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### DEPARTMENT OF VETERANS AFFAIRS MEDICAL PROGRAMS ENHANCEMENT ACT OF 2001

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Mr. ROCKEFELLER, from the Committee on Veterans' Affairs,  
submitted the following

### REPORT

[To accompany S. 1188]

The Committee on Veterans' Affairs, to which was referred the bill S. 1188, to amend title 38, United States Code, to enhance the authority of the Secretary of Veterans Affairs to recruit and retain qualified nurses for the Veterans Health Administration, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and an amendment to the title, and recommends that the bill, as amended, do pass.

#### INTRODUCTION

On June 14, 2001, the Committee held a hearing to develop a greater understanding of the factors underlying the imminent shortage of professional nurses and its projected impact on health care in the Department of Veterans Affairs. Those testifying at the hearing included: Senator Max Cleland; Thomas L. Garthwaite, M.D., Under Secretary for Health, Department of Veterans Affairs (VA); Catherine J. Rick, R.N., M.S.N., Chief Nurse Consultant, Nursing Strategic Health Care Group, VA; Sarah Myers, R.N., Ph.D., President of the Nurses Organization of Veterans Affairs, Atlanta, GA; Sandra McMeans, R.N., Representative, American Nurses Association, Martinsburg, WV; J. David Cox, R.N., First Vice President, National VA Council, American Federation of Government Employees, Washington, DC; Sandra K. Janzen, R.N., M.S., Chief Nurse Executive, Tampa (James A. Haley) VA Medical Center, Tampa, FL; Robert A. Petzel, M.D., Director, VA Upper Midwest Health Care Network, Minneapolis, MN; Karen Robinson, Ph.D., R.N., Chairperson, VISN 13 Nurse Managed Care Initiative,

Fargo, ND; and Mary Raymer, R.N., M.A., Associate Chief of Staff for Patient Care Services, Salem VA Medical Center, Salem, VA.

Building upon this hearing and other oversight work, Committee Chairman John D. Rockefeller IV introduced S. 1188 on July 17, 2001, with the cosponsorship of Ranking Republican Member Arlen Specter and Senator Max Cleland, to improve nurse recruitment and retention within VA.

Earlier, on July 10, 2001, Chairman Rockefeller introduced S. 1160, with Senator Larry Craig joining later as a cosponsor. S. 1160 would provide the Secretary of Veterans Affairs authority to provide service dogs to certain disabled veterans.

On July 23, 2001, Ranking Republican Member Specter introduced S. 1221, which would provide an additional basis for establishing the inability of veterans to defray expenses of necessary medical care.

On July 19, 2001, the Committee held a hearing, chaired by Committee Member Paul Wellstone, to receive testimony on S. 739, S. 1160, S. 1188, and a draft bill prepared by Ranking Republican Member Specter to change the means test used by the VA in determining whether veterans will be placed in enrollment priority group 5 or 7. Written testimony was accepted for all pending veterans health-related legislation, including S. 739, S. 1160, S. 1188, and the draft bill, although oral testimony was limited to S. 739 (reported elsewhere).

#### COMMITTEE MEETING

On August 2, 2001, the Committee met in open session to consider, among other matters, S. 1188 with an amendment in the nature of a substitute incorporating provisions from S. 1160, S. 1188, and S. 1221. Present were Senators Rockefeller, Wellstone, Murray, Miller, Nelson, Specter, Thurmond, and Hutchison. The Committee voted unanimously to report favorably S. 1188, as amended, to the Senate.

#### SUMMARY OF S. 1188 AS REPORTED

S. 1188, as reported (herein referred to as the "Committee Bill") consists of two titles, summarized below.

##### TITLE 1—THE DEPARTMENT OF VETERANS AFFAIRS NURSE RECRUITMENT AND RETENTION ENHANCEMENT ACT OF 2001

###### *Subtitle A—Recruitment Authorities*

Section 111 permanently authorizes the Employee Incentive Scholarship Program; reduces the minimum period of employment for eligibility in the program from 2 years to 1 year; removes the award limit for education pursued during a particular school year by a participant so long as the participant does not exceed the overall limitation for the equivalent of 3 years of full-time education; and extends authority to increase the award amounts based on general Federal pay increases.

Section 112 permanently authorizes the Education Debt Reduction Program (EDRP); expands the list of eligible individuals to include those providing direct patient care services or services incident to direct patient care services; extends the number of years that an employee may participate in the EDRP to 5 years and in-

increases the overall award limit to \$44,000, with the award payments for the fourth and fifth years of an employee's participation in the program limited to \$10,000 each; provides limited special authority (until December 31, 2001) for the Secretary to waive the eligibility requirement limiting EDRP participation to recently appointed employees on a case-by-case basis for individuals appointed on or after January 1, 1999, through September 30, 2000.

Section 113 requires VA to report on the use of authority to request waivers of the pay reduction for re-employed annuitants in order to meet the requirements for appointments to nurse positions.

*Subtitle B—Retention Authorities*

Section 121 mandates that VA provide Saturday premium pay to employees specified in Section 7454(b), the so-called "title 5/title 38 hybrids." Such hybrids include licensed practical nurses, pharmacists, certified or registered respiratory therapists, physical therapists, and occupational therapists.

Section 122 gives VA nurses enrolled in the Federal Employee Retirement System the same ability to use unused sick leave as part of the retirement year calculation that VA nurses enrolled in the Civilian Retirement System have.

Section 123 requires VA to carry out an evaluation of nurse-managed clinics, including primary care and geriatric clinics. Matters to be evaluated include patient satisfaction, provider experiences, cost of care, access to care, and functional status of patients. This evaluation will be reported to the House and Senate Committees on Veterans' Affairs not later than 18 months after enactment of this act.

Section 124 requires VA to develop a nationwide policy on staffing standards to ensure that veterans are provided with safe and high quality care. Such staffing standards should consider the numbers and skill mix required of staff in specific medical settings (such as critical care and long-term care).

Section 125 requires VA to submit an annual report on exceptions of experienced nurses from VA's nurse qualification standards, as set forth by VA directive. The report would include information on the number of waivers requested and granted to promote nurses who have not received a bachelor's of science degree in nursing, as well as information on age, race, and years of experience of the individuals subject to such waiver requests and waivers, as the case may be.

Section 126 requires VA to submit a report on the use of mandatory overtime by licensed nursing staff and nursing assistants in each facility during 2001, not later than 180 days after passage of this act. The report would include a description of the amount of mandatory overtime used by facilities, a description of the mechanisms employed by VA to monitor overtime, an assessment of the effects of mandatory overtime on patient care, and recommendations regarding ways to prevent the use of mandatory overtime in other than emergency situations.

*Subtitle C—Other Matters*

Section 131 elevates the office of the VA Nurse Consultant so that individual would report directly to the VA Under Secretary for Health.

Section 132 exempts registered nurses, physician assistants, and expanded-function dental auxiliaries from the requirement that part-time service performed prior to April 7, 1986, be prorated when calculating retirement annuities.

Section 133 makes modifications to the nurse locality pay authorities, including allowing VA to use third-party survey data.

## TITLE 2—OTHER MATTERS

Section 201 authorizes VA to provide certain hearing-impaired veterans, blind veterans, and veterans with spinal cord injury or dysfunction, or other chronic physical or mental impairment that substantially limits mobility, hearing, or activities of daily living, with service dogs to assist them with everyday activities.

Section 202 modifies the methodology used by the VA in determining whether veterans will be placed in enrollment priority group 5 or 7 based on income levels. The current placement eligibility threshold is set at approximately \$24,000 in the preceding calendar year, regardless of where in the country the veteran is living.

Section 203 requires that the compliance and oversight activities carried out by field-based units of the Department of Veterans Affairs Office of Research Compliance and Assurance shall be charged to the Medical Care appropriation.

## BACKGROUND AND DISCUSSION

TITLE 1—THE DEPARTMENT OF VETERANS AFFAIRS NURSE  
RECRUITMENT AND RETENTION ENHANCEMENT ACT OF 2001

As the average lifespan lengthens in the United States, the elderly make up a growing proportion of the population. Researchers project that the proportion of Americans age 65 or older will expand from approximately 13 percent to 20 percent between 2010 and 2030, an increase of about 30 million people. The population age 85 and older is the fastest growing age group in the United States; and the likelihood that an individual will require skilled nursing care increases with age. The demand for skilled nursing care, especially long-term care services, is projected to increase as the pool of potential caregivers remains constant or shrinks.

Over the last decade, VA and community health care providers have embraced managed care principles, which limit inpatient treatment to the sickest of patients. The demands on professional nurses have evolved as a growing proportion of hospitalized patients require highly technical, complex nursing care. Simultaneously, the explosive growth in community-based care has increased demand for nursing professionals in outpatient settings.

Registered nurses (RNs) and licensed practical nurses (LPNs) represent, respectively, the largest and second-largest groups of health care providers in the United States. VA employs over 35,000 RNs, and about 10,000 LPNs; together, nurses represent about one-third of all VA health care professionals. The Health Resources and

Services Administration's 2000 National Sample Survey of Registered Nurses shows that women continue to comprise the vast majority—more than 95 percent—of professional nurses. As career opportunities for women have broadened, enrollment in nursing diploma programs has declined precipitously. In 2000, the average age of working RNs was 45 years nationally and 48 years within VA. The average age of a newly hired nurse within VA has climbed to 39 years. Half of VA's nursing workforce will be eligible for retirement in the next 15 years, with 35 percent of RNs and 29 percent of LPNs eligible to retire by 2005.

Surveys by the American Nurses Association (hereafter ANA), the Department of Health and Human Services (hereafter HHS), and academic researchers show that stress, frustration, and low morale among working nurses have also contributed to the shrinking workforce. Recent years have seen growing job dissatisfaction among nurses, including 37 significant nursing strikes over issues such as the safety of the working environment, inflexible or excessive work hours, inadequate wages and benefits, and the lack of a voice in management.

As the number of experienced nurses willing to work in critical and long-term care declines, understaffing has already begun to affect medical facilities nationwide. Dr. Thomas L. Garthwaite, VA Under Secretary for Health, testified at the Committee's June 14, 2001, hearing that VA can currently "meet most of the demands for nursing staff. However, there are increasing difficulties in filling positions in some locations, and extreme difficulty filling some specialty assignments."

This difficulty in filling positions may translate into adverse working conditions for nurses and diminished services for veterans. Sandra McMeans, a Martinsburg (WV) VA Medical Center staff nurse and representative of the ANA, testified at the Committee's hearing that:

I believe personally that you will see . . . a decrease in the patient load in the Martinsburg VA, because I look for the nurses to leave . . . I see a lot of nurses who are eligible for retirement who are tired because of the mandatory overtime, because of having to stay [for] late shifts . . . I see them leaving and going to the private sector.

A recent report by HHS confirmed earlier studies showing that the quality of care declines and the length of inpatient stays increases when nursing staff levels dwindle.<sup>1</sup> Long-term strategies are needed to avert a national health care crisis already developing due to the looming nursing shortage. While this issue is getting attention in Congress, pending legislation developed by other congressional committees has not addressed the needs of nurses in Federal health care systems. In an effort to improve prospects for nursing careers in general, and to offer VA strategies to recruit and retain skilled nurses within an increasingly competitive market, the Committee has developed the legislation described below.

<sup>1</sup>*Nurse Staffing and Patient Outcomes in Hospitals (2001)*. Health Resource and Services Administration. Department of Health and Human Services, Washington, DC.

## RECRUITMENT AUTHORITIES

The increased demand for nurses able to provide either complex technical care or direct outpatient care has not been matched by a growing supply. Despite Bureau of Labor Statistics estimates showing that employment opportunities for registered nurses will grow more rapidly through 2008 than for all other occupations in the United States, a smaller percentage of graduating high school students enter nursing degree programs each year. Between 1995 and 1998, enrollment in nursing baccalaureate programs declined 19 percent. Predictably, the number of new nurses has steadily declined over the last 5 years, resulting in a shrinking labor pool available to VA and community health care providers. As medical facilities compete for an ever-diminishing number of qualified professionals, understaffing has become a constant factor in the health care environment.

Testimony offered by each of the registered nurses at the Committee's June 14, 2001, hearing confirmed that inadequate staffing creates stressful working conditions for nurses and endangers patient safety. Understaffing endangers not only the quality of direct patient care, but impedes VA's ability to conduct clinical research and to provide nursing and medical students with critical supervision and training. However, mandating that VA increase staffing levels is simply not an option without a pool of qualified nurses willing to enter and remain in the field.

VA faces the same challenges as private sector hospitals in recruiting and retaining nurses, exacerbated by budget constraints and a nursing workforce more rapidly approaching retirement. The passage of the Department of Veterans Affairs Health Care Personnel Incentive Act of 1998 as Public Law 105-368 offered VA means to recruit and retain qualified health care professionals in fields where high demand produces competition from the private sector. The Employee Incentive Scholarship Program (hereafter EISP) authorized VA to award up to \$10,000 per year of scholarship money toward full-time study, for up to 3 years, to eligible VA health care professionals in return for a period of obligated service. Currently, enrollment in the scholarship program is limited to employees with 2 or more years of VA employment and is scheduled to terminate on December 31, 2001.

This legislation also authorized the Education Debt Reduction Program (hereafter EDRP), allowing VA to repay education-related loans incurred by recently hired professionals in high-demand areas. This program, still in the final implementation process and also scheduled to terminate on December 31, 2001, authorized VA to pay \$6,000, \$8,000, and \$10,000 per year, respectively, over 3 years toward principal and interest on educational loans for professionals in high-demand fields.

As of June 14, 2001, VA had awarded 189 scholarships amounting to over \$1.7 million, primarily for nursing and pharmacist degrees, through the EISP and VA's National Nursing Education Initiative. As evidenced by many letters from VA employees submitted for the record of the Committee's hearing, the EISP provides an excellent incentive for recruiting nurses and other health care professionals to VA. Section 111 of the Committee bill would permanently authorize the EISP, reduce the minimum period of employ-

ment for eligibility from 2 years to 1 year, and remove the award limit for a participant's educational expenses during a single school year as long as these do not exceed the overall limitation for the equivalent of 3 years of full-time education. Section 112 of the Committee bill would permanently authorize the EDRP; would expand the list of eligible individuals to include those providing either direct or incidental patient care services; would extend the window of participation to 5 years and the overall award limit to \$44,000, with the payments for the fourth and fifth years limited to \$10,000 each; and would provide limited authority (until December 31, 2001) for the Secretary to extend EDRP participation to recently appointed employees on a case-by-case basis. These changes, supported by both the American Federation of Government Employees (hereafter AFGE), and the Nurses Organization of Veterans Affairs, will allow VA to compete more aggressively with similar educational recruitment packages that private sector employers can offer to nurses and other highly sought health care professionals.

Attracting a new generation of nursing students into the profession is essential to ensuring that VA and other health care providers can replace retiring nurses in the next two decades. Many working nurses were introduced to nursing careers through now defunct youth service organizations, such as the American Red Cross "candystriper" program. New programs, such as the recently developed VA Nurse Cadet program at the Salem (Virginia) VA Medical Center, must now fill the need to introduce students to nursing and to professional nurse role models. Mary Raymer, R.N., and founder of the VA Nurse Cadet program, testified at the Committee hearing that:

With no formal mentoring programs and frequent media attention to the problems and hazards of the nurses' work environment, there are few positive messages to choose nursing. Interventions to correct workplace issues must be made in concert with developing and expanding mentoring programs, such as the VA Cadet, that provide the youth opportunities for positive experiences in the healthcare setting.

However, until such programs can be expanded successfully, immediate measures must be taken to increase the pool of working skilled nurses. Within VA, allowing annuitants to work without endangering their retirement pay would provide an immediate reserve of qualified nurses. The testimony of VA Under Secretary for Health Garthwaite at the Committee's hearing stated that VA has existing authority to request that the Office of Personnel Management waive dual compensation restrictions under special conditions. The frequency with which these waivers have been applied to rehiring retired nurses is unclear. Section 111 of the Committee bill would require VA to report on the use of these waivers to assist in filling appointments to VA nursing positions.

#### RETENTION AUTHORITIES

A large survey recently conducted by the University of Pennsylvania's Center for Health Outcomes and Policy Research showed that more than 40 percent of American nurses surveyed reported being dissatisfied with their jobs, and that more than 20 percent planned to leave those jobs in the next year. Job dissatisfaction re-

lated to issues of “burnout,” with the majority of nurses surveyed reporting that too few nurses care for too many patients, that nurses are not included in management and scheduling decisions, and that inadequate support staffing further strains already over-extended professional nurses by forcing RNs to take on non-nursing tasks.

Although VA enjoys a lower rate of nurse turnover systemwide than the national average (8.5% as compared to 15% in 1999), the testimony of all three VA field nurses at the Committee’s hearing indicated that nurses’ morale has begun to decline as staffing shortages worsen in VA. Although competitive salaries and scholarship bonuses offer VA means to recruit qualified nurses, new initiatives will be needed to retain these nurses. The Committee bill includes provisions intended to help VA become a national model for safe working conditions and the employer of choice for professional nurses.

Sufficient pay, with wages equivalent to other local health care providers, is an obvious cornerstone of nurse recruitment and retention. Premium pay in particular refers to a differential rate of pay offered for undesirable tours of duty, such as weekends or holidays. Currently, title 38 guarantees premium pay (at 25 percent over the basic rate) for VA RNs who work regular Saturday and Sunday shifts. However, LPNs and other support personnel who straddle both title 5 and title 38 authorities are eligible only for Sunday premium pay, leaving Saturday premium pay at the discretion of the medical facility directors. Under this law, LPNs and other “title 5/title 38 hybrids” working side-by-side with RNs may not receive the same benefits for serving during unpopular tours.

Section 121 of the Committee bill establishes Saturday premium pay standards for LPNs and other professionals (pharmacists, certified or registered respiratory therapists, physical therapists, and occupational therapists) classified as “title 5/title 38 hybrids.” Creating equitable premium pay rates for these professionals should improve VA’s ability to recruit and retain these personnel, whose efforts are essential both to direct patient care and to supporting RNs.

Currently, VA RNs enrolled in the Civilian Retirement System can receive credit for days of unused sick leave in calculating total days of service for annuity benefits. However, the same benefit is not available to nurses who enrolled in the Federal Employee Retirement System. Section 122 of the Committee bill would establish parity for nurses enrolled in these retirement programs in computing total service.

Although salary levels certainly play a critical role in drawing nurses to specific providers, working conditions have a far greater impact on nurse recruitment and retention. In response to the nursing surveys cited above, RNs consistently identified opportunities for career development as a key component of professional satisfaction. Several studies have also shown that both patient outcomes and nurse recruitment improve in health care settings in which nurses have direct control over the patient care environment.

Nurse-managed clinics offer advanced practice nurses increased authority as independent primary care providers. Four nurse-managed community-based outpatient clinics established in VA’s Upper

Midwest Health Care Network have operated since 1999, providing primary care to an average of 1,000 veterans. Dr. Robert Petzel, director of this network, testified at the Committee's hearing that "nurse practitioners are effective as providers of safe, high-quality, cost-effective primary care, which results in high patient satisfaction," but acknowledged that "we must now demonstrate in terms of outcomes-based research the services that nurse practitioners provide and their positive impact on client outcomes."

Preliminary findings suggest that these nurse-managed clinics not only improve veterans' access to care, but may promote improved health outcomes through better patient education. Nurse-managed clinics might prove especially valuable as an avenue to provide preventive and chronic care to the aging veterans population. To test this theory, section 123 of the Committee bill requires VA to evaluate how nurse-managed clinics affect patient health care outcomes as well as nurse retention.

Staffing levels also contribute to the nursing work environment and nurse retention, with nurses increasingly expressing frustration over growing patient-to-nurse ratios. In a recent ANA survey, 75 percent of more than 7,000 nurses surveyed felt that the quality of nursing care in their work settings had declined in the past two years, with inadequate staffing cited as a chief cause. Research supports these perceptions. This February, HHS released the aforementioned study on patient outcomes and nurse staffing, based on data from more than 5 million inpatient discharges in 11 states. The HHS study confirmed earlier research demonstrating a strong relationship between higher nurse staffing levels and lower rates of serious adverse events such as urinary tract infections, pneumonia, shock, and upper gastrointestinal bleeding. High nurse staffing also correlated with shorter lengths of inpatient stay, reducing costs to the hospitals as well as the burdens for patients and their families.

Given the clearly established connections between adequate nurse staffing levels and improved patient outcomes, a nationally recognized safe staffing standard would provide an essential tool for maintaining high quality health care and improving working conditions for nurses. No such national standard currently exists, and older systems for determining staffing levels no longer suit the rapidly evolving health care environment in the United States. According to the June 14 testimony submitted by David Cox, RN, representing AFGE:

Currently, DVA only maintains staffing standards for Intensive Care Units and the operating room. These standards have forced DVA to maintain minimal staffing ratios on these wards. In other wards, like psychiatric and medical, staffing standards are determined by the number of staff on duty, not the needs of the patients. In other words, staffing standards at the DVA are not consistent from facility to facility. Nor are the staffing levels adequately measured or rational. Moreover, there is no accountability for unsafe staffing levels.

Recent studies by HHS,<sup>2,3</sup> the Institute of Medicine,<sup>4,5</sup> and the General Accounting Office<sup>6</sup> have all recognized the link between nurse staffing standards and patient safety. In addition, they also found that adequate staffing plays a significant role in creating a favorable work environment for nurses. Rather than prescribing specific staffing ratios, section 124 of the Committee bill would require VA to develop a national policy on nurse staffing standards that considers intensity of care and other issues of patient acuity, addresses patient safety and health outcomes, and improves the working environment for professional nurses.

In an effort to encourage nursing education, VA recently implemented a directive on revised Nursing Qualification Standards that requires VA's registered nurses to hold a bachelor's in nursing (BSN) degree to advance beyond entry level by 2005, effective immediately for new hires. While these standards promote professional development and a more skilled nursing staff, they limit promotions and salary increases for nurses without bachelor's degrees, regardless of experience. The Nurses Organization of Veterans Affairs estimates that 35 percent of new hires will not advance beyond entry level under the new standards if they do not take advantage of scholarship initiatives. This may shrink the pool of nurses willing to work for VA at a time when VA facilities are already struggling to meet staffing needs.

Nurse Professional Standards Boards in each network have the authority to waive degree requirements for experienced nurses who completed nursing diplomas or associate's degrees, but nurses have reported encountering varying degrees of resistance in obtaining these waivers, leading to the loss of experienced nurses to the private sector. In order to temper higher educational standards with the need to retain experienced nurses, section 125 of the Committee bill would require VA to report annually on the use of education requirement waivers systemwide to identify the numbers of waivers requested and granted, and how these relate to the age, race, and experience of the applicants.

To meet demands for skilled nurses, many health care organizations rely heavily upon mandatory overtime to fill staffing gaps. Unplanned and significant increases in working hours, often in consecutive shifts, lead to dangerous fatigue and a high turnover rate. A lack of nursing executives leaves nurses with little administrative support for reporting unsafe conditions. RNs who refuse overtime can be charged with patient abandonment, endangering their licenses.

Testimony given at the June 14, 2001, hearing suggested that some VA medical centers rely on mandatory overtime regularly,

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<sup>2</sup>*Ibid.*

<sup>3</sup>*Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes (2001)*. Report to Congress, Health Care Financing Administration, Department of Health and Human Services, Washington, DC.

<sup>4</sup>*Nursing Staff in Hospitals and Nursing Homes: Is it Adequate? (1996)*. Wunderlich, G.S., Sloan, F.A. and Davis, C.K., Editors. Institute of Medicine, National Academy of Sciences. Washington, DC: National Academy Press.

<sup>5</sup>*Improving the Quality of Long-Term Care (2001)*. Gooloo, S., Wunderlich, G.S., and Kohler, P.O., Editors. Committee on Improving Quality in Long-Term Care, Division of Health Care Services, Institute of Medicine, National Academy of Sciences. Washington, DC: National Academy Press.

<sup>6</sup>*Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides is a Growing Concern (2001)*. Testimony before the Senate Committee on Health, Education, Labor, and Pensions. General Accounting Office, Washington, DC.

and that its use makes VA a less attractive employer in areas where community hospitals offer solely voluntary overtime. The AFGE estimates that VA has nearly doubled its costs for overtime in the past few years, from \$31.5 million in FY 1997 to \$57.6 million in FY 2000, supporting estimates that VA has increased its dependence on overtime as a tool to meet staffing needs. According to testimony submitted by the AFGE:

The DVA does not have a nationwide policy on mandatory overtime, nor does DVA take disciplinary actions against Medical Directors or nurse managers who rely upon mandatory overtime excessively in lieu of adequate staffing. Only the patient and the RN suffer the consequences when a bleary-eyed RN makes a medical error at the end of two consecutive tours of duty. AFGE regards DVA's failure to hold management accountable for excessive overtime as a disturbing indication of DVA's lack of commitment to patient safety and in becoming the employer of choice.

Catherine J. Rick, VA's Chief Nurse Consultant, testified that VA has experienced a "slight increase in the use of overtime over the past three years," but acknowledged that VA Headquarters has no systemwide policy on mandatory overtime and initiated surveys to determine the extent of mandatory overtime use in the field only in immediate anticipation of the Committee's hearing. As the Committee is deeply concerned about growing dependence on a potentially unsafe working practice, section 126 of the Committee bill would require VA to report not later than 180 days after the passage of this act on the use of mandatory overtime in the VA health care system in 2001, to assess its effects on patient care, and to identify strategies for eliminating its use.

#### TITLE 1—OTHER MATTERS

RNs comprise the largest group of health care workers within VA, providing the greatest proportion of direct health care services to veterans. To improve communication to and from this essential workforce, VA has recently transformed the Nursing Service office into the Nursing Strategic Healthcare Group (NSHG), which serves as a resource for the development of policies and research strategies to support the nursing workforce. However, despite the realignment of VHA Headquarters to create executive level offices that reflect key functions within VA's health care system, the office of the nurse consultant remains outside of the chief officer structure.

Section 131 of the Committee bill would elevate the office of the VA Nurse Consultant to report directly to the VA Under Secretary for Health, which would be analogous to similar positions within HHS and the Office of the Surgeon General. Creating this position would provide the VA Under Secretary for Health with a clearly recognized source of information on the roles and needs of nurses, and demonstrate an unmistakable commitment to including nurses within health care decision-making processes.

Section 132 of the Committee bill addresses an issue of fairness in retirement annuity benefits promised to part-time VA nurses prior to 1986. Organizations that provide inpatient care face the perennial challenge of recruiting highly skilled health care pro-

viders amenable to working night shifts, weekends, and holidays. In the past, VA offered retirement incentives for part-time nurses as a mechanism of preventing nursing shortages and encouraging part-time nurses to work unpopular tours of duty on nights and weekends. Specifically, VA recruited title 38 medical staff by offering to credit these employees with 40 hours of work per week for retirement purposes, regardless of the actual number of hours worked. In return, these staff committed to VA as an exclusive employer, enabling VA to secure coverage for undesirable shifts at the discretion of medical facility directors.

Prior to 1980, the civil service annuity formula used to determine pension levels relied upon the highest salary received in the average year of the highest-paid 3 years (high-3 pay) of Federal employment, with no distinction between the pensions of full-time and part-time workers except for salary level. Public Law 96-330, requested by VA and passed in 1980, amended section 4109 of title 38 to use the full-time equivalent of the high-3 pay for part-time VA medical personnel, prorated to the portion of time actually worked. VA sought this legislation to eliminate disproportionately large annuities accruing to staff (particularly physicians) who had worked a mixture of full- and part-time hours during their careers. Subsequent "technical amendments" passed sequentially in Public Law 96-385 (section 508) and Public Law 97-72 (section 402) first repealed and then restored the retrospective changes.

When Congress passed Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), all part-time employees in the federal workforce including those covered by titles 5 and 38 became subject to the same retirement formula, with annuities based on full-time equivalent high-3 pay prorated to the portion of time worked. This law "grandfathered" any part-time service completed before its enactment on April 6, 1986, and repealed section 4109(b) of title 38, which treated VA medical personnel covered under title 38 differently than other Federal employees. This restored full-time work credit to VA nurses who had been recruited under the part-time work agreement prior to the enactment date.

In response, VA requested legislation to exclude all title 38 employees from the provision giving full-time retirement credit for part-time work in Public Law 99-272. VA's request was based on the assumption that many part-time VA physicians enjoyed lucrative outside salaries, including private medical practices. Congress granted the VA's request, incorporating the change into Public Law 99-509 (section 7003), the 1986 Omnibus Budget Reconciliation. This provision removed all title 38 employees from Public Law 99-272 and restored all prospective and retrospective part-time retirement annuity provisions in Public Law 96-330 (section 114). Thus, current law treats retirement credit for VA nurses for part-time work performed prior to April 6, 1986, differently from any other part-time Federal employees.

Section 132 of the Committee bill would amend section 7426 of title 38 to exempt registered nurses, physician assistants, and expanded-function dental auxiliaries from the requirement that part-time service performed prior to April 7, 1986, be prorated when calculating retirement annuities. This action would restore the commitment made to VA nurses and support personnel who forfeited

the opportunity to seek other full-time or supplemental part-time work in return for retirement annuity benefit. This provision would not restore full-time work credits toward the annuities for physicians or dentists, addressing VA's historical concerns about the costs of such benefits.

Section 133 of the Committee bill would make modifications to the nurse locality pay authorities, including allowing VA to use third-party survey data to establish consistency in wages for nurses at all rates of compensation, rather than only on beginning rates. Section 7251 of title 38 allows the directors of VA health care facilities to request adjustments to the minimum rates of basic pay for nurses based on local variations in the labor market. This ability to modify nurse salaries to achieve consistency with the local market conditions allows VA to recruit nurses competitively in regions with high demand. Currently, VA health care facilities must rely on industry-wage surveys provided by the Bureau of Labor Statistics (BLS), or upon third-party industry wage surveys if no BLS data is available, to calculate beginning rates of compensation for corresponding health care professionals.

## TITLE 2—OTHER MATTERS

### SEC. 201. SERVICE DOGS FOR CERTAIN DISABLED VETERANS

Section 201 of the Committee bill, which would authorize the Secretary to provide dog-guides to blind veterans and authorize the provision of service dogs to hearing-impaired veterans and veterans with spinal cord injuries, is drawn directly from S. 1160, introduced by Committee Chairman Rockefeller. Service dogs have traditionally been viewed only as assisting the visually impaired. However, primarily as a result of the Americans with Disabilities Act of 1990, there have been efforts in recent years to find alternative methods of providing assistance to people with various kinds of disabilities. While there have been many technological developments in this field, a need still remains for long-term assistance that allows for the greatest possible independence on the part of the disabled individual. The Paralyzed Veterans Association of America strongly endorses this goal, stating that:

For over half a century, PVA has fought for the integration of people with disabilities into the economic and social life of our Nation. Providing service dogs to veterans who need them would be a major step forward in the ultimate realization of this goal.

There are numerous ways in which service dogs can assist their owners. Tasks such as opening and closing doors, turning switches on and off, carrying bags, and dragging a person to safety in the case of an emergency are just a few of the standard duties for service dogs. Their ability to perform these types of duties makes them invaluable to those who require day-to-day aid. Dr. Ronald D. Fletcher, a veteran from Fayetteville, Pennsylvania, wrote to the Committee Chairman, stating that he had to pay out of his own pocket to acquire a service dog. He expressed that: "Because of my dog-hearing guide, I live a happier and more independent life." Having this sort of assistance can make a big difference in terms of offering not only physical support, but companionship as well.

Various types of evidence illustrate the value of companion pets, not just to the disabled, but to everyone. The *Journal of the American Medical Association* published a trial study a few years ago that examined the impact of service dogs on the lives of people with disabilities—both in terms of economic and social impacts. The study concluded that:

Substantial positive changes on most dependent measures were associated with the presence of a service dog both between and within groups. Psychologically, all participants showed substantial improvements in self-esteem, internal locus of control, and psychological well-being within 6 months after receiving their service dogs. Socially, all participants showed similar improvements in community integration. Demographically, participants demonstrated substantial increases in terms of school attendance and part-time employment. Economically, all participants showed dramatic decreases in the number of paid assistance hours.

Overall, the JAMA study concluded that service dogs can greatly improve the quality of life for the disabled. Given the various ways in which these dogs can assist their owners and the relatively low cost of implementing this program, the Committee has included section 201 in the Committee bill.

#### SEC. 202. MODIFICATION OF MEANS TEST

Section 202, which is drawn from S. 1221, as introduced by Senator Specter, modifies the means test used by VA in determining whether veterans will be placed in enrollment priority group 5 or 7. In accordance with section 1722(a) of title 38, United States Code, veterans with incomes below specified levels currently set at approximately \$24,000 for veterans with no dependents are placed in enrollment priority group 5 and as such, are eligible to receive medical care at VA facilities at no charge. Under current law, only one means test threshold is set for all non-service-connected veterans seeking access to VA health care, with no variation based upon locality. Section 202 would establish new geographically based income thresholds for VA.

The purpose of the change proposed in section 202 is to eliminate the inequity imposed on those veterans living in higher cost-of-living areas. The cost of living in large urban areas is generally much greater than in many rural parts of the country. This provision restructures the means tests threshold to make it locality based, by taking the costs of living in each region into account when determining a veteran's eligibility for certain VA health care treatment. As the Paralyzed Veterans of America (PVA), which supports this change, testified, the VA already has experience using locality based pricing for its reasonable charges for the recovery of third-party health care costs and for VERA calculations.

The Department of Housing and Urban Development (HUD) has an index for determining income levels that is based upon the cost of living for an identified locality, as well as the number of dependents within the family. PVA provided testimony that veterans in high cost-of-living areas would benefit from the higher income standard found in the HUD formula, with many being qualified for

enrollment priority 5 because of their increased inability to defray copayments.

This provision changes section 1722 of title 38, United States Code, to also include the HUD income index in determining eligibility for treatment as a low-income family based upon the veteran's permanent residence. This eligibility determinant is in addition to ability to receive state assistance under title XIX of the Social Security Act, the receipt of pension under section 1521 of title 38, United States Code, or meeting VA's annual means test thresholds. An important goal in creating this additional eligibility determinant is to protect those veterans already enrolled in priority 5 from being reevaluated and placed into priority 7, thereby triggering various copayment requirements. Thus, the current national threshold would remain in place as the base figure even if the HUD formula determines the low-income rate for a particular area is actually less than that amount.

The effective date of this change is January 1, 2002, and shall apply to all means tests after December 31, 2001, using data from the HUD index at the time the means test is given.

#### SEC. 203. FUNDING OF COMPLIANCE AND OVERSIGHT ACTIVITIES

Section 203 of the Committee bill addresses funding of the VA office which is responsible for the protection of human research subjects and research integrity within VA medical centers, the Office of Research Compliance and Assurance (hereafter ORCA). The rapid pace of biomedical research in recent years has led to substantial medical advancements, and concomitantly, to a dramatic increase in research trials involving human and animal subjects. VA established ORCA by directive in 1999, in the wake of an NIH-mandated shutdown of all human studies at the VA Greater Los Angeles Healthcare System because of lax procedures for approving and overseeing trials involving human research subjects.

The staff of ORCA advises the VA Under Secretary for Health on all matters affecting the integrity of research, the safety of human research subjects and research personnel, and the welfare of laboratory animals, and investigates any allegations of research improprieties or scientific misconduct. ORCA staff at VA Headquarters work with other appropriate Federal and VA offices to provide guidance and develop policies and procedures related to research safety and integrity. Staff from the four ORCA regional offices conduct both routine periodic and unannounced inspections of research programs at VA medical centers within their designated geographical areas to ensure compliance with policies concerning research integrity and scientific misconduct. The ORCA regional staff investigate allegations of non-compliance with research and safety policies and procedures, develop appropriate educational materials and administer remedial training if necessary, and assist research staff in restoring compliance.

The ORCA Chief Officer reports to the office of the Under Secretary for Health, and funding for the headquarters ORCA office comes from the Medical Administration and Miscellaneous Operating Expenses (MAMOE) account. However, VA currently funds ORCA's regional offices from the Medical and Prosthetic Research Program account, the account which is intended to cover the direct costs of research projects.

HHS recently recognized an inherent conflict of interest in allowing the National Institutes of Health (hereafter NIH) to manage and fund the oversight of safety and integrity in human studies research. In June 2000, HHS eliminated the NIH Office of Protection from Research Risks and transferred all authority for human subject protection to the Office of Human Research Protections, which reports directly to the HHS Under Secretary for Health and receives funding from non-research accounts.

Funding of the ORCA regional offices from VA's Research account creates a similar conflict of interest, and does not ensure human research subjects of oversight protection by an appropriately independent, objective, and unbiased entity. Other oversight mechanisms within VA, such as Institutional Review Boards, are not funded from the Research account. VA's General Counsel has determined that congressional authority is required to allow VA to fund ORCA's regional offices from accounts other than the research appropriation. Therefore, section 203 of the Committee bill would authorize VA to fund ORCA's regional offices out of the Medical Care appropriation, as these offices directly protect patient and human subject welfare.

#### COST ESTIMATE

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the Committee, based on information supplied by the Congressional Budget Office (CBO), estimates that, compared to the CBO baseline, there would be costs resulting from enactment of the Committee bill.

The cost estimate provided by CBO follows:

U.S. CONGRESS,  
CONGRESSIONAL BUDGET OFFICE,  
*Washington, DC, September 10, 2001.*

Hon. JOHN D. ROCKEFELLER IV,  
*Chairman, Committee on Veterans' Affairs,*  
*U.S. Senate, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 1188, the Department of Veterans Affairs Medical Programs Enhancement Act of 2001.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Sam Papenfuss.

Sincerely,

DAN L. CRIPPEN, *Director.*

Enclosure.

*S. 1188, Department of Veterans Affairs Medical Programs Enhancement Act of 2001 (As ordered reported by the Senate Committee on Veterans' Affairs on August 2, 2001)*

S. 1188 would change how the Department of Veterans Affairs (VA) compensates nurses and other employees and would provide expanded medical benefits to some veterans. The bill would increase retirement benefits for VA nurses by changing how retirement annuities are calculated and would make permanent the authority to provide scholarships and pay school debts as an incentive to attract and keep employees in critical occupations. Under the

bill, certain VA employees also would be eligible for premium pay for working on Saturdays. Finally, S. 1188 would calculate the income thresholds for determining whether a veteran qualifies for free health care on a regional basis rather than using a single national level.

CBO estimates that enacting the bill would increase direct spending by \$1 million in 2002, \$9 million over the 2002–2006 period, and \$26 million over the 2002–2011 period. Because the bill would affect direct spending, pay-as-you-go procedures would apply. In addition, S. 1188 would authorize funding or modify provisions governing discretionary spending for veterans' programs, which CBO estimates would result in additional outlays of about \$390 million in 2002 and about \$3 billion over the 2002–2006 period, assuming appropriation of the estimated amounts.

S. 1188 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would not affect the budgets of state, local, or tribal governments.

#### ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of S. 1188 is shown in Table 1. This estimate assumes the legislation will be enacted near the start of fiscal year 2002 and that the necessary funds for implementing the bill will be provided for each year. The costs of this legislation fall within budget functions 600 (income security) and 700 (veterans benefits and services).

Table 1.—Estimated Budgetary Impact of S. 1188  
[By Fiscal Year, in Millions of Dollars]

	2002	2003	2004	2005	2006
Changes in Direct Spending					
Estimated Budget Authority .....	1	1	2	2	2
Estimated Outlays .....	1	1	2	2	2
Changes in Spending Subject to Appropriation					
Estimated Authorization Level .....	428	559	691	714	726
Estimated Outlays .....	388	539	671	704	716

#### *Direct Spending*

Section 132 would change the way part-time service performed by registered nurses, physicians assistants, and certain dental technicians at VA prior to April 7, 1986, is treated in calculating retirement annuities. Under current law, retirement benefits for these workers are calculated according to a formula that prorates all part-time service performed in these positions. For most other federal workers, part-time service performed prior to April 7, 1986, is treated as full-time service when calculating retirement annuities. Information about these employees is limited, but based on information supplied by VA, CBO estimates there are about 1,600 of these workers still employed by the federal government. Assuming that retirement benefits calculated under the new formula would be between 4 percent and 13 percent higher than under the current formula, depending on how much part-time service was performed before April 7, 1986, CBO estimates that enacting this section would increase direct spending by \$1 million in 2002, \$8

million over the 2002–2006 period, and \$23 million over the 2002–2011 period.

Section 122 would authorize unused sick leave to be counted toward total years of service when calculating retirement benefits accrued by registered nurses who are employed by the Veterans Health Administration and retire under the Federal Employees' Retirement System (FERS). Under current law, unused sick leave is counted toward total service under the Civil Service Retirement System, but not under FERS. According to information from VA, about 1,000 registered nurses retire from VA every year, and most employees have between 3 and 6 months of accrued sick leave upon retirement. CBO estimates that enacting this provision would increase direct spending by less than \$500,000 every year until 2011 when the increase would round to \$1 million, with the 10-year costs totaling \$3 million.

#### *Spending Subject to Appropriation*

Table 2 shows the estimated effects of S. 1188 on discretionary spending for veterans' programs, assuming that appropriations are provided in the amounts of the estimated authorizations.

Table 2.—Estimated Changes in Spending Subject to Appropriations for S. 1188  
[By Fiscal Year, in Millions of Dollars]

	2001	2002	2003	2004	2005	2006
Spending Under Current Law for Veterans' Medical Care						
Estimated Authorization Level <sup>a</sup> .....	20,863	21,866	22,110	22,839	23,547	24,285
Estimated Outlays .....	20,418	21,501	22,020	22,613	23,298	24,028
Proposed Changes						
Compensation:						
Estimated Authorization Level .....	0	8	9	11	14	16
Estimated Outlays .....	0	8	9	11	14	16
Income Threshold:						
Estimated Authorization Level .....	0	420	550	680	700	710
Estimated Outlays .....	0	380	530	660	690	700
Total Changes:						
Estimated Authorization Level .....	0	428	559	691	714	726
Estimated Outlays .....	0	388	539	671	704	716
Spending Under S. 1188						
Estimated Authorization Level .....	20,863	22,294	22,669	23,530	24,261	25,011
Estimated Outlays .....	20,418	21,889	22,559	23,284	24,002	24,744

<sup>a</sup>The 2001 level is the estimated net amount appropriated for that year. The current-law amounts for the 2002–2006 period assume that appropriations remain at the 2001 level, with adjustments for inflation.

**Compensation.** S. 1188 contains several provisions that would increase compensation and benefits for health care workers employed by VA. CBO estimates that these provisions would increase discretionary spending by \$8 million in 2002 and by \$58 million over the 2002–2006 period, assuming appropriation of the necessary amounts.

**Employee Incentive Scholarships.** VA currently administers a program to provide scholarships for employees in the Veterans Health Administration as an incentive to help meet staffing needs in critical occupations. The authority to provide those incentive scholarships expires on December 31, 2001. Section 111 would permanently extend this authority as well as clarify the rules for awarding full-time and part-time scholarships. VA expects to spend about \$7 million on this program in fiscal year 2001. CBO estimates that allowing VA to continue to provide those scholarships would cost

\$7 million in 2002 and \$58 million over the 2002–2006 period, assuming appropriation of the estimated amounts. Because VA is currently funding this program, the costs associated with this provision are assumed in the baseline levels shown for veterans' medical care.

*Education Debt Reduction.* VA currently has the authority to reimburse new employees for employee payments of principal and interest on debts incurred for education related to the position the employee presently holds. The authority to enroll employees into this program expires on December 31, 2001. To date, VA has not implemented this program nor has it finalized the regulations under which the program would operate. Section 112 would extend this authority permanently, increase the maximum amount that could be reimbursed from \$24,000 over three years to \$44,000 over five years, and temporarily expand the definition of a new employee through December 31, 2001. CBO estimates that about 200 employees would take advantage of this program on an annual basis, with about two-thirds receiving the full amount allowed under the bill. CBO estimates that extending this authority along with the other changes would cost \$4 million in 2002 and \$36 million over the 2002–2006 period, assuming both appropriation of the estimated amounts and that VA actually implements this program by January 1, 2002. Since this program has not yet begun operation, the current law baseline does not reflect the costs of extending the program and these costs are included in the "Compensation" section of Table 2.

*Saturday Pay.* Currently, pharmacists, licensed practical nurses, and many therapists receive premium pay when they work on Sundays, but premium pay for work performed on Saturdays is managed at a local level and many do not receive such pay for Saturday work. Section 121 would require that all these employees receive premium pay, equal to 25 percent of their hourly wage, for all hours worked on Saturday. Using data from VA, CBO estimates that this provision would cost \$4 million in 2002 and \$22 million over the 2002–2006 period, assuming appropriation of the estimated amounts.

*Income Threshold.* Under current law, VA furnishes free medical care to veterans who meet certain eligibility requirements—one of which is an income threshold. Any veteran eligible for Medicaid, or who receives a VA pension, or who has an income below a statutory level (currently \$23,688 for a veteran without a dependent) can receive free health care. Under the bill, veterans eligible for low-income housing also would qualify for free medical care. In general, the Department of Housing and Urban Development sets eligibility for low-income housing at 80 percent of each county's median income with adjustments for cost-of-living.

This provision would affect both veterans who currently receive medical care from VA and those who do not currently use VA health care services. CBO estimates that the total cost associated with expanding eligibility for free VA medical care would be \$380 million in 2002 and about \$3 billion over the 2002–2006 period, assuming appropriation of the estimated amounts.

*Current VA Health Care Users.* Using data from VA and the Current Population Survey, CBO estimates that under this provision about 1.4 million veterans would become eligible for free health

care. CBO estimates that this number includes more than 250,000 veterans who currently use VA medical facilities but are not presently eligible for free health care. Under the bill, these veterans would no longer need to make copayments when receiving health care benefits. Because individuals use more health care services when they do not face any out-of-pocket costs, the cost of providing medical care would increase for those users who become eligible for free health care. Using data from VA and from published research, CBO estimates that those veterans receiving free health care would cost VA about \$700 more per person in 2002. Using that information and adjusting for inflation, CBO estimates that providing free health care to veterans currently using VA would cost about \$170 million in 2002 and almost \$1 billion over the 2002–2006 period, assuming appropriation of the estimated amounts.

Because the veterans discussed above would be eligible for free health care, VA also would lose the copayments that these veterans make when receiving care. CBO estimates that the lost copayments would total about \$40 million over the 2002–2006 period. Under current law, those copayments can be spent by VA, if authorized by the appropriators. Since CBO’s baseline assumes both the collection and the spending of those copayments, the budgetary effect would be neutral. Although there is no net budgetary impact, VA would not be able to provide the same level of care as they currently do without additional appropriations to replace the lost copayments.

*New VA Health Care Users.* CBO also estimates that some veterans who do not currently use VA medical facilities because of the requirement to make copayments would do so once they became eligible for free health care. Currently, only about 20 percent of veterans eligible for free health care based on income actually use VA medical facilities. CBO expects that an even lower percentage of those who would become eligible for free health care would end up using VA medical facilities, because some of those veterans have access to health care from other sources. CBO estimates that eventually about 100,000 newly eligible veterans would begin using VA medical care at a cost of more than \$4,000 per person. CBO estimates that providing free health care to these veterans would cost \$210 million in 2002 and about \$2 billion over the 2002–2006 period, assuming appropriation of the estimated amounts.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays that are subject to pay-as-you-go procedures are shown in Table 3. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

Table 3.—Estimated Impact of S. 1188 on Direct Spending and Receipts  
[By Fiscal Year, in Millions of Dollars]

	2001	2002	2003	2004	2005	2006	2007	2008	2009
Changes in outlays .....	0	1	1	2	2	2	3	3	3
Changes in receipts*									

\* Not applicable.

## INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

S. 1188 contains no intergovernmental or private-sector mandates as defined in UMRA and would not affect the budgets of state, local, or tribal governments.

Estimate prepared by: Federal Costs: Sam Papenfuss and Geoffrey Gerhardt. Impact on State, Local, and Tribal Governments: Elyse Goldman. Impact on the Private Sector: Allison Percy.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis, Congressional Budget Office.

## REGULATORY IMPACT STATEMENT

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs has made an evaluation of the regulatory impact that would be incurred in carrying out the Committee bill. The Committee finds that the Committee bill would not entail any regulation of individuals or businesses or result in any impact on the personal privacy of any individuals and that the paperwork resulting from enactment would be minimal.

## TABULATION OF VOTES CAST IN COMMITTEE

In compliance with paragraph 7 of rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in person or by proxy by members of the Committee on Veterans' Affairs at its August 2, 2001, meeting. On that date, the Committee, by unanimous voice vote, ordered S. 1188, as amended, reported favorably to the Senate.

## AGENCY REPORT

On August 31, 2001, the Honorable Anthony J. Principi, Secretary of the Department of Veterans Affairs, transmitted the Department's views on S. 1811, a bill to enhance the authority of the Secretary of Veterans Affairs to recruit and retain qualified nurses for the Veterans Health Administration, and for other purposes. Excerpts from Secretary Principi's correspondence are reprinted below:

\* \* \* \* \*

I am pleased to provide the Department's views on S. 1188, a bill "to enhance the authority of the Secretary of Veterans Affairs to recruit and retain qualified nurses for the Veterans Health Administration, and for other purposes." VA's nurses are critical front-line components of the VA health-care team. Our health-care providers are our most important resource in delivering high-quality, compassionate care to our Nation's veterans. VA must maintain the ability to recruit and retain well-qualified nurses in order to continue that care. Compensation, employment benefits and workplace factors affect that ability, particularly in highly competitive labor markets and for hard-to-fill specialty assignments. While VA is able to offer generally competitive pay in most markets, the Department must continuously monitor the recruitment and retention of health-care providers, particularly nurses, and trends in private sector employment and workforce projections. Although VA nurse staffing is generally stable overall, VA is experiencing increasing difficulties in

filling positions in some locations, and filling some specialty assignments is extremely difficult.

S. 1188 contains several proposals that VA believes would assist us in meeting the challenge of recruiting and retaining the nurses required to meet VA's patient care needs. However, it also contains provisions that VA does not support, as explained below.

Sections 101 and 102 of S. 1188 would make permanent the Department's Employee Incentive Scholarship Program (EISP) and Education Debt Reduction Program (EDRP) and make other technical changes. Specifically, the bill would make the authority for each of these programs permanent. It would also require the Secretary to make periodic adjustments to the amount of assistance paid under these programs when adjustments are made to the Federal General Schedule. Such adjustments are now required in the other Educational Assistance Programs authorized in chapter 76. The bill would also expand eligibility so that more employees could participate in these programs. In addition, it would provide that EISP payments are to be made on a school year basis instead of a calendar year basis. It would extend to five years (from the current three) the length of time that an employee may participate in the EDRP and increase the overall award limit to \$44,000.

VA supports the intent of sections 101 and 102 of the bill. The EISP and EDRP are valuable recruitment and retention tools for the Department. Indeed, we consider these programs to be vital in assuring VA's continued ability to place health-care professionals in hard-to-fill occupations, in ensuring that VA's registered nurses have the educational foundation to perform their enhanced role in health-care management, and in enabling VA to compete with the private sector for highly qualified health-care professionals.

Section 103 of S. 1188 would require a report on VA's use of the authority in sections 8344 and 8468 of title 5 to request waivers of the pay reduction for reemployed annuitants for appointments to VHA nurse positions. VA supports this provision.

Section 201 would mandate Saturday premium pay for hybrid employees. VA does not support this provision because it appears to be unnecessary. Under the provisions of 38 U.S.C. 7454(b) and (c), the Secretary may authorize premium pay under Title 38, including Saturday premium pay, for hybrid employees at any location. This authority has been delegated to facility directors. VHA believes that the flexibility to authorize premium pay according to local practices and to maintain VA's competitive stance is the most equitable and cost-effective method of adjusting premium pay. The cost estimate for this provision is under development.

Section 202 would amend section 8415 of title 5, United States Code, by adding a new subsection (I) to allow the use of unused sick leave in the annuity computations of registered nurses with the Veterans Health Administration (VHA). This would provide an incentive for VA nurses to accumulate and save their sick leave because the unused sick leave would count as additional service credit upon retirement and would increase the employees' annuities. VA opposes this provision. It is inappropriate to extend this incentive to such a narrow class of Federal employees. Further, this provision would likely have PAYGO costs for the civil service retirement and disability fund, although no estimate has been developed yet.

Section 203 of S. 1188 would require an evaluation of VA nurse-managed care clinics, including primary care and geriatric clinics located in three different Veterans Integrated Service Networks (VISNs). If VHA does not have three such clinics, VHA would be required to establish three. The evaluation is to address: patient satisfaction; provider experiences; access to care, including waiting time; functional status of clinic patients; other matters determined by the Secretary. VA would be required to provide a report on the evaluation. VA supports this provision. VA intends to use current nurse-managed care clinics or convert existing clinics to nurse-managed care clinics as evaluation sites.

Section 204 of the bill would require that we establish a nationwide policy for assuring adequate staffing to maintain VHA capacity mandated by section 8110, taking into account staffing levels and skill mix required for the range of patient care and services provided in VA facilities. It also would require that we have staffing necessary to maintain mandated VHA capacity, consistent with our overtime policies, and consistent with the new nationwide staffing policy.

VA opposes section 204. There are currently no universally accepted staffing guidelines or staffing ratios in the public or private sector. While a mandated standard would seemingly make determination of quality a matter of a simple equation, staffing is too multi-factorial to be so easily structured. All facilities must comply with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) staffing standards. JCAHO does not look for rigid staffing standards or staff-to-patient ratios since these measures have proven to be ineffective predictors of quality. JCAHO is currently piloting a staffing standard that takes into account clinical/service indicators (quality outcomes) in combination with human resource indicators (both direct and indirect caregivers). The approach calls for multiple indicators to be considered in combination. This has been the recommended VHA approach for staffing methodology over the past several years. Professional judgment is the essence and final guarantor of quality care; VA's system is designed to foster such professionalism. Some of the complex factors that influence staffing decisions are:

- Patient acuity and mix on a given unit
- Availability of varying personnel types, i.e., physician specialties, RNs, LPNs, and nursing assistants
- Experience, education and quality of staff
- Availability of other professional partners (i.e. social workers, pharmacists)
- Availability of support services, supplies and equipment
- Physical layout of the patient care and treatment areas
- Technological and administrative support availability
- Academic affiliation, etc.

Staffing decisions are dependent upon these factors applied on a 24-hour and seven-day per week basis. VA believes that staffing decisions must be made near the site of care. There is no known national methodology that is workable. Additional costs can be anticipated to result from an inflexible national staffing standard.

Section 205 of the bill would require an annual report, beginning in 2002, concerning VA's use of authorities to enhance retention of experienced nurses. Included are educational assistance programs,

waivers of educational requirements (by age, race, and years of experience) in the VA nurse qualification standard and other available retention authorities. VA supports this provision.

Section 206 would require a report on the use of mandatory overtime by licensed nursing staff and nursing assistants in each facility. The report would include a description of mechanisms to monitor mandatory overtime, an assessment of the effects of mandatory overtime, including its contribution to medical errors, recommendations concerning mechanisms for preventing mandatory overtime other than for emergency situations, and other matters VA considers appropriate. VA supports this provision.

Section 301 of S. 1188 would elevate the position of the Chief Consultant for Nursing Programs (Director, Nursing Service) so that it would report directly to the Under Secretary for Health. Currently, this position reports to the Under Secretary through the Chief Patient Care Services Officer (Associate Deputy Under Secretary for Health). The effect of this provision is to recognize the importance of this position as the chief advisor to the Under Secretary for Health on nursing issues, as well as its role as the operational head for VA nursing programs. VA supports this provision.

Section 302 would change the treatment, for purposes of retirement credit, of part-time service performed by certain title 38 employees prior to April 7, 1986. Currently, part-time service performed by title 5 employees prior to April 7, 1986, is treated as full-time service; title 38 employees' part-time service prior to April 7, 1986, is credited as part-time service on a pro rata basis, thus resulting in lower annuities. Part-time service after April 6, 1986, is prorated for both title 5 and title 38 employees. VA believes there should be parity in the treatment of part-time service for title 38 and title 5 employees for retirement purposes. There are some potential unintended effects associated with this provision. Therefore, the Administration is seeking to resolve, in a comprehensive manner, technical problems associated with computations of part-time service. This provision would likely have PAYGO costs for the civil service retirement and disability fund, although no estimate has been developed yet.

Section 303 of S. 1188 would make clarifying amendments to VA's nurse locality pay statute, 38 U.S.C. § 7451, consistent with recent changes made by Public Law 106-419. Those changes were intended to improve the survey process used to adjust nurse locality pay rates. This provision would amend subparagraphs (A) and (B) of section 7451(d)(3) by deleting the phrase "beginning rates of" throughout. This is consistent with the requirement under the recent amendments that third-party surveys conducted under this authority must now include broader compensation data. It also would delete the phrase "or at any other time that an adjustment in rates of pay is scheduled to take place" in section 7451(d)(4). This provision provided VA medical center directors with discretion to not pass on General Schedule adjustments to nurse salaries. The recent amendments provide for an automatic adjustment to nurse salaries at the same time and in the same amount as the General Schedule increase; facility directors no longer have discretion to limit such increases.

Further, section 303 of S. 1188 would eliminate the requirement that facility directors notify the Under Secretary for Health within

10 days of a decision not to adjust salary rates based on survey data as unnecessary. Public Law 106-419 reinstated an annual reporting requirement, which includes information concerning facility directors' decisions not to adjust salary rates based on survey data. Finally, this proposal would delete references to "grades" of positions in the report required under section 7451(e)(4) so as to achieve consistency with the way VA collects information for the report. These amendments would improve administration of the complicated nurse locality pay system, consistent with the intent of the amendments in Public Law 106-419.

Section 304 of S. 1188 would make technical amendments to section 38 U.S.C. § 7631.

Because S. 1188 would affect direct spending, it is subject to the pay-as-you-go (PAYGO) requirement of the Omnibus Budget Reconciliation Act of 1990. VA's cost estimate of S. 1188 is under development and will be provided to you when complete.

The Office of Management and Budget has advised that there is no objection to the submission of this report from the standpoint of the Administration's program.

\* \* \* \* \*

On July 19, 2001, the Honorable Thomas L. Garthwaite, MD, Under Secretary for Health, Department of Veterans Affairs, appeared before the Committee and submitted testimony on, among other things, S. 1188, S. 1160, and a draft bill to change the means test used by the VA in determining whether veterans will be placed in enrollment priority group 5 or 7. Excerpts from this statement are reprinted below:

**STATEMENT OF THOMAS L. GARTHWAITE, MD, UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS**

Mr. Chairman and Members of the Committee, I am pleased to be here to present the Department's views on six different bills being considered by the Committee. They cover a wide range of subjects related to personnel matters and VA's provision of health care services to veterans. We support many provisions in the bills before the Committee, however there are some on which we recommend modifications, and others which we cannot support at this time. Thank you for the opportunity to testify today on several legislative items of great interest to veterans.

\* \* \* \* \*

S. 1188

Mr. Chairman I will next present our views on S. 1188, a bill designed to improve the recruitment and retention of VA nurses. Our nurses are critical front-line components of the VA health care team. Our health care providers are our most important resource in delivering high-quality, compassionate care to our Nation's veterans. We must maintain the ability to recruit and retain well-qualified nurses in order to continue that care. Compensation, employment benefits and workplace factors affect that ability, particularly in highly competitive labor markets and for hard-to-fill specialty assignments. Thanks to the efforts of this Committee and the House Veterans' Affairs Committee, we have been able to offer gen-

erally competitive pay in most markets. We continuously monitor the recruitment and retention of health care providers, particularly nurses, and trends in private sector employment and workforce projections. As we noted in testimony before this committee last month, VA nurse staffing is generally stable overall, but there are increasing difficulties in filling positions in some locations, and filling some specialty assignments is extremely difficult. However, I am not prepared to give the Administration's views on this bill without further study. We will provide our views on this measure as soon as possible.

\* \* \* \* \*

S. 1160

Mr. Chairman I now turn to S. 1160, a bill that would authorize us to furnish a service dog to any veteran with a compensable service-connected disability who is hearing impaired or who has a spinal cord injury or dysfunction. Service dogs can assist a disabled person in his or her daily life and can assist that person during medical emergencies. They can be trained in many tasks, including, but not limited to, pulling a wheelchair, carrying a back-pack, opening and closing doors, helping with dressing and undressing, picking up things one drops, picking up the phone, and hitting a distress button on the phone. Such dogs can also notice when the disabled individual is in distress and can find help. Dogs can also assist the hearing impaired by alerting them to doorbells, ringing phones, smoke detectors, crying babies, and emergency sirens on vehicles. We support this bill, and any new costs will be handled under existing resources within the FY 2002 President's Budget. Having said that, however if it were to become law, we would promulgate prescription criteria and guidelines for provision of such dogs to insure that we provide animals only to those veterans who can most benefit from them.

\* \* \* \* \*

DRAFT LEGISLATION ON THE MEANS TEST THRESHOLD

Mr. Chairman, also on the agenda is a draft bill that would establish new geographically based income thresholds for VA to use in determining a nonservice-connected veteran's priority for receiving VA care and whether the veteran must agree to pay copayments in order to receive that care. As you know, Mr. Chairman, the law now requires that most veterans enroll in our health care system in order to receive care. Enrollees are placed in an enrollment priority group that is based, in many instances, on their level of income and net worth. Although we currently provide care to veterans in all enrollment priority groups, if there were funding shortages in the future, it might be necessary to determine that those with relatively higher incomes must be disenrolled, meaning they could no longer receive VA care. Current law establishes, on a National basis, the specific income thresholds that we must use to determine the priority group of any given enrollee with no service-connected disability or other special status. We place higher income veterans in priority group 7 and lower income veterans in priority group 5. This draft bill would establish new geographically based income thresholds that VA could use for placing veterans in

those priority groups. The draft bill would use a specific statutorily based poverty index used by the Department of Housing and Urban Development that is established for Metropolitan Statistical Areas (MSA's), Primary Metropolitan Statistical Areas (PMSA's) and counties. The index defines a family as low income if family income does not exceed 80% of the median family income for the area in which the family resides. If we determined that a veteran's income was below the threshold for the specific area where the veteran lived, and his net worth was below our threshold, we would place that veteran in enrollment priority category 5. In many instances, particularly in urban areas, this new income threshold is greater than the current statutory income threshold that we use for determining whether a veteran should be placed in priority group 5. The draft bill would provide that if the new geographically based income threshold is lower than the current threshold, VA would use the old threshold as that would benefit the veteran.

We in VA are very interested in examining the use of geographically based income thresholds for placing nonservice-connected veterans in different enrollment priority groups. We recognize that the cost of living in large urban areas is much greater than in many more rural parts of the country. What might be considered a reasonably high income in some locations may be totally inadequate in other higher cost locations. However, at this time we cannot support the methodology proposed in the draft bill. There are many poverty indexes that are established in various ways. However, there are serious issues about what these indexes really measure. We believe further study is needed to determine the most appropriate method for tackling this problem. I will next present our views on S. 1188, a bill designed to improve the recruitment and retention of VA nurses. Our nurses are critical front-line components of the VA health care team. Our health care providers are our most important resource in delivering high-quality, compassionate care to our Nation's veterans. We must maintain the ability to recruit and retain well-qualified nurses in order to continue that care. Compensation, employment benefits and workplace factors affect that ability, particularly in highly competitive labor markets and for hard-to-fill specialty assignments. Thanks to the efforts of this Committee and the House Veterans' Affairs Committee, we have been able to offer generally competitive pay in most markets. We continuously monitor the recruitment and retention of health care providers, particularly nurses, and trends in private sector employment and workforce projections. As we noted in testimony before this committee last month, VA nurse staffing is generally stable overall, but there are increasing difficulties in filling positions in some locations, and filling some specialty assignments is extremely difficult. However, I am not prepared to give the Administration's views on this bill without further study. We will provide our views on this measure as soon as possible.

CHANGES IN EXISTING LAW MADE BY THE COMMITTEE BILL, AS  
REPORTED

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new mat-

ter is printed in italic, existing law in which no change is proposed is shown in roman):

**TITLE 38, UNITED STATES CODE**

\* \* \* \* \*

**CHAPTER 17—HOSPITAL, NURSING HOME,  
DOMICILIARY, AND MEDICAL CARE**

SUBCHAPTER I—GENERAL

Sec.

1701. \* \* \*

\* \* \* \* \*

SUBCHAPTER II—HOSPITAL, NURSING HOME OR DOMICILIARY CARE  
AND MEDICAL TREATMENT

\* \* \* \* \*

**【1714. Fitting and training in use of prosthetic appliances; seeing-eye dogs.】**

*1714. Fitting and training in use of prosthetic appliances; dog-guides and service dogs.*

\* \* \* \* \*

**【§ 1714. Fitting and training in use of prosthetic appliances;  
seeing-eye dogs】**

**§ 1714. *Fitting and training in use of prosthetic appliances;  
dog-guides and service dogs***

\* \* \* \* \*

**【(b) The Secretary may provide seeing-eye or guide dogs trained for the aid of the blind to veterans who are entitled to disability compensation, and may pay travel and incidental expenses (under the terms and conditions set forth in section 111 of this title) to and from their homes and incurred in becoming adjusted to such seeing-eye or guide dogs. The Secretary may also provide such veterans with mechanical or electronic equipment for aiding them in overcoming the handicap of blindness.】**

*(b)(1) The Secretary may provide any blind veteran who is entitled to disability compensation with—*

- (A) a dog-guide trained for the aid of the blind; and*
- (B) mechanical or electronic equipment for aid in overcoming the disability of blindness.*

*(2) The Secretary may provide a service dog to the following:*

- (A) Any hearing-impaired veteran who is entitled to disability compensation.*
- (B) Any veteran with a spinal cord injury or dysfunction who is entitled to disability compensation.*
- (C) Any veteran entitled to disability compensation who has any other chronic physical or mental impairment that substantially limits mobility, hearing, or activities of daily living in order to assist such veteran in overcoming such physical or mental impairment.*

(3) *In providing a dog-guide or service dog to a veteran under this subsection, the Secretary may pay travel and incidental expenses (under the terms and conditions set forth in section 111 of this title) of the veteran to and from the veteran's home and incurred in becoming adjusted to the dog-guide or service dog, as the case may be.*

\* \* \* \* \*

**§ 1722. Determination of inability to defray necessary expenses; income thresholds**

(a) For the purposes of section 1710(a)(2)(G) of this title, a veteran shall be considered to be unable to defray the expenses of necessary care if—

(1) the veteran is eligible to receive medical assistance under a State plan approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

(2) the veteran is in receipt of pension under section 1521 of this title; **[or]**

(3) the veteran's attributable income is not greater than the amount set forth in subsection (b)**[.1]**; or

(4) *the veteran (including any applicable part of the veteran's family) is eligible for treatment as a low-income family under section 3 of the United States Housing Act of 1937 (42 U.S.C. 1437a) for the area in which the veteran resides.*

\* \* \* \* \*

**CHAPTER 73—VETERANS HEALTH ADMINISTRATION—  
ORGANIZATION AND FUNCTIONS**

**SUBCHAPTER I—ORGANIZATION**

Sec.

7301. \* \* \*

\* \* \* \* \*

7324. *Annual report on use of authorities to enhance retention of experienced nurses.*

**§ 7306. Office of the Under Secretary for Health**

(a) The Office of the Under Secretary for Health shall consist of the following:

\* \* \* \* \*

(5) A Director of Nursing Service, who shall be a qualified registered nurse and who shall be responsible to, *and report directly to*, the Under Secretary for Health for the operation of the Nursing Service.

\* \* \* \* \*

**§ 7324. Annual report on use of authorities to enhance retention of experienced nurses**

(a) *ANNUAL REPORT.—Not later than January 31 each year, the Secretary, acting through the Under Secretary for Health, shall submit to Congress a report on the use during the preceding year of authorities for purposes of retaining experienced nurses in the Veterans Health Administration, as follows:*

(1) *The authorities under chapter 76 of this title.*

(2) *The authority under VA Directive 5102.1, relating to the Department of Veterans Affairs nurse qualification standard, dated November 10, 1999, or any successor directive.*

(3) *Any other authorities available to the Secretary for those purposes.*

(b) **REPORT ELEMENTS.**—*Each report under subsection (a) shall specify for the period covered by such report, for each Department medical facility and for each Veterans Integrated Service Network, the following:*

(1) *The number of waivers requested under the authority referred to in subsection (a)(2), and the number of waivers granted under that authority, to promote to the Nurse II grade or Nurse III grade under the Nurse Schedule under section 7404(b)(1) of this title any nurse who has not completed a bachelors of science in nursing in a recognized school of nursing, set forth by age, race, and years of experience of the individuals subject to such waiver requests and waivers, as the case may be.*

(2) *The programs carried out to facilitate the use of nursing education programs by experienced nurses, including programs for flexible scheduling, scholarships, salary replacement pay, and on-site classes.*

\* \* \* \* \*

**§ 7426. Retirement rights**

\* \* \* \* \*

(c) *The provisions of subsection (b) shall not apply to the part-time service before April 7, 1986, of a registered nurse, physician assistant, or expanded-function dental auxiliary. In computing the annuity under the applicable provision of law specified in that subsection of an individual covered by the preceding sentence, the service described in that sentence shall be credited as full-time service.*

\* \* \* \* \*

**§ 7451. Nurses and other health-care personnel: competitive pay**

\* \* \* \* \*

(d)(1) \* \* \*

\* \* \* \* \*

(3)(A) In the case of a Department health-care facility located in an area for which there is current information, based upon an industry-wage survey by the Bureau of Labor Statistics for that labor market, on [beginning rates of] compensation for corresponding health-care professionals for the BLS labor-market area of that facility, the director of the facility concerned shall use that information as the basis for making adjustments in rates of pay under this subsection. Whenever the Bureau of Labor Statistics releases the results of a new industry-wage survey for that labor market that includes information on [beginning rates of] compensation for corresponding health-care professional, the director of that facility shall determine, not later than 30 days after the results of the survey are released whether an adjustment in rates of pay for employees at that facility for any covered position is necessary in order

to meet the purposes of this section. If the director determines that such an adjustment is necessary, the adjustment, based upon the information determined in the survey, shall take effect on the first day of the first pay period beginning after that determination.

(B) In the case of a Department health-care facility located in an area for which the Bureau of Labor Statistic does not have current information on [beginning rates of] compensation for corresponding health-care professional for the labor-market area of that facility for any covered position, the director of that facility shall conduct a survey in accordance with this subparagraph and shall adjust the amount of the minimum rate of basic pay for grades in that covered position at that facility based upon that survey. To the extent practicable, the director shall use third-party industry wage surveys to meet the requirements of the preceding sentence. Any such survey shall be conducted in accordance with regulations prescribed by the Secretary. Those regulations shall be developed in consultation with the Secretary of Labor in order to ensure that the director of a facility collects information that is valid and reliable and is consistent with standards of the Bureau. The survey should be conducted using methodology comparable to that used by the Bureau in making industry-wage surveys except to the extent determined infeasible by the Secretary. To the extent practicable, all surveys conducted pursuant to this subparagraph or subparagraph (A) shall include the collection of salary midpoints, actual salaries, lowest and highest salaries, average salaries, bonuses, incentive pays, differential pays, actual beginning rates of pay, and such other information needed to meet the purpose of this section. Upon conducting a survey under this subparagraph the director concerned shall determine, not later than 30 days after the date on which the collection of information through the survey is completed or published, whether an adjustment in rates of pay for employees at that facility for any covered position is necessary in order to meet the purposes of this section. If the director determines that such an adjustment is necessary, the adjustment, based upon the information determined in the survey, shall take effect on the first day of the first pay period beginning after that determination.

(C)(i) A director of a Department health-care facility may use data on the [beginning rates of] compensation paid to certified registered nurse anesthetists who are employed on a salary basis by entities that provide anesthesia services through certified registered nurse anesthetists in the labor-market area only if the director—

(I) has conducted a survey of [beginning rates of] compensation for certified registered nurse anesthetists in the local labor-market area of the facility under subparagraph (B);

\* \* \* \* \*

(4) If the director of a Department health-care facility, or the Under Secretary for Health with respect to Regional and Central Office employees, determines, after any survey under paragraph (3)(B) [or at any other time that an adjustment in rates of pay is scheduled to take place under this subsection], that it is not necessary to adjust the rates of basic pay for employees in a grade of a covered position at that facility in order to carry out the purpose of this section, such an adjustment for employees at that facility in

that grade shall not be made. [Whenever a director makes such a determination, the director shall within 10 days notify the Under Secretary for Health of the decision and the reasons for the decision.]

\* \* \* \* \*  
(e)(1) \* \* \*  
\* \* \* \* \*

(4) Each director of a Department health-care facility shall provide to the Secretary, not later than July 31 each year, a report on staffing for covered positions at that facility. The report shall include the following:

(A) Information on turnover rates and vacancy rates for each [grade in a] covered position, including a comparison of those rates with the rates for the preceding three years.

(B) The director's findings concerning the review and evaluation of the facility's staffing situation, including whether there is, or is likely to be, in accordance with criteria established by the Secretary, a significant pay-related staffing problem at that facility for any [grade of a] covered position and, if so, whether a wage survey was conducted, or will be conducted with respect to that grade.

\* \* \* \* \*  
(D) In any case in which the director, after finding that there is, or is likely to be, in accordance with criteria established by the Secretary, a significant pay-related staffing problem at that facility for any [grade of a] covered position, determines not to conduct a wage survey with respect to that position, a statement of the reasons why the director did not conduct such a survey.

\* \* \* \* \*  
**§ 7454. Physician assistants and other health care professionals: additional pay**

\* \* \* \* \*  
(b)(1) When the Secretary determines it to be necessary in order to obtain or retain the services of certified or registered respiratory therapists, licensed physical therapists, licensed practical or vocational nurses, pharmacists, or occupational therapists, the Secretary may, on a nationwide, local, or other geographic basis, pay persons employed in such positions additional pay on the same basis as provided for nurses in section 7453 of this title.

(2) *Health care professionals employed in positions referred to in paragraph (1) shall be entitled to additional pay on the same basis as provided for nurses in section 7453(c) of this title.*

\* \* \* \* \*  
**§ 7631. Periodic adjustments in amount of assistance**

(a)(1) Whenever there is a general Federal pay increase, the Secretary shall increase the maximum monthly stipend amount, the maximum tuition reimbursement amount, [and the maximum Selected Reserve member stipend amount] *the maximum Selected Reserve member stipend amount, the maximum employee incentive*

*scholarship amount.* Any such increase shall take effect with respect to any school year that ends in the fiscal year in which the pay increase takes effect, and the maximum education debt reduction payments amount.

(2) The amount of any increase under paragraph (1) of this subsection is the previous maximum amount under that paragraph multiplied by the overall percentage of the adjustment in the rates of pay under the General Schedule made under the general Federal pay increase. Such amount shall be rounded to the next lower multiple of \$1.

(b) For purposes of this section:

\* \* \* \* \*

(4) The term “maximum employee incentive scholarship amount” means the maximum amount of the scholarship payable to a participant in the Department of Veterans Affairs Employee Incentive Scholarship Program under subchapter VI of this chapter, as specified in section 7673(b)(1) of this title and as previously adjusted (if at all) in accordance with this section.

(5) The term “maximum education debt reduction payments amount” means the maximum amount of education debt reduction payments payable to a participant in the Department of Veterans Affairs Education Debt Reduction Program under subchapter VII of this chapter, as specified in section 7683(d)(1) of this title and as previously adjusted (if at all) in accordance with this section.

[(4)] (6) The term “general Federal pay increase” means an adjustment (if an increase) in the rates of pay under the General Schedule under subchapter III of chapter 53 of title 5.

\* \* \* \* \*

**§ 7631. Periodic adjustments in amount of assistance**

\* \* \* \* \*

(b) For purposes of this section:

(1) The term “maximum monthly stipend amount” means the maximum monthly stipend that may be paid to a participant in the Scholarship Program specified in section 7613(b) of this title and as previously adjusted (if at all) in accordance with this [subsection] section.

(2) The term “maximum tuition reimbursement amount” means the maximum amount of tuition reimbursement provided to a participant in the Tuition Reimbursement Program specified in section 7622(e) of this title and as previously adjusted (if at all) in accordance with this [subsection] section.

(3) The term “maximum Selected Reserve member stipend amount” means the maximum amount of assistance provided to a person receiving assistance under subchapter V of this chapter, as specified in section 7653 of this title and as previously adjusted (if at all) in accordance with this [subsection] section.

\* \* \* \* \*

**§ 7672. Eligibility; agreement**

\* \* \* \* \*

(b) ELIGIBLE DEPARTMENT EMPLOYEES.—For purposes of subsection (a), an eligible Department employee is any employee of the Department who, as of the date on which the employee submits an application for participation in the Program, has been continuously employed by the Department for not less than [2 years] *one year*.

\* \* \* \* \*

**§ 7673. Scholarship**

\* \* \* \* \*

(b) AMOUNTS.—The total amount of the scholarship payable under subsection (a)—

(1) in the case of a participant in the Program who is a full-time student, may not exceed \$10,000 [for any 1 year]; and

[(2) in the case of a participant in the Program who is a part-time student, shall be the amount specified in paragraph (1) reduced in accordance with the proportion that the number of credit hours carried by the participant in that school year bears to the number of credit hours required to be carried by a full-time student in the course of education or training being pursued by the participant.

[(c) LIMITATION ON YEARS OF PAYMENT.—(1) Subject to paragraph (2), a participant in the Program may not receive a scholarship under subsection (a) for more than three school years.

[(2) The Secretary may extend the number of school years for which a scholarship may be awarded to a participant in the Program who is a part-time student to a maximum of six school years if the Secretary determines that the extension would be in the best interest of the United States.]

*(2) in the case of a participant in the Program who is a part-time student, shall bear the same ratio to the amount that would be paid under paragraph (1) if the participant were a full-time student in the course of education or training being pursued by the participant as the coursework carried by the student bears to full-time coursework in that course of education or training.*

(c) LIMITATIONS ON PERIOD OF PAYMENT.—(1) The maximum number of school years for which a scholarship may be paid under subsection (a) to a participant in the Program shall be six school years.

(2) A participant in the Program may not receive a scholarship under subsection (a) for more than the equivalent of three years of full-time coursework.

\* \* \* \* \*

(e) FULL-TIME COURSEWORK.—For purposes of this section, full-time coursework shall consist of the following:

(1) In the case of undergraduate coursework, 30 semester hours per undergraduate school year.

(2) In the case of graduate coursework, 18 semester hours per graduate school year.

\* \* \* \* \*

[Section 7676 is repealed.]

\* \* \* \* \*

**§ 7682. Eligibility**

\* \* \* \* \*

(a) ELIGIBILITY.—An individual is eligible to participate in the Education Debt Reduction Program if the individual—

(1) is a recently appointed employee in the Veterans Health Administration serving **[(under an appointment under section 7402(b) of this title in a position] in a position (as determined by the Secretary) providing direct-patient care services or services incident to direct-patient care services for which recruitment or retention of qualified health-care personnel [(as determined by the Secretary)] (as so determined)** is difficult; and

\* \* \* \* \*

**§ 7683. Education debt reduction**

\* \* \* \* \*

(d) MAXIMUM ANNUAL AMOUNT.—(1) Subject to paragraph (2), the amount of education debt reduction payments made to a participant **[for a year]** under the Education Debt Reduction Program may not **[exceed—**

**[(A) \$6,000 for the first year of the participant’s participation in the Program;**

**[(B) \$8,000 for the second year of the participant’s participation in the Program; and**

**[(C) \$10,000 for the third year of the participant’s participation in the Program.**

**[(2) The total amount payable to a participant in such Program for any year may not exceed the amount of the principal and interest on loans referred to in subsection (a) that is paid by the individual during such year.] exceed \$44,000 over a total of five years of participation in the Program, of which not more than \$10,000 of such payments may be made in each of the fourth and fifth years of participation in the Program.**

\* \* \* \* \*

**[Section 7684 is repealed.]**

\* \* \* \* \*

**§ 8110. Operation of medical facilities**

(a)(1) The Secretary shall establish the total number of hospital beds and nursing home beds in medical facilities over which the Secretary has direct jurisdiction for the care and treatment of eligible veterans at not more than 125,000 and not less than 100,000. The Secretary shall establish the total number of such beds so as to maintain a contingency capacity to assist the Department of Defense in time of war or national emergency to care for the casualties of such war or national emergency. Of the number of beds authorized pursuant to the preceding sentence, the Secretary shall operate and maintain a total of not less than 90,000 hospital beds and nursing home beds and shall maintain the availability of such additional beds and facilities in addition to the operating bed level as the Secretary considers necessary for such contingency purposes. The President shall include in the Budget transmitted to the Congress for each fiscal year pursuant to section 1105 of title 31, an amount for medical care and amounts for construction sufficient to

enable the Department to operate and maintain a total of not less than 90,000 hospital and nursing home beds in accordance with this paragraph and to maintain the availability of the contingency capacity referred to in the second sentence of this paragraph. The Secretary shall staff and maintain, in such a manner as to ensure the immediate acceptance and timely and complete care of patients, *and in a manner consistent with the policies of the Secretary on overtime*, sufficient beds and other treatment capacities to accommodate, and provide such care to, eligible veterans applying for admission and found to be in need of hospital care or medical services.

(2) The Secretary shall maintain the bed and treatment capacities of all Department medical facilities, *including the staffing required to maintain such capacities*, so as to ensure the accessibility and availability of such beds and treatment capacities to eligible veterans in all States **[and to minimize]** *to minimize* delays in admissions and in the provision of hospital, nursing home, and domiciliary care, and of medical services furnished pursuant to section 1710(a) of this title, *and to ensure that eligible veterans are provided such care and services in an appropriate manner.*

(3)(A) The Under Secretary for Health shall at the end of each fiscal year (i) analyze agencywide admission policies and the records of those eligible veterans who apply for hospital care, medical services, and nursing home care, but are rejected or not immediately admitted or provided such care or services, and (ii) review and make recommendations regarding *the adequacy of staff levels for compliance with the policy established under subparagraph (C)*, the adequacy of the established operating bed levels, the geographic distribution of operating beds, the demographic characteristics of the veteran population and the associated need for medical care and nursing home facilities and services in each State, and the proportion of the total number of operating beds that are hospital beds and that are nursing home beds.

\* \* \* \* \*

*(C) The Secretary shall, in consultation with the Under Secretary for Health, establish a nationwide policy on the staffing of Department medical facilities in order to ensure that such facilities have adequate staff for the provision to veterans of appropriate, high-quality care and services. The policy shall take into account the staffing levels and mixture of staff skills required for the range of care and services provided veterans in Department facilities.*

\* \* \* \* \*

**TITLE 5, UNITED STATES CODE**

\* \* \* \* \*

**§ 8415. Computation of basic annuity**

\* \* \* \* \*

*(i) In computing an annuity under this subchapter, the total service of an employee who retires from the position of a registered nurse with the Veterans Health Administration on an immediate annuity, or dies while employed in that position leaving any survivor entitled*

*to an annuity, includes the days of unused sick leave to the credit of that employee under a formal leave system, except that such days shall not be counted in determining average pay or annuity eligibility under this subchapter.*

\* \* \* \* \*

**§ 8422. Deductions from pay; contributions for military service**

\* \* \* \* \*

(d)(1) Under such regulations as the Office may prescribe, amounts deducted under subsection (a) shall be entered on individual retirement records.

(2) *Deposit may not be required for days of unused sick leave credited under section 8415(i).*

