's internal assessment and those by the Government Accountability Office and VA inspector general have identified serious human capital challenges and weaknesses within the VHA's human resources operations.

Most recently, we all heard about the inadequate staffing and human resources management deficiencies that contributed to the failures at the Washington, D.C., VA Medical Center.

This issue hits very close to home for me after the VA National Center for Patient Safety surveyed the Marion VA Medical Center. The Marion VA's Patient Safety Culture Survey showed a considerable decline in key factors, such as communications between management and staff and the frequency of reporting problems to management.

During the site visit, multiple employees raised concerns about poor management and poor communications, distrust between leadership and management, and the lack of accountability.

These factors helped measure the culture at the VA facility, and it was clear that the employees were unsatisfied with their work environment.

Following this report, General Bergman and I sent a letter to then-Secretary Shulkin requesting that the VA further investigate this matter. The effort was followed up by an Oversight and Inves-

tigations Subcommittee staff visit to the Marion VA Medical Center in order to get a firsthand look at the issues at the facility.

A report of the Subcommittee's findings confirmed a lack of accountability, improper communication, and a lack of standards to measure the success of the H.R. department. We also learned that there are limited education qualifications required to be chief of human resources in the VA.

I do not know of any health system that has a chief of HR without a college degree overseeing thousands of employees and responsible for negotiating job offers and proposing disciplinary action. I also do not know of any health care system that would hire or promote an individual to manage and oversee a human resources department without requiring a college degree.

During my time on the Committee, I have seen that it is common in the VA to move problem employees into higher-level jobs, with greater responsibility, without assessing their prior leadership experience and performance.

Unfortunately, despite the Subcommittee's findings and several efforts to encourage the VA headquarters leadership to address these problems, limited actions have been taken. My office continues to receive complaints about the mistrust of the medical center leadership, confusion and inconsistencies in its disciplinary process, and failures to track employee performances and outcomes.

Human resources management is a critical part of delivering quality health care. HR is responsible for recruiting and retaining highly qualified personnel and professionals, and the current status quo within the VHA's HR offices cannot continue.

H.R. 5864, the VA HELP Act, will ensure that the VA addresses deficiencies within its human resources department by giving it the ability to compare the performance of the departments across the VHA and to measure their successes.

This straightforward legislation instructs the Secretary of the VA to establish qualifications for human resources positions within the Veterans Health Administration. It also requires the VA to establish standardized performance metrics for human resources positions.

These commonsense reforms will ensure that the human resources departments at the VA medical centers are operating on a uniform standard and that it is clear who qualifies to hold such important positions.

In closing, I would like to thank Representative Sinema for her helping to introduce this legislation, and would like to thank you, Mr. Chairman and Ranking Member Brownley, for allowing me to testify before the Subcommittee. I hope that we can work together on H.R. 5864 to ensure that our Nation's veterans are being provided for with the best possible care from our VA employees.

And with that, Mr. Chairman, I yield back.

[THE PREPARED STATEMENT OF MIKE BOST APPEARS IN THE APPENDIX]

Mr. DUNN. Thank you, Representative Bost.

I now recognize for 5 minutes Congresswoman Jenniffer Gonzalez-Colon.

STATEMENT OF THE HONORABLE JENNIFFER GONZELEZ-COLON

Miss GONZALEZ-COLON. Thank you, Chairman Dunn and Ranking Member Brownley, for having this hearing today, and all Members here. And thank you for including H.R. 5938, the Veterans Serving Veterans Act, as part of the agenda for this afternoon.

As previously stated on several occasions before this Committee, the Department of Veterans Affairs suffers chronic staffing challenges that complicate the delivery of proper and timely care. These challenges are often exacerbated by a time-consuming hiring process.

The VA facilities within my district are no exception to that. As a matter of fact, this issue never fails to come up during meetings with veterans in Puerto Rico.

Therefore, as an effort to identify a remedial option, my bill seeks to amendment Section 208 of the Choice and Quality Employment Act of 2017 to include military occupational specialties of soon-to-be-discharged servicemembers that correspond to vacant positions in the VA in the recruiting database, as well as servicemembers' contact information and the date of discharge.

Employment after separating from the military is beneficial for veterans from a psychological and financial perspective.

My bill would require the VA to first coordinate with the Department of Defense to identify soon-to-be-separated servicemembers with military occupational specialties needed by Veterans Affairs and obtain their date of separation and basic contact information.

Second, to maintain a database searchable by VA personnel for purposes of hiring soon-to-be-separated servicemembers.

And third, implement direct hiring and appointment procedures for vacant positions listed on the database for servicemembers who apply for these positions.

Another objective of this bill will require the VA to implement a program to train and certify former DoD health care technicians as intermediate care technicians, or ICTs, and to address the large demand for health care providers at the Veterans Health Administration.

Currently, these very skilled technicians, trained by the Department of Defense at significant taxpayer expense, have difficulty gaining employment in their field after separating from the Armed Forces due to the lack of a certification. At the same time, the Veterans Health Administration has significant shortages of providers.

VHA instituted the Intermediate Care Technician Pilot Program in 2013 to train and utilize ICTs at the VA facilities in a variety of roles. The program has since then received remarkable satisfaction rates and helped fill a void of medical providers.

Implementing a program to train and certify eligible veterans to work as ICTs will help formalize the process, as well as provide for continued program support and expansion, ensure rigor in curriculum development, competency assessment, program monitoring, and allow the pool of eligible ICTs to continue growing to meet veterans' health care needs.

Mr. Chairman and Members of this Committee, it is important to keep in mind that servicemembers are a remarkable asset upon transitioning from military service. This bill seeks to further close

the gap between transitioning members and the VA by helping them occupy positions currently in demand and provides an opportunity for greater access to medical care. Moreover, it allows for veterans to be cared for by fellow veterans in ways that are most needed by the VA.

As a former State legislator in Puerto Rico, I am aware that no bill is set in stone, and legislation is often the product of several reviews and revisions, and I look forward to receiving the feedback of this panel and welcome any comments or suggestions on ways that we can move this forward. But I want to thank the people from the American Legion and the Disabled American Veterans and the Military Officers Association of America for their support for this bill.

With that, I yield the balance of my time.

[THE PREPARED STATEMENT OF JENNIFFER GONZALEZ-COLON APPEARS IN THE APPENDIX]

Mr. DUNN. Thank you, Representative Gonzalez-Colon.

I will now recognize former United States Air Force veteran Representative Jeff Denham from California for 5 minutes.

You are recognized.

STATEMENT OF THE HONORABLE JEFF DENHAM

Mr. DENHAM. Thank you, Mr. Chairman. It is good to be back with the Committee that I spent a number of years on, as well, fighting for America's veterans. Thank you for this opportunity to speak on H.R. 5974, the VA COST SAVINGS Enhancement Act. I introduced this bipartisan bill to improve care for our veterans and ensure we are using the latest cost-saving technology.

Specifically, this deals with VA medical waste in facilities across the entire country, resulting in huge savings within the next 5 years. System-wide, this will save the VA millions of dollars each year and directly improve safety and health care for our veterans.

The medical waste, known as red bag or biohazardous waste, is infectious waste produced at VA facilities and hospitals. Since this waste is contaminated by bloody and bodily fluids it poses a risk of transmitting an infection and has to be handled in a special way.

If a VA facility was doing this on-site sterilization through these large machines, this waste can be not only disinfected immediately, but also avoiding costly off-site movements. Meaning that this waste, which can't be compacted, fills trucks very, very quickly, ends up with a lot of trucks on the road. And as we have seen from other national disasters, this infectious waste could end up in the wrong areas within our community.

So handling it on-site is not only a huge cost savings, but handling it on-site is also much safer for our veterans, as well as the communities that this would normally be trucked through.

On the cost side, currently technologies can treat waste for 7 to 9 cents per pound compared to 30 to 60 cents off-site. So again, we are wasting millions of dollars each year shipping this infectious waste around the country. This bill stops that.

The VA recognizes the benefits of this technology, and approximately 20 percent of the VA facilities already have these machines on-site, but, unfortunately, they have been very slow in expanding these across the country.

In 2016 the MilCon-VA appropriations bill acknowledged the huge cost savings, as well as the beneficial environmental impacts and the energy savings associated with on-site medical waste treatment. The VA developed a blanket purchase agreement to streamline the purchasing of these machines, but, unfortunately, again implementation has been very slow.

It is time to realize the full benefits of this technology and bring the VA into the 21st century. Our veterans deserve the highest quality of care we can provide. And this technology improves the crisis readiness and is safer, more efficient, more cost effective and environmentally friendly than traditional medical waste disposal.

Installing these machines immediately can begin the savings of millions of dollars for the VA and directly improve our care for our veterans.

I urge my colleagues to support this policy.

[THE PREPARED STATEMENT OF JEFF DENHAM APPEARS IN THE APPENDIX]

Mr. DUNN. Thank you very much, Representative Denham.

Once again, I thank all of you for being here and for sponsoring these bills on our agenda this afternoon. The first panel is now excused. I will pause while the members of the second panel settle themselves here at the table.

Mr. DUNN. I will now welcome the second panel to the witness table. Joining us on the second panel is first Mr. Roscoe Butler, the deputy director for health care, veterans affairs and rehabilitation for the American Legion; Jeremy Villanueva, the associate national legislative director for Disabled American Veterans; Kayda Keleher, the associate director for national legislative service for the Veterans of Foreign Wars of the United States; and Ms. Jessica Bonjorni, acting assistant deputy Under Secretary for health for workforce services for the Veterans Health Administration of the U.S. Department of Veterans Affairs. And joining Ms. Bonjorni is Dayna Cooper, the director of home and community-based programs for the Veterans Health Administration.

We will begin this afternoon with Mr. Butler.

You are now recognized for 5 minutes.

STATEMENT OF ROSCOE BUTLER

Mr. BUTLER. Thank you.

According to a March 2017 study commissioned by the Association of American Medical Colleges, there will be a shortage of more than 100,000 doctors by 2030. According to a September 2017 VA OIG report, the largest staffing shortages in the Veterans Health Administration were medical officers, nurses, psychologists, physician assistants, and medical technologists.

Many of the bills being discussed today are designed to address the VHA staffing crisis, and the American Legion thanks this Subcommittee for holding this important hearing.

Good afternoon, Chairman Dunn, Ranking Member Brownley, and distinguished Members of the Subcommittee on Health. On behalf of the national commander, Denise H. Rohan, and the American Legion, the country's largest patriotic wartime veterans service organization, comprising over two million members and serving

every man and woman who has worn the uniform for this country, we thank you for the opportunity to testify on behalf of the American Legion's position on the following pending and draft legislation.

H.R. 2787, the Veterans-Specific Education for Tomorrow's Medical Doctors Act. This bill will establish a pilot clinical observation program within the Department of Veterans Affairs for premed students preparing to attend medical school.

The American Legion is deeply troubled by staffing shortages within the Department of Veterans Affairs, particularly within the Veterans Health Administration, and has consistently voiced concerns since the inception of our System Worth Saving Program in 2003.

The American Legion has identified and reported staffing shortages at every VA medical center and reported these critical deficiencies to Congress, VA's central office, and the President of the United States. The American Legion believes this bill will make a difference and supports H.R. 2787.

H.R. 3696, the Wounded Warrior Workforce Enhancement Act. The American Legion believes, due to the shortage of physicians in critical specialized areas, such as orthotics and prosthetics, Congress must ensure resources and funding are available to support continuing education and training of such physicians.

We know as the number of veterans needing orthotics and prosthetic services increases there will be a continuing need for clinicians at the master's degree level to meet this increasing demand. For this reason, the American Legion supports H.R. 3696.

H.R. 5521, the VA Hiring Enhancement Act. The American Legion has long expressed concerns about staffing shortages at Department of Veterans Affairs Veterans Health Administration medical facilities, to include physicians and medical specialist staffing.

We, the American Legion, believe the VA Hiring Enhancement Act will help ensure when a qualified physician who is an applicant for an appointment to a position in the Veterans Health Administration has entered into a covenant not to compete with a non-department facility, the individual will not be barred from accepting an appointment to a position in the Veterans Health Administration.

The American Legion believes enforcing noncompete agreements to VA hires is overly broad and should be unenforceable under public policy. Traditional reasons behind noncompete agreements to bar competitive advantages to protect sensitive information simply do not exist in this context. For this reason, the American Legion supports 5521.

The American Legion also supports H.R. 5693, the Long-Term Care Veterans Choice Act, and H.R. 5938, the Veterans Serving Veterans Act of 2018.

However, the American Legion does not have an official position on H.R. 5864; the VA COST SAVINGS Enhancement Act; and the draft bill to improve the productivity of the management of Department of Veterans Affairs health care, and for other purposes.

In conclusion, the American Legion thanks this Subcommittee for the opportunity to voice the position of the over two million veteran

members of this organization, and I am available to answer any questions that you and the Subcommittee may have.

[THE PREPARED STATEMENT OF ROSCOE BUTLER APPEARS IN THE APPENDIX]

Mr. DUNN. Thank you very much, Mr. Butler.

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

STATEMENT OF JEREMY VILLANUEVA

Mr. VILLANUEVA. Thank you. Chairman Dunn, Ranking Member Brownley, and Members of the Subcommittee, thank you for inviting DAV to testify at this legislative hearing of the Subcommittee on Health.

DAV, a nonprofit veterans service organization comprised of over one million wartime service-disabled veterans, is dedicated to a single purpose: empowering veterans to lead high quality lives with respect and dignity. As a service-disabled veteran myself and one who uses the VA health care system, I am pleased to be here to present DAV's views on the bills under consideration by the Subcommittee.

H.R. 5521, the VA Hiring Enhancement Act, would render noncompete agreements between an applicant for VA employment and a previous employer nonapplicable with regard to VA employment. Employees appointed with this understanding would be required to serve at least 1 year in their position or the remainder of their noncompete agreement, whichever is longer.

The bill would also authorize VA to hire on a contingency basis physicians completing residencies not later than 2 years after appointment. If the contingent employee has not satisfied VA requirements for the position in that time, that individual will not be appointed to the position.

DAV supports efforts to recruit, retain, and develop a skilled clinical workforce to need the needs of veterans. We thereby share the goal of this legislation in creating as large as possible an applicant pool for qualified medical professionals to treat our service-disabled veterans in the VA.

DAV Resolution No. 228 calls for effective recruitment, retention, and development of the VA health care workforce. Because this measure attempts to reduce barriers for the VA to hire physicians, we support the intent of this bill.

We thank the Subcommittee for considering H.R. 5693, the Long-Term Care Veterans Choice Act, that would improve VA's medical foster home program.

Medical foster homes enable those veterans with serious chronic conditions that meet nursing home level of care to remain in a residential environment instead of being institutionalized. Participation in this program is voluntary, and veteran residents have reported very high satisfaction ratings.

Currently, veterans who wish to reside in a medical foster home but are unable to pay the approximately $1,500 to $3,000 per month are not able to utilize this program, so many are placed in nursing homes at much greater cost to the VA. Moreover, VA would pay more than twice as much for nursing home care than

if the VA was granted this bill's proposed authority to pay for VA medical foster homes.

Mr. Chairman, we must be fully cognizant of our aging veteran population's need for programs such as this. DAV's Resolution No. 227 calls for legislation that increases access and improves long-term services and supports for service-connected disabled veterans.

To allow a veteran to stay in their community while receiving the best quality of care and maintaining a semblance of independence would in some small way show this Nation's gratitude to those who have sacrificed for it. DAV strongly supports this legislation and calls for swift passage.

H.R. 5864, the VA Hospitals Establishing Leadership Performance Act, would establish qualifications for each human resource position with the VHA, establish standardized performance metrics for each such position, and submit to Congress a report that details the actions taken.

The VA has long needed improvement in the performance of their human resources staff. This has been noted by organizations such as the Commission on Care and the GAO. Each organization has indicated that administration-wide improvement requires systemic changes that would fundamentally alter the operations, leadership, and guidance of the current human capital management system.

We believe that H.R. 5864 offers a good starting point for the fundamental overhaul of VA's human capital management system, but it is only a start. VA also needs to look at streamlining and simplifying its recruitment and hiring practices. It needs to look at different programs and practices for staff retention, development, employment benefits, and performance management to maximize employee engagement.

Most importantly, human capital management reform will require a long-term commitment from VA's leadership and Congress. However, the intent of H.R. 5864 will likely not be fully realized if VA is incapable of hiring or developing the human talent necessary to fill these positions.

DAV supports this legislation, in accordance with DAV Resolution No. 228, which calls for a simple-to-administer alternative VHA personnel system in law and regulation which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector; and Resolution No. 221, which supports VA's use of meaningful and clearly articulated measures to gauge employees' performance.

Mr. Chairman, this concludes my testimony, and I would be pleased to address any questions related to the bills discussed today.

[THE PREPARED STATEMENT OF JEREMY VILLANUEVA APPEARS IN THE APPENDIX]

Mr. DUNN. Thank you, Mr. Villanueva.

Ms. Keleher, you are now recognized for 5 minutes.

STATEMENT OF KAYDA KELEHER

Ms. KELEHER. Chairman Dunn, Ranking Member Brownley, and Members of the Subcommittee, it is my honor to represent the women and men of the VFW and our Auxiliary.

The VFW agrees with the intent of the Wounded Warrior Workforce Enhancement Act, but it has some serious concerns which prevent our organization from providing support at this time.

One of VA's four statutory missions is to educate and train health professionals to enhance the quality of care provided to patients within VA. VA accomplishes this through coordinated programs and partnerships with affiliated academic institutions.

Section 2 of this legislation would require VA to provide grants to orthotics and prosthetics graduate programs which are accredited by the National Commission on Orthopedic and Prosthetic Education in cooperation with the Commission on Accreditation of Allied Health Education Programs. These grants would be eligible for use at the selected institutions to expand sites, build infrastructure, supplement salaries, provide financial aid, or purchase equipment.

While providing this in such ways, these grants could be of value to VA and VA patients, but the VFW does not believe this legislation would be of value in the way it is currently written. This is because the grants may be paid to institutions without any tie to VA.

Priority for grant recipients would go to institutions partnered with VA, but is not a requirement. For institutions applying for the program they must show a willingness to participate with VA, but, again, they are not required to actually participate.

The VFW believes for these institutions to receive these grants they must agree to some level of partnership and participation with VA.

Section 3 of this legislation would provide a larger grant to one institution to become a center of excellence for orthotics and prosthetics. VA and DoD already have these facilities, which provide those best practices to veterans. This grant would also not require any form of partnership or participation from these institutions with VA.

The VFW cannot justify outsourcing valuable VA resources to bolster a non- VA entity that would not benefit veterans.

The VFW is pleased the VA Hiring Enhancement Act would remove noncompete contracts for providers who want to work for VA and supports removing this barrier to employment, though the VFW cannot support the remaining provisions within Section 3, which would limit VA's hiring pool for health care providers as well as duplicate current law providing VA the authority to make job offers to current residents.

We are all aware that VA currently has 38,000 job vacancies. These vacancies must be significantly reduced before the VFW feels more restrictions may be put upon VA regarding who the agency may hire. To address quality of care, which VFW members prefer from VA, we must address access to care.

The VFW agrees with the intent of the Veterans Serving Veterans Act of 2018, but has concerns with the legislation as it is currently written.

This legislation would establish a database worked on by DoD and VA, and this technology would withhold information of individuals currently serving in the military with job positions which are needed within VA.

Servicemembers wanting to opt out of this database and having their personally identifiable information shared with an array of VA employees would be required to submit a letter. This database would then be used by VA to recruit potential employees for DoD before they exit from service.

Aside from our concerns over the access to this personal information, the VFW believes these servicemembers should have to opt into the database, and that they would also still be subjected to experiencing bureaucratic difficulties while switching from DoD to VA.

The VFW agrees that DoD and VA need to work together to identify medical professionals currently serving who are interested in coming over to VA and that these individuals need to have their credentials streamlined so that the day they receive their DD 214 in hand they can walk into their new office at VA.

The VFW agrees with the intent of the draft legislation to improve productivity of the management of VA health care, but has some concerns with it as currently written.

RVUs are used as a national standard for determining budget expenses, cost benchmarks, and productivity within the private sector. They are primarily used in the private sector to determine provider payments, something that is not an issue for VA providers on a government salary.

The VFW believes there is a value to tracking RVUs within VA, and our organization also believes that as funding increased, and hopefully continues to increase, that the RVUs would show an increase in productivity.

With that said, the private sector is not required to publicly report most data that VA is required to publicly report, and that includes RVUs. While this legislation would take into account nonclinical duties, the VFW is concerned about more double standards possibly being held to VA.

Chairman Dunn, Ranking Member Brownley, and Members of the Subcommittee, this concludes my testimony. Thank you again for the opportunity to represent the Nation's largest combat veteran's organization, and I look forward to taking your questions.

[THE PREPARED STATEMENT OF KAYDA KELEHER APPEARS IN THE APPENDIX]

Mr. DUNN. Thank you, Ms. Keleher.

Ms. Bonjorni, you are now recognized for 5 minutes.

STATEMENT OF JESSICA BONJORNI

Ms. BONJORNI. Good afternoon, Chairman Dunn, Ranking Member Brownley, and Members of the Subcommittee. I am accompanied today by Ms. Dayna Cooper, director of home and community care from the Office of Geriatrics and Extended Care. We appreciate the opportunity to discuss VA's views on pending health care legislation, much of which is aimed at bolstering VA's critical workforce management programs.

There is one bill, the draft VA COST SAVINGS Enhancement Act, for which we are unable to provide views at this time because it came late to the agenda, but we will follow up with the Committee as soon as possible.

Chairman Dunn, we appreciate the Committee's focus on the topic of human resources as a key to filling the Department's mission of serving veterans. We are grateful for the human capital authorities extended to the VA in the recently passed VA MISSION Act and in last year's VA Choice and Quality Employment Act.

As just one example of how those new laws have helped VA, we have recently developed a joint program with the Department of Defense called the Military Transition and Training Advancement Course, which is an entry-level program that allows transitioning servicemembers to be trained in occupations before they separate and then make a seamless transition into the VA. We are trying this right now in the national capital region.

In the interest of being brief, I will highlight a few points regarding the bills on the agenda today, and of course our written testimony provides further details.

VA supports the intent of H.R. 2787, the VET MD Act, to develop a clinical observation pilot program within VA for premedical undergraduate students to shadow physicians. However, we do note in our testimony concerns about high unfunded costs, implementation challenges, and suggestions for improvements.

VA continues to recommend providing clinical observation opportunities for all pre-health occupation students, rather than focusing exclusively on premedical students. In addition, VA recommends including both undergraduate and postbaccalaureate students, since these students have displayed interest in pursuing health careers.

We would be glad to discuss further with the Committee how we believe the bill can be improved.

H.R. 3696, the Wounded Warrior Workforce Enhancement Act, calls for establishing a new or expanding existing prosthetic or orthopedic graduate programs and the establishment of one prosthetic/orthotic research center of excellence.

VA does not support this bill because we believe VA already fulfills the intent, using interdisciplinary teams that provide rehabilitation services to veterans' unique needs. VA offers these in-house services at 84 laboratories across VA. In addition, VA contracts with more than 600 specialized vendors.

Through both in-house staffing and contractual arrangements, VA is able to provide state-of-the-art, commercially available items ranging from advanced myoelectric prosthetic arms to specific custom-fitted orthoses.

H.R. 5521, the VA Hiring Enhancement Act, would give VA additional tools in the hiring of title 38 employees, and in particular physicians.

Noncomplete clauses often prevent VA from freely hiring physicians from the local medical community. Exempting VA from these restrictive and nonapplicable covenants would prove beneficial. VA would hope to restrict this section to physicians hired under 7401(1) of this title.

Section 3 of the bill would permit VHA to make a contingent appointment as a VHA physician on the basis of a physician completing their physician residency training. VA endorses Sections 1 and 2 of this bill, however, has concerns with Section 3 and requests the opportunity to discuss with the Committee.

We appreciate the vision and compassion outlined in H.R. 5693, the Long-Term Care Veterans Choice Act, which will help VA meet the escalating demand for nursing home care, which is projected to double over the next decade for Priority 1A veterans, while also providing veterans a choice.

VA covers 100 percent of their nursing home costs. However, if these veterans with highly service-connected conditions would prefer to receive their care in a VA medical foster home they must pay out of pocket at an average cost of $2,400 per month because VA does not currently have the authority to pay.

This bill will help VA meet this increasing demand for nursing home care by offering the option of a VA-approved medical foster home while simultaneously reducing the need to build more nursing homes or double VA's nursing home expenditures.

H.R. 5864, VA HELP Act, proposes to standardize qualification requirements and performance metrics for human resources positions.

VA does not support the intent of this bill, but does support efforts to professionalize the H.R. function throughout government.

Creating VA-specific standards would negatively impact VA's ability to retain current staff or recruit H.R. professionals from other Federal agencies. VA is currently developing standardized performance metrics for HR specialists to be implemented in fiscal year 2019.

If a decision is made to proceed with the bill, VA requests the opportunity to meet with the Committee to propose revisions of language to address our concerns.

Regarding the draft Veterans Serving Veterans Act of 2018, VA supports the intent of this bill. However, we believe VA is able to accomplish the content of this bill with existing authorities.

Efforts are already underway to target transitioning military members for mission-critical and difficult-to-fill positions by using data contained in a VADIR database that already exists. The resource has resulted in a recruitment pipeline that will now allow VA to reach out directly to transitioning servicemembers.

Finally, the draft bill to improve the productivity of VA health care calls for VA to track relative value unit production standards and includes other associated requirements.

VA does not support the bill as we already track RVUs for licensed independent providers, and performance standards and productivity targets are established with annual reviews currently in place at a minimum.

VA has significant concerns about the mandatory training required in the bill, which would take providers away from providing direct patient care. VA would like to discuss this bill with the Committee.

Mr. Chairman, this concludes my testimony. My colleagues and I are prepared to answer questions.

[THE PREPARED STATEMENT OF JESSICA BONJORNI APPEARS IN THE APPENDIX]

Mr. DUNN. Thank you, Ms. Bonjorni.

And I thank the entire panel for being here. We will move to the questioning portion of the panel now.

I do want to make mention that votes may have been moved up, maybe as early as 4:15, so I am going ask the Members of the panel to make their questions succinct to give the panel witnesses maximum time to answer. And I am also going to ask the witnesses on the panel to try to be concise in your answers so that we can get as many questions in as we possibly can.

I now yield myself 5 minutes.

I will start with Ms. Bonjorni and Ms. Cooper. Many of the bills on today's agenda have financial scores that will require offsets before they can potentially move to the floor. Will you commit to working with the Subcommittee to find offsets within our jurisdiction for the proposals that you support?

Ms. BONJORNI. Yes, we will.

Mr. DUNN. Excellent.

Again, Ms. Bonjorni, when do you expect to have a cost estimate for H.R. 5521, the VA Hiring Enhancement Act, available for us to look at?

Ms. BONJORNI. I believe we will be able to have that within the next 2 weeks, if not sooner.

Mr. DUNN. Okay. Excellent. We will be looking for that.

Ms. Bonjorni, your opposition to Section 3, H.R. 5521, the Hiring Enhancement Act, is based on the fact that you think the VA already has rules requiring completion of residency. The wording of that is such that it is residency or its equivalent. What is the equivalent to completion of a residency in VA standards?

Ms. BONJORNI. The equivalent is something that is determined by the professional standards board to have met the intention of a residency program. It is extremely rare for us to hire people who have not gone through a residency program.

Mr. DUNN. Would not it be more transparent and easier to simply require the staff physician, in order to be a staff physician in a VA facility, you have to complete residency training, just say that outright?

Ms. BONJORNI. It may be.

Mr. DUNN. All right. We think it might be, too.

Ms. Keleher, your opposition to Section 3, H.R. 5521, was that you thought it might be duplicative of current law. We looked at that same law. We thought that it did not apply to physicians, but rather other professionals in the VA. Do you interpret that law differently than we do?

Ms. KELEHER. Yes, Mr. Chairman, we do.

Mr. DUNN. You feel pretty confident in that?

Ms. KELEHER. Yes, sir.

Mr. DUNN. All right. Well, let's talk about that.

Ms. Bonjorni, how many more veterans do you think would elect to receive—let me change the order of these questions.

How many of the veterans currently in medical foster homes would otherwise be entitled to VA-paid nursing home care?

Ms. BONJORNI. I am going to defer that question to Ms. Cooper.

Mr. DUNN. Excellent.

Ms. COOPER. Currently, there are just under 300 veterans in medical foster homes that are paying for their care that would be eligible to receive the payment under this bill. There are approximately 15,000 Priority 1A veterans that are receiving care in a nursing home. We anticipate that there would be approximately 5,000 of those that would down the road be choosing a medical foster home.

Mr. DUNN. So you anticipate a future demand of approximately 5,000 veterans—

Ms. COOPER. Based on our current—

Mr. DUNN [continued].—if we were to open this up?

Ms. COOPER. Correct.

Mr. DUNN. All right. Well, that answered my next question.

And I think I will be careful with the Committee's time, and I will yield now to Ms. Brownley, the Ranking Member.

Ms. BROWNLEY. Thank you, Mr. Chairman.

I wanted to talk a little bit about H.R. 6066.

So, Mr. Villanueva, could you talk to me a little bit about—I know you have already said something about this particular bill—but with regards to how your membership feels and sort of trying to outline for the Committee some of the differences between VA delivery of health care and productivity and private providers?

Mr. VILLANUEVA. Thank you for that.

Ms. BROWNLEY. This is the RFUs measurement for productivity.

Mr. VILLANUEVA. Right, right. And thank you for that question. It is indeed my pleasure to answer that.

Essentially, we don't have a position on this bill as of yet. We do believe that there are still some clarifications that need to be made, specifically what exactly these RVUs would be used for, how they would receive them from the private care community, and how they would be comparing them.

Because we do believe that with the VA being a capitation system and the private care community not, that it would be essentially, like I believe one of my colleagues at this table has said, be tantamount to comparing apples to oranges.

Ms. BROWNLEY. And, Ms. Keleher, do you have any comments relative—

Ms. KELEHER. Yes, thank you.

As my colleague next to me has stated, we do have concerns with the apples-to-oranges comparison. I think everybody has kind of beat it over the head here with VA, and their productivity varies compared to the private sector not just based on income, but also on quality of care.

VFW has conducted multiple, multiple surveys in recent years and we get consistent feedback from our members.

Some quotes. We have a World War II veteran from Florida who said, "VA doctors listen to me and take time to explain the answers to my questions." Or we have others who say, "They treat me like a hero and give me the time that I actually need." That was a Vietnam veteran.

With that said, the number three problem that our members say they face when using non-VA care is actually timeliness, and they

feel rushed with their providers. So we don't want that to be an unintended negative outcome.

Ms. BROWNLEY. I think in some way we are going to have to figure out how to measure productivity, but also putting a value on the fact that doctors, medical professionals within the VA spend time with veterans to answer their questions. We are asking more and more for doctors to screen for various other things that they might not have an appointment for.

And I think we place a value on that. But somehow understanding that we are placing a value on that, but also being able to properly measure our efficiencies and productivities as well. So somehow, some way, we are going to have to figure that one out.

Mr. Higgins, by the way, I like your bill. I think it is a good bill.

Mr. HIGGINS. Thank you, ma'am.

Ms. BROWNLEY. And to Mr. Butler, so is this a bill that is important to your membership? And I think it is, but if you would express to us why.

Mr. BUTLER. The medical foster home?

Ms. BROWNLEY. Yes.

Mr. BUTLER. Currently right now VA is not eligible to pay for care for veterans. They just refer veterans to a foster home. So any veteran who is eligible for nursing home care, this bill gives VA the authority to pay for their care in medical foster homes, which could result in a significant cost savings to the VA and the government.

So we fully support the bill because we believe that any money saved is a benefit to our Nation's veterans and the American taxpayer.

Ms. BROWNLEY. And this is for any of the VSOs. Do you feel an increased demand for a program like this amongst your veterans?

Ms. KELEHER. I personally have not heard specifically from VFW members, but as—

Ms. BROWNLEY. Do you think they know about the program?

Ms. KELEHER. Personally, probably not, but I do hope they do.

As we see the population of veterans continuously age, I think we can all agree that we are going to see them not only knowing the program more and more, but requiring it as well. And I would assume that the quality outcomes are much better than putting them in an institutionalized setting.

Ms. BROWNLEY. Anybody else have a comment?

No?

With that, I will yield back.

Mr. DUNN. Thank you very much, Representative Brownley.

We now recognize Congressman Higgins for 5 minutes.

Mr. HIGGINS. Thank you, Mr. Chairman.

Ms. Bonjorni, thank you for your service to your country, madam.

Do you see my bill, 5693, as a net win for America and America's veterans?

Ms. BONJORNI. Yes. Thank you for the question, sir.

Mr. HIGGINS. That is the short answer. We can stop there. Mr. Chairman, I yield back. I yield the balance of my time. America wins. Veterans win, baby. That is why we are here, right?

Mr. DUNN. Well, I thank you, Congressman Higgins. Let me say that, as a veteran, when you retire and you need care, I will give you care in my own home. How is that?

We now recognize Representative Kuster for 5 minutes. Thank you.

Ms. KUSTER. Thank you very much, Mr. Chairman.

And thank you to our panel and to all of our colleagues introducing these bills. This is a great array of bills. And I particularly appreciate the help from the VSOs and from the VA as we sort them out.

I want to start by focusing my attention on Dr. Wenstrup's bill, because we had a roundtable this morning with Dr. Roe. We were talking about the issue of general medical education and increasing the number of physicians being trained at the VA going forward. And we were talking about what I would consider to be unintended consequences of Dr. Wenstrup's concept about measuring these RVUs as they are measured in the public domain, in the public—I am sorry, in private medicine—and trying to compare that to the VA.

And in particular, I think the VFW testimony talked about there is value in tracking, but you have to be careful because of the nonclinical burdens on VA health care providers.

In particular, could you comment—and to the VFW, but if anyone else wants to comment—on the obligation of supervising medical training? And so, for example, during residency, Dr. Roe talked at length about the amount of time that that takes and that you are not as efficient when you are doing that.

Could you comment on that? And also the specifics about other elements that are different. For example, the physical facilities, you don't have the same ratio of rooms for medical appointments that you do in the private sector. You don't have the same ratio of support staff that you do in the private sector. How do these factors change the equation from trying to compare apples to apples with RVUs?

Ms. KELEHER. Thank you for the question. I will try to go in order of the way that you did ask.

In regard to training, VA does provide ample training to America's providers, whether they end up at VA or not. And that is clearly very time consuming.

I use VA for all of my health care. And I have had many times where my provider asks before the appointment if it is okay if they have new residents come in, because they are going through and explaining things more by process. There are chances that the resident is not going to be as understanding of things.

So that is a clearly very timely constraint on VA. And if they are taking in more residents and doing more training than in the private sector, that would be one great example of how the RVUs could have a negative comparison.

VA also does a lot of research. They don't, as you said, have all of the staff that in the private sector they may. And the Subcommittee and the Committee at large have been wonderful at trying to address those needs within VA. We are just a little off still on the timing.

We do believe that the RVUs could provide great outcomes. We do think that you are going to see the productivity continuously increasing for VA.

But we are concerned about the way that will be used. Is that going to be used for appropriation purposes? Are we going to have a journalist pick it up and want to do another big article about VA being less proficient, maybe, than the private sector, when the private sector isn't publicly making that data available simply because they don't have to, so why would they?

So it is something that we definitely are interested in continuing to talk about with the Committee.

Ms. KUSTER. Thank you very much.

And I do want to say on the record, I am all for efficiency and would like to have further conversations about that.

I do want to make sure to get on the record that I support Mr. Denham's bill with regard to medical waste. I am a cosponsor of that bill. And just experience that I have on the private sector with disposal of medical waste, I would like to work with you all going forward to pass that bill.

And then, my time is very limited, but I did have a quick question on—if I can get it in. I may have to take it for the record. But this was on the whole issue about—I am sorry, excuse me—the performance. But my time is up, so I will come back another round. Thank you.

Mr. DUNN. Thank you, Representative Kuster.

I will now recognize Congresswoman Gonzalez-Colon for 5 minutes.

Miss GONZALEZ-COLON. Thank you, Mr. Chairman.

I will go directly with Ms. Bonjorni.

First of all, I want to say that I do support Mr. Higgins' bill. I don't know if you could so you can have both.

Anyway, you say that you have underway some of the proposal of the bills under the Veterans Administration. I want to know how many of those veterans or servicemembers were not working anymore at the Armed Forces have already been hired at the Veterans Administration. Do we have a rate?

Ms. BONJORNI. How many veterans are we hiring?

Miss GONZALEZ-COLON. No, no. You say that you already have the database, you are sharing the information from the Department of Defense with the VA, correct?

Ms. BONJORNI. Yes.

Miss GONZALEZ-COLON. You are having that effort already undergoing.

Ms. BONJORNI. We have just received access to the data, and so our targeted marketing toward specific occupations will be starting by the end of this month.

Miss GONZALEZ-COLON. Okay. So how long will it take for you to make the whole program work? Because you said in your written statement that it will take at least 180 days to make that happen?

Ms. BONJORNI. Yes. So thank you for the question.

I think that in looking at what was actually the initial draft of what is in the current law for the VA Choice and Quality Employment Act, we are right now using our existing personnel database to fulfill that requirement.

The data that we are receiving from DoD is specific to the transitioning servicemembers. Right now that is not linked, the two systems aren't linked. And so we would need some time, if that is

the long-term intent, to link those two sources of information. But right now we are able to go ahead and use the data about the transitioning servicemembers to market.

Miss GONZALEZ-COLON. So it could be less time?

Ms. BONJORNI. Yeah.

Miss GONZALEZ-COLON. Okay. So I like that answer.

And then my second question will be, you are saying that there is intent of the administration to use, not just the Department of Defense data, but using the whole government to make that happen, correct?

Ms. BONJORNI. Could you elaborate on your question?

Miss GONZALEZ-COLON. You said that the administration wants to extend the database portion of the act of government-wide intention to have access to the rest of the government instead of using just the Department of Defense.

Ms. BONJORNI. I am not certain what other—what you are allowing to be authorized.

Miss GONZALEZ-COLON. In your written statement that is the implication, that is what I read in that statement, that the intention was not just the Department of Defense using the database, but extending that to the rest of the government.

Ms. BONJORNI. As a long-term plan.

Miss GONZALEZ-COLON. Exactly.

Ms. BONJORNI. But the VA is not actively pursuing that right now, yes.

Miss GONZALEZ-COLON. But it is on your written statement. So maybe a long-term option is there, right?

Ms. BONJORNI. Yes.

Miss GONZALEZ-COLON. So I do understand that this bill that we just filed could be the best pilot program to have in the public law to be enforced, and you already are having those kind of ideas undergoing, but including—I mean, I think having veterans serving veterans is the first thing. Saving taxpayers money is the second biggest implementation of this bill.

Third, I think having the opportunity to cut the staffing shortages that we have in the VA, the hiring process that is always so difficult. We are facing that problem in Puerto Rico, as a matter of fact.

And, of course, having the certifications for the ICTs that you already have in place with remarkable reviews in so many areas. Why not having that as not just a choice of public policy in between the agency, but as a mandate of Congress?

And that is the reason of this bill, and I do support it. And as you just said in your written statement, I do believe that you are in support of it.

Ms. BONJORNI. Yes, we are in support.

Miss GONZALEZ-COLON. Thank you. I yield back. I will do the same thing that Mr. Higgins did.

Mr. DUNN. Thank you, Representative Gonzalez-Colon.

And we now recognize for 5 minutes Congressman Correa from California.

Mr. CORREA. Mr. Chairman, we will try to make it in 2. How is that?

I just wanted to very quickly say I also support Mr. Higgins' legislation. And wanted to also say that I joined Representative Hartzler in introducing H.R. 5521 to address the issue you are talking about, which is the physician shortage and the ever-increasing physician shortage.

And I know that, Ms. Keleher, I know the VFW has some issues, maybe some concerns. I hope we can work through those issues and make sure they are all on board, because getting good docs into the VA is an important goal. And I hope all of us can work towards that.

With that, Mr. Chairman, I yield the remainder of my time.

Mr. DUNN. You have been very kind with the Committee's time, Congressman Correa. Thank you very much for that.

Votes have been called, so the panel is going to be winding down.

I do want to make the editorial comment that the use of relative value units is not intended to be punitive. It is intended to be a measure of productivity and efficiency. And I think we have to get there somehow. Somehow we have to measure our efficiency given the amount of the people's treasure that has been entrusted to us in this Committee.

With that, I want to thank the panel for the time that you have put in and for coming up here and being willing to see us and talk to us and answer our questions.

The Subcommittee is adjourned.

[Whereupon, at 4:14 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Congresswoman Vicky Hartzler

Chairman Roe, Ranking Member Walz, and distinguished Members of the Committee, thank you for allowing me this time to testify about HR 5521, The VA Hiring Enhancement Act.

Our veterans deserve the best. Unfortunately, top-notch care is often hampered by a shortage of doctors at the VA. I believe that this bill, which I introduced along with Congres7smen Correa and Congressman Bost will help the VA to fill some of these vacancies.

Our bill has three main provisions. First, it would allow physicians to be released from non-compete agreements only for the purpose of serving in the VA for at least one year. Non-compete agreements are supposed to prevent a physician from building up a patient base, and then taking those patients with them as they set up their own practice. A physician moving to the VA simply does not fit that description. This provision would ensure that a non-compete agreement is never used to keep a physician from serving veterans at a VA facility, and only applies to such a circumstance.

Second, our bill updates the minimum training requirements for VA physicians. Completion of a medical residency is widely accepted as standard comprehensive training for clinical physicians in the United States. However, current law only requires that a physician be licensed in order to treat veterans. In the case of some medical specialties, the difference between licensing and completing residency can represent six years of training.

Some have suggested that this provision would exacerbate the shortage of physicians at the VA by shrinking the pool from which the VA can hire. However, the VA currently hires almost exclusively those physicians which have completed residency training, so this provision would not result in such an impact.

Others have rightly submitted that veterans are largely satisfied with the quality of care they receive at the VA. They therefore submit that we do not need to legislate a higher standard. I contend that as long as Congress sees fit to impose any standard on the VA regarding those caring for veterans, we have a duty to ensure that the standard is appropriate. Completion of residency training is the accepted standard in this nation, and we should never expect veterans to accept anything less. This is a common-sense update to something federal law already addresses, and ensures that only fully trained physicians care for those who have served our nation.

Finally, our bill would place veterans' hospitals on a level playing field with the private sector when it comes to recruiting timelines. Often, private sector health care providers begin recruiting medical residents as they begin their final year of residency, sometimes even earlier.

Most residents have school debt they will need to start paying off-an average of $190,000. During residency they treat patients and work upwards of 80 hours a week, sometimes with single shifts up to 28 hours. These residents-rightfully motivated to secure a post-residency job with better pay and better hours-often accept a solid job offer from the private sector before VA recruiters are able to get their recruiting process started.

Our bill authorizes VA recruiters to make job offers to physicians up to 2 years prior to fulfilling all of the VA's requirements, contingent on meeting all requirements before they begin treating veterans. It offers job security to medical residents who want to work at the VA when they complete their training, and allows VA facilities and recruiters to shore up appointments further in advance, helping them to plan and forecast medical workforce needs.

VA recruiters are already pitching a great opportunity for physicians, and we owe them policies that make them as competitive as possible with private sector recruiters. I believe that advancement of this legislation will help begin to fill the VA's many vacant health care positions.

We've worked closely with this Committee's staff, VA recruiters, and VSOs on this bill, and I'm pleased to report that it has garnered wide support, including formal endorsement from the American Legion and Paralyzed Veterans of America. It's my hope we can work together to move this bill to the House floor soon. Thank you again for allowing me this time, I yield back.

Prepared Statement of Congressman Brad Wenstrup

Chairman, Members of the Health Subcommittee, thank you for welcoming me back today.

As a Member of the House Veterans' Affairs Committee for many years, one of my reoccurring frustrations was an inability to use metric-driven standards to comprehensively examine and improve how the VA was using its resources to deliver health care.

An axiom I heard often when I started on the Committee was that "when you've seen one VA, you've seen one VA."

My frustration grew every time I sat where you sit now, and asked VHA's past leadership if they were able to provide metrics on health care delivered per resources expended.

I was often told the numbers existed, but metrics never seemed to materialize.

Reports

In foreshadowing the VA wait list crisis that became evident in 2014, VA's Office of the Inspector General issued a report in 2012, entitled Audit of Physician Staffing Levels for Specialty Care Services, finding that:

"VHA did not have an effective staffing methodology to ensure appropriate staffing levels for specialty care services. Specifically, VHA did not establish productivity standards for all specialties and VA medical facility management did not develop staffing plans. This occurred because there is a lack of agreement within VHA on how to develop a methodology to measure productivity, and current VHA policy does not provide sufficient guidance on developing medical facility staffing plans. As a result, VHA's lack of productivity standards and staffing plans limit the ability of medical facility officials to make informed business decisions on the appropriate number of specialty physicians to meet patient care needs, such as access and quality of care." [1]

The OIG went on to recommend that VHA:

"establish productivity standards for at least five specialty care services by the end of FY 2013 and approve a plan that ensures all specialty care services have productivity standards within 3 years. We also recommended that the Under Secretary provide medical facility management with specific guidance on development and annual review of staffing plans."

Five year later, the VA now tracks productivity metrics across more than 30 specialties, but significant gaps persist in the effectiveness and completeness of the current reporting. This inhibits their ability to optimize resources to better deliver care to our veterans.

Last year, the GAO released a report entitled Improvements Needed in Data and Monitoring of Clinical Productivity and Efficiency [2]. This report found that current VA productivity metrics, including relative value units, are not complete and may not be accurate. Clinical specialties are siloed, certain inpatient work is not measured, and contract providers go unmeasured. Data is not always usefully accessible, and remediation plans do not rise above the VISN level.

This GAO report contained four recommendations:

"1. expand existing productivity metrics to track the productivity of all providers of care to veterans by, for example, including contract physicians who are not VA employees as well as advance practice providers acting as sole providers;

2. help ensure the accuracy of underlying staffing and workload data by, for example, developing training to all providers on coding clinical procedures;

3. develop a policy requiring VAMCs to monitor and improve clinical efficiency through a standard process, such as establishing performance standards based on

[1] https://www.va.gov/oig/pubs/VAOIG–11–01827–36.pdf
[2] https://www.gao.gov/assets/690/684869.pdf

VA's efficiency models and developing a remediation plan for addressing clinical inefficiency; and

4. establish an ongoing process to systematically review VAMCs' remediation plans and ensure that VAMCs and VISNs are successfully implementing remediation plans for addressing low clinical productivity and inefficiency."

H.R. 6066

H.R. 6066 is legislation to tackle these recommendations by tracking relative value units across all providers and providing a more comprehensive and systematic review and reaction to the tracked data.

By more accurately tracking the work all our VA physicians and health care providers conduct, we can better use existing resources to deliver more care to our veterans. The GAO reported just a few examples of how this data can help inform administrators, from reconfiguring appointment scheduling to reprioritizing procedures to ensure the most care possible can be delivered.

In my own career as a health care provider, I know that productivity metrics, such as RVUs, can alert the caregiver that they may be less efficient than they could be. This metric may bring to light the need for greater medical assistance or more treatment rooms being available.

Last year, working with the Committee, we drafted the language found in this bill in response to the May 2017 GAO report and recommendations, and from years of observation from the dais where you now sit.

At that time, we worked to incorporate feedback from stakeholders, including flexibility towards value-based care and accounting for non-clinical duties. This language was included in H.R. 4242 when it passed out of this very Committee last November, though did not make the final VA MISSION Act.

That is why I am introducing this language as standalone bill. Our veterans and our doctors deserve to know that all the VA's resources are being optimized to deliver care.

The VA, like all government agencies, is operating in a resource constrained environment. It is our obligation to make sure that the resources we do have are directed at the veterans that need care. If we can't measure this, we cannot improve.

In closing, I look forward to hearing input and perspective from Members of the Committee, the VA, and VSOs on this legislation. None of us can claim to have a monopoly on good ideas, and I stand ready to work with all interested parties to make sure that every dollar we spend within the Veterans Health Administration is being used to effectively deliver care to our veterans.

Thank you.

Prepared Statement of Congressman Clay Higgins

Mr. Chairman,

My bill, HR 5693, the Long Term Care Veterans Choice Act, authorizes the Department of Veterans Affairs (VA) for three years to cover the cost of long-term care at medical foster homes for up to 900 veterans otherwise eligible for nursing home care through the VA.

Medical Foster Homes (MFH) are private homes in which a caregiver provides services to a small group of individuals who are unable to live without day to day assistance, and are an alternative to nursing homes for those who require nursing home care but prefer a non-institutional setting with fewer residents. For many young veterans in need of round-the-clock-care, MFHs can provide a more age-appropriate, independent setting than traditional nursing homes.

The US Department of Veterans Affairs (VA) has run its medical foster home initiative since 2000, and today the Veterans Health Administration oversees more than 700 licensed caregivers caring for nearly 1,000 veterans in 42 states. To be eligible to provide care to veterans, VA medical foster home providers must already pass a background check, complete 80 hours of initial training and 20 hours annually afterwards, and cannot work outside the home.

Unfortunately, while the VA will cover the cost of Home Based Primary Care for eligible veterans living in MFHs, the VA does not cover the cost of MFH living arrangements for veterans otherwise eligible for nursing home care through the VA. Instead, these veterans must pay for MFH services out of pocket or through private insurance. Costs associated with MFH services range between $1500 - $3000 a month, which is significantly lower than the nearly $7,000 VA would otherwise pay per patient at a state VA nursing home.

In my home state of Louisiana, the VA operates state of the art Veterans Homes that provide residents a high quality of care in an understanding, supportive environment. Last summer I toured the Southwest Louisiana Veterans Home in Jennings and I can personally attest to the high quality of care and sense of well-being among veterans. But much like in the civilian world, there is no one-size-fits-all standard of care for veterans. Veterans should be afforded flexibility to use the benefits they righteously earned in a manner that best suits their individual needs.

HR 5693 gives much needed choice and personal agency back to these brave men and women who have selflessly sacrificed for our nation.

Thank you.

Prepared Statement of Congressman Mike Bost

H.R. 5864 - VA Hospitals Establishing Leadership Performance Act

Script

Thank you Mr. Chairman and Ranking Member Brownley for providing me the opportunity to testify before the Subcommittee on Health on my legislation, H.R. 5864, the VA Hospitals Establishing Leadership Performance Act or VA HELP Act.

The mission of the Department of Veterans Affairs is to care for those "who shall have borne the battle." When our heroes transition from the military, they deserve to have access to quality healthcare and services.

Unfortunately, VA continues to fall short on that promise, due in part to failures in human resources management and operations. VA's internal assessments, and those by the Government Accountability Office and VA Inspector General, have identified serious human capital challenges and weaknesses within VHA's Human Resources operations. Most recently, we all heard about inadequate staffing and human resource management deficiencies that contributed to failures at the Washington DC VAMC.

This issue hit close to home for me after the VA National Center for Patient Safety surveyed the Marion VA Medical Center.

The Marion VA's Patient Safety Culture Survey showed a considerable decline in key factors such as communication between management and staff and the frequency of reporting problems to management. During the site visit, multiple employees raised concerns about poor management and poor communication, distrust between leadership and management, and the lack of accountability.

These factors help measure the culture at VA facilities, and it was clear that employees were unsatisfied with their work environment.

Following this report, General Bergman and I sent a letter to then Secretary Shulkin requesting that the VA further investigate this matter. This effort was followed-up by an Oversight and Investigations Subcommittee staff visit to the Marion VAMC in order to get a firsthand look at the issues at the facility.

A report of the Subcommittee's findings confirmed a lack of accountability, improper communication and a lack of standards to measure the success of the HR department. We also learned that you do not need a college degree to be a Chief of Human Resources in the VA. I do not know of any health system that has a Chief of HR without a college degree overseeing thousands of employees and responsible for negotiating job offers and proposing disciplinary actions. I also do not know of any health system that would hire or promote an individual to manage and oversee a human resources department without requiring a college degree.

During my time on this Committee I have seen that it is common in VA to move problem employees into high-level jobs with greater responsibility, without assessing their prior leadership experience and performance.

Unfortunately, despite the Subcommittee's findings and several efforts to encourage VA Headquarters leadership to address these problems, limited actions have been taken. My office continues to receive complaints about the mistrust of medical center leadership, confusion and inconsistencies in disciplinary processes, and failures to track employee performance and outcomes.

Human resource management is a critical part of delivering quality healthcare. HR is responsible for recruiting and retaining highly qualified professionals, and the current status quo within VHA's HR offices cannot continue.

H.R. 5864, the VA HELP Act will ensure that the VA addresses deficiencies within its Human Resources departments by giving it the ability to compare the performance of departments across VHA and measure their success.

This straightforward legislation instructs the Secretary of Veterans Affairs (VA) to establish qualifications for Human Resources positions within the Veterans

Health Administration (VHA). It also requires the VA to establish standardized performance metrics for Human Resources positions. These commonsense reforms will ensure that the Human Resources departments at VAMCs are operating on a uniform standard, and that it is clear who qualifies to hold such an important position.

In closing, I would like to thank Representative Sinema for helping to introduce the legislation and would like to thank you, Mr. Chairman and Ranking Member Brownley, for allowing me to testify before the Subcommittee. I hope that we can work together on H.R. 5864 to ensure that our nation's veterans are being provided the best possible care from VA employees.

Prepared Statement of The Honorable Jenniffer Gonzalez–Colon

Chairman Neal Dunn, Ranking Member Julia Brownley, thank you for this afternoon's legislative hearing and thank you for including H.R. 5938, the Veterans Serving Veterans Act as part of the agenda. I would also like to thank the panel for their testimony.

Mr. Chairman, as previously stated on several occasions before this Committee, the Department of Veterans' Affairs (VA) suffers chronic staffing challenges that at times complicate the delivery of proper and timely care. These challenges are often exacerbated by a complex and time-consuming hiring process that extends the time in between the need for a position, and filling it with appropriate staff members. VA facilities within my district are no exception. As a matter of fact, this issue never fails to come up during meetings with veterans in Puerto Rico. Therefore, as an effort to identify a remedial option, the Veterans Serving Veterans Act seeks to amend section 208 of the Choice and Quality Employment Act of 2017 to include Military Occupational Specialties (MOS) that correspond to vacant positions at the VA in the recruiting database, as well as service member's contact information, date of discharge, and the MOS they have acquired.

Employment after separating from the military is beneficial for veterans from a psychological and financial perspective. A process for identifying separating service members with military occupational specialties that match VA position needs and matching them with open positions will be valuable for both the service member and the VA. Therefore, H.R. 5938 will require VA to:

- Coordinate with DOD to identify soon to be separated service members with military occupational specialties needed by VA and to obtain their military specialties, date of separation, and contact information.
- Maintain a database searchable by VA personnel for purposes of hiring soon to be separated service members; and,
- Implement direct hiring and appointment procedures for vacant positions listed in the database for service members who apply for these positions.

Lastly, Section 3 of H.R. 5938 is designed to assist our veterans by requiring VA to implement a program to train and certify former Department of Defense healthcare technicians as Intermediate Care Technicians (ICTs), and to address the large demand for healthcare providers at the Veterans Health Administration (VHA). Currently, these very skilled technicians, trained at significant taxpayer expense, have difficulty gaining employment in their field of specialization after separation from the Armed Forces due to lack of a certification. At the same time, VHA has a significant shortage of providers.

VHA instituted the Intermediate Care Technician Pilot Program in 2013 to train and utilize ICTs at VA facilities in a variety of roles. In March 2015, the program was expanded and has since then received remarkable satisfaction rates and helped fill a void of medical providers within VA medical centers. As of April 2017, 25 VA Medical Centers are utilizing ICTs, are in the process of hiring ICTs, or have indicated the intent to hire ICTs. 34 ICTs have been hired since the end of the pilot.

Despite the high success rate of the program, it is currently operating in a case by case basis, contingent on availability of funds at individual medical centers, and with a limited number of training centers. Implementing a program to train and certify eligible veterans to work as ICTs will provide for continued program support and expansion, ensure rigor in curriculum development, competency assessment, and program monitoring, and allow the pool of eligible ICTs to continue growing to meet veterans' healthcare needs.

Mr. Chairman, it is important to keep in mind that service members are a remarkable asset upon transitioning from military service. The Department of Defense invests millions of dollars in their training, and they develop skills that have proven valuable to the Department of Veterans' Affairs. This bill seeks to further

close the gap between transitioning members and the VA by helping them occupy positions currently in demand at the Department and provides an opportunity for greater access to medical care. Moreover, it allows for veterans to be cared by fellow veterans in ways that are most needed by the VA at this moment.

Again, thank you for including it in today's agenda. I look forward to receiving feedback from our panel and fellow colleagues on ways to move forward with this bill.

Thank you.

Prepared Statement of Honorable Jeff Denham

HR 5974, the VA COST SAVINGS Enhancements Act

Mr. Chairman: Thank you for the opportunity to speak in support of HR 5974, the VA COST SAVINGS Enhancements Act.

I introduced this bipartisan bill to improve care for our veterans and ensure we are using the latest cost-saving technology.

Specifically, it directs the VA to install on-site medical waste treatment systems in facilities where this will result in a cost-savings within 5 years.

System-wide, this will save the VA millions of dollars each year and directly improve safety and healthcare for our veterans.

Medical waste, also known as "red bag" or "biohazardous" waste, is infectious waste produced at VA facilities and hospitals.

Since this waste is contaminated by blood or bodily fluids, it poses a risk of transmitting an infection and has to be handled in a special way.

If a VA facility has an on-site sterilization machine, this waste can be disinfected immediately. Otherwise, it must be taken to a special facility off-site.

On-site sterilization machines, or autoclaves, are steam sterilizers that use temperature and pressure to compact waste and destroy all microbial life.

This process renders a completely safe byproduct that can be disposed of as normal waste.

This technology is vetted by the EPA, and is considered a best practice by the Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO).

So, this policy brings the VA in line with the medical community's recommended practices.

When VA facilities do not treat waste on-site, they have to load it in trucks and drive it to regional waste disposal centers. This is both inefficient and expensive.

It can't be compacted otherwise infections will spread, so the trucks fill up fast.

Additionally, contracting with third parties to ship this waste is expensive.

In a report to Congress, the VA found that on-site treatment costs half as much as hauling waste off-site. Often much less.

Current technologies can treat waste for 7 to 9 cents per pound, compared to 30 to 60 cents off-site.

We are wasting millions of dollars each year shipping infectious waste around the country. My bill stops that.

In addition to the enormous cost savings, this technology is safer, more environmentally friendly, and increases crisis readiness.

Safety is paramount when caring for out vets, and treating waste on-site prevents the spread of infections. That is why the CDC recommends this technology.

It also reduces carbon emissions.

HR 5974 eliminates the need for hundreds of trucks to be on the road, and stops VA hospitals from shipping infectious waste back through the communities they serve.

Furthermore, it enhances operational stability and improves disaster response.

In the event of an earthquake or flood, transportation infrastructure can be compromised and prevent trucks from reaching a facility.

This ends reliance on outside contractors and ensures medical waste can be immediately dealt with in a disaster scenario.

The VA recognizes the benefits of this technology and approximately 20% of VA facilities have already installed on-site sterilization.

The 2016 Military Construction and Veterans Affairs Appropriations bill acknowledges 'there are cost savings as well as beneficial environmental impacts and [energy] savings associated with on-site medical waste treatment."

Accordingly, the VA developed a Blanket Purchase Agreement to streamline purchasing of these machines. Unfortunately - implementation has been slow.

It is time to realize the full benefits of this technology and bring the VA into the 21st century.

Our veterans deserve the highest-quality care we can provide.

This technology improves crisis-readiness, and is safer, more efficient, more cost-effective, and more environmentally friendly than traditional medical waste disposal.

Installing these machines will immediately begin saving the VA millions of dollars per year, and directly improve care for our veterans.

I urge my colleagues to support this policy.

Prepared Statement of Congressman Matt Cartwright

Chairman Dunn, Ranking Member Brownlee, and Members of the Committee, thank you for including H.R. 3696, the Wounded Warrior Workforce Enhancement Act, as part of the hearing today and for the opportunity to speak to the Committee about this very important piece of legislation.

Additionally, I would like to thank the American Orthotics and Prosthetics Association as well as Senator Durbin as they have been instrumental in focusing attention on this critical issue facing our nation's veterans.

The field of orthotics and prosthetics is at a critical tipping point in terms of the future viability of its workforce and the ability of those professionals to provide the best-tailored care to our nation's service members and veterans.

The American Orthotics and Prosthetics Association has stated that there has an approximately 300% increase in the number of veterans with amputations served by the VA since the year 2000.

Unfortunately, currently only 7100 practitioners specially trained in O&P nationwide serve more than 80,000 vets with amputations. Of those trained practitioners, one in five is either past retirement age or eligible to retire in the next five years.

However, there are only 13 schools around the country with master's degree programs in this field with the largest program supporting less than 50 students.

With the growing demand of amputee treatment outpacing the number of new practitioners trained to replace an aging workforce, it is clear that we must act now to meet our moral obligation of providing our heroes with the best health care available.

The Wounded Warrior Workforce Enhancement Act is a cost-effective approach to assisting universities in creating or expanding accredited master's degree programs in orthotics and prosthetics.

Specifically, the bill addresses these issues by authorizing a competitive grant of program of $5 million per year for 3 years to help colleges and universities develop master's degree programs focusing on orthotics and prosthetics.

The bill also requires the VA to establish a Center of Excellence in Prosthetic and Orthotic Education to provide evidence-based research on the knowledge, skills, and training clinical professionals need to care for veterans.

These prosthetic and orthotic treatments serve soldiers who suffered limb loss injuries because they put their bodies on the line for our country, and as a result, have their lives forever changed. With Veterans Day just last week, it is a very good reminder just how much we owe our wounded warriors.

Thank you again Chairman Dunn, Ranking Member Brownlee, and Members of the Committee for your consideration of this bill today and for bringing attention to the important issue of providing veterans with the best possible prosthetic and orthotic treatment possible. I look forward to working with you and your staff on advancing this important piece of legislation.

Prepared Statement of The Honorable Marcy Kaptur (D–OH)

Concerning

H.R. 2787, the Veterans-Specific Education for Tomorrow's Medical Doctors (VET MD) Act

Chairman Dunn, Ranking Member Brownley, and members of the Subcommittee, thank you for the invitation to appear before you today. I truly appreciate the opportunity to join you to discuss how we can increase opportunities for future physicians interested in veterans' health care. At the same time, we have the potential to address the critical physician shortage facing the Veterans Health Administration.

Thank you for including in today's hearing, bipartisan legislation I introduced to create a shadowing program for pre-medical undergraduate students who need to gain clinical observation experience. H.R. 2787, the Veterans-Specific Education for Tomorrow's Medical Doctors (VET MD) Act, would expose America's future physicians to the unique needs faced by our veteran population. This exposure would better prepare future physicians to provide veteran-centered care no matter where they choose to practice.

Several years ago, two pre-medical undergraduate students highlighted to my team the struggles disadvantaged, minority, and other young people who lack personal and familial connections in medical communities face as they apply for medical school. Through their own struggle to access clinical observation experience, they realized an immense opportunity.

In the current medical school admissions system, 73 percent of medical schools either highly recommend or require applicants to have clinical observation experience.[1] In fact, medical schools recommend applicants have 40 hours of observation experience at minimum. However, there is no formal system through which students can apply to shadow or observe clinicians in hospital or clinical settings.

More than 87 percent of medical schools report that applicants without clinical observation experience may be at a disadvantage in the admissions phase and that preference tends to be given to applicants with observation experience.[2] Further exacerbating the situation, opportunities for clinical observation are very limited. Students from or who attend schools outside major cities and whose families lack connections to the medical community are at a significant disadvantage in the search to find clinical observation opportunities.

In 2015, the percentage of Black or African American medical school graduates was 6 percent and Hispanic or Latino medical school graduates was 5 percent.[3] Whites and Asians continue to represent the largest proportion of medical school graduates with 58.8 percent and 19.8 percent respectively.[4] Yet, as the American population becomes more diverse, the same trends are anticipated of our veteran population too. In the next thirty years, the number of veterans who are non-Hispanic White is expected to drop from 77 percent to 64 percent. The number of Hispanic veterans is expected to nearly double from 7 percent to 13 percent, while the number of Black veterans is expected to increase from 12 percent to 16 percent.[5] It is vital we work to find solutions to build and increase the diversity of the physician pipeline. We know that a more diverse medical profession means better care for a diverse America, especially for our veterans.

After working closely with experts at the VA, their recommendations were included in the discussion draft to ensure the pilot program is more manageable for VA hospitals, clinicians, and participating students and we prioritize student applicants from Minority-Serving Institutions. These revisions do not change the underlying intent of the original bill, to create a pilot program for undergraduate premedical students to participate in clinical observation opportunities.

While the primary purpose of this bill is to provide a pathway for pre-med students to gain valuable shadowing hours, an important secondary goal is to address the physician shortage at the VA. Not only does the VA have a high demand for physicians, a critical needs occupation according to the VA Office of Inspector General (OIG), recruitment and retaining of physicians are both especially challenging. In an FY17 report from the VA OIG, total gains in critical needs occupation were offset by total losses.[6] As you all are acutely aware, the VA is facing many staffing challenges.

In a 2017 Government Accountability Office (GAO) report about physician staffing at the VHA, the GAO identified incomplete data issues which prevented the VHA to accurately count the number of physicians who provide care at VA Medical Centers. This report also identifies that the VHA is unable to estimate their own staff-

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[1] Association of American Medical Colleges. (2016). Clinical Experiences Survey Summary. Retrieved from https://www.aamc.org/download/474256/data/gsa-coa-clinical-shadowing-experience-executive-summary.pdf

[2] Association of Medical Colleges, Ibid.

[3] Association of American Medical Colleges. (2016). Current Trends in Medical Education. Retrieved from http://aamcdiversityfactsandfigures2016.org/report-section/section-3/

[4] Association of American Medical Colleges, Ibid.

[5] Bialik, K. (2017, November 10). The changing face of America's veteran population. Retrieved from http://www.pewresearch.org/fact-tank/2017/11/10/the-changing-face-of-americas-veteran-population/

[6] Department of Veterans Affairs Office of the Inspector General. (2017, September). OIG Determination of VHA Occupational Staffing Shortages FY2017. Retrieved from https://www.va.gov/oig/pubs/VAOIG–17–00936–385.pdf

ing shortages due to data collection issues.[7] However, the United States overall will face a physician shortage of between 40,000 and 104,000 by 2030, according to the Association of American Medical Colleges.[8] Even though the VA's share of that immense shortage is unknown, Members of Congress must be able to craft creative solutions to make a dent in those enormous numbers.

Creating a pipeline of physicians with veteran specific exposure at an early point in medical training is incumbent upon us as policymakers. As health professionals serving within the VHA are well aware, men and women who have served in the armed forces have specific medical needs such as exposure-based conditions and mental health issues.

A deeper understanding of veterans' specific health needs and experiences is critical for these health professionals. This pilot program has great potential to train the next generation of VHA physicians. Our number one priority is to ensure that our veterans, those who have sacrificed so much for their country, receive high quality health care from highly trained physicians. We have a responsibility as Members of Congress to guarantee that health professionals who serve those who served us, are highly trained in practicing medicine and in veteran centered care.

Thank you again for inviting me to testify regarding H.R. 2787, the VET MD Act. This legislation will allow the VA to create a pilot program for pre-med students to gain the observation experience they need to become qualified medical school applicants. I look forward to working with you to move this bill forward and am happy to answer any questions you may have.

Prepared Statement of Roscoe Butler

Chairman Dunn, Ranking Member Brownley and distinguished members of the Subcommittee on Health; on behalf of National Commander Denise H. Rohan and The American Legion, the country's largest patriotic wartime veterans service organization, comprising over 2 million members and serving every man and woman who has worn the uniform for this country, we thank you for the opportunity to testify on the following pending and draft legislation.

H.R. 2787 - Veterans-Specific Education for Tomorrow's Medical Doctors Act

To establish in the Department of Veterans Affairs a pilot program instituting a clinical observation program for pre-med students preparing to attend medical school.

The American Legion is deeply troubled by the Department of Veterans Affairs (VA) leadership, physicians and medical specialist staffing shortages within the Veterans Health Administration (VHA). Since the inception of our System Worth Saving program in 2003, The American Legion has identified, and reported staffing shortages at every VA medical facility and reported these critical deficiencies to Congress, the VA Central Office (VACO), and the President of the United States.

In 2018, VA reported there were more than 33,000 full-time vacancies.[1] Many of these vacancies included hard-to-fill clinical positions, as well as occupations identified under 38 U.S.C. 7412. These findings were reinforced by a VA's Office of Inspector General (VAOIG) report determining the largest critical need occupations are medical officers, nurses, psychologists, physician assistants, and medical technologists.[2] The VA needs to identify and attract as many qualified candidates as possible as soon as possible.

This bill requires the Secretary of the Department of Veterans Affairs to carry out a pilot program to provide undergraduate students a clinical observation experience at VA medical centers.

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[7] U.S. Government Accountability Office. (2017, October 19). Veterans Health Administration: Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies. Retrieved from https://www.gao.gov/products/GAO–18–124

[8] Research Shows Shortage of More than 100,000 Doctors by 2030. (2017, March 14). Retrieved from https://news.aamc.org/medical-education/article/new-aamc-research-reaffirms-looming-physician-shor/

[1] VA Vacancies - https://www.washingtonpost.com/world/national-security/trump-says-veterans-wait-too-long-for-health-care-vas-33000-vacancies-might-have-something-to-do-with-that/2018/04/10/d20bc890–3ccf-11e8–974f-aacd97698cef—story.html?noredirect=on&utm—term=.58facbebf668

[2] VAOIG Report 17–00936–835

Currently, VHA provides care at more than 1,233 healthcare facilities, including 168 VA medical centers and 1,063 VHA outpatient clinics.[3] The American Legion believes access to basic healthcare services, offered by qualified providers, should be broadly available and staffed with the best personnel. Establishing a clinical observation program for premedical students preparing to attend medical school can serve as a recruiting tool to attract individuals who may not have considered VHA. VA recognizes the value of such programs as they already conduct the largest education and training programs for health professionals in the United States.[4] VA has affiliations with more than 1,800 educational institutions; more than 70 percent of all doctors in the U.S. have received training in the VA healthcare system.[5]

Through American Legion Resolutions No. 115, Department of Veterans Affairs Recruitment and Retention,[6] and No. 377, Support for Veteran Quality of Life, we support legislation addressing recruitment and retention challenges, and any legislation or programs within VA that enhance, promote, restore or preserve benefits for veterans and their dependents, including, but not limited to, the following: timely access to quality VA health care, timely decisions on claims and receipt of earned benefits, and final resting places in national shrines with lasting tributes that commemorate their service.[7]

The American Legion supports H.R. 2787.

H.R. 3696 - Wounded Warrior Workforce Enhancement Act

To require the Secretary of Veterans Affairs to award grants to establish, or expand upon, master's degree programs in orthotics and prosthetics, and for other purposes.

The American Legion believes, due to the shortage of physicians in certain specialized areas, such as orthotics and prosthetics, Congress must ensure resources and funding are available to support their continued education and training. We know there will be a continual increasing need for clinicians at the master degree level to meet this demand as the number of veterans needing orthotics and prosthetics services increases.[8]

According to May 2, 2017 testimony provided by the American Orthotic and Prosthetic Association, in past wars 3 percent of servicemembers injured required amputations in previous wars; of those wounded in Iraq, 6 percent have required amputations. In the year 2000, the VA served 25,000 veterans with amputations, according to the VHA Amputation System of Care figures. By 2016, that number had more than tripled to 89,921. Between 2008 and 2013, VA performed an average of 7,669 new amputations for veterans every year; in 2016, the number of amputation surgeries rose to 11,879.

This bill would authorize the Secretary of the VA to award grants to eligible institutions enabling schools to establish a master's degree program in orthotics and prosthetics; or to expand upon an existing master's degree program in orthotics and prosthetics, including; by admitting more students, further training faculty, expanding facilities, or increasing cooperation with VA and the Department of Defense. This Wounded Warrior Workforce Enhancement Act recognizes the ever-increasing need for specialists in orthotics and prosthetics.

Through American Legion Resolution No. 311, The American Legion Policy on VA Physicians and Medical Specialist Staffing Guidelines, we support this bill.[9] VA will benefit from the medical professionals who complete the program and continue to serve veterans at medical centers around the world.

The American Legion Supports H.R. 3696.

H.R 5521 - VA Hiring Enhancement Act

To amend title 38, United States Code, to provide for the non-applicability of non-Department of Veterans Affairs covenants not to compete to the appointment of certain Veterans Health Administration personnel, to permit the Veterans Health Ad-

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[3] VHA: Where do I get the care I need?:https://www.va.gov/health/findcare.asp'

[4] VA News Release dated February 12, 2016: https://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=2747

[5] Id.

[6] The American Legion Resolution No. 115 (2016): Department of Veterans Affairs Recruitment and Retention

[7] The American Legion Resolution No. 377 (2016): Support for Veteran Quality of Life

[8] American Orthotic and Prosthetic Association Testimony www.aopanet.org/wp-content/.../AOPA–VA–Health-Subcommittee-Testimony-5.2.pdf

[9] The American Legion Resolution No. 311 (1998): The American Legion Policy on VA Physicians and Medical Specialists Staffing Guidelines

ministration to make contingent appointments, and to require certain Veterans Health Administration physicians to complete residency training.

The American Legion, as previously stated, has long expressed concern about staffing shortages at VA/VHA medical facilities to include physicians and medical specialist staffing.

The VA Hiring Enhancement Act will help address the shortcomings in recruitment and retention of highly qualified physicians. The bill allows VA to make binding job offers up to 2 years prior to completion of medical residency, eliminating much of the bureaucratic red tape that slows the hiring of newly recruited individuals. This legislation allows physicians completing their education to immediately begin treating veterans. By allowing VA to make binding offers, veterans will receive treatment by qualified physicians that have completed their residency. This bill aligns the hiring practices of VA to those of the private sector ensuring top quality healthcare is provided to our veterans.

Further, this bill also releases physicians from "non-compete agreements" for the purpose of serving in the VHA. The American Legion believes enforcing non-compete agreements to VHA hires is over-broad and should be unenforceable under public policy. Traditional reasoning behind non-compete agreements to bar competitive advantages or protect sensitive information simply do not exist in this context.

Through American Legion Resolution No. 115, Department of Veterans Affairs Recruitment and Retention, we support legislation addressing the recruitment and retention challenges of the Department of Veterans Affairs.[10] We support legislation that addresses pay disparities among physicians and medical specialists who are providing direct health care to our nation's veterans.

The American Legion supports H.R. 5521.

H.R. 5693 - Long-Term Care Veterans Choice Act

To amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to enter into contracts and agreements for the placement of veterans in non-Department medical foster homes for certain veterans who are unable to live independently.

Veterans Health Administration directive provides specific policy and guidance for establishing and operating a Medical Foster Home (MFH) Program under the standards of the Department of Veterans Affairs Community Residential Care (CRC) Program, of which it is a sub-component. Medical Foster Homes serve as an alternative to nursing home care for veterans unable to live without day-to-day assistance, while also providing a non-institutional setting with fewer residents.

Currently, veterans enrolled in Home Based Primary Care through the VA may elect to receive their care at MFHs. However, veterans eligible for nursing home care through the VA are not eligible to receive their care at MFHs, nor does the VA cover the cost of these living arrangements. Instead, these veterans must pay for MFH services out of pocket or through private insurance. Costs associated with MFH services are significantly lower than what the VA would otherwise pay per patient at a state VA nursing home.

This bill would require the Secretary of the VA, beginning on October 1, 2019, to provide nursing home care under section 1710A, at the request of a veteran. The Secretary may then place the veteran in a medical foster home that meets Department standards, at the expense of the United States, pursuant to a contract or agreement entered into between the Secretary and the medical foster home for such purposes. A veteran who is placed in a medical foster home under this authority shall agree, as a condition of such placement, to accept home health services furnished by the Secretary under title 38 U.S.C. 1717.

Medical Foster Homes are private homes in which a caregiver provides services to a small group of individuals who are unable to live without day to day assistance. MFHs are an alternative to nursing homes for those who require nursing home care but prefer a non-institutional setting with fewer residents. When one or more eligible veterans reside in a MFH, the VA ensures that the MFH caregiver is well-trained to provide VA planned care.

Allowing veterans to exercise greater flexibility over their benefits ensures that their individual needs are best met. This legislation offers a cost-saving alternative to nursing home care, while providing veterans with more personal, quality health services. This is reflective of our overall effort to provide veterans with greater choice and freedom over their benefits while preserving the VA system.

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[10] The American Legion Resolution No. 115 (2016): Department of Veterans Affairs Recruitment and Retention

Through American Legion Resolution No. 114, Department of Veterans Affairs Provider Agreements with Non-VA Providers, we support legislation allowing the Department of Veterans Affairs to enter into provider agreements with eligible non-VA providers to obtain needed healthcare services for the care and treatment of eligible veterans. [11] The VA must be authorized to obtain healthcare services from non-VA providers, particularly when it is most effective for the veteran and the taxpayer.

The American Legion supports H.R. 5693.

H.R. 5864 - VA Hospitals Establishing Leadership Performance Act

To direct the Secretary of Veterans Affairs to establish qualifications for the human resources positions within the Veterans Health Administration of the Department of Veterans Affairs, and for other purposes.

The provisions in this bill fall outside the scope of established resolutions of The American Legion. The American Legion does not have a resolution that addresses qualification standards and performance metrics for VHA human resource positions. As a large, grassroots organization, The American Legion takes positions on legislation based on resolutions passed by our membership. With no resolutions addressing the provisions of the legislation, The American Legion is researching the material and working with our membership to determine the course of action that best serves veterans.

The American Legion has no position on H.R. 5864.

H.R. 5938 - Veterans Serving Veterans Act of 2018

To amend the VA Choice and Quality Employment Act to direct the Secretary of Veterans Affairs to establish a vacancy and recruitment database to facilitate the recruitment of certain members of the Armed Forces to satisfy the occupational needs of the Department of Veterans Affairs, to establish and implement a training and certification program for intermediate care technicians in that Department, and for other purposes.

On August 12, 2017, Congress passed and the President signed into law, Public Law 115–46, the VA Choice and Quality Employment Act of 2017. This law established a recruiting database covering every vacancy in VA, with the ability to select applicants for positions other than the one for which they originally applied. The Veterans Serving Veterans Act of 2018 will expand the existing database to include members of the Armed Forces in the talent pool to meet the Department's occupational needs.

The American Legion strives to ensure our veterans and their families receive the support and recognition they deserve. Every member of our organization is a wartime veteran, so we understand the value of our fellow citizens' support during and after our military service. Saying thank you is only the beginning of how we should honor America's newest generation of warriors and veterans. This bill recognizes servicemembers require continued support and recognition of their unique skills and needs.

The database, to be known as the Recruitment Database of the Department of Defense and the Department of Veterans Affairs, would provide the military occupational specialty or skills that corresponds to each vacant position, in consultation with the Secretary of the Department of Defense, as well as with each qualified member of the Armed Forces who could be recruited to fill the position before their separation from active service. This bill would require the Secretary of the VA to implement direct procedures for hiring and appointment for the vacant positions that appear in the database for qualified members of the Armed Forces that apply to these positions.

Further, The Veterans Serving Veterans Act of 2018 also requires the Secretary of VA to implement a program to train and certify covered veterans to work as Intermediate Care Technicians (ICTs) in the Department. A "covered veteran" will be defined as a veteran who the Secretary determines served as a basic health care technician while serving in the Armed Forces. This recognizes our warfighters within all branches of the Armed Forces with training and experience in medical care, but do not have a civil certification to continue providing these services once they are separated from the military.

The American Legion has long recognized the need for certification of skills earned in the military since it championed the Veterans Skills to Jobs Act, signed

[11] The American Legion Resolution No. 114 (2016): Department of Veterans Affairs Provider Agreements with Non-VA Providers

into law in 2012. Legionnaires at the state and post levels have, and will continue to demand their legislatures and general assemblies pass new licensing and credentialing laws in their states affirming skills of separating servicemembers. The economics are easy to understand. The military and the taxpaying public have already paid for these veterans to be trained. Forcing veterans to spend taxpayer-funded education benefits on certification classes is the equivalent of paying them to be trained twice, and it places an unnecessary burden on veterans trying to make the transition to civilian careers.

Through American Legion Resolution No. 115, Department of Veterans Affairs Recruitment and Retention, we support legislation addressing the recruitment and retention challenges of the Department of Veterans Affairs.[12] We support legislation calling on VA to work more comprehensively with community partners when struggling to fill critical shortages within VA's ranks. Adding qualifying members of the Armed Forces who may be recruited to fill positions in the VA before the member of the Armed Forces has been discharged and released from active duty fulfils these criteria as well as supports our nation's warfighters transitioning out of the military.

The American Legion supports H.R. 5938.

H.R. 5974 - VA COST SAVINGS Enhancement Act

To direct the Secretary of Veterans Affairs to use on-site regulated medical waste treatment systems at certain Department of Veterans Affairs facilities, and for other purposes.

The provisions in this bill fall outside the scope of established resolutions of The American Legion. The American Legion does not have a resolution that addresses on-site regulated medical waste treatment systems at certain Department of Veterans Affairs facilities. As a large, grassroots organization, The American Legion takes positions on legislation based on resolutions passed by our membership. With no resolutions addressing the provisions of the legislation, The American Legion is researching the material and working with our membership to determine the course of action that best serves veterans.

The American Legion has no position on H.R. 5974.

Draft Bill

To amend title 38, United States Code, to improve the productivity of the management of Department of Veterans Affairs health care, and for other purposes.

The provisions in this bill fall outside the scope of established resolutions of The American Legion. The American Legion does not have a resolution that addresses this issue. As a large, grassroots organization, The American Legion takes positions on legislation based on resolutions passed by our membership. With no resolutions addressing the provisions of the legislation, The American Legion is researching the material and working with our membership to determine the course of action that best serves veterans.

The American Legion has no position on the Draft Bill.

Conclusion

Chairman Dunn, Ranking Member Brownley and distinguished members of this critical Committee, The American Legion thanks this Subcommittee for the opportunity to elucidate the position of our 2 million veteran members of this organization. For additional information regarding this testimony, please contact Assistant Director of the Legislative Division, Larry Lohmann, at (202) 861–2700 or llohmann@legion.org.

Prepared Statement of Jeremy M. Villanueva

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting DAV (Disabled American Veterans) to testify at this legislative hearing of the Subcommittee on Health of the House Veterans' Affairs Committee. As you know, DAV is a non-profit veterans service organization comprised of more than one million wartime service-disabled veterans that is dedicated to a

[12] The American Legion Resolution No. 115 (2016): Department of Veterans Affairs Recruitment and Retention

single purpose: empowering veterans to lead high-quality lives with respect and dignity. DAV is pleased to offer our views on the bills under consideration by the Subcommittee.

H.R. 2787, the Veterans-Specific Education for Tomorrow's Medical Doctors Act or VET MD Act

H.R. 2787 would establish a three-year pilot project instituting a clinical observation program for students enrolled in a "pre-med" or science curriculum who plan to attend medical school. Students would spend a certain number of hours observing a practicing physician to expose the student to a variety of health care experiences. The pilot would be established at no fewer than five Department of Veterans Affairs (VA) medical centers. The goal of the pilot is to increase awareness among America's future physicians related to veterans' issues. It is also intended to raise cultural awareness and sensitivity in addressing their specific health care concerns, as well as engender interest in pursuing medical careers, in general, and particularly, within the Department, in these students. Following the program, participants would be asked to fill out a "reflection" survey, developed by VA, about their experience.

Mr. Chairman, DAV has no resolution on the development of such a program within VA, but believes the intent of this legislation is in keeping with the goals of developing a more robust field of candidates for medical professions employed by the VA and ensuring more medical professionals in the community have some awareness and understanding of veterans' unique medical issues. We therefore have no objection to this legislation's favorable consideration.

H.R. 3696, the Wounded Warrior Workforce Enhancement Act

H.R. 3696 would require the VA Secretary to award grants to educational institutions of $1 million to $1.5 million to create or expand master's degree programs in orthotics and prosthetics. An appropriation of $15 million would be made available through the end of fiscal year (FY) 2020 with unexpended obligations returned to the U.S. Treasury at that time. Initially, VA would be required to establish a request for proposal for awarding these grants. Only educational institutions that have accreditation by the National Commission of Orthotic and Prosthetic Education and ones that demonstrate the ability to meet accreditation requirements would be eligible to receive grants. Priority for grants would be given to programs that establish clinical rotations with the VA. The Secretary may also require an institution to demonstrate its commitment to continue the program after the VA grant expires. Finally, the bill would require the Secretary to award a grant of $5 million to establish a Center of Excellence in Orthotic and Prosthetic Education in the private sector.

DAV notes the need to develop additional orthotic and prosthetic expertise in the private sector based on the Bureau of Labor Statistics projection of a 22 percent growth in need for these professionals between 2016 and 2026 due to the aging of "baby boomers" who are prone to diabetes and cardiovascular conditions that may cause limb loss and be in need of these specialized services.

However, the Veterans Health Administration (VHA) is not reporting difficulty in recruiting or retaining orthotists and prosthetists and notes its training capacity (about 20 residents in 2017) is adequate to serve the needs of the Department. In contrast, the Department does have notable shortages in medical officers, nurses, psychologists and medical clerks. Dedicating $15 million to train students who will primarily provide care to patients outside of VA may further impair VHA's ability to hire more in demand care providers. Additionally, VA currently has five centers of excellence in prosthetic research associated with academic affiliates which creates a number of opportunities for interns and students from affiliated institutions to provide care to veterans in VA.

For these reasons, DAV is unable to support H.R. 3696 at this time.

H.R. 5521, the VA Hiring Enhancement Act

H.R. 5521, the VA Hiring Enhancement Act, would render "non-compete" agreements between an applicant for VA employment and a previous employer non-applicable with regard to VA employment. Employees appointed with this understanding would be required to serve out the length of their non-compete agreement within their VA position or serve in that position for at least one year (whichever is longer). The bill intends to allow VA, on a contingent basis, to begin recruiting and hiring physicians up to two years before they complete their residency, as well as physicians who have completed their residencies leading to board certification. These contingent appointed physicians must satisfy VA's requirements to receive a permanent appointment.

DAV fully supports efforts to recruit, retain and develop a skilled clinical workforce to meet the needs of veterans. We appreciate the goal of this legislation aimed at creating as large an applicant pool for qualified medical professionals to treat our service disabled veterans as possible in VA. DAV Resolution No. 228 calls for effective recruitment, retention and development of the VA health care workforce. Because this measure attempts to reduce barriers for employment at VA for physicians; we are pleased to support the bill's passage.

H.R. 5693, the Long-Term Care Veterans Choice Act

In accordance with DAV Resolution No. 227, calling for legislation to improve the comprehensive program of long-term services and supports for service-connected disabled veterans regardless of their disability ratings, DAV supports this measure.

If enacted, this measure (H.R. 5693) would provide veterans who are no longer capable of living independently an alternative to nursing home care, in which the veteran would continue to receive the care that they need in an intimate home-like environment through VA's Home-Based Primary Care program, and the Medical Foster Home (MFH) attendant. Medical Foster Homes are a type of Community Residential Care by which veterans with serious chronic disabling conditions requiring nursing home level care and coordination of services are able to receive these services in a non-institutional setting. Patient participation in the MFH program is voluntary and veteran residents report very high satisfaction ratings.

Currently, the administrative costs for VA per veteran in the MFH program, including the cost of Home Based Primary Care, medications and supplies average less than $63 per day. However, veterans who qualify for nursing home care fully paid for by the government, must pay the full cost for room, board, and personal assistance out of their own pocket, which averages to be about $110 per day to live in a MFH.

Veterans who wish to reside in a Medical Foster Home but are unable to pay approximately $1,500 to $3,000 per month are not able to avail themselves of this benefit, so many are placed in nursing homes at much greater cost to VA. This measure would address this inequity by giving VA a three-year authority to pay for veterans, who would qualify for VA-paid nursing home care placement, so they can reside in a VA-approved MFH.

As the veteran population continues to age, the need for long-term care services will continue to grow. Home-based community programs like MFHs will enable VA to meet the needs of aging veterans in a manner closer to independent living than institutionalized care. With the passage of this bill, veterans would have the option of care that more closely aligns with their independence while maintaining their quality of life.

H.R. 5864, to direct the Secretary of Veterans Affairs to establish qualification for the human resources positions within the Veterans Health Administration

H.R. 5864, the VA Hospitals Establishing Leadership Performance Act would require the Secretary of Veterans Affairs to establish qualifications and standardized performance metrics for each human resources position within the Veterans Health Administration within 180 days of enactment. Upon establishing such qualifications and standardized performance metrics for these positions, VA would be required to submit a report to Congress. The Comptroller General would then be required to submit a report describing implementation of the qualifications and performance metrics and assess the quality of such measures within 180 days.

DAV supports this legislation in accordance with DAV Resolution No. 228, which calls for a simple-to-administer alternative VHA personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector and DAV Resolution No. 221, which supports VA's use of meaningful and clearly articulated measures to gauge employees' performance.

VA acknowledges the need for reforming its human capital management system, but leadership has not always provided strong guidance, oversight or resource support to carry out such reforms. VA's human capital management is also hampered by the Department's current IT systems that provide organizational data and by its real and perceived need to comply with a collection of byzantine laws, regulations, and internal policies that guide its functions.

In VA's latest Strategic Plan, it states: "A robust human capital management capability is paramount to VA's ability to effectively and efficiently employ its work-

force in service to Veterans."[1] The plan identifies several strategies to modernize its human capital management capabilities objective including:

1.Standardize Human Capital Policies Enterprise-wide

2.Improve Staffing to Ensure a Qualified VA Workforce is in Place

3.Improve Leadership and Workforce Competency

4.Institute Manpower Management to Optimize VA Human Capital Resources

Many organizations have opined about improving VA's competency and performance of human resources staff including the Commission on Care, the Government Accountability Office and the CMS Alliance to Modernize Healthcare Federally Funded Research and Development Center who produced the Congressionally mandated Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs. All indicate that system-wide improvement requires systemic change which would fundamentally alter the current operations, leadership, and inputs (including informatics and policy guidance) of the current human capital management system.

DAV believes H.R. 5864 offers a good starting point for the fundamental overhaul of VA's human capital management system needed within the Department, but it is just a start. While standardized position descriptions with corresponding performance measures must be developed, VA also needs to ensure that it streamlines and simplifies policies surrounding such practices as recruitment and hiring. It must create specialists within the system who are informed by best practices in such functional areas as recruitment, retention, staff development, employee benefits, and performance management as well as expertise in important clinical staff professions such as doctors, nurses, allied health professionals and clinical support staff.

As long as VA must work with four personnel hiring authorities, each with its own requirements, specialists within VA's Central Office or the VISN must understand the intricacies of each. These specialized experts can serve as consultants to field level specialists who are actually performing the functions. VA human resources professionals will certainly require better informatics and many may require training to overcome deficits in core competencies to meet the minimal qualifications of new position descriptions. Most importantly, Human Capital Management Reform will require a long-term commitment from VA's leadership and Congress. The core position descriptions developed under H.R. 5864 will not be valuable if VA is unable to hire or develop the human talent necessary to fill these positions.

Congress should maintain oversight and continue to work on ways to simplify personnel policies and procedures for the Department, including working toward a system that administers personnel matters under a single system and is driven by best practices within the federal government and private sector. This will limit the need for expertise in so many systems and may make VA more responsive to market factors that affect hiring and retaining the best talent. Only when a systemic approach to reform is taken, will VA be able to optimize human capital management to identify more effective ways to use its scarcest resource-well trained and compassionate people who effectively provide care to our nation's veterans.

H.R. 5938, the Veterans Serving Veterans Act

This bill would establish a vacancy and recruitment database to facilitate the recruitment of certain members of the Armed Forces to satisfy the occupational needs of the VA and establish a training and certification program for intermediate care technicians within the Department. We support H.R. 5938 based on DAV Resolution No. 228, which calls for effective recruitment, retention and development efforts within VA.

This bill also recognizes the service member's military vocational training as being valuable in the civilian workforce. DAV Resolution No. 248 calls for the elimination of employment barriers that impede the transfer of occupations to the civilian labor market. This bill is in the spirit of that goal.

DAV and our Independent Budget (IB) partners have also urged Congress to support improvements to the VA's human capital management systems by providing the necessary funding and authorities to implement system reform and for VA to utilize the broad-based recruitment and employment incentives available in order to attract workforce talent and to remain competitive in various workforce markets.

The IB partners acknowledge that VA's HR system is complicated and therefore demands a holistic approach to workforce development that allows VA to recruit, train, and retain a high-quality workforce of talented and compassionate profes-

[1] Department of Veterans Affairs: Strategic Plan 2018–2024. P. 30

sionals capable of caring for our veterans, while simultaneously ensuring that VA has the authority to properly reward and hold employees accountable. This must include acknowledging that employee experience is equally vital to its transformation efforts. If Congress is intent on helping VA transform its culture and workforce, we suggest the Department is provided the leverage to hire employees more quickly and offer compensation that is competitive and commensurate with their skill levels.

In addition, it should be noted that this bill could help the transition process from military to civilian life, a process that can be difficult for many separating service men and women. By allowing the VHA to directly hire separating service members, it allows the Department to inquire about an applicant's skills and qualifications that would likely otherwise go unnoticed in the current process and would provide the veteran employment from day one aiding in a successful transition from military to civilian life.

With passage of this measure, Congress would ensure that the VA is hiring highly skilled and culturally invested applicants and would showcase the military as one of the nation's finest providers of vocational training.

H.R. 5974: The VA COST SAVINGS Enhancement Act

The VA COST SAVINGS Enhancements Act would require VA to conduct a cost analysis model to determine if the installation and use of an on-site medical waste treatment system, in selected VA medical facilities, will result in a cost-savings over a 5 year period.

Currently, biohazardous medical waste, specifically items contaminated by body fluids and deemed potentially infectious, must be disposed of off-site at specially designated regional disposal centers. This bill proposes the use of on-site sterilization machines to compact "red bag" medical waste to destroy microbial life, thus rendering the hazardous bio-waste material safe for routine disposal.

DAV does not have a resolution specific to this issue and takes no position on the bill.

Draft bill, to improve the productivity and management of VA health care facilities

This bill would amend current law requiring the VA Secretary, in managing the VA health care system, to establish a new management authority tracking relative value units (RVU) for all VA providers, provide training for all VA providers on clinical procedure coding, and establish performance standards to evaluate clinical productivity based on nationally recognized RVUs for each profession and each VA medical facility.

Public Law 107–135 mandated that VA establish a nationwide policy to ensure medical facilities have adequate staff to provide appropriate, high-quality care and services. In this regard, VA's current policy outlines productivity and staffing for Specialty Group Practice providers, Mental Health and Emergency Medicine. Of the total RVU, which consists of three components: work performed (wRVU), practice expense (peRVU), and malpractice (mpRVU) expense, VA's policy on productivity measurement only uses wRVU, which is perhaps the best known and most-often utilized RVU component. When VA specialty provider group practices are out of production range for its specialty and peer grouping, remediation plans are required to be developed, reviewed, receive concurrence from leadership, and implemented to improve specialty physician group practice productivity.

Previous testimony before this Subcommittee on factors affecting clinical productivity noted the following:

1)The number of patients assigned to VHA general primary care providers is 12 percent lower than the private sector benchmark for patients of a similar acuity.

2)With respect to specialty providers, [ ] analysis shows that VHA specialists are less productive than their private sector counterparts on two industry measures - encounters and work relative value units (wRVUs). Many specialties fall in the 50th percentile of private sector providers; others are as low as the 25th percentile. However, when encounters (visits) are used as a measure, the gap shrinks and VHA specialty care compares more favorably to the private sector. In a system as large and varied as VHA, we did find variation in the relative productivity of providers. For instance, specialty care providers at the most complex facilities were found to be more productive than their peers, and the most productive VHA providers (those at the 75th percentile of VHA providers) are often more productive than the private sector. Mental health provider productivity at VHA was calculated to be in the 100th and 72nd percentiles as measured by both wRVUs and encounters, compared to industry benchmarks.

Because relative value units may not capture other factors that impact health care productivity (compared to the private sector, VA providers have a lower room-to-patient ratio and have significantly fewer nurses and administrative support staff), we urge the Subcommittee consider these proximate factors in requiring VA to track productivity. VA's own management tool, the Specialty Productivity Access Report and Quadrant, recognizes this in part by including some support staff ratios in assessing productivity and staffing standards. Supporting infrastructure issues are addressed in remediation plans.

Moreover, recognizing the methods to measure and determine productivity, budgeting, allocating expenses, and cost benchmarking continue to evolve, as well as VA's work to address four recommendations in the June 23, 2017, Government Accountability Report, we recommend the Subcommittee consider under paragraph 2 to include subparagraph "(c) other productivity measures and models determined appropriate by the Secretary."

Finally, we recommend the Subcommittee make clear whether the remediation plan required by this bill is intended to affect the remediation plan in Section 109 of S. 2372, the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 or the VA MISSION Act of 2018.

Mr. Chairman, we must acknowledge that the VA health care system is unlike most private sector health care systems in that its resources are distributed by a capitation system to more equitably allocate funds across a health care system that spans this nation and its territories. While all funding models have strength and weaknesses, in a capitation model there is strong incentive to conserve resources to focus more on value than volume unlike fee schedule or other retrospective payment models.

Policy proposals to manage inpatient and outpatient clinical productivity in such a health care system must recognize and work within these specific operating environments to achieve the appropriate balance of efficiency and effectiveness while preserving the high quality care VA provides to our nation's ill and injured veterans.

This concludes my testimony, Mr. Chairman. DAV would be pleased to respond for the record to any questions from you or the Subcommittee Members concerning our views on these bills.

Prepared Statement of Kayda Keleher

Chairman Wenstrup, Ranking Member Brownley, and members of the Subcommittee, on behalf of the women and men of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide our remarks on legislation pending before this Subcommittee.

H.R. 2787, Veterans-Specific Education for Tomorrow's Medical Doctors Act or the VET MD Act

The VFW supports the Veterans-Specific Education for Tomorrow's Medical Doctors Act, with suggestions to improve the legislation. This legislation would mandate VA carry out a pilot program at no less than five Department of Veterans Affairs (VA) facilities to provide a diverse selection of undergraduate students with clinical observation experience. The goals of this clinical observation pilot would be to increase awareness and knowledge of veterans' health care of future medical professionals and increase the diversity of future medical professionals.

While VA facilities across the country are already allowing students to observe clinical hours, this program would be a practical way to expand this practice. The VFW also finds it to be valuable that the legislation includes consideration of areas with staffing shortages within VA, in an attempt to hopefully later recruit new providers. However, the VFW would find this to be more advantageous if the language also included projected staffing shortages within VA. The VFW suggests including veterans as a priority along with those who live in an area with a shortage of health care professionals and/or are first generation college students.

The VFW also suggests more precisely defining the term "timely manner" under "Other Matters" regarding the notification to Congress, as the term can be too loosely defined and may result in Congress receiving notification at a much slower rate than intended. Lastly, the VFW recommends including metrics to determine how many students who took part in the program go on to a graduate medical program for fields determined to have a staffing shortage within VA.

H.R. 3696, Wounded Warrior Workforce Enhancement Act

Section 2

The VFW agrees with the intent of this section, but cannot support the language as written. This section would mandate that VA provide grants to research programs with orthotic and prosthetics education programs accredited by the National Commission on Orthotic and Prosthetic Education in cooperation with the Commission on Accreditation of Allied Health Education Programs.

One of VA's four statutory missions is to educate and train health professionals to enhance the quality of care provided to veteran patients within VA. This is accomplished through coordinated programs and partnerships with affiliated academic institutions.

The Wounded Warrior Workforce Enhancement Act would not require any form of partnership, yet would provide millions of dollars in grants for non-VA institutions to expand, build, supplement salaries, provide financial aid, or purchase equipment for graduate level orthotic and prosthetics programs for very specifically defined institutions. While the language does state that schools that are partnered with VA would be prioritized for grants, and schools that apply must show a willingness to participate; that is not enough. The VFW believes this must be tied back to delivery of care for veteran patients within VA. If VA is to fund grants such as this, veterans must see a positive outcome from which they can benefit.

Section 3

The VFW opposes this section, which would require VA to provide a grant to build a non-VA center of excellence for orthotics and prosthetics at a graduate orthotic and prosthetics program accredited by the National Commission on Orthotic and Prosthetic Education in cooperation with the Commission on Accreditation of Allied Health Education Programs. Aside from the same concerns as in Section 2 regarding the lack of partnership or contracts with VA, this section would ultimately require VA to fund this non-VA entity that is not only unnecessary as VA and the Department of Defense (DOD) lead the way in orthotics and prosthetics, but would again have no direct tie to care provided to veterans.

It is imperative that America's providers are able to treat patients for orthotics and prosthetics. There are currently five Polytrauma Rehabilitation Centers and 21 Polytrauma Network Sites within VA—that does not include the Polytrauma Support Clinic Teams, Polytrauma Points of Contact or Department of Defense prosthetic centers of excellence and other clinics. With this in mind, the VFW cannot justify outsourcing valuable VA resources to bolster a non-VA entity that would not benefit veterans. The grant for this program, which would be substantial, would again be eligible for use toward training, salary supplementation, financial aid, building renovations and equipment purchases.

H.R. 5521, VA Hiring Enhancement Act

Section 2

The VFW supports this section which would remove barriers for employment of health care providers who were required to sign a non-compete contract with previous employers. By removing this barrier more medical professionals who want to treat veterans would be able to pursue a career at VA medical facilities.

Section 3

This section would require VA to hire health care providers who are board eligible. The Choice Act required VA's Office of Inspector General to annually determine the top five hiring shortages. Since this enactment in 2014, medical officers have been ranked as the number one staffing need within VA. With nearly 38,000 current job vacancies within VA, the VFW cannot support limiting VA's hiring pool.

As determined by studies such as Comparing VA and Non-VA Quality of Care: A Systematic Review, published by the RAND Corporation in the Journal of General Internal Medicine, 2016, VA either outperforms or performs on par with non-VA care. So while this legislation is intended to limit applications to the most highly qualified, the VFW feels this is not a necessary precaution at this time.

Lastly, this section's attempt to provide VA the authority to hire residents is redundant with current law. In Section 206 of VA Choice and Quality Employment Act of 2017 the secretary received authority to hire students and recent graduates.

H.R. 5693, Long-Term Care Veterans Choice Act

The VFW supports this legislation which would authorize VA to enter into contract agreements for non-VA medical foster homes. By expanding this option of long-term care to veterans who are unable to live independently but do not want to be institutionalized, Congress would be providing veterans with the ability to receive

the care they need while also maintaining a higher quality of life. The VFW urges Congress to pass this legislation, which would provide more options for veterans to decide what form of long-term care is right for them.

H.R. 5864, VA Hospitals Establishing Leadership Performance Act

The VFW supports this legislation which would establish qualifications for human resources positions within the Veterans Health Administration. In doing so, this legislation would assure standardized performance metrics and require VA to report the established qualifications and metrics, as well as the implementation and quality of the metrics.

H.R. 5938, Veterans Serving Veterans Act of 2018

The VFW agrees with the intent of this draft legislation, but has very serious concerns with its impact on privacy. This draft legislation would establish a vacancy and recruitment database to facilitate recruitment of members of the armed forces to fill open positions within VA.

Requiring VA and DOD to work together to establish a functional and correct database of individuals actively serving in the military with military occupational specialties that would link individuals with corresponding vacant positions within VA, would require excessive amounts of time, funding and technology. While the desired goal of filling desperately needed positions is commendable, establishing a database is neither realistic nor the right way to do it.

The VFW also has concern with how this legislation would allow those in the armed forces to elect not to be listed in the database, but requires the member to submit this request in writing with no other options or outreach directive to assure they are properly notified of this option. Once on the list, the secretary of VA would have authority to determine who within the department has access to the information. These options are listed as offices, officials and employees. The VFW believes that VA must be more selective with who has access to the name, contact information and other personal information of transitioning service members.

H.R. 5974, Department of Veterans Affairs Creation of On-Site Treatment Systems Affording Veterans Improvements and Numerous General Safety Enhancements Act

The VFW supports this legislation which would direct VA to use on-site regulated medical waste treatment systems. At this point in time, most VA facilities are contracting out medical and biohazardous waste disposal. These contracts come with a high price tag and require the transportation of infectious waste such as blood, microbiological cultures, body parts, used dressings and more. In areas where it would result in cost savings, there is absolutely no reason why VA should not be discarding their own medical waste instead of using contractors.

Draft Legislation to improve productivity of the management of Department of Veterans Affairs health care, and for other purposes.

The VFW agrees with the intent of this draft legislation but has some concerns that must be addressed before we are able to support. This legislation would require VA to reports its relative value units (RVUs). RVUs are a national standard used for determining budget, expenses, cost benchmarking and productivity, which was first introduced by the American health care systems by Centers for Medicare and Medicaid Services in 1992. While the private sector has found RVUs to be statistically reliable, they are at times flawed - and predominantly used to determine provider payments.

There would most certainly be value to tracking RVUs and the levels of productivity within VA. The VFW believes it would provide data showcasing that as funding increases within VA, so does productivity. With this said, there are still concerns regarding comparison to the private sector and maintaining the level of care that veterans prefer.

The private sector is not required to make data publicly available the way VA is required, which at times causes an unsettling double standard. VFW members report in surveys time and time again that one of the reasons they prefer VA is due to increased face time with their providers. VA providers typically spend more time with patients, which leads to higher patient satisfaction and better quality care. Veteran patients who use VA are also statistically sicker than patients who do not use VA. This requires more time between patients and their providers. These and other factors are not reflected in RVUs. The VFW is grateful this legislation would take into account non-clinical duties, as VA providers conduct more research and training than private sector providers. However, the VFW would like to know how Congress intends to use RVUs before supporting this bill. The VFW warns against

basing legislation or appropriations on how VA RVUs compare to private sector RVUs. Doing so would fail veterans and the system specifically created to meet their health care needs.

Mr. Chairman, this concludes my testimony. I am prepared to take any questions you or the Subcommittee members may have.

Prepared Statement of Jessica Bonjorni

Good morning Chairman Dunn, Ranking Member Brownley, and Members of the Subcommittee. I appreciate the opportunity to discuss the Department of Veterans Affairs' (VA) views on pending legislation, including H.R. 2787, H.R. 3696, H.R. 5521, H.R. 5693, H.R. 5864, and two draft bills related to the Veterans Serving Veterans Act and the improvement of VHA productivity and efficiency. Due to the delay in notification regarding the draft "VA COST SAVINGS Enhancements Act", we are unable to provide views on that bill at this time, but will follow up with the Committee as soon as possible. I am accompanied today by Ms. Dayna Cooper, Director, Home and Community-Based Programs, Veterans Health Administration.

H.R. 2787: Vet MD Act

The VA supports the intent of this bill to develop a nation-wide pre-health shadowing program within VA for undergraduate students who want to have a healthcare career. This bill, H.R. 2787, is an almost exact duplicate of H.R. 6187 from 2016. At that time, VA worked on extensive technical assists to improve the bill, improving the likelihood it could be implemented easily and at the lowest cost within VA. Unfortunately, the new bill contains nearly all the same technical limitations of H.R. 6187 and does not reflect prior feedback.

The bill focuses on pre-medical students to the exclusion of all other health occupations. VA has previously advised that the bill should apply to all pre-health students and include both undergraduate students and post-baccalaureate students, since all such students already display a high level of interest in pursuing a health career.

The bill describes a three-year pilot program that would start no later than August 15, 2020. Unfortunately, this program would require VA to promulgate regulations and depending on the bill passage, that start date would be very challenging to meet. The bill also requires surveys of all participants both pre- and post- observation, curriculum development at all sites to ensure a standardized experience, and 18,000 observation hours within VA clinical sites (5 centers x 20 students/center x 60 hours of observation, repeated three times a year).

One of the largest technical hurdles to the bill is the requirement to have an applicant online portal developed to take student applications. The USAJOBS/USA Staffing system could be used for this initiative, but it would require customization of the applicant system for these student observers. On the other hand, to alleviate the time-intensive and therefore costly applicant selection process, VA has previously recommended using the Deans' offices of VA-affiliated educational institutions to provide applicant reference letters and to screen applicants rather than hosting an applicant portal by whichever Information Technology (IT) mechanism is least costly.

The bill essentially requires VA to act as an educational institution by creating "standardized application, assessment, selection and processing requirements." VA does not believe that it should independently develop a student applicant rating and ranking system, but rather should rely on pre-health advisors at affiliated institutions to refer best qualified candidates.

The Congressional notification requirements include notifying Congress of sites chosen in a timely manner. The reporting burden is significant, and includes, not later than 60 days before completion of the three-year pilot, reporting on the number and demographics of all applicants, selectees, and all that completed the program, and before and after participant survey results.

For the bill as written, the expected timeline would be as follows:

- Fiscal Year (FY) 2019 - Bill passes; staff recruitment process begins. IT dollars for customization of applicant portal in USA Jobs/USA Staffing awarded;
- FY 2020 - Staff hired mid-way through year (1/2 salary support). Regulation development begins. Customization of USA Jobs/USA Staffing begun;
- FY 2021 - Regulations completed. Applicant portal completed. RFP process begins and ends for medical center sites. Sites recruit for and hire GS–12 Site Coordinators;
- FY 2022 - Pilot begins;

- FY 2023 - Second year of pilot starts;
- FY 2024 - Third year of pilot starts;
- FY 2025 - Pilot ends; Evaluation and analysis begin;
- FY 2026 - VA staff complete work including Congressional report and are reassigned if initiative is not authorized to continue.

VA would require major staff support to implement this bill as written. We assume one Nurse IV Program Manager, one General Schedule (GS)-14 Management Analyst, one GS–13 Education Program Specialist, and one GS–11 Staff Assistant to manage this program. We also assume a GS–12 site coordinator at each of the five medical centers starting in 2021 after the sites are chosen. We assume that in FY 2020 we incur half the cost of VA Full-time Equivalent (FTE) due to recruitment delays. In addition, we would require IT dollars to modify the USAJOBS / USA Staffing system for customization for this initiative over a two-year period.

We estimate the total cost of this bill as follows: $436,453 One Year Total; $7,068,192 Five Year Total; and $9,363,343 Ten Year Total.

H.R. 3696: Wounded Warrior Workforce Enhancement Act

Two sections of this bill call for establishing new or expanding existing prosthetic/orthotic graduate programs (total limit of $15 million and site limit of $1.5 million), and the establishment of one prosthetic/orthotic research Center of Excellence (CoE) ($5 million).

Section 2 of the bill requires the expansion of prosthetic/orthotic graduate programs.

VA does not support this bill because VA already provides rehabilitation services to Veterans with a mix of providers, including physical medicine and rehabilitation physicians, physical therapists, occupational therapists, prosthetists and orthotists, all of whom work with the Veteran to enable the best possible rehabilitation given the individual's needs. VA offers in-house orthotic and prosthetic services at 84 laboratories across VA; in addition, VA contracts with more than 600 vendors for specialized orthotic and prosthetic services. Through both in-house staffing and contractual arrangements, VA is able to provide state-of-the-art commercially available items ranging from advanced myoelectric prosthetic arms to specific custom fitted orthoses.

Nationally, VA has approximately 340 clinical orthotic and prosthetic staff. VA offers one of the largest orthotic and prosthetic residency programs in the nation. In FY 2017, VA's Office of Academic Affiliations allocated $894,838 to support 20 Orthotics/Prosthetics residents at 13 Veterans Affairs Medical Centers. The training consists of a yearlong post-master's residency, with an average stipend of $44,000 per trainee. In recent years, VA has expanded the number of training sites and the number of trainees. From this pool of advanced trainees, we are able to employ orthotists and prosthetists without the burden of supporting trainees though their full graduate training.

Much of the specialized orthotic and prosthetic capacity of VA is met through contract mechanisms. Direct grants to schools to start or expand masters or doctoral training programs would serve the private sector rather than VA or Veterans. VA does not currently serve as a granting authority for educational programs, and therefore VA does not presently have regulations which would oversee these activities. Rather, VA provides focused clinical practica at or near the end of formal training. This bill would establish a precedent for other educational institutions to receive grant funds to establish or enhance their own educational programs with no clear-cut benefit or linkage to VA's needs. In the future, Congress and VA might be pressured to provide grants to educational institutions for an additional 40 health professions.

Section 3 of the bill would require VA to award a grant to an eligible institution to enable that institution to establish a CoE in Orthotic and Prosthetic Education and enable that institution to improve orthotic and prosthetic outcomes for Veterans, Service members, and civilians by conducting evidence-based research. VA would be required to give priority in the award of a grant to an eligible institution that has in force, or demonstrates the willingness and ability to enter into, a Memorandum of Understanding (MOU) with VA, the Department of Defense (DoD), or another appropriate Federal agency, or a cooperative agreement with an appropriate private sector entity that provides for the provision of resources to the Center and assistance to the Center in conducting research and disseminating the results of such research. The grant awarded under this section could not exceed $5 million. Within 90 days of the date of the enactment of this Act, VA would have to issue a request for proposals from eligible institutions for the grant available under this

section. The grantee would be required to use the grant to develop an agenda for orthotics and prosthetics education research, fund research in orthotics and prosthetics education, and publish or otherwise disseminate research findings relating to orthotics and prosthetics education. The grantee could use the funds of the grant for a period of 5 years from the date of the award of the grant. To be eligible for the grant, an institution would have to: have a robust research program; offer an orthotics and prosthetics education program accredited by the National Commission on Orthotic and Prosthetic Education in cooperation with the Commission on Accreditation of Allied Health Education Programs; be well recognized in the field of orthotics and prosthetics education; and have an established association with a VA medical center or clinic and a local rehabilitation hospital. There would be authorized to be appropriated for fiscal year 2018 $5 million to carry out this section.

VA does not support section 3 because we do not believe that a new Center is necessary. DoD has an Extremity Trauma and Amputation Center of Excellence, and VA and DoD work closely to provide care and conduct scientific research to minimize the effect of traumatic injuries and improve outcomes of wounded Veterans suffering from traumatic injury. VA is already a world leader in prosthetics/orthotics research. VA has five Rehabilitation Research and Development Centers that conduct research related to prosthetic and orthotic interventions, amputation, and restoration of function following trauma:

1. Center for Limb Loss Prevention and Prosthetic Engineering in Seattle, WA.

2. Center for Wheelchairs and Associated Rehabilitation Engineering in Pittsburgh, PA.

3. Center for Functional Electrical Stimulation in Cleveland, OH.

4. Center for Advanced Platform Technology in Cleveland, OH.

5. Center for Neurorestoration and Neurotechnology in Providence, RI.

These Centers provide a rich scientific environment in which clinicians work closely with researchers to improve and enhance care. They are not positioned to confer terminal degrees for prosthetic and orthotic care/research, but they are engaged in training and mentoring clinicians and engineers to develop lines of inquiry that will have a positive impact on amputee care. Moreover, VA would not have oversight of the Center.

VA is already investing a great deal into advancing prosthetic technology, and these Centers incorporate our interns and residents as well as graduate students from affiliated academic institutions. Each Center is funded with a base budget of nearly $1 million, but they are further required to seek VA or agency research funding. With these Centers and staffing in place, VA is additionally bringing in grants of approximately $10 million per year. As VA has already established internal research resources in this domain, the value to VA and Veterans for establishing a sixth non-VA research center does not seem warranted.

Finally, we believe the requirement to issue a request for proposals (RFP) within 90 days of enactment would be very difficult to meet as VA would first need to promulgate regulations prior to being able to issue the RFP.

We note that the language in section 3(a)(2), regarding how VA would give priority in the award of a grant, refers to at least some types of arrangements that could not exist. For example, VA does not have legal authority to enter into an MOU for the provision of resources, whether in cash or in-kind, to an institution; similarly, we are unsure as to whether the bill means to refer to a "cooperative agreement", as that term is used in Federal procurement, but we would appreciate the opportunity to discuss this further with the Committee. We would be happy to work with the Committee to revise this language to reflect the intended effect.

When considering implementation, VA provides the following training proposal assumptions:

- Enabling regulations would be developed and published within the first two FYs;
- Legal clarification between "grants" and the prescribed "RFP" methodology is achieved;
- Sufficient interest from accredited schools of Orthotics/Prosthetics;
- Sufficient VA staff hired to plan, execute and monitor the program;
- Contracting to support program and evaluation services to assess quality of the two components of this initiative;
- The proposal mentions an implementation in the current FY. We assume this is referring to the year this bill is passed, 2019 or later; and

- While the bill does not state the desired number of programs, with a site limit of $1.5 million and an overall cap of $15 million, this would cap the program at eight facilities, with additional funding being used for program administration.

Regarding the research proposal, VA provides the following assumptions:

- VA would develop and publish enabling regulations in the first two years FY 2019–2020;
- Staff would begin reaching out to potential academic partners;
- A quality assessment plan for both programs would be established and periodic site visitation would be conducted;
- During FY 2020, the RFPs for academic programs (up to 8 sites) would be developed, released, and an expert peer-review panel would make funding recommendations. Awards would be distributed in FY 2021;
- Enabling regulations would be developed and published within the first two fiscal years; and
- In 2020, the RFP for the Research CoE (one site) would be developed, released, and an expert peer-review panel would make the funding recommendation, with funds to be distributed in 2021.

We estimate the total cost of this bill as follows: $183,811 One Year Total and $20,604,079 Five/Ten Year Total.

H.R. 5521: VA Hiring Enhancement Act

Section 2 of this bill would amend title 38, United States Code, to restrict the applicability of non-VA covenants not to compete to the appointment of certain VHA personnel, specifically those appointed under 38 U.S.C. Section 7401. Section 2 would further require an individual appointed to such a position to agree to provide clinical services at VA for a duration beginning from the date of their appointment and ending on the latter of either one year after the date of appointment, or the termination date of any covenant not to compete that was entered into between the individual and the non-VA facility. The Secretary would have the authority to waive this particular requirement.

VA has concerns with section 2 of this proposed bill and requests the opportunity to discuss the bill further with the Committee.

Section 3 of the bill would permit VHA to make a contingent appointment as a VHA physician on the basis of the physician completing their residency training.

VA also has concerns with this section and requests an opportunity to further discuss. With regard to section 3, VA recommends removing the language regarding the completion of a residency leading to board eligibility, subsection (b)(1)(B)(i), since the requirement for residency training is provided in the published Department of Veterans Affairs (VA) physician qualification standard (VA Handbook 5005, Part II, Appendix G2). Physicians must have completed residency training or its equivalent, approved by the Secretary of VA in an accredited core specialty training program leading to eligibility for board certification. Approved residencies are:

- Those approved by the accrediting bodies for graduate medical education, the Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA), in the list published for the year the residency was completed, or
- Other residencies or their equivalents which the local Professional Standards Board determines to have provided an applicant with appropriate professional training. The qualification standard also allows for facilities to require VA physicians involved in academic training programs to be board certified for faculty status.

VA also recommends removing the language regarding an offer for an appointment on a contingent basis, subsection (b)(1)(B)(ii), since VA may currently provide job offers to physicians pending completion of residency training. There are no restrictions in statute or VA policy on making job offers contingent upon completing residency training and meeting other requirements for appointments as physicians within VHA. If this needs to be clarified in statute, VA suggests including the information in a new subsection (h) as follows: Section 7402 of title 38, United States Code, is amended by adding at the end the following subsection (h): "(h) The Secretary may provide job offers to physicians pending completion of residency training programs and completing the requirements for appointments under subsection (b) by not later than two years after the date of the job offer."

At this time, VA does not have a cost estimate for this bill.

H.R. 5693: Long-Term Care Veterans Choice Act

H.R. 5693, the Long-Term Care Veterans Choice Act, would amend section 1720 of title 38 U.S.C. to add a new subsection (h) providing authority for the Secretary to pay for long-term care for certain Veterans in medical foster homes (MFH) that meet Department standards. Specifically, the draft bill would allow Veterans, for whom VA is required by law to offer to purchase or provide nursing home care, to be offered placement in homes designed to provide non-institutional long-term supportive care for Veterans who are unable to live independently and prefer to live in a family setting. VA would pay MFH expenses by a contract or agreement with the home. VA would be limited to furnishing care and services to no more than 900 veterans placed in a medical foster home before or after the date of the enactment of this subsection. One condition of providing support for care in a MFH would be the Veteran's agreement to accept home health care services furnished by VA.

VA endorses the concept of using MFHs for Veterans who meet the appropriateness criteria to receive such care in a more personal home setting. VA endorsed this idea in its Fiscal Year (FY) 2018 and 2019 budget submissions and appreciates the Committee's consideration of this concept. Our experience has shown that VA-approved MFHs can offer safe, highly Veteran-centric care that is preferred by many Veterans at a lower cost than traditional nursing home care. VA currently manages the MFH program at over two-thirds of our medical centers; partnering with homes in the community to provide care to nearly 1,000 Veterans every day. Our experience also shows that MFHs can be used to increase access and promote Veteran choice-of-care options.

While VA fully supports the MFH concept, we would look forward to working with you to resolve a few technical issues in this bill. For example, the limitation in proposed subsection (h)(2), regarding a limit of 900 Veterans receiving care, is ambiguous; it is unclear whether this is intended to be an average daily census limitation, or if this is intended to be a hard cap on the total number of Veterans who could receive care under this program during the entire 3-year period. Moreover, while VA currently provides care through MFHs to approximately 1,000 Veterans, most of these are not Veterans who would qualify for care under section 1710A of title 38. Another change we recommend is to revise the language in subsection (h)(1) to refer to "contracts, agreements, or other arrangements." VA would like to work with the Committee to ensure VA can effectively incorporate MFHs into the continuum of authorized long-term services and support available to Veterans. We are happy to provide the Committee with technical assistance on this matter and are available for further discussion.

VHA estimates that, if enacted, this bill would cost $37.2 million in FY 2019, $50.64 million in FY 2020, and a total of $150.2 million over three years. Additionally, this bill could potentially divert approximately $24.47 million in FY 2019, $33.34 million in FY 2020, and a total of $98.90 million over 3 years from VA nursing home care costs, depending on whether those beds are backfilled.

H.R. 5864: VA Hospitals Establishing Leadership Performance Act ("VA HELP Act")

This bill proposes to standardize qualification requirements and performance metrics for human resources positions.

VA does not support the intent of this bill, but does support efforts to modernize and professionalize the HR function throughout the Government, including addressing the special needs of agencies that employ physicians and other clinical professionals. The Human Resources Management - GS–0200 series is under Title 5 and as such, is covered by the Office of Personnel Management's (OPM) General Schedule Qualification standards. These standards are broadly written for Government-wide application and are not intended to provide detailed information about specific qualification requirements for individual positions at a particular agency. The HR occupation remains on the Government Accountability Office's high risk list and have been identified as a skills gap. To address this issue, OPM currently is developing competencies for each HR specialty, and these competencies will be linked with training. In addition, as part of the President's Management Agenda, OPM will review and develop competency-based standards for the HR occupation, and these standards also will be used Government-wide. VA would support OPM addressing the issue across the federal government by creating higher standards for the HR Specialists, as government-wide surveys have found federal managers express the lowest satisfaction with the quality of their HR services, more than any other mission-support function.

It is important to note that all Federal agencies use OPM-approved qualification standards, and creating VA specific standards would negatively impact VA's ability

to retain current staff, as well as to recruit human resources (HR) professionals from other Federal agencies. OPM states that such information (i.e., a description of any specialized experience requirements that an agency may deem necessary for a particular position) should be included in the vacancy announcements issued by the agency. As such, rather than standardized qualification requirements across VA, individual vacancy announcements are customized to reflect the specialized experience (qualification requirements) for the particular position itself. VA already utilizes this method of applying specialized qualification requirements in all HR job announcements. Additionally, performance standards are developed on an annual basis for each HR position in the Department. These performance standards are aligned with the specific functions and specialized area of HR being performed by each HR professional.

While VA does not support the bill as written, if a decision is made to proceed with the bill, VA requests the opportunity to meet with the Committee to propose revisions to the language to address our concerns. A few examples include:

- Clearly define references to "each human resources position" to identify occupation specific series.
- The GS–200 Human Resources Management series currently has numerous individual occupational series and title codes, of which many have varying specialized experience requirements;
- Revise references to VHA throughout the bill to reflect VA is not limiting applicability to VHA.

Should this bill be revised as suggested, we would convene a workgroup led by the Office of Human Resources and Administration and would include subject matter experts (SMEs) from the three VA administrations. This workgroup would meet regularly and would be similar to the SME workgroups currently working on the development of new Hybrid Title 38 qualification standards. The review and proposed revisions would potentially take less than one year to complete. No new FTE would be required. The VA anticipates minimal cost to the Department if this bill is passed with suggested revisions.

H.R. 5938: Veterans Serving Veterans Act of 2018

Efforts are already underway to target transitioning military members for mission critical and difficult to fill positions by utilizing data contained in the Veterans Affairs/Department of Defense Identity Repository (VADIR) database. Directly targeting transitioning service members for mission critical and hard to fill VA positions should result in more transitioning military members choosing to work for VA and serve as a pipeline to fill critical vacancies. That said, because of the level of coordination required with DoD, VA requests that the bill be amended to require an implementation plan within 180 days, instead of requiring the establishment of a database within that timeframe. Additionally, the Administration requests that the Act be extended Government-wide. Leveraging this effort would both support efforts to hire more veterans into Government, and assist agencies that face similar hiring barriers.

An Intermediate Care Technician (ICT) training program has already been implemented at 23 VA Medical Centers (VAMC) with ICTs on staff. We are currently pursuing the establishment of an ICT Program at additional VAMC locations which will meet the requirements outlined in the bill. The ICT program has been considering the creation of "centers" at medical facilities to train and certify Veterans to work as ICTs. The ICT program is currently evaluating whether to designate one (or two) VAMCs as VA National ICT Training sites. These sites would be utilized as the entry point for all VA-hired ICTs. After completing a prescribed training curriculum, the ICTs would then proceed to the VAMC that hired them. The ICT program is considering the elements listed in the proposed bill when evaluating a possible National ICT Training site, including the experience and success of VAMCs in training ICTs and resource support for the ICTs or the ICT program at individual VAMCs.

The estimated costs do not include the cost of hiring and training an ICT, since that will depend on geographic location and the number of ICTs hired by each VAMC. With that in mind, we estimate the total cost of this bill as follows: $220 thousand in FY 2020 Total; $598 thousand over five years; and $1.2 million over 10 years.

Draft Bill to Improve the Productivity of VA Health Care

This bill calls for VA to track relative value unit production standards; requires all Department providers to attend training on clinical procedure coding; mandates establishment of standardized performance standards based on nationally recog-

nized relative value unit production standards; and requires submission of a report on the implementation of the bill's requirements.

VA does not support this bill as written, and would like to discuss the bill with the Committee to further refine the language. In support of VA's position, it should be noted that VA already tracks relative value units for Department Providers (Licensed Independent Providers (LIP) as defined by the bill). A six-module online training program in Clinical Procedure Coding is in development with a target release date of late FY 2018. VA is concerned about the implementation of this component in that the time required to train providers in coding will significantly reduce their availability to provide timely health care to Veterans.

Additionally, requiring LIPs to learn and become proficient in skills not essential to direct patient care will have a detrimental impact on the timely delivery of health care. VA is also concerned about whether mandatory training of providers is the most effective and efficient means to create system improvements. Also, VA has performance standards in place, broken out by provider type and location. Specialty specific productivity targets are established and are reviewed annually at a minimum. Remediation plans are developed for provider practices that do not meet minimum thresholds. Lastly, VA currently has the tools in place to create the required report.

Pending VA meeting with the Committee to further discuss the coding training requirement for LIPs, VA is not able to accurately develop costs. Primary topics impacting the cost estimate include:

- Determining the number of LIPs who would be impacted.
- The time LIPs would be taken away from direct patient care, and
- Determining the number of Contract LIPs who would be needed to fill the gap created when providers are required to use duty hours to attend extensive training.

Mr. Chairman, this concludes my testimony. My colleagues and I are prepared to answer any questions the Subcommittee may have.

Statements For The Record

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO

Chairman Wenstrup, Ranking Member Brownley and Members of the Subcommittee:

The American Federation of Government Employees, AFL–CIO (AFGE) and its National Veterans Affairs Council (NVAC) appreciate the opportunity to submit a statement for the record on pending legislation.

AFGE represents nearly 700,000 federal employees, including 250,000 front-line employees at the Department of Veterans Affairs (VA) providing medical care, mental health treatment and other essential services to our nation's veterans.

H.R. 6066, To improve productivity of the management of Department of Veterans Affairs health care, and for other purposes

AFGE and NVAC strongly oppose expanding management authority to measure VA provider productivity through relative value units (RVUs). RVUs fail to measure the many essential services that bring value to the VA's mission of treating the complex needs of our wounded warriors, including coordination of care, clinical research, palliative care, triage, clinician training, dietary counseling, chemotherapy teaching, and pre-op and post-op care among many other routine VA medical center activities.

This bill ignores that far greater urgency of filling the thousands of unfilled VA provider positions that have placed VA providers under tremendous pressure to care for veterans with complex needs while operating with excessive panel sizes, large numbers of unassigned patients, and daily additional responsibilities such as responding to computer view alerts and following up on lab reports.

In addition, as GAO noted in its May 2017 report on clinical productivity and efficiency (GAO–17–480), VA could achieve significant increases in productivity through the hiring of additional support staff and improved infrastructure including both exam and procedure rooms and adequately equipped facilities.

In the words of one of our discouraged VA front line physicians "When RVUs are applied to physicians it places quantity over quality of care. People are not widgets and the principles of mass production should not be applied to patient care or we unduly increase the risk of adverse patient outcomes".

Veterans using the VA deserve better. Only the VA provides them with adequate time to be properly diagnosed, treated, and referred to the appropriate additional care. RVUs were designed for for-profit health care and have absolutely no place in the VA health care system. As another frontline clinician commented, "Billing codes and encounter codes don't capture the veteran's care accurately. You can't quantify this unique type of care with coding."

Furthermore, the unilateral use of RVUs to measure VA in-house provider productivity would exacerbate the double standard already in place that fails to measure the quality and access of private sector care, thus depriving veterans of making an informed decision about whether to seek care in the VA or use a Choice provider.

H.R. 2787, the Veterans-Specific Education for Tomorrow's Medical Doctors Act

AFGE supports H.R. 2787. This bill would increase opportunities for pre-medical undergraduate students to gain clinical observation experiences at VA medical facilities. The intent of the bill is to expose future physicians to veteran-centric care, increase the diversity of the medical profession and address the nation's physician shortage. AFGE supports H.R. 2787.

H.R. 3696, the Wounded Warrior Workforce Enhancement Act

AFGE and NVAC take no position on H.R. 3696, a bill to award educational grants to expand master's degree programs in orthotics and prosthetics.

H.R. 5521, the VA Hiring Enhancement Act

AFGE and NVAC take no position on H.R. 5521, a bill that would make pre-existing non-compete clauses nonapplicable to VA health care personnel appointed under Title 38, and that would authorize physician appointments on a contingent basis prior to the completion of medical training.

H.R. 5693, the Long-Term Care Veterans Choice Act

AFGE and NVAC take no position on this bill on medical foster homes.

H.R. 5864, the VA Hospitals Establishing Leadership Performance Act

AFGE and NVAC support this bill to establish standards and performance measures for all Veterans Health Administration human resources (HR) positions, but we also urge additional training and modernization of the Department's HR workforce to reduce the widespread violation of workplace rights and compensation laws applicable to VA employees.

H.R. 5938, the Veterans Serving Veterans Act of 2018

AFGE and NVAC take no position on this bill expanding VA job opportunities for active duty personnel.

H.R. 5974, the Department of Veterans Affairs Creation of On-Site Treatment Systems Affording Veterans Improvements and Numerous General Safety Enhancements Act

AFGE and NVAC take no position on this bill on VA medical waste treatment systems but commends the intent of the bill to reduce costs by taking steps to insource this function back to VA medical centers and reduce reliance on costly contractors.

Thank you.

AMERICAN ORTHOTICS AND PROSTHETICS ASSOCIATION

Chairman Dunn, Ranking Member Brownley, and Members of the Committee,

Thank you for inviting the American Orthotic and Prosthetic Association to offer its perspective on the need to expand our pool of highly educated clinicians who can offer prosthetic and orthotic care to Wounded Warriors who have lost limbs or sustained chronic limb impairment on the battlefield. We thank you for including HR 3696, the Wounded Warrior Workforce Enhancement Act, in this hearing.

AOPA represents over 2,000 orthotic and prosthetic patient care facilities and suppliers that evaluate patients for and design, fabricate, fit, adjust and supervise the use of orthoses and prostheses. Our members serve Veterans and civilians in the communities where they live, and our goal is to ensure that every patient has access to the highest standard of O&P care from a well-trained clinician. It is not widely known that 80–90% of prosthetic/orthotic care delivered to Veterans is provided in a community-based setting, outside the walls of a VA Medical Center. The

vast majority of your constituents who are Veterans and who need a prosthesis or orthosis received a device that was provided and maintained by an AOPA member.

The VA contracts with community-based providers to offer Veterans timely, convenient and high quality prosthetic and orthotic care near the locations where they live and work. Because such a high percentage of care is delivered by community-based providers, the private sector workforce and procurement relationships with the VA must be a part of any discussion of lower extremity prosthetic and orthotic care for Veterans.

Wounded Warriors Need Orthotic and Prosthetic Care

Traumatic Brain Injury (TBI) and amputation are signature injuries of the wars in Iraq and Afghanistan. Traumatic Brain Injury often manifests in the same way as stroke, with orthotic intervention needed to address drop foot and other challenges balancing, standing and walking. The Defense and Veterans Brain Injury Center has reported that by the start of calendar year 2018, more than 379,500 service members had suffered a TBI.

Although the death rate from conflicts in Iraq and Afghanistan is much lower than in previous wars, the amputation rate doubled. The Department of Defense and the Department of Veterans' Affairs have reported that in past wars, 3% of service members injured required amputations; of those wounded in Iraq, 6% have required amputations. The DoD Surgeon General reported to CRS more than 1,600 service-related amputations from 2001–2016. More than 80% of amputees lost one or both legs. Concussion blasts, multiple amputations, and other conditions of war have resulted in injuries that are medically more complex than in previous conflicts. The majority of these amputees are young men and women who should be able to live long, active, independent lives - sometimes even return to active duty - if they receive timely, high quality, and consistent prosthetic care.

Senior Veterans Need Orthotic and Prosthetic Care

Most Americans are unaware that the majority of Veterans with amputations undergo the procedure as a result of diabetes or cardiovascular disease. According to VA statistics, one out of every four Veterans receiving care has diabetes; 52% have hypertension; 36% are obese. These conditions are associated with higher risk for stroke, neuropathy, and amputation.

These underlying health conditions are the reason that the number of Veterans undergoing amputation is increasing dramatically, and is expected to increase at an even more rapid pace in the future. VHA Amputation System of Care figures show that, in the year 2000, 25,000 Veterans with amputations were served by the VA. By 2016, that number had more than tripled to 89,921. Between 2008–2013, an average of 7,669 new amputations were performed for Veterans every year; in 2016, 11,879 amputation surgeries were performed. 78% of the Veterans undergoing amputation last year were diabetics. 42% had a service-connected amputation condition.

Demand for High Quality Care is Growing While Provider Population Shrinks

From the battlefield to the homeland, medical conditions requiring prosthetic and orthotic care have become more complex and more challenging to treat. New prosthetic and orthotic technology is more sophisticated, and offers potential for greater functional restoration. To ensure professional, high quality care that responds to these shifts, earlier this decade the entry-level qualifications for prosthetists and orthotists were elevated from a bachelor's degree to a master's degree.

Veterans need and deserve clinicians who can successfully respond to their battlefield injuries and service-related health conditions with appropriate, advanced technologies. As the population of amputees grows, many experienced professionals who were inspired to enter the field to care for Vietnam Veterans are retiring. Currently, only 13 American universities offer master's degrees in prosthetics and orthotics. The largest progra admits fewer than 50 students each year. The majority of programs enroll fewer than 20 students. Despite receiving multiple qualified applicants for every seat, fewer than 250 students are able to enroll in all 13 programs combined each year. Providing high quality care to our Wounded Warriors and Veterans with limb loss and impairment is going to require more master's degree graduates from American universities to be the next generation of practitioners.

The National Commission on Orthotics and Prosthetics Education (NCOPE) joined with AOPA to commission an independent study of the O&P field, which was completed in May of 2015. The study found that in 2014, there were 6,675 licensed and/or certified orthotists and prosthetists in the United States. It concluded that, by 2025, "overall supply of credentialed O&P providers would need to increase by about

60 percent to meet the growing demand." Subsequent analysis conducted by NCOPE and AOPA suggests that the current number of providers is closer to 5,500, an even more significant shortage than than previously predicted.

Current accredited schools will barely graduate enough entry-level students with master's degrees to replace the clinicians who will be retiring in coming years. Class sizes simply aren't adequate to meet the growing demand for O&P care created by an aging population and rising incidence of chronic disease.

Positions as licensed, certified prosthetists and orthotists are good jobs. Nationally, the average wage exceeds $65,000. These jobs pay good wages, support a family, and can't be outsourced overseas. Most importantly, they help improve the health and quality of life for our Veterans. Veterans need care. The providers who care for them need high quality employees. People want fulfilling careers, and feel great about caring for the men and women who have so nobly served our country. Schools are getting more applicants for O&P programs than they can accept. Where is the imbalance?

The Wounded Warrior Workforce Enhancement Act

O&P master's programs are costly and challenging to expand. The need for lab space and sophisticated equipment, and the scarcity of qualified faculty with PhDs in related fields, contribute to the barriers to expanding existing accredited programs. There are currently no federal resources available to schools to help create or expand advanced education programs in O&P. Funding is available for scholarships to help students attend O&P programs, but do not assist in expanding the number of students those programs can accept.

One way to address this problem is by passing The Wounded Warrior Workforce Enhancement Act, introduced in the House by Representative Cartwright with bipartisan support. This bill is a limited, cost-effective approach to assisting universities in creating or expanding accredited master's degree programs in orthotics and prosthetics. It authorizes $5 million per year for three years to provide one-time competitive grants of $1–1.5 million to qualified universities to create or expand accredited advanced education programs in prosthetics and orthotics. Priority is given to programs that have a partnership with Veterans' or Department of Defense facilities, including opportunities for clinical training, to ensure that students become familiar with and can respond to the unique needs of service members and Veterans. The bill was endorsed by Vietnam Veterans of America and VetsFirst, which recognize the need for additional highly qualified practitioners to care for wounded warriors.

In May of 2013, the Senate Committee on Veterans Affairs held a hearing to consider the Wounded Warrior Workforce Enhancement Act and other Veterans' health legislation. The VA testified that the grants to schools were not necessary because it did not anticipate any difficulty filling its seven open internal positions in prosthetics and orthotics. The VA testified that its O&P fellowship program, which accepted nineteen students that year, was a sufficient pipeline to meet its need for internal staff. The VA offered similar testimony at a House Veterans Affairs Health Subcommittee hearing in November 2015.

The Senate rejected the VA's argument. Acknowledging that most prosthetic and orthotic care to Veterans is provided by community-based facilities, the Committee concluded that nineteen students could not meet the system-wide need. Committee members also agreed that Veterans and the VA would benefit from a larger pool of clinicians with master's degrees, whether those graduates were hired internally at the VA, or by community-based providers. The Committee included provisions of the Wounded Warrior Workforce Enhancement Act in S. 1950, which passed Senate VA Committee unanimously in 2013. Due to factors unrelated to O&P, the omnibus bill did not advance. Related provisions were included in the Senate's omnibus package Veterans' legislation in 2016, but were not included in the final conferenced bill.

AOPA looks forward to working with you to expand the number of highly qualified prosthetists and orthotists who can meet the needs of Veterans with limb loss and limb impairment, and to reducing the barriers to timely, appropriate lower extremity care. No Veteran should suffer from decreased mobility or independence because of lack of access to high quality care, regardless of where it is provided.

A Proud History of Caring for Veterans in the Community Is Under Threat

AOPA commends the VA for its historical leadership in ensuring that Veterans who have undergone amputations have access to appropriate, advanced prosthetic technology, often before the same technology is made available to patients in the private sector. For example, when the first microprocessor-controlled knee came to market, it was initially considered beneficial for the fittest, most active amputees. Fred Downs, then National Director of the Prosthetic and Sensory Aids Service, was

himself a Vietnam Veteran who lost an arm in combat. He had the idea that the greater stability offered by microprocessor control might be even more beneficial to older, less active Veterans with limb loss who were less steady on their feet. After testing the computer-controlled knees with older Veterans undertaking activities such as walking in the community and riding Metro escalators, the VA became the first payor to approve microprocessor-controlled knees for older and less active patients. Today, following the VA, Medicare and private insurance companies widely accept that microprocessor-controlled knees improve safety and increase activity levels for patients with limb loss across a wide spectrum of activity levels.

O&P care is unusual in providing care to Veterans largely through contracts with private sector providers - often family-owned, small businesses. There are multiple advantages to the VA, and to Veterans, from this long-time public-private partnership in O&P. With a private sector network of O&P clinics supplementing care available from VA employees, wait times are reduced and Veterans receive the care they need more quickly than if they were relying solely on overburdened VA facilities and federal employees. Community-based providers are often closer to Veterans' homes or workplaces. Frequently, they offer Veterans more convenient care, with less travel time and expense, less time away from work, and less interruption to their daily lives.

It is in part because of this strong history of providing high quality care in the community to Veterans who need it that AOPA is deeply concerned by the October 16, 2017 Federal Register Notice and proposed rule regarding "Prosthetic and Rehabilitative Items and Services." Under the proposed rule, the Veterans' Administration, not the Veteran, would decide if a Veteran can receive care from a local provider or if that Veteran must drive - sometimes for hours, over hundreds of miles - to receive care in a VA facility. In fact, the proposed policy states that, if the VA has the materials in-house, care shall be provided in the VA. The policy, which is described in the Federal Register as a "clarification," in fact upends decades-long precedent allowing Veterans to choose to receive prosthetic and orthotic care in the community. AOPA is grateful to Representatives Walberg and Rutherford, who recently offered an amendment prohibiting use of appropriated funds to finalize the proposed policy. AOPA joins with Veterans' Service Organizations that have called for the VA to withdraw this proposal immediately, and urges the VA instead to affirmatively rebuild the public-private partnership that has provided such high quality care.

AOPA is also deeply concerned about the impediments the coding policies of the Centers for Medicare and Medicaid services are posing with respect to the development of new, more advanced technologies needed by prosthetic and orthotics patients, and Veteran access to these advanced technologies. The VA recently announced that it would reverse its longstanding practice of making payments for new prosthetic technologies under a "Not Otherwise Classified" code. This decision, and other related policies, appear to be limiting Veterans' access to newer, advanced and more effective prosthetic and orthotic technologies. The VA has never provided a comprehensive explanation for its policy changes. We are grateful to former Subcommittee Chairman Wenstrup for his work on this issue, including his work on a joint hearing or round table with the House Ways and Means Committee.

Chairman Dunn, Ranking Member Brownley, and members of the Committee, we know you share our belief that Veterans who have suffered limb loss or limb impairment as a result of their military service, or as a result of service-connected illness, deserve the best possible care that a grateful country can provide. We look forward to working with you to ensure that all Veterans continue to receive that care.

MILITARY OFFICERS ASSOCIATION OF AMERICA

CHAIRMAN DUNN, RANKING MEMBER BROWNLEY, and Members of the Subcommittee on Health, the Military Officers Association of America (MOAA) is pleased to submit its views on pending legislation under consideration.

MOAA does not receive any grants or contracts from the federal government.

EXECUTIVE SUMMARY

On behalf of the 350,000 members of the Military Officers Association of America, the largest military service organization representing the seven uniformed services, including active duty and Guard and Reserve members, retirees, veterans, and survivors and their families, thank you for your commitment and enduring support of our nation's servicemembers, veterans and their families.

MOAA offers our position on the following bills.

- H.R. 2787, Veterans-Specific Education for Tomorrow's Medical Doctors Act
- H.R. 3696, Wounded Warrior Workforce Enhancement Act
- H.R. 5693, Long-Term Care Veterans Choice Act
- H.R. 5864, VA Hospitals Establishing Leadership Performance Act
- DRAFT Bill, Veterans Serving Veterans Act

MOAA takes no position on: H.R. 5521, VA Hiring Enhancement Act; H.R. 5974, VA COST SAVINGS Enhancement Act; and, the draft bill To Improve the Productivity and Management of VA Health Care Facilities. These bills are outside of our scope of expertise.

PENDING LEGISLATION

H.R. 2787, Veterans-Specific Education for Tomorrow's Medical Doctors Act (VET MD Act). MOAA supports this legislation. However, we urge Congress to commit the necessary resources and funding to execute the program.

The VET MD Act would allow the VA to establish a pilot program instituting a clinical observation program for pre-med students preparing to attend medical school.

The association is grateful to Representatives Kaptur, Jones, and Ryan for introducing the bill and for the Subcommittee's consideration of this important piece of legislation. Like lawmakers, MOAA is eager for the VA to try new and innovative approaches growing the agency's medical workforce and eliminating the current 30,000-plus vacancies across its health care system. This legislation would introduce prospective medical students to the kinds of health care conditions common to the veteran population and help the VA encourage students to choose a career in medicine, particularly in occupational fields with high staffing shortages, such as women's health care and psychiatric care and/or consider a career in veterans' health care at the agency.

While the legislation only requires the VA to establish procedures to track students participating in the clinical observation program to determine if the student was accepted into medical school, MOAA recommends this Subcommittee consider adding a provision requiring the VA to continue tracking these students through medical school and residency programs in an effort to secure medical professionals for VA employment and to ascertain the effectiveness of the clinical observation program to individuals deciding on a career in medicine who are interested in treating the veteran population.

H.R. 3696, Wounded Warrior Workforce Enhancement Act. MOAA supports this legislation and requests Congress provide the associated funding needed to support the legislative requirements of this bill.

The Wounded Warrior Workforce Enhancement Act would require the VA to award grants to establish or expand upon master's degree programs with academic medical institutions in the fields of orthotics and prosthetics. Further, the VA shall award a grant to an eligible institution to establish a Center of Excellence in Orthotic and Prosthetic Education to conduct evidence-based research and to improve health outcomes for veterans, servicemembers, and civilians.

The legislation also allows grants to eligible institutions planning to expand their existing master's degree program in these two fields by admitting more students or adding faculty to the program, expanding existing facilities, or by increasing cooperative partnerships with the VA and DoD.

Military service today has unique occupational demands and hazards. Servicemembers are required to carry heavy rucksacks and body armor in physically demanding training and harsh combat environments. Increased exposure to improvised explosive devices has resulted higher rates of injury among Post-9/11 troops, including amputations, and lower extremity conditions. Veterans are also presenting in increasing numbers for foot and ankle ailments, conditions complicated by diabetes, and neuropathy often associated with Agent Orange exposure, orthopedic, or vascular problems.

MOAA believes H.R. 3696 would provide the VA an additional tool it needs to address staffing shortages in the area of orthotics and prosthetics and help the agency attract high quality providers to meet current and future needs of veterans needing these important services within VA's integrated network of care.

H.R. 5693, Long-Term Care Veterans Choice Act. MOAA supports this bill as long as the requisite associated funding is provided for implementation.

The Long-Term Care Veterans Choice Act would authorize the VA to place veterans who are unable to live independently in private medical foster homes at the expense of the government.

Many veterans live with complex chronic diseases or disabling traumatic injuries and over time these individuals may be unable to live independently or their health

care needs become such their family caregiver may no longer be able to manage their care. In recent years, the VA has established a medical foster home program to prevent this population of veterans being institutionalized or delay entering nursing home care, instead allowing for them to be placed in a home in their community as a more acceptable alternative of care for the veteran. Veterans are placed in a home with other veterans and have a live-in qualified caregiver to support their medical needs 24/7.

While VA is required to provide institutional care, such as nursing home services to veterans who qualify for health care and have a service-connected disability rating of 70 percent or higher or are considered unemployable and have a disability rating of 60 percent or higher, the agency cannot directly pay for care through the medical foster home program. Veterans participating in the foster home program typically pay for these services from monthly VA disability compensation and Social Security payments and personal saving accounts.

VA recognizes the positive health outcomes and costs savings associated with veterans receiving care and services through the foster home program. This legislation would provide VA the mechanism to pay for the care directly so veterans and their families would not have to forfeit earned benefits to pay for care they would otherwise be entitled to if they were receiving institutionalized care.

H.R. 5864, VA Hospitals Establishing Leadership Performance Act. MOAA supports this legislation.

H.R. 5864 would require the VA to establish qualifications and standardized performance metrics for each human resources position within the veterans' health care system and submit a report to Congress on these qualifications and standards. The Comptroller General is required to follow up with a report on how the VA implemented the requirement to include an assessment of the quality of the qualifications and performance metrics adopted by the agency.

MOAA is pleased to see the legislation put forth to improve and strengthen VA's human resources system. Effective transformation will require leaders at all levels of the organization to be responsible and accountable for improving organizational health and staff engagement. Such transformation must include reforming and modernizing the VA's leadership and human capital management systems across the enterprise. While MOAA would like to see more comprehensive human resources strategy for system change along with the technology, resources, and funding to support the overhaul, H.R. 5864 is a foundational element to begin the massive overhaul needed to recruit, retain, and sustain a viable workforce. If we are to address the ongoing medical staffing shortages within the VA, then securing and sustaining high quality human resource professionals is essential.

DRAFT Bill, Veterans Serving Veterans Act. MOAA supports this legislation.

The Veterans Serving Veterans Act would permit the department to establish a database to capture specialties and skills of medical members of the Armed Forces to facilitate recruitment and address the occupational workforce needs of the VA.

The legislation would also require the department to establish and implement a training and certification program for veterans to work as medical technicians in VA.

The database, to be called the "Department of Defense and Veterans Affairs Recruitment Database," is intended to be a single, searchable platform by which the two departments can exchange information on military occupational specialty or skills of consenting members of the Armed Forces who might be qualified after being discharged and released from active duty to fill medical vacancies in the VA. VA would be authorized to use direct hiring and appointment authorities and may authorize a relocation bonus to expedite hiring.

Just as H.R. 5864 listed above offers an opportunity to address critical workforce shortfalls, the Veterans Serving Veterans Act is equally important in identifying and securing critical medical professionals who may be qualified and interested in serving in the VA. MOAA has advocated for years for more collaboration and communications between DoD and VA as one of many ways to address VA's critical professional and technical medical staffing shortages. MOAA is pleased to support this important legislation and is confident DoD and VA can implement the provisions in this bill with minimal cost to either department as the database should be considered a standard tool and requirement for use by human resources professionals.

MOAA thanks the Subcommittee for considering these important pieces of legislation and we look forward to working with members of Congress in making the necessary changes listed above and to move the bills quickly through the Congress for final passage.

PARALYZED VETERANS OF AMERICA

Chairman Dunn, Ranking Member Brownley, and members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views on the broad array of pending legislation impacting the Department of Veterans Affairs (VA) that is before the Subcommittee. No group of veterans better understands the full scope of care provided by the VA than PVA's members-veterans who have incurred a spinal cord injury or disease. Most PVA members depend on VA for 100 percent of their care and are the most vulnerable when access and quality of care is threatened. Several of these bills will help to ensure veterans receive timely, quality care and services.

H.R. 2787, the "Veterans-Specific Education for Tomorrow's Medical Doctors Act"

PVA supports H.R. 2787, the "Veterans-Specific Education for Tomorrow's Medical Doctors Act." This bill would establish a pilot program in the VA for pre-med students to experience clinical observation before attending medical school. The pilot would be carried out for a three-year period at no more than five medical centers. The goals of this clinical observation pilot would be to increase awareness and knowledge of veterans' health care for future medical professionals and increase provider diversity. While VA does already allow for clinical observation, this pilot would assist in enhancing the awareness of veteran-specific needs among future medical professionals. Each session would allow for no fewer than 20 students and 60 observational hours with three sessions per calendar year. In selecting which medical centers and specialties are to participate, the Secretary may select those with the largest staffing shortages. PVA recommends VA provide the participating students with information regarding employment at VA, including educational opportunities and loan repayment programs.

H.R. 3696, the "Wounded Warrior Workforce Enhancement Act"

PVA supports the goal of this legislation to the extent that it attempts to rejuvenate a declining orthotics and prosthetics workforce. We have a concern, however, as to whether the veteran community will truly capitalize on the return on this investment if the legislation does not require some level of service commitment from student beneficiaries.

Quality orthotic and prosthetic care is of the utmost importance to PVA members. No group of veterans understands the importance of prosthetics and orthotics more than veterans with spinal cord injury or disease. The Independent Budget Veteran Service Organizations (IBVSOs) maintain that the VA must ensure that prosthetics departments are staffed by certified professional personnel or contracted staff that can maintain and repair the latest technological prosthetic devices. A key component to this is continued support for the VA National Prosthetics Technical Career Program which aims to address the projected personnel shortages.

In June of 2015, the National Commission on Orthotic and Prosthetic Education (NCOPE) released its analysis projecting orthotics and prosthetics workforce supply and patient demand over the next ten years. The analysis showed that the overall number of credentialed O&P providers will need to increase approximately 60 percent by 2025 to meet the growing demand. This is in part due to the fact that attrition rates from the profession will surpass the graduation rates of those entering the field, ultimately resulting in a decreasing supply of orthotics and prosthetics providers. Failure to address both the decreasing supply of providers and the increasing demand for their services will very likely cause the workforce to shift toward non-credentialed providers. Our veterans deserve to be cared for by competent and highly trained individuals.

This legislation is an important step toward ensuring that our veterans continue to be treated by credentialed providers. It promotes the expansion of a qualified teaching and faculty pool which will provide the foundation to accommodate and train a growing number of students seeking to become providers. In addition to the expected dissemination of best practices and knowledge from the proposed Center of Excellence, the legislation also provides eligible institutions built-in flexibility to tailor and use the funds for educational areas where they can achieve the goal of expanding the orthotics and prosthetics workforce most effectively. PVA also supports the proposed veterans' preference in the admissions process. As the IBVSOs have stated before, employing veterans in this arena will ensure a balance between the perspective of the clinical professionals and the personal needs of the disabled veterans.

PVA's concern, though, is that the bill misses an opportunity to capture a more predictable and tangible return on investment. Requiring scholarship recipients to

serve a commitment with the VA is a way to strengthen the precision with which these funds are allocated without reducing the previously mentioned institutional flexibility. The goal of this legislation is, after all, to expand the orthotics and prosthetics workforce in order to better serve veterans. While the proposed approach of expanding the overall pool of qualified service providers within the community writ large might have a trickle effect of ensuring that the VA continues to offer certified providers, we believe this suggested change would have a stronger and more immediate impact.

H.R. 5521, the "VA Hiring Enhancement Act"

PVA supports H.R. 5521, the "VA Hiring Enhancement Act." The bill would amend title 38 to provide for the non-applicability of non-VA covenants not to compete to the appointment of certain Veterans Health Administration personnel. It would also permit VHA to make contingent appointments and require VA physicians to complete residency training. This bill intends to fill vacancies and make VA more competitive by authorizing VHA to begin the recruitment and hiring process up to two years prior to the completion of required training. This would allow for physicians to quickly begin work at VA medical centers upon the completion of their education. This could help to stem the flow of the ever recurring stories of young clinicians who wished to serve veterans but were unable to endure the months of an uncertain onboarding process. Veterans deserve the best this country can offer. Congress should explore every means to ensure VA does not lose out on young professionals due to inefficient hiring practices.

H.R. 5693, the "Long-Term Care Veterans Choice Act"

PVA supports H.R. 5693, the "Long-Term Care Veterans Choice Act." This bill proposes to amend title 38 to authorize the VA to enter into contracts or agreements for the transfer of veterans to non-VA adult foster homes for certain veterans who are unable to live independently. PVA believes that VA's primary obligation involving long-term support services is to provide veterans with quality medical care in a healthy and safe environment.

As it relates to veterans with a catastrophic injury or disability, it is PVA's position that adult foster homes are only appropriate for disabled veterans who do not require regular monitoring by licensed providers, but rather are able to maintain a high level of independence despite needing assistance due to having a catastrophic injury or disability. When these veterans are transferred to adult foster homes, care coordination with VA specialized systems of care is vital to the veterans' overall health and well-being. The drafted text of this bill requires the veteran to receive VA home health services as a condition to be transferred. As such, PVA believes that if a veteran with a spinal cord injury or disease (SCI/D) is eligible and willing to be transferred to an adult foster home, the VA must have an established system in place that requires the VA home-based primary care team to coordinate care with the VA SCI/D Center and the SCI/D primary care team that is in closest proximity to the adult foster home. When caring for a veteran with a catastrophic injury or disability this specialized expertise is extremely important to prevent and treat associated illnesses that can quickly manifest and jeopardize the health of the veteran. When catastrophically injured or disabled veterans who receive services from one of the VA's specialized systems of care are placed in a non-VA adult foster home they must be regularly evaluated by specialized providers who are trained to meet the needs of their specific conditions.

H.R. 5864, the "VA Hospitals Establishing Leadership Performance Act"

PVA supports H.R. 5864, the "VA Hospitals Establishing Leadership Performance Act" that would direct the Secretary to establish qualifications for the human resources positions within VHA. It would also require VA to standardize performance metrics and report the findings to Congress. There currently are no such requirements.

H.R. 5974, the "Department of Veterans Affairs Creation of On-Site Treatment Systems Affording Veterans Improvements and Numerous General Safety Enhancements Act"

PVA supports H.R. 5974, the "Department of Veterans Affairs Creation of On-Site Treatment Systems Affording Veterans Improvements and Numerous General Safety Enhancements Act." This legislation would direct the Secretary to use on-site regulated medical waste treatment systems at certain VA facilities.

Currently, most VA facilities dispose of medical and biohazardous waste by contracting for its removal by truck. This method is expensive, and poses inherent risk by loading waste, such as blood, microbiological cultures, body parts, dressings, etc.,

onto vehicles that must travel to disposal sites. The opportunity for accidents, spillage, and exposure to the public are ever present. This legislation would allow, where it results in savings, for VA to discard its own waste using on-site regulated medical waste treatment systems.

H.R. 5938, the "Veterans Serving Veterans Act of 2018″

PVA supports the intent of this legislation. However, we have some concerns regarding the level of interagency cooperation it would take to enact this legislation. We are eager to learn the position of VA and the Department of Defense (DOD) regarding this bill. Additionally, we have some concerns regarding privacy.

The draft bill would establish a vacancy and recruitment database to facilitate the recruitment of soon to separate members of the Armed Forces in order to fill vacant positions at VA. To do so, it requires DOD to provide the names and contact information of every member of the Armed Forces whose military occupational specialty or skill corresponds to an employment vacancy at the VA. We are unconvinced the current employment databases are so insufficient to navigate that it justifies this degree of interagency upkeep as well as the upfront provision of the names, contact information, and skillsets of individuals soon to leave the military. Most concerning, this database of DOD information, to be maintained by VA, would automatically submit service members' information and require one to opt-out, rather than opt-in, in writing. While PVA commends the intent of this legislation, to fill vacancies and provide suitable employment to newly separated service members, we recommend privacy and efficiency concerns be addressed.

Draft legislation, "to improve productivity of the management of Department of Veterans Affairs health care, and for other purposes"

PVA supports the intent of this draft legislation. As written, the draft would require VA to track relative value units (RVU) for all VA providers. It would also require all providers to attend training on clinical procedure coding. In addition, it would direct the Secretary to establish for each facility standardized performance standards based on RVUs that are applicable to each specialty, as well as remediation plans for low productivity and clinical inefficiencies.

RVUs, a private sector standard used to determine productivity against expenses, has been a widely used tool by the Centers for Medicare and Medicaid Services for decades. The primary purpose of which is not to enhance patient outcomes but to determine provider payments. While RVUs could be useful, they are not perfectly applicable for a holistic health system like VA.

PVA strongly supports the use of any tool that betters the care veterans receive. If legislation proposed a tool that would both increase quality and save the taxpayer, we would support it. However, we are not convinced the RVU measure will motivate providers at facilities appropriately. A private sector model is not applicable to veteran centric, complex care provided at VA. As the private sector rarely discloses their own performance under such measurement, we are hesitant to support a flawed comparison between the two systems that benefits neither.

As is often noted, VA providers spend far more time with patients compared with the private sector, to the increased satisfaction of the veteran. And since providers are not compensated by quantity of patients seen, the incentive to spend quality time with a patient is encouraged. We are eager to learn VA's position on this bill.

PVA would once again like to thank the Subcommittee for the opportunity to submit our views on the programs affecting veterans. We look forward to working with you to ensure our catastrophically disabled veterans and their families receive the medical services and supports they need.

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