

TO AMEND TITLE 38, UNITED STATES CODE, TO IMPROVE THE PRODUCTIVITY OF THE MANAGEMENT OF DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE, AND FOR OTHER PURPOSES

NOVEMBER 16, 2018.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. ROE of Tennessee, from the Committee on Veterans' Affairs, submitted the following

R E P O R T

together with

MINORITY VIEWS

[To accompany H.R. 6066]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 6066) to amend title 38, United States Code, to improve the productivity of the management of Department of Veterans Affairs health care, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE PRODUCTIVITY IMPROVEMENT.

(a) IN GENERAL.—Subchapter I of chapter 17 of title 38, United States Code, is amended by inserting after section 1705A the following new section:

“§ 1705B. Management of health care: productivity

“(a) RELATIVE VALUE UNIT TRACKING.—The Secretary shall track relative value units for all Department providers.

“(b) CLINICAL PROCEDURE CODING TRAINING.—If the coding accuracy of a Department provider within a clinical area of responsibility of the provider falls below the minimum threshold set by the Secretary, the Secretary shall require the Department provider to attend training on clinical procedure coding.

“(c) PERFORMANCE STANDARDS.—(1) The Secretary shall establish for each Department facility—

“(A) in accordance with paragraph (2), standardized performance standards based on nationally recognized relative value unit production standards applicable to each specific profession in order to evaluate clinical productivity at the provider and facility level;

“(B) remediation plans to address low clinical productivity and clinical inefficiency; and

“(C) an ongoing process to systematically review the content, implementation, and outcome of the plans developed under subparagraph (B).

“(2) In establishing the performance standards under paragraph (1)(A), the Secretary—

“(A) may incorporate values-based productivity models and may incorporate other productivity measures and models determined appropriate by the Secretary; and

“(B) shall take into account non-clinical duties, including with respect to training and research;

“(C) shall take into account factors that impede productivity and efficiency and, in developing remediation plans under paragraph (1)(B), shall incorporate action plans to address such factors.

“(d) DEFINITIONS.—In this section:

“(1) The term ‘Department provider’ means an employee of the Department who has been appointed to the Veterans Health Administration as a physician, a dentist, an optometrist, a podiatrist, a chiropractor, an advanced practice registered nurse, or a physician’s assistant acting as an independent provider.

“(2) The term ‘relative value unit’ means a unit for measuring workload by determining the time, mental effort and judgment, technical skill, physical effort, and stress involved in delivering a service.”.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1705A the following new item:

“1705B. Management of health care: productivity.”.

(c) REPORT.—Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to Congress a report on the implementation of section 1705B of title 38, United States Code, as added by subsection (a). Such report shall include, for each professional category of Department of Veterans Affairs providers, the relative value unit of such category of providers at the national, Veterans Integrated Service Network, and facility levels.

(d) COMPREHENSIVE STAFFING MODELS.—Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs shall develop comprehensive staffing models for all Department of Veterans Affairs medical centers.

PURPOSE AND SUMMARY

H.R. 6066, as amended, a bill to amend title 38, United States Code (U.S.C.), to improve the productivity of the management of Department of Veterans Affairs (VA) health care, and for other purposes, would require VA to take certain steps to improve the

productivity and efficiency of VA medical facilities. Representative Brad Wenstrup of Ohio introduced H.R. 6066 on June 8, 2018.

BACKGROUND AND NEED FOR LEGISLATION

The Committee believes that VA medical facilities must be well-staffed and achieve a high level of productivity and efficiency in order to maximize access to care for veteran patients and ensure a prudent use of taxpayer dollars in support of the VA healthcare system. However, the Committee is alarmed by several analyses over a multi-year period that have called into question how well VA tracks and monitors provider staffing, productivity, and efficiency across the VA healthcare system.

In 2012, the VA Inspector General (IG) issued a report on staffing for specialty care services, which found that VA lacks an effective staffing methodology to ensure appropriate staffing levels for specialty care services.¹ In this report, the IG also found that VA lacks productivity standards for all specialties and that VA medical center leads had failed to develop staffing plans.² This led the IG to conclude that, “VHA’s lack of productivity standards and staffing plans limit the ability of medical facility officials to make informed business decisions on the appropriate number of specialty physicians to meet patient care needs, such as access and quality of care.”³

In 2015, the VA Independent Assessment of the Health Care Delivery Systems and Management Processes (Independent Assessment) released a report on staffing and productivity, which found that VA specialty providers are less productive than their private sector counterparts on two industry measures—encounters and relative value units (RVUs).⁴ RVUs are a commonly used measure of a provider’s productivity that take into account the time, technical skill, mental effort, and stress that are needed for a clinician to provide a given clinical service.⁵ The Independent Assessment also found that VA lacked staffing standards; that VA specialty physician staffing levels are lower than industry ratios for most specialties; that the number of patients assigned to VA primary care providers is lower than the private sector benchmark for patients of a similar acuity; and that insufficient exam room space, poor configuration of clinical areas, and unsatisfactory clinical and administrative support staff ratios limited productivity and efficiency—and, therefore, access—across the VA healthcare system.⁶

In 2017, the Government Accountability Office (GAO) released a report on clinical productivity and efficiency, which found that VA lacks complete and accurate information on provider productivity

¹ VA Office of the Inspector General 11–01827–36, December 2012, “Audit of Physician Staffing Levels for Specialty Care Services,” <https://www.va.gov/oig/pubs/VAOIG-11-01827-36.pdf>.

² *Ibid.*

³ *Ibid.*

⁴ CMS Alliance to Modernize Healthcare Federally Funded Research and Development Center, September 1, 2015, “Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs,” https://www.va.gov/opa/choiceact/documents/assessments/Integrated_Report.pdf.

⁵ January 12, 2015, National Health Policy Forum, “The Basics: Relative Value Units,” https://www.nhpf.org/library/the-basics/Basics_RVUs_01-12-15.pdf.

⁶ *Ibid.*

and efficiency.⁷ GAO also found that VA Central Office does not systematically oversee productivity and efficiency.⁸ As a result, VA cannot ensure that low productivity and clinical inefficiencies are addressed at individual VA medical facilities or identify and correct patterns that could increase productivity and efficiency across the VA health care system.⁹ In testimony regarding this report, GAO noted that, “[a]s VA’s funding levels increase, it is increasingly important that the Department spend these funds wisely and ensure that VA attains high levels of productivity among its clinical services and operational efficiency to maximize veterans’ access to care and minimize costs.”¹⁰

In 2018, the IG released a report on staffing shortages, which found that physicians and nurses were the top two most commonly cited shortage occupations across the VA healthcare system.¹¹ The Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 128 STAT. 1754) first established the requirement for an annual IG report on VA staffing shortages. The report was then modified by the VA Choice and Quality Employment Act of 2017 (Public Law 115–46; 131 STAT. 958). Since the first such report was released in 2014, the findings have remained largely consistent, with the largest clinical staffing shortages being physicians, nurses, psychologists, physician assistants, medical technologists, and physical therapists.¹² To address these findings, the IG has recommended since 2015 that VA develop staffing models for critical occupations.¹³ The 2018 report notes that, “the [IG] has made recommendations related to the development and implementation of a staffing model in each of its previous staffing determination reports,” and, “re-emphasizes the need for VHA to develop and implement a robust and targeted staffing model.”¹⁴

The Committee is concerned that, despite the significant amount of study and analysis and repeated recommendations for action, VA continues to struggle with medical facility staffing, productivity, and efficiency and continues to lack relevant models, tracking mechanisms, and plans to improve. Accordingly, section 1 of the bill would require VA to develop comprehensive staffing models for all VA medical centers, track RVUs for all providers, establish performance standards to evaluate clinical productivity and efficiency, develop remediation plans to address low clinical productivity and inefficiency, and ensure that providers who fall below minimum thresholds attend training on clinical procedure coding. The Committee recognizes that factors outside of an individual provider’s control—like insufficient exam room space or support staff—may negatively impact productivity and efficiency. The Committee also recognizes that some VA providers perform important and nec-

⁷ GAO–17–480, May 2017, “Improvements Needed in Data and Monitoring of Clinical Productivity and Efficiency,” <https://www.gao.gov/assets/690/684869.pdf>.

⁸ *Ibid.*

⁹ *Ibid.*

¹⁰ United States Cong. House Committee on Veterans’ Affairs. “*Maximizing Access and Resources: An Examination of VA Productivity and Efficiency.*” July 13, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (testimony of Randall B. Williamson, Director, Health Care, Government Accountability Office.).

¹¹ VA Office of the Inspector General 18-01693-196, June 2018, “OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages,” <https://www.va.gov/oig/pubs/VAOIG-18-01693-196.pdf>.

¹² *Ibid.*

¹³ *Ibid.*

¹⁴ *Ibid.*

essary functions—like training and research—that may also impede productivity and efficiency. As such, section 1 of the bill would require VA to take non-clinical duties and productivity-limiting factors into account when developing performance standards and remediation plans. The Committee further recognizes that there may be non-RVU based measures and models that may be useful for VA to consider when implementing the requirements of this bill. In light of that, section 1 of the bill would also authorize VA to incorporate values-based productivity models. Feedback from stakeholder groups, including multiple veteran service organizations, was taken into account in the drafting of this bill and the Committee is grateful for their input. The Committee is also grateful for a letter provided by the Nurses Organization of Veterans Affairs (NOVA), which expressed support for an RVU-based system to capture and compare provider productivity and efficiency across the VA healthcare system, noted that VA already uses RVUs to track provider productivity in certain specialty services, and stated that that, “[b]y tracking these metrics, leadership would have a clearer picture of how resources are being used in each facility with the goal of providing effective and efficiency high-quality care.”¹⁵ The Committee agrees with that assessment. NOVA also requested that, “consideration of any new requirement to address performance measures of providers take into account VA’s ‘whole health’ approach to care and the complex injuries of the veteran patients they serve.”¹⁶ The Committee certainly expects that, in developing the performance standards and remediation plans that would be required by this bill, VA would account for the Department’s unique mission, needs, and initiatives.

HEARINGS

On June 13, 2018, the Subcommittee on Health conducted a legislative hearing on a number of bills including H.R. 6066.

The following witnesses testified:

The Honorable Vicky Hartzler, U.S. House of Representatives, 4th District, Missouri; The Honorable Marcy Kaptur, U.S. House of Representatives, 9th District, Ohio; The Honorable Matt Cartwright, U.S. House of Representatives, 17th District, Pennsylvania; The Honorable Clay Higgins, U.S. House of Representatives, 3rd District, Louisiana; The Honorable Mike Bost, U.S. House of Representatives, 12th District, Illinois; The Honorable Jeff Denham, U.S. House of Representatives, 10th District, California; The Honorable Jennifer Gonzalez-Colon, U.S. House of Representatives, Puerto Rico; The Honorable Brad Wenstrup, U.S. House of Representatives, 2nd District, Ohio; Roscoe Butler, Deputy Director for Health Care, Veterans Affairs and Rehabilitation, The American Legion; Jeremy Villanueva, Associate National Legislative Director, Disabled American Veterans; Kayda Keleher, Associate Director, National Legislative Service, Veterans of Foreign Wars of

¹⁵ July 11, 2018, Letter from Thelma Roach-Sherry BSN, RN, NE-BC., President, Nurses Organization of Veterans Affairs, to the Honorable David P. Roe, Chairman, Committee on Veterans’ Affairs, U.S. House of Representatives regarding H.R. 6066, as amended.

¹⁶ July 11, 2018, Letter from Thelma Roach-Sherry BSN, RN, NE-BC., President, Nurses Organization of Veterans Affairs, to the Honorable David P. Roe, Chairman, Committee on Veterans’ Affairs, U.S. House of Representatives regarding H.R. 6066, as amended.

the United States; and Jessica Bonjorni MBA, PMP, SPHR, Acting Assistant Deputy Under Secretary for Health for Workforce Services, Veterans Health Administration, U.S. Department of Veterans Affairs, who was accompanied by Dayna Cooper MSN, RN, Director, Home and Community-Based Programs, Veterans Health Administration, U.S. Department of Veterans Affairs.

Statements for the record were submitted by:

American Orthotic and Prosthetic Association, Paralyzed Veterans of America, and Military Officers Association of America.

SUBCOMMITTEE CONSIDERATION

On June 27, 2018, the Subcommittee on Health met in open markup session, a quorum being present and favorably forwarded H.R. 6066, as amended, to the Full Committee. During consideration of the bills, the following amendment was considered and agreed to by voice vote:

An amendment in the nature of a substitute offered by Representative Neal Dunn of Florida, which would modify the performance standards and remediation plans as well as require VA to develop comprehensive staffing models for all VA medical centers.

COMMITTEE CONSIDERATION

On July 12, 2018, the full Committee met in open markup session, a quorum being present, and ordered H.R. 6066, as amended, to be reported favorably to the House of Representatives by voice vote. During consideration of the bill, the following amendment was considered:

An amendment in the nature of a substitute offered by Representative Ann Kuster of New Hampshire, which would—with the exception of the requirement for VA to develop comprehensive staffing models for VA medical centers—convert the bill to a three-year pilot program and impose numerous reporting requirements on VA and GAO. The amendment was not agreed to by voice vote.

COMMITTEE VOTES

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, there were no recorded votes taken on amendments or in connection with ordering H.R. 6066, as amended, reported to the House. A motion by Representative Gus Bilirakis of Florida to report H.R. 6066, as amended, favorably to the House of Representatives was adopted by voice vote.

COMMITTEE OVERSIGHT FINDINGS

In compliance with clause 3(c)(1) of rule XIII and clause (2)(b)(1) of rule X of the Rules of the House of Representatives, the Committee's oversight findings and recommendations are reflected in the descriptive portions of this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee's performance goals and objectives are to increase the productivity and efficiency of VA medical facilities in order to improve the accessibility and quality of care that VA provides to veteran patients.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee adopts as its own the estimate of new budget authority, entitlement authority, or tax expenditures or revenues contained in the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

EARMARKS AND TAX AND TARIFF BENEFITS

H.R. 6066, as amended, does not contain any Congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of rule XXI of the Rules of the House of Representatives.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate on H.R. 6066, as amended, prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate for H.R. 6066, as amended, provided by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 1, 2018.

Hon. PHIL ROE, M.D.,
*Chairman, Committee on Veterans' Affairs,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 6066, a bill to amend title 38, United States Code, to improve the productivity of the management of Department of Veterans Affairs health care, and for other purposes.

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

Sincerely,

KEITH HALL,
Director.

Enclosure.

H.R. 6066—A bill to amend title 38, United States Code, to improve the productivity of the management of Department of Veterans Affairs health care, and for other purposes

Summary: H.R. 6066 would require the Department of Veterans Affairs (VA) to train certain medical staff to identify the level of resources used to provide medical services. CBO estimates that implementing the bill would cost \$320 million over the 2019–2023 period, assuming appropriation of the necessary amounts.

Enacting the bill would not affect direct spending or revenues; therefore, pay-as-you-go procedures do not apply.

CBO estimates that enacting H.R. 6066 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2029.

H.R. 6066 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated Cost to the Federal Government: The estimated budgetary effect of H.R. 6066 is shown in the following table. The costs of the legislation fall within budget function 700 (veterans benefits and services).

	By fiscal year, in millions of dollars—						
	2018	2019	2020	2021	2022	2023	2019– 2023
INCREASES IN SPENDING SUBJECT TO APPROPRIATION							
Estimated Authorization Level	0	90	70	60	60	50	330
Estimated Outlays	0	80	70	60	60	50	320

Basis of estimate: For this estimate, CBO assumes that H.R. 6066 will be enacted near the beginning of fiscal year 2019 and that the estimated amounts will be appropriated each year. Estimated outlays are based on historical spending patterns for the affected programs.

The bill would require VA to train licensed independent providers (also known as LIPs, which include physicians, dentists, and nurses) who fail to meet certain standards for using relative-value units (RVUs) to evaluate medical services. RVUs are tools used by physicians participating in Medicare to rank on a common scale the resources (such as time, technical skill, and physical effort) used to provide various health care services.

VA currently tracks RVUs for health care provided by the agency. Furthermore, the department is in the process of developing an internal website to offer voluntary training to its medical providers on using RVUs. However, according to VA, only 5 percent of the 63,000 LIPs accurately document their medical services using RVUs.

Using information from VA, CBO estimates that under the bill the department would train roughly 60,000 medical staff to use RVUs in 2019. We expect that training would be repeated annually until LIPs demonstrated sustained proficiency. On average, each LIP would require about three hours of training, which equates to a loss of about 540,000 clinical visits at an average cost of \$145 per visit, CBO estimates. In order to continue the provision of health care, CBO expects VA would utilize community care to cover appointments while the LIPs are in training. Over time, CBO expects LIPs at VA would become increasingly proficient in using RVUs,

and would therefore require less training. On that basis, CBO estimates that providing training on using RVUs would cost \$70 million in 2019 and \$260 million over the 2019–2023 period.

In addition, CBO expects VA would need to hire the equivalent of 140 full-time staff at an annual compensation rate of \$80,000 each to provide ongoing training and support at each medical facility. VA also would hire an additional staff member at VA’s central office at an annual compensation of \$135,000 in 2019 for oversight. After factoring in inflation, CBO estimates that the increase in support staff would cost \$10 million in 2019 and \$60 million over the 2019–2023. CBO estimates minimal costs to prepare a one-time report and comprehensive staffing models within one year of enactment.

In total, CBO estimates implementing H.R. 6066 would cost \$320 million over the 2019–2023 period.

Pay-As-You-Go considerations: None.

Increase in long-term direct spending and deficits: CBO estimates that enacting H.R. 6066 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2029.

Mandates: H.R. 6066 contains no intergovernmental or private-sector mandates as defined in UMRA.

Previous CBO Estimate: On February 15, 2018, CBO transmitted a cost estimate for H.R. 4242, the VA Care in the Community Act, as ordered reported by the House Committee on Veterans’ Affairs on December 19, 2017. H.R. 6066 is similar to section 205 of H.R. 4242. CBO estimated that implementing section 205 of H.R. 4242 would cost \$9 million over 5 years for the direct costs of training and support. The estimated costs for implementing the similar requirements in this bill are higher, however, because new information from VA indicates that the department believes it would be required to spend more time and funding to train and support VA personnel on using RVUs. In addition, the department would outsource appointments while the VA personnel undergo training.

Estimate prepared by: Federal costs: Ann E. Futrell; Mandates: Andrew Laughlin.

Estimate reviewed by: Sarah Jennings, Chief, Defense, International Affairs, and Veterans’ Affairs Cost Estimates Unit; Leo Lex, Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates regarding H.R. 6066, as amended, prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act would be created by H.R. 6066, as amended.

STATEMENT OF CONSTITUTIONAL AUTHORITY

Pursuant to Article I, section 8 of the United States Constitution, H.R. 6066, as amended, is authorized by Congress’ power to “pro-

vide for the common Defense and general Welfare of the United States.”

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that H.R. 6066, as amended, does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

STATEMENT ON DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee finds that no provision of H.R. 6066, as amended, establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

DISCLOSURE OF DIRECTED RULEMAKING

Pursuant to section 3(i) of H. Res. 5, 115th Cong. (2017), the Committee estimates that H.R. 6066, as amended, contains no directed rulemaking that would require the Secretary to prescribe regulations.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Department of Veterans Affairs health care productivity improvement

Section 1(a) of the bill would amend subchapter I of chapter 17 of title 38 U.S.C. by inserting after section 1705A a new section “§ 1705B. Management of health care; productivity”.

The new section 1705B(a) would require VA to track RVUs for all VA providers.

The new section 1705B(b) would require VA to require VA providers to attend training on clinical procedure coding if the coding accuracy of the VA provider within their clinical area of responsibility falls below the minimum threshold set by VA.

The new section 1705B(c) would require VA to establish, for each VA facility: standardized performance standards based on nationally recognized RVU production standards applicable to each specific professional in order to evaluate clinical productivity at the provider and facility level; remediation plans to address low clinical productivity and clinical inefficiency; and an ongoing process to systematically review the content, implementation, and outcome of such plans. In fulfilling these requirements, the new section 1705B would authorize VA to incorporate values-based productivity models and other productivity measures and models as determined appropriate by VA as well as require VA to take into account non-clinical duties, (including with respect to training and research), factors that impede productivity and efficiency, and actions plans to address such factors.

The new section 1705B(d) would define “Department provider” to mean an employee of VA who has been appointed to the Veterans

Health Administration as a physician, dentist, optometrist, podiatrist, chiropractor, advanced practice registered nurse, or physician's assistant acting as an independent provider and "relative value unit" to mean a unit for measuring workload by determining the time, mental effort and judgement, technical skill, physical effort, and stress involved in delivering a service.

Section (b) of the bill would amend the table of contents at the beginning of chapter 17 of title 38 U.S.C. by inserting after the item relating to section 1705A the following new item: "§ 1705B. Management of health care; productivity."

Section (c) of the bill would require VA, not later than one year after the date of enactment of this Act, to submit to Congress a report on the implementation of the new section 1705B of title 38 U.S.C. and require such report to include, for each professional category of VA providers, the RVU of each category at the national, regional, and facility levels.

Section (d) of the bill would require VA, not later than one year after the date of enactment of this Act, to develop comprehensive staffing models for all VA medical centers.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, and existing law in which no change is proposed is shown in roman):

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in italic and existing law in which no change is proposed is shown in roman):

TITLE 38, UNITED STATES CODE

* * * * *

PART II—GENERAL BENEFITS

* * * * *

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

SUBCHAPTER I—GENERAL

Sec.
1701. Definitions.

* * * * *

1705A. Management of health care: information regarding health-plan contracts.
1705B. *Management of health care: productivity.*

* * * * *

SUBCHAPTER I—GENERAL

* * * * *

§ 1705B. Management of health care: productivity

(a) *RELATIVE VALUE UNIT TRACKING.*—The Secretary shall track relative value units for all Department providers.

(b) *CLINICAL PROCEDURE CODING TRAINING.*—If the coding accuracy of a Department provider within a clinical area of responsibility of the provider falls below the minimum threshold set by the Secretary, the Secretary shall require the Department provider to attend training on clinical procedure coding.

(c) *PERFORMANCE STANDARDS.*—(1) The Secretary shall establish for each Department facility—

(A) in accordance with paragraph (2), standardized performance standards based on nationally recognized relative value unit production standards applicable to each specific profession in order to evaluate clinical productivity at the provider and facility level;

(B) remediation plans to address low clinical productivity and clinical inefficiency; and

(C) an ongoing process to systematically review the content, implementation, and outcome of the plans developed under subparagraph (B).

(2) In establishing the performance standards under paragraph (1)(A), the Secretary—

(A) may incorporate values-based productivity models and may incorporate other productivity measures and models determined appropriate by the Secretary; and

(B) shall take into account non-clinical duties, including with respect to training and research;

(C) shall take into account factors that impede productivity and efficiency and, in developing remediation plans under paragraph (1)(B), shall incorporate action plans to address such factors.

(d) *DEFINITIONS.*—In this section:

(1) The term “Department provider” means an employee of the Department who has been appointed to the Veterans Health Administration as a physician, a dentist, an optometrist, a podiatrist, a chiropractor, an advanced practice registered nurse, or a physician’s assistant acting as an independent provider.

(2) The term “relative value unit” means a unit for measuring workload by determining the time, mental effort and judgment, technical skill, physical effort, and stress involved in delivering a service.

* * * * *

MINORITY VIEWS

As written, the Minority has serious concerns with H.R. 6066. In particular, we are concerned the implementation of this measure on a permanent basis will erode the unique the patient-provider relationship within the Department of Veterans' Affairs (VA). In addition, this measure could also lead Congress to misinterpret VA's budgetary needs and workload as it considers appropriations measures in the coming years.

Not only is the measure superfluous in its call for collection of RVUs, but redundant as VHA has collected and reported back to facilities on clinical productivity metrics since 2013. By utilizing the Specialty Productivity-Access Report and Quadrant (SPARQ) tool, VHA "measures specialty physician value in the form of "compensation per RVU" so as to demonstrate [its] ability to be good stewards of public healthcare resources."¹

While we agree with the Majority that increasing provider productivity at VA should be addressed in order to ensure VHA remains a leader in the delivery of veterans' health care, we are alarmed this provision could have unintended consequences as we move forward. For this reason, we must align ourselves with the concerns expressed by a variety of witnesses in regard to the measure including VA and Veterans Service Organizations (VSOs).

On July 13, 2017, the Members of the Subcommittee on Health heard from several witnesses, including representatives from the Government Accountability Office (GAO) and VA, that each indicated the capture of traditional RVUs at VA would not provide the most accurate reflection of provider productivity for several reasons. Chief among these is attempting to compare RVUs at VA with the private sector.

As witnesses stated, this is problematic because the comparison is not apples-to-apples. Instead it is more akin to apples-to-oranges. Witnesses pointed out (1) VA providers have limited space with a provider-to-office ratio of 1:1 whereas private industry is 1:3 or 4 even; and (2) veteran care is more time consuming as veterans tend to list a litany of ailments during a Primary Care Provider visit due to their likelihood of having multiple comorbidities; whereas civilians tend to experience one health issue at a time.

While the measure at hand does not call for an explicit comparison of VA to private sector RVUs, the capture and public reporting to Congress on this data would provide opponents of VA with fodder to further misrepresent VA's capacity to deliver quality healthcare. By taking the data produced as a result of this measure

¹ United States Cong. House Committee on Veterans' Affairs, Subcommittee on Health Oversight Hearing—"Clinical Productivity and Efficiency in the Department of Veterans' Affairs Healthcare System." July 13, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement from Carolyn Clancy, M.D., Deputy Under Secretary for Organizational Excellence at the Veterans Health Administration of the Department of Veterans' Affairs).

and comparing it to various private sector facilities, opponents of VA could argue that taxpayer's money would be better spent in the community. However, the services provided by VA when compared to the private sector are more comprehensive, time consuming, and of a higher quality.² The Minority is not confident this data would be published in a responsible manner that would lead to an increase in VA productivity.

In addition, the implementation of this measure system-wide would threaten the integrity of VHA's currently data architecture, the Veterans Information Systems and Technology Architecture (VistA). In July 2017, VA testified that VistA "was never designed to capture data related to billing type, so a variety of complex workarounds are needed to assemble an approximation of RVUs. These workarounds introduce a risk of reporting inaccurate numbers; and we magnify that risk by expanding the scope of measurement."³

However, in May 2018, VA officially signed a contract to modernize VHA's electronic health record system by adopting a system similar to that of the Department of Defense's. Among other advancements, the new electronic health records system is expected to be "better configured for workload capture and billing using private-sector standards, and could help embed workflow indicators that transparently capture data regarding productivity and minimize inaccuracies due to our current workarounds."⁴

Given all of these concerns, the Minority offered an alternative at markup which would have created a three-year pilot program to be carried out at 15 medical facilities in which VHA tracks the relative value units of health care providers. Much like H.R. 6066, the Secretary would be required to provide additional training to providers falling below an average level of productivity and would be required to establish performance standards for each medical facility. Additionally, it called on VA to submit a well-rounded implementation plan, quarterly reports and a final report on whether it was feasible and advisable to extend the program. GAO would be required to assess both the implementation plan and final report within 60 days of its submission. Unfortunately, it was not adopted.

² Comparing Quality of Care in Veterans Affairs and Non-Veterans Affairs Settings, https://www.rand.org/pubs/external_publications/EP67588.html.

³ United States Cong. House Committee on Veterans' Affairs, Subcommittee on Health Oversight Hearing—"Clinical Productivity and Efficiency in the Department of Veterans' Affairs Healthcare System." July 13, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement from Carolyn Clancy, M.D., Deputy Under Secretary for Organizational Excellence at the Veterans Health Administration of the Department of Veterans' Affairs).

⁴ Id.

The Committee is in agreement that the productivity of healthcare providers employed by the Department of Veterans' Affairs should increase in accord with budgetary increases, the minority is not convinced that the tracking of RVUs will produce reliable information upon which veteran-patients and Congressional appropriators should base their decisions.

MARK TAKANO,
Vice Ranking Member.

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