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VETERANS AFFAIRS PHYSICIAN AND DENTIST COMPENSATION ISSUES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

OCTOBER 21, 2003

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VETERANS AFFAIRS PHYSICIAN AND DENTIST COMPENSATION ISSUES

TUESDAY, OCTOBER 21, 2003

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

The subcommittee met, pursuant to notice, at 2:10 p.m., in room 334, Cannon House Office Building, Hon. Rob Simmons (chairman of the subcommittee) presiding.

Present: Representatives Simmons, Boozman, Brown-Waite, Rodriguez, Strickland, Berkley, and Ryan.

OPENING STATEMENT OF CHAIRMAN SIMMONS

Mr. SIMMONS. The subcommittee will come to order. Good afternoon, everybody. I am told that my friend and colleague, the distinguished Representative from Texas, Mr. Rodriguez, is running just a few minutes late. My friend, Mr. Strickland, has agreed to represent his side of the dais for a few minutes while we get this hearing under way, and I thank the gentleman for that courtesy.

Doctors have traditionally been called "the engines" of medicine and health care, which I believe is an indicator of their importance to the diagnosis and treatment of illness and injury.

Certainly, physicians are one of the most important professions in human affairs across human history. They are healers, and as healers, they are precious to us.

Generally speaking, throughout the history of Western civilization, physicians have been highly respected and compensated for what they do, perhaps more so than any other profession or occupation. Certainly, in this country, the United States of America, physicians are well-compensated for their service.

However, I think that we have encountered certain instances where physicians do not receive remuneration consistent with their role and status in our society, and perhaps one of those areas might be in the area of compensation for VA physicians.

Over the years, Congress has preoccupied itself to ease physician shortages and improve their distribution across the country, in particular, in rural areas, and that is why in the 1970s, Congress enacted legislation that would establish five new state schools for medicine to address specific geographic shortages in West Virginia, South Carolina, Texas, Ohio and Tennessee.

This Committee has long taken an interest in this issue, and currently we are awaiting the report of the Veterans' Administration

national Commission on Nursing, which this Committee authorized in law, and this report is due here next year.

I am told that the VA currently employs about 6,000 physicians and reports about 950 physician vacancies that it presumably would fill if it were able to recruit these professionals.

It is my understanding that nearly 13 years have elapsed since Congress last reformed VA physician pay. I understand the Chairman and the Ranking Member intend to craft legislation that might address this issue, hopefully in concert with this Subcommittee and its Members, and that that legislation will become the law of the land for many years to come.

I would ask unanimous consent that my whole opening statement be entered into the record as if read, and I would ask if my colleague on the other side of the aisle has any comments that he would like to make.

[The prepared statement of Chairman Simmons appears on p. 53.]

OPENING STATEMENT OF HON. TED STRICKLAND

Mr. STRICKLAND. Thank you, Mr. Chairman. Just very briefly, I was struck last week when we were able to receive testimony from those who had been injured and appeared before this Committee.

I was especially impressed by I think without exception, they shared with us that they were pleased with the quality of the care providers. Their complaints dealt more with delays and inability to access staff in a timely manner, but once they had that connection with the provider, they seemed to be pleased with the quality of that service which they received.

I think that is a credit to the VA and to the people who provide these medical services within our VA. Not everyone is perfect. The system is not perfect.

The only thing that I would like for us to emphasize as we consider this important matter is that I think most of the time you get what you pay for, and what we need to be looking at is a system that provides adequate compensation for those who provide these very critical services to our veterans.

With that, I will yield back.

Mr. SIMMONS. I thank the gentleman. I share his observations completely. I think the Full Committee hearing on that issue was very instructive. I agree with your comments.

I see we are joined by our distinguished Ranking Member, Mr. Rodriguez. I yield to you, sir.

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you very much, Mr. Chairman, and thank you for holding this forum here and this hearing.

Dr. Roswell, welcome. I'm most aware that the VA Health Administration is interested in addressing the physician and dentist compensation issues as it prepares a workforce that can meet the challenges of the VA Health Care System in the 21st Century.

I think that we will find that the issue is confronting medical centers in every region, including my home town of San Antonio, in South Texas, an area where we need to work.

I want to welcome also Dr. Richard Bauer. Do you want to stand up? Let's give him a big hand.

(Applause.)

Mr. RODRIGUEZ. Thank you. If there are any other Texans, we will also give you a big hand. Chief of Staff of the South Texas Veterans' Health Care System, and he will tell us what the issues are that are important.

Some experts believe that we may face physician shortages, particularly for specialties in the near future. In fact, there is no doubt that we are going to face some serious problems.

The data shows, and I keep saying that, the data shows that we produce about 13,000, and this figure goes a little ways back, but we have not produced any more medical schools, so we produce about 14,000 doctors and we bring in close to 4,000 to 5,000 from abroad each year. We have a real serious problem.

Right up to 9/11, Mr. Chairman, we brought in close to 5,000, a little less than 5,000 doctors alone from other countries. We have actually been a brain drain on the rest of the world when it comes to some of the health care professionals, so there is a real need for us to come to grips with that and see what we are going to do in that area.

I know that the VA and everyone else is encountering some real serious difficulties.

VA physicians are underpaid compared to their counterparts in the private sector. We have not considered pay legislation in 13 years. There are currently 900 vacancies that I have been informed about, about ten percent of the VA's full time physician workforce, and Dr. Roswell also says the VA would recruit for these if it could offer to compensate in terms of dealing with the competition.

I understand that the contracts for specialists that the VA often uses as an alternative may be more expensive than just hiring the specialists at the competitive salaries.

I also want to share with you that we have to make sure that we provide top notch care when it comes to our veterans, and we cannot afford to do any less.

The VA could have a challenge given the inadequate budget that we have been provided. We are hoping and we will continue the battle of adding some additional resources.

Dr. Roswell, I hope that the VA and the administration are giving thoughtful consideration to the funding and how much money you will request. That fight also has to come from inside internally. I know the VA organizations, from the American Legion to the G.I. Forum and all the others are out there doing their part in addressing the fact that there is a need for over $3 billion in additional resources, and I know that we all recognize that. It is just a matter of putting pressure.

It's election year. Both Democrats and Republicans are coming up. I do not want to be too partisan here. I will hit both parties. We need to hold everybody accountable. We have to make sure that we do the right thing.

Thank you very much.

[The prepared statement of Congressman Rodriguez appears on p. 55.]

Mr. SIMMONS. I thank the gentleman for his comments, and I agree completely. We have to hold everybody accountable.

We have three panels today speaking, and one panel submitting for the record. We have a lot of information that is going to be passed across. I realize that we do not have all of the Members of the Subcommittee here today. This is a hearing on an important topic, and we will ensure they receive the information. Some will be in and out as we proceed.

Panel one, we have our friend, the distinguished Under Secretary for Health, Dr. Robert H. Roswell, of the Department of Veterans Affairs. I understand you are accompanied by Ms. Mari A. Horak, who is the Associate Chief of Patient Care Services at the Veterans Health Administration.

Please proceed.

STATEMENT OF ROBERT H. ROSWELL, UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY MARI A. HORAK, ASSOCIATE CHIEF PATIENT CARE SERVICES OFFICER, VETERANS HEALTH ADMINISTRATION

Dr. ROSWELL. Thank you, Mr. Chairman and Mr. Rodriguez, Mr. Strickland. It is, as always, a real distinct pleasure to be here before you today. I am pleased to discuss our legislative proposals that will greatly enhance VA's ability to recruit and retain the highest quality physicians, dentists and nurses, to care for our Nation's veterans.

With me today, as you pointed out, Mr. Chairman, is Mari Horak, who is our Associate Chief, Patient Care Services, and a tremendous expert on the pay legislation that we will be discussing today.

The VA compensation structure for physicians and dentists has not changed since 1991. The current system is extremely complex and does not provide the flexibility to respond to the changing competitive market for many medical specialties, especially for the highest paid medical subspecialties.

Also, a national shortage of many physician specialties critical to our health care mission further affects our ability to fill key vacancies. In these shortage specialties, VA total compensation lags behind private or academic sectors by as much as 67 percent.

If we are to maintain our tertiary care capability and our capacity to offer a full range of health care services to veterans, including those now serving in far away parts of the world, we must be able to offer competitive salaries.

For several specialties, we are losing staff faster than we can hire them. In some critical specialties, our turnover rate exceeds 25 percent a year. Many facilities are not actively recruiting, as Mr. Rodriguez pointed out, to fill some key vacancies because they simply cannot find viable candidates at current VA salary rates.

It is estimated that there are over 900 such positions nationwide for physician specialties.

Non-competitive pay and benefits are also reflected in dramatic increases in our scarce specialty, fee basis, and contractual expenditures. These expenditures, which are necessitated when we cannot

hire physicians, have risen from $180 million a year in 1995 to over $850 million a year last year.

Additionally, we increasingly must hire non-U.S. citizens under the VA's J–1 visa waiver authority, and international medical graduates now constitute almost 30 percent of our entire VA physician workforce.

The problems with the current system are clear. Special pay rates are fixed in statute so that over time, their values are eroded by inflation, and VA pay falls behind the market. We now pay the maximum authorized amounts for some scarce specialists, and have no discretion under existing statute to pay more to retain these mission critical employees.

To respond to this pending crisis, we are proposing to completely revise the VA physician and dentist pay system, to allow VA to adjust physician and dentist compensation levels according to market forces.

Under our proposal, the physician pay would included three bands, base pay, market pay, and performance based pay. VA would benchmark the sum of all three bands to the 50th percentile of the Association of American Medical Colleges associate professor compensation levels for physicians, and to the 75th percentile of the American Dental Association practice guidelines for net practice income for our dentists.

For executives at the chief of staff level and above, the benchmarks would be hospital and HMO executive compensation levels.

The base pay component would be increased by the annual comparability adjustments to Federal pay authorized by Executive Order each year.

The system's simplicity and flexibility would ensure that VA physician and dentist compensation levels and practices do not become outdated over time due to statutory limits.

The draft bill would also prohibit senior Title 38 officials at the chief of staff level and above from receiving current or delayed compensation from medical schools affiliated with their respective VA medical centers. This prohibition will ensure that senior clinical leadership can participate in discussions and negotiations with our affiliates, without conflict of interest implications.

Our proposed physician and dentist pay would be effective on the first day of the first pay period on or after the later of April 1, 2004, or 6 months after the date of enactment.

Our bill also included important provisions allowing more flexible tours for nurses and an executive pay proposal for nurse leaders.

The proposals in our bill will help VA remain a competitive employer for nurses, and meet current and future health care needs.

We also request that the Committee act on a draft bill we recently forwarded to Congress that would clarify the authority of the Secretary to promulgate regulations relating to staff adjustments of Title 38 employees, and to clarify the exclusion from coverage under general Civil Service laws of Title 38 personnel laws and regulations.

A recent Federal Court decision has diluted the Secretary's authority to prescribe the conditions of employment for all Title 38 medical professionals. This decision would have us make decisions

regarding staffing at particular facilities without regard to the individual's professional competencies or our patient care needs.

This consideration is critical to staffing a health care system in which staff providers' particular competencies dictate the quality of care a facility can provide.

Mr. Chairman, we are in a critical situation with increasing demand for veterans' health care, yet our current pay system leaves us unable to recruit the staff we need today and well into the future.

This concludes my statement. Ms. Horak and I would be pleased to answer your questions.

[The prepared statement of Dr. Roswell appears on p. 59.]

Mr. SIMMONS. Thank you, Dr. Roswell. I have a couple of quick questions here. What percentage of VA physicians would receive an increase in total compensation if the proposed legislation were enacted by Congress?

Dr. ROSWELL. The current, as it is proposed, approximately 30 percent of physicians would receive a pay raise if we indexed to the 50th percentile of the associate professor's schedule of the AAMC.

Mr. SIMMONS. Is that enough?

Dr. ROSWELL. Obviously, we provide care in a cost contained environment. Is it enough is a difficult question to answer. I believe the outstanding work done by VA physicians all over this great Nation warrants a pay raise, and certainly I would love to see a greater percentage of VA physicians receive a pay raise.

Mr. SIMMONS. One of the issues that has been before this Subcommittee quite a bit, an issue that concerns me and I think the ranking member as well, specifically because of our districts, is the issue relative to the provision of VA health care in rural areas.

How would this proposal affect that issue? Would it be a positive step? Would it provide incentives for VA physicians to serve in rural areas, or would it be neutral on that issue?

Dr. ROSWELL. It would not specifically address compensation for work in rural areas, although I would point out that in many of our rural facilities, we do not have academic affiliations, and the academic salary rates would still be matched, even though an individual may not have academic responsibilities.

I believe it would clearly help us recruit certain specialties in rural areas, but because of the need for primary care and general internal medicine types of specialties, a higher pay raise or a broader range might be advantageous to recruit to those areas.

Mr. SIMMONS. Finally, without prejudicing the discussion thus far on the issue of physician pay, is pay the only incentive that we need to be looking at here, or are there other incentives as well?

Dr. ROSWELL. Well, maybe you are asking the wrong person, Mr. Chairman.

Mr. SIMMONS. I am asking a doctor.

Dr. ROSWELL. I think the Veterans Health Administration is the most outstanding place any physician could ever aspire to work. We have a noble mission, caring for America's veterans. We do that in affiliation with America's medical schools, where we have an opportunity to engage in medical education and research. We embrace cutting edge technology; the computerized patient record sys-

tem that the VA offers is world class. There is no better environment to pursue the practice of medicine than the VA.

But that is not a substitute for just compensation for the outstanding clinicians that provide care to our Nation's veterans.

Mr. SIMMONS. Thank you. I now yield to my colleague, Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you. Thank you very much for your testimony. I wanted to ask you, I know we have talked about the need in the area and we have thrown out figures of $3 billion. I am just curious how much those recommendations that talk about also the infrastructure, that we needed some money to look at the infrastructure of our hospitals.

On the report on personnel, do we have a figure for what is needed just for personnel upgrade, in terms of the positions that are lacking and the money that is out there?

Is there any appropriation numbers that have been thrown out, taking away the infrastructure money, that is needed there, the money just to keep existing services there and additional ones? Just in terms of the staff that is needed.

Do we have a figure there that maybe has not been looked at?

Dr. ROSWELL. We have looked at it, Mr. Rodriguez. In fiscal year 2004, we estimate we need to hire a minimum of 2,500 additional nurses, and at least 800 additional physicians.

Mr. RODRIGUEZ. 800 physicians?

Dr. ROSWELL. At least.

Mr. RODRIGUEZ. Do we know what the cost of that is?

Dr. ROSWELL. I would be happy to submit it for the record. I do not have an exact cost.

(Subsequently, the Department of Veterans Affairs provided the following information:)

The Honorable J. Dennis Hastert
Speaker of the House of Representatives
Washington, DC 20515

Dear Mr. Speaker:

There is transmitted herein a draft bill "To amend title 38, United States Code, to simplify and improve pay provisions for physicians and dentists, to authorize alternate work schedules and executive pay for nurses." We request that it be referred to the appropriate committee for prompt consideration and enactment.

The revised physician and dentist pay system and nursing provisions were included in the President's budget. They would be effective on the first day of the first pay period on or after the later of April 1, 2004, or six months after the date of enactment.

ENHANCED PHYSICIAN/DENTIST PAY

This bill will greatly enhance ability of the Department of Veterans Affairs (VA) to recruit and retain the highest quality physicians and dentists to treat the Nation's veterans. It would completely revise the VA physician and dentist pay system to allow VA to adjust physician and dentist compensation levels according to market forces. The system's simplicity and flexibility would ensure that VA physician and dentist compensation levels and practices do not become outdated over time due to statutory limits. This system also would ensure that VA pay levels do not fall drastically behind while awaiting adjustment to the statutory authority. It will be a living system that adjusts to changing forces in the healthcare labor market. Generally, amounts paid under this system will be considered pay for all purposes, including retirement benefits under chapters 83 and 84 of title 5, United States Code, and other benefits. However, amounts paid under the performance pay component will not be considered pay for retirement benefits.

The Honorable J. Dennis Hastert
VA Staffing Challenges

The VA compensation structure for physicians and dentists has not changed since 1991. The current system is extremely complex, comprising seven or eight different special pay components in addition to basic pay. The system offers insufficient flexibility to respond to the changing competitive market for many of the medical specialties, especially for the highest paid medical subspecialties. VA is no longer able to compete for these critical subspecialties. Also, although Congress increased special pay for dentists in 2000, those increases did not bring VA pay up to the levels in private dental practice. The effects of noncompetitive pay and benefits are reflected in dramatic increases in VA's scarce specialty, fee basis, and contractual expenditures.

VA is facing a critical situation. Its compensation system for physicians and dentists is unable to respond to the demands of the current market. Severe shortages of qualified physician specialists currently exist throughout the country in specialties critical to VA's health care mission, such as Anesthesiology, Radiology, Cardiology, Urology, Gastroenterology, Oncology, and Orthopedic Surgery. These shortages have driven compensation levels dramatically upward. In these shortage specialties, VA total compensation lags behind the private or academic sectors by 35 percent or more. Such compensation gaps make recruitment almost impossible and retention becomes more difficult. This legislation will enable VA to compete for physicians in the higher-paid, critical specialties and will protect other physicians' and dentists' pay. Moreover, VA will be able to offer to all physicians and dentists the prospect, now and in the future, of market-sensitive pay rates, with a portion of their compensation based on achievement of specific performance goals.

The problems with the current system are clear: special pay rates are fixed in statute, so over time their values are eroded by inflation, and VA pay eventually falls behind the market. The mechanisms available to VA to adjust physician and dentist pay are not able to respond to fluctuations in market levels of incomes for the different specialties. VA physician and dentist base salary rates increase by the amount of the annual national comparability adjustment that Federal employees generally receive; however, there is no increase in special pay amounts. Compensation for many specialties has risen significantly in the private sector, and VA pay cannot be increased to keep pace. VA is already paying the maximum authorized amounts for scarce specialists; there is no discretion under existing statute to pay more to retain employees.

Additionally, the current system does not adequately recognize disparities in pay among specialties. This results in serious pay compression and makes it difficult for VA to compete for the most highly paid specialists. For example, the difference between the average pay of non-Federal cardiologists vs. primary care

practitioners is about 100 percent; in VA, the difference averages about 20 percent.

VA historically had been able to use the Federal benefits package as a major recruitment tool. To offset pay disparities with the private sector, VA publicized its benefits, such as the generous leave policies, opportunities to pursue research and education activities, and formal relationships with academic affiliates. More and more, though, the private sector offers comparable or better benefits. Some benefits widely available in the private sector exceed VA's offerings including paid relocation as a recruiting incentive, cafeteria-style benefit plans, payment for courses to acquire continuing medical education (CME) credits for license and board renewal, disability insurance, and retirement benefits.

Increased enrollment by veterans for Veterans Health Administration (VHA) services and the need for more comprehensive care to aging veteran patients will result in an increase in workload across the system over the next 5 years. Current trends indicate a steady decrease in the number of physicians and dentists VHA will be able to employ over the same period. This decrease will result from increased retirements, losses to the private sector, a shrinking dentist labor supply, and increasing difficulty in recruiting replacements. These factors will combine to create significant gaps between VHA's staffing needs and available resources for most physician specialties.

Without the flexibility to adjust pay in response to market pressures and improve its competitive position in recruiting and retaining physicians, the Department will be unable to meet the demands of its increasing workload. VHA will be forced to rely more heavily on scarce medical specialist contracts and fee basis care, which often cost more than using VHA physicians. It is critical that VHA be able to offer more competitive compensation for physicians and dentists.

Proposed New VA Physician/Dentist Pay System

We propose a three-tiered system of base pay, market pay, and performance-based pay. VA would benchmark the sum of all three bands to the 50th percentile of the Association of American Medical Colleges (AAMC) Associate Professor compensation (for physicians) and 75 percent of American Dental Association (ADA) net private practice income (for dentists). The base pay component would be increased by the annual comparability adjustments to Federal pay authorized by Executive Order.

First Tier – Base Pay. A uniform base pay band will apply to all positions in VHA, without grade distinctions. The proposed range is Chief grade, step 10 of the VA Physician/Dentist Schedule to Level V of the Executive Schedule, from roughly $110,000 to $125,000. This change will dramatically simplify hiring and

employment and facilitate reassignments and position changes. Placement in this band would be based on the individual's qualifications. This band would form the floor below which no individual's pay would ever go.

Second Tier – Market Pay. The second tier, the market pay band, will be determined according to geographic area, specialty, assignment, personal qualifications and individual experience. It would be indexed to the salaries of similarly qualified non-Department physicians, dentists, and health-care executives at the entry, mid-career, and senior levels. The flexibility of this tier allows VA to keep pace with the market, both on upward and downward trends. VA would link the market band for clinicians to AAMC faculty compensation. For executives at the Chief of Staff (COS) level and above, the benchmarks would be hospital and HMO executive compensation levels. For dentists, the benchmark will be American Dental Association (ADA) net private practice income.

Third Tier – Performance Pay. The third band will be linked to performance, and would be paid for discrete achievements in quality, productivity, and support of corporate goals. The measures will be flexible and generally set locally; national objectives could also be mandated. VA facilities may authorize performance pay of up to $10,000 for physicians and dentists below the Chief of Staff (COS) level. For managers at the COS level and above, ten percent of their benchmarked pay would be at risk, and would be payable to the extent that performance goals are met. This will address a concern that has been raised by the General Accounting Office and others of a disconnect between employees' performance and their pay.

The draft bill also would prohibit senior title 38 officials at the Chief of Staff level and above from receiving any compensation, whether from employment or contract, and from accepting any offers of future employment, from medical schools affiliated with their respective VAMCs. This prohibition will reduce the risk of potential conflicts of interest, and will ensure that the Department's interests in agreements with affiliated medical schools are adequately protected. It is highly desirable to have an independent senior clinical official at each facility. VA's implementation of the bill will increase executive compensation to a level that would offset any loss of outside income resulting from this provision. In limited circumstances, the Secretary could suspend or waive this prohibition.

Details of VA's Implementation Plan

- Salary benchmarks will be set at the national level and communicated to networks. Local facilities would set pay levels within a range (± 10 percent of the benchmark) according to local circumstances. Any decision to set pay outside the 10-percent band will require higher-level approval.

The Honorable J. Dennis Hastert

- Benchmark salaries will be set for each specialty and location, at entry, mid-career, and senior levels. Increments and graduated benchmarks will be set to reflect varying levels of experience and to provide for reasonable income growth over a period of time.
- VA will use ADA net private practice income to set VA dentist salary benchmarks. About 93 percent of all practicing dentists are employed in private practice, so VA's primary competition in the marketplace is private practice income.
- Specific amounts of each tier and the total payable for each clinician will be set at the local level. This continues the VA practice of local pay setting based on national policy (used for physician and dentist special pay, nurse locality pay system, and special salary rates).
- This proposal will greatly enhance VA's ability to compete for the full range of skilled medical and dental services at the most reasonable cost. VA will be able to offer competitive compensation to full-time, part-time, or occasional staff, or pay on contract, according to the most clinically appropriate and efficient option.

This proposed physician and dentist pay aligns with the President's budget and would be effective on the first day of the first pay period on or after the later of April 1, 2004, or six months after the date of enactment.

Examples

An example of how this system will work for Internal Medicine:

VA internist with 10 years of experience, 2003	$142,682
AAMC Associate Professor median salary, 2001–2002	$142,000
Benchmark for VA Salary (±10% of AAMC)	$127,800 – 156,200
Targeted Increase	$0 - $13,518

An example of how this system will work for Therapeutic Radiologists:

VA radiologist with 10 years of experience, 2003	$190,682
AAMC Associate Professor median salary, 2001–2002	$248,000
Benchmark for VA Salary (±10% of AAMC)	$223,200 – 272,800
Targeted Increase	$32,518 - 82,118

An example of how this system will work for General Dentists:

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VA general dentist with 10 years of experience, 2003[1]	$131,682
ADA net private practice income (minus benefits), 2002[2]	$134,928
Benchmark for VA Salary (±10% of ADA)	$121,435 – 148,421
Targeted Increase	$0 – $16,739

Estimated Costs/ Savings

VA estimates the first year costs to be $69.42 million, with ten-year costs of $1.59 billion. There are expected savings from productivity and the avoidance of costly specialty contracts resulting from more competitive pay. The net first year costs are $48.47 million, with net ten-years costs of $636.25 million. A detailed explanation is in the attached charts.

ENHANCEMENTS FOR NURSES

Over the next several years the projected increase in the number of aging veterans and increased enrollment in the VA healthcare system by veterans of all ages will increase workload across the VA healthcare system. Between 2000 and 2010, the number of veterans age 75 and above will increase from 4 million to 4.5 million and within that number, those veterans age 85 and older will triple from 422,000 to 1.3 million. Veteran enrollees in the VA healthcare system will increase from approximately 6 million in FY 2002, to approximately 7.75 million in FY 2007. This increasing and aging population of veterans will exhibit higher co-morbidity and require more comprehensive care both as inpatients and as outpatients.

At the same time, national nursing leaders and healthcare organizations project a shortage of registered nurses that will be unlike any experienced in the past. Changes in healthcare delivery requiring larger numbers of professional nurses to perform increasingly complex functions in hospitals and the community has heightened the demand for professional nurses. Given the aging of the current registered nurse workforce (average age nationally, 45.2 yrs., in VA, 46 yrs.), and the decreasing number of students who choose nursing as a career, the future availability of professional, registered nurses (RN) will be insufficient to meet our national healthcare needs. Negative perceptions of nursing as a profession (i.e., perceived negative work environment and pay inequities between nurses and a wide range of alternative career options that require less education and have less responsibility) have exacerbated this situation. VA already is experiencing some staffing difficulties. VA's nurse vacancy and

[1] No discretionary special pay components (computed without geographic location pay, exceptional qualifications pay, or scarce specialty pay).
[2] ADA data as of 2000, increased by the CPI-Medical to obtain 2002 estimate, minus 25.56 percent for the cost of Federal benefits.

turnover rates have greatly increased since 1998. VA must better position itself to attract the nurses to meet current and future healthcare needs.

Nurse shortages, complex healthcare environments and growing administrative demands require highly skilled nurse executives at facility and national levels with the knowledge and experience to develop responsive care delivery models in an ever-changing healthcare environment. VA nursing leadership must be highly qualified and capable of implementing cutting edge, innovative changes. Current VA pay for nurse executives is not comparable to private sector pay and perquisites. As a result, VA often is not in a position to hire and retain nurse executives with exceptional skills. The current pay structure offers little or no incentive for current VA nurse executives and potential nurse leaders to take on progressively more responsible and complex assignments. Moreover, the current VA pay structure is generally not attractive to highly skilled and experienced non-VA nurse executives.

Approximately 55 percent of all VA Nurse Executives are eligible for retirement by 2005; 69 percent will be eligible by 2008. In addition, 35 percent of all current VA registered nurses are eligible to retire by 2005. When coupled with the national shortage, this potential loss of nurses could jeopardize VA's ability to accomplish its healthcare mission.

Thus, we propose legislation enabling VA medical centers (VAMCs) to offer flexible tours, and establishing a nurse executive special pay program.

Flexible Tours

The proposed legislation would authorize VA to offer registered nurses the following flexible tours:

(1) Three 12-hour tours (36 hours) in a workweek paid as 40 hours;
(2) 7 ten-hour days/7 days off in a pay period, with pay for 80 hours;
(3) 9 months of work with 3 months off, with pay apportioned over a 12-month period.

Inflexibility in work schedules is a major cause of dissatisfaction in nurse employment. A 2000 survey conducted by the American Organization of Nurse Executives (AONE), found that after salary, the top benefit sought by nurses was "flexible scheduling and control over shifts." Providing different options for scheduling would be a way of bringing more nurses into the workplace and retaining their services.

VAMCs across the country must compete in local employment markets that offer a variety of flexible working schedules and pay practices to professional nurses. Such options are popular among nurses because it allows them to accommodate individual lifestyles and personal obligations. The proposed

changes would allow VAMCs to implement flexible pay and work-schedule options common in many job markets. The ability to offer options comparable to those offered by their competitors would enhance VAMCs' ability to remain competitive employers. These flexible nurse tour proposals align with the President's budget and would be effective on the first day of the first pay period on or after the later of April 1, 2004, or six months after the date of enactment.

Nurse Executive Special Pay

The proposed legislation also would authorize VA to approve special pay to the nurse executive at each VA medical center or VA Central Office. The special pay would range from a minimum of $10,000 to a maximum of $25,000, based on factors such as the grade of the nurse executive, the scope and complexity of the nurse executive position, the nurse executive's personal qualifications, the characteristics of the of the healthcare facility, e.g., tertiary, single site or multi-site, nature and number of specialty care units, demonstrated recruitment and retention difficulties, and such other factors as the Secretary deems appropriate.

This proposed nurse executive pay aligns with the President's budget and would be effective on the first day of the first pay period on or after the later of April 1, 2004, or six months after the date of enactment.

There are significant inadequacies in the VA nurse locality pay system (LPS) as it relates to nurse executive compensation. There are difficulties in obtaining comparative survey data on non-VA nurse executive positions to use in making an informed determination concerning locality pay. Non-VA employers often do not cooperate in the survey process. Nurse executive positions are often one-of-a-kind positions making it difficult to match VA and non-VA jobs. Non-VA employers typically do not include nurse executives in compensation surveys. With the organizational changes and scope of responsibilities changes for nurse executives occurring in both VA and non-VA healthcare facilities, lines of authority and levels of responsibilities for executive nurses are changing. Thus, job and pay matching for nurse executives at VAMCs and non-VA healthcare facilities is extremely difficult. Furthermore, nurse executives work in a national labor market, or at least a regional one. LPS compares jobs on a local basis. Another major problem is that VA nurse executives are capped at Level V of the Executive Schedule (EL-V), $125,400. There is no such cap in the non-VA healthcare industry. The EL-V rate is no longer competitive with non-VA nurse executive positions. Moreover, non-VA employers negotiate nurse executive compensation as a total compensation package, often including bonuses and other incentives in addition to base pay. VA is unable to do that.

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The proposal derives from a recommendation of the VHA Future Nursing Workforce Planning Group. This group, composed of Medical Center Administrators, Nurse Executives, Network Managers and clinicians, has identified the $10,000 - $25,000 range as the amount that most commonly would mirror salary and/or community based perquisites of non-VA nurse executives, while not making VA the pay leader within the community. It is also consistent with the range of special pay currently available to VA physician executives.

Responsibilities of VA nurse executives are rapidly changing and becoming more varied and complex. VA's pay system for them must address this growing variety and complexity.

Costs

Flexible Tours

(1) Three 12-hour tours (36 hours) paid as 40 hours

Assumptions:

- Based on a 36 hour work week/ 72 hours per pay period for selected RNs.
- 40 hours/wk (Full-time) – 36 hours/wk (Full-time requested)= 4
- Average VA RN hourly wage= $29.02 (using FY02 avg RN salary = $56,679, adjusted by 3.2% annual pay increase = $60,364, divided by 2,080)

Cost is 4 hours per week/208 hours per year per nurse

Cost per RN per week	4 x $29.02 = $116.08
Cost per RN per year	208 x $29.02 = $6036

Based on an estimated 25 nurses per facility, the cost would be as follows:

25 (RNs) x $6036= $150,900
162 (VAMCs) x $150,900= $24.4 million

FY 2004 costs would be $12,222,900 (half-year implementation)

Costs in future years increased by 3.2%

FY05	$25.22 million
FY06	26.03
FY07	26.86
FY08	27.72
FY09	28.61
FY10	29.53
FY11	30.47
FY12	31.45

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FY13	32.45
TOTAL	$270.56 million over 10 years

(2) 9 months of work with 3 months off, with pay apportioned over a 12-month period

This is an authorization to pay RNs who are hired under this provision *less than* full time pay for full time worked. RNs would work a full nine months prior to pay continuance for 3 months. Registered nurses hired under this provision would reflect the following:

1. hired as part-time employees .75 FTE
2. each would work full-time (40 hr/wk) for nine months
3. while working full time for 9 months they would agree to be paid .75 salary
4. while not working for a period of 3 months, they would continue to be paid .75 salary

VAMCs would determine when such appointments would begin, based on regional needs (e.g. higher winter workload in the Sunbelt) and community-based competitive factors.

There are no costs associated with this proposal. It is estimated that VAMCs will derive fiscal benefits from deferring 25 percent of pay for full-time work over a 9-month period.

(3) 7 ten-hour days/7 days off, with pay for 80 hours

Assumptions:

- Based on paying an RN who works 70 hours as if 80 hours are worked?
- Average hourly wage= $29.02 (using FY02 avg RN salary = $56,679, adjusted by 3.2% annual pay increase = $60,364, divided by 2,080)

Cost is 10 hours per pay period/260 hours per year
Cost per RN per pay period 10 x $29.02 = $290.20
Cost per RN per year 260 x $29.02 = $7,545

Based on an estimated 15 nurses per facility, the cost would be as follows:

15 (RNs) x $7,545 = $113,175
162 (VAMCs) x $113,175= $18,334,350

FY 2004 costs would be $9,167,175 (half-year implementation)

Costs in future years increased by 3.2%

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FY05	$ 18.92 million
FY06	19.53
FY07	20.15
FY08	20.80
FY09	21.46
FY10	22.15
FY11	22.86
FY12	23.59
FY13	24.34
TOTAL	$203.00 million over 10 years

Nurse Executive Pay

Assumptions:

One nurse executive at each of the 162 VHA medical centers would be authorized to receive the executive special pay, [Note: the estimate below is a maximum estimate since in any given year there will be a varying number of nurse executive vacancies. On board strength is estimated to average 150 nurse executives. This number also includes 5 nurse executives in the VACO Office of Nursing Services]. The average per executive would be $17,500, $2.62 million per year for 150 executives.

YEAR	COST (millions)
2004	1.31
	(Based on April 4, 2004 effective date)
2005	2.62
2006	2.62
2007	2.62
2008	2.62
2009	2.62
2010	2.62
2011	2.62
2012	2.62
2013	2.62
TOTAL	$24.89

Mr. RODRIGUEZ. I would like to get the cost of that, and then also, of course, the increases, at least some increases in terms of being comparable to the private sector or somewhat close. Is that figure a 60 percent increase that is needed to get it comparable with the private sector?

Dr. ROSWELL. In certain specialties, yes.

Mr. RODRIGUEZ. I would like to see some kind of report. I know I have seen the ones on the infrastructure and I have seen the ones on special services that are needed. I thought maybe I had overlooked it.

In terms of the salaries, that is one of the areas where we have not talked about much, and we need to, because that has a lot to do with the morale and the quality of people that you also keep, because at a certain point, people get burned out, and decide if they do not have the assistance and the help and the nurses that are needed there, other people are not going to be there.

If you could get that for me, I would appreciate it.

(See 11 Quadrennial Report on p. 77.)

I also wanted to ask you, based on the policy recommendations and the differences that the administration is proposing, and the draft of the legislation, do you think there are other things the legislation maybe does not address that we ought to be looking at?

Dr. ROSWELL. I think the legislation as proposed addresses the critical areas. It may not be a perfect bill in certain areas, but clearly, the ability to address greater flexibility in compensation is the highest priority we face right now as we deal with waiting lists, increased demand for care, high turnover rates, and increasing percentage of international medical graduates, and the flexibility in compensation afforded by this bill would go a long ways to help us deal with that problem.

Mr. RODRIGUEZ. Do you know how many H–1 visas we might have within the system?

Dr. ROSWELL. I believe last year processed approximately 175 H–1 visas.

Mr. RODRIGUEZ. 175 professionals from abroad working with the VA?

Dr. ROSWELL. We have about 13,000 physicians, and 29 percent are international medical graduates. Ms. Horak may have more precise numbers.

Ms. HORAK. Yes, sir. What I can tell you is that we do not know at this point in time how many H–1 visas or J–1 visa waiver employees we have, although we can get that information for the record.

In the last year, fiscal year 2002, we did process 198 waiver cases, and in fiscal year 2003, we had 146 or 147 processed.

Mr. RODRIGUEZ. I just thought I would mention that because I know we do have a couple of members, such as Congressman Ric Keller, that talk about immigration. He forgets that we are a brain drain on the rest of the world. Until we decide that we want to produce our own, which we have not decided, and we are unwilling to provide the resources to make that happen, and I do encourage that we need to see how we can produce more doctors and more professionals.

Thank you.

Mr. SIMMONS. Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman.

I would like to ask Dr. Roswell, it is my understanding that the VA has asked for legislative relief regarding the VA's responsibility to give preference consideration for Title 38 employment decisions.

The question I have, why does the VA—if that is true, why does the VA believe it requires such relief, and what kind of message might this send to other Federal agencies regarding their requirement to abide by veterans' preference? Would you please speak to that?

Dr. ROSWELL. Title 38 was specifically crafted to allow us to address the clinical specialties and the care needed. It allows us to access various clinical specialties needed to provide care to our veterans. It does not always allow—the issue is the recent court decision I referred to in my testimony essentially says that if we ever have the need to execute a reduction in force, that we must administer that with Title V, not Title 38, personnel regulations, which means that a general internist is considered a physician and might wind up being reassigned to a cardiac surgery slot. I certainly would not want a general internist—I am one—I would not want one doing cardiac surgery on me.

The Title 38 staffing reduction or the Title 38 restrictions we are seeking allow us more if we are looking at a reduction in workforce or what we would call a Title 38 staffing adjustment, to be able to look at specialties and competencies in making reassignments under that circumstance.

Ms. HORAK. That is correct, and it is important to emphasize that under our Title 38 employment system, we do follow veterans' preference, and fully protect the veterans' right for priority consideration in all employment decisions.

Mr. STRICKLAND. This would only be used to enable you to maintain the proper skill mix for what you need in order to provide——

Ms. HORAK. It is very important that we are able to identify and select individuals for employment and retained employment, to ensure that the appropriate clinical skills are retained to meet veterans' needs and to deliver high quality care.

Mr. STRICKLAND. Thank you for that explanation.

At least one of the witnesses that will be providing testimony today has cautioned that predictability of salary or income is in fact a recruitment or a retention tool within the VA.

The proposed legislation, as I understand it, would make up to 20 percent of a physician's salary discretionary. Explain how you believe that would aid you in the recruitment and retention of physicians, having that portion of the salary discretionary.

Dr. ROSWELL. Certainly, the discretionary component is the flexibility in indexing the so-called market pay to the AAMC salary, plus or minus ten percent of the 50th percentile of the associate professor salary survey.

That does allow some flexibility because not all physicians will be at the associate professor level. Someone may be very senior, very talented, and there would need to be some discretion on looking at that.

We currently have discretion, but it is administered based on years of tenure, not years of experience. It is a shame that when

we look at a very distinguished physician who may have had a very laudable health care career, we cannot provide any compensation for tenure if that career was not performed in the VA.

The market base pay allows us some discretion in looking at, but of course, in no circumstance would anyone have a reduction in pay, as that is being applied.

Mr. STRICKLAND. Mr. Chairman, can I follow up real quickly?

Mr. SIMMONS. Without objection.

Mr. STRICKLAND. Does your answer imply then that if someone comes into the VA system after having practiced medicine elsewhere, that would give you the ability to accommodate them for the years of service they had outside the VA prior?

Dr. ROSWELL. Exactly. We tend to skew our workforce towards international medical graduates and more junior level practitioners because we are competitive at the entry levels, and we may be competitive at the more senior levels, if someone has spent their entire career in the VA, but we are not competitive to bring someone into the VA at mid-career, but this would give us that flexibility.

Mr. STRICKLAND. Thank you both.

Mr. SIMMONS. I thank the gentleman. The chair recognizes Ms. Brown-Waite.

Ms. BROWN-WAITE. Mr. Chairman, I do not have any questions at this time. Thank you.

Mr. SIMMONS. I thank the lady. The chair recognizes Ms. Berkley.

OPENING STATEMENT OF HON. SHELLEY BERKLEY

Ms. BERKLEY. Thank you. Dr. Roswell, it is a pleasure to see you again. I am sure you are aware we went out to bid yesterday, posted notice in all of the Las Vegas papers, only looking for 50 acres so we could build this hospital.

I think by now the entire world knows that Las Vegas is in need of a new medical facility, outpatient clinic, hospital, long term care facility, but along with those facilities, we also need the physicians, nurses and dentists to care for the men and women who live in Las Vegas who have sacrificed for our Nation.

In Nevada, in addition to my veterans' woes, has a major health care crisis as well, which is going to make it increasingly difficult for the VA to recruit and retain doctors. Currently, there are 91 full and part time doctors servicing 160,000 veterans in Las Vegas. That is one for 1,700 patients. That is not very many.

Even with these numbers, I am told we are not experiencing a significant shortage in general practitioners, but our specialties, we are having a very hard time filling, particularly oncology, hematology, and pulmonary specialists.

As you said, you may be a great general practitioner, but you would not want to be practicing what the cardiologists do.

Like many communities around the Nation, we have significant nursing shortages as well. I think we can all agree that the veterans' assess to quality health care is a major priority, but we need to get these physicians, nurses and dentists committed to ensure that the VA health care professionals are adequately compensated. If there is a significant pay disparity between VA doctors and private doctors and this continues, we are not going to have the physi-

cians to care for VA patients, and once again, we are going to break another promise.

I can tell you prior to being in Congress, I was a university and community college regent for 8 years. When I first started, in 1990, we had a waiting list to go to the University of Nevada/Reno medical school, and we were turning significant numbers of students away. Eight years later, when I retired from the Board of Regents, we were recalling people that we had turned down to see if they would like to resubmit their application.

I do not think it is only the VA that is experiencing a shortage of qualified doctors, but that is something that the entire Nation is experiencing, and it is going to get worse before it gets better.

Consequently, because of our commitment to our veterans, we need to ensure that the compensation is compensatory, or the compensation is commensurate with private practice.

I am somewhat puzzled by the VA request that all pay bands established be consistent with the 50 percentile of compensation for the associate professors, tracked by the American Association of Medical Colleges. It is my understanding that the 95th percentile would be commensurate with what most doctors are getting paid.

Can you explain to me the disparity and why you were willing to peg it at 50 percent instead of at the preferred 95 percent? Is it simply a matter of money?

Dr. ROSWELL. Certainly, money is an issue. Let me point out that the majority of our tertiary medical centers are affiliated with the Nation's medical schools, and in fact, the new medical center in Las Vegas is something that we certainly will want to look at to see if there are medical school affiliation possibilities, and I hope to be able to discuss that with you in the future.

In looking at that, the 50th percentile was a reasonable figure that gave 30 percent of the workforce a pay raise. If we were to increase that to the 75th percentile of the associate professor's salary survey, then over 99 percent of VA physicians would be eligible for a pay raise. That might be a more effective way to address some of the recruitment needs we have.

Our average recruitment currently is over 7 months and growing for physicians. Obviously, when we are looking at a very large new medical center, we will need to recruit a physician workforce fairly rapidly to be able to staff a facility such as that.

Greater flexibility, in fact, would be very beneficial.

Ms. BERKLEY. Let me mention this to you. A couple of weeks ago, the president of the University of Nevada/Reno was in my office, and a large part of our conversation was about the future VA hospital, and they are very anxious to form a relationship. When you are ready, please call me. I will give you his number. He is waiting for your call. Thanks a lot.

Dr. ROSWELL. Thank you.

Mr. SIMMONS. We thank the lady. The chair recognizes Mr. Boozman.

Mr. BOOZMAN. I really do not have a question. I do appreciate your work on this. I think it is very, very important. I appreciate your leadership.

All of us are committed to trying to lessen the waiting times for our veterans. The Committee is. I know you all are also. Regardless

of what we do, this has to be done. If we do not have the providers in the system, and it is becoming a problem not only in the VA, but in Medicare and many other things, if we do not have the providers in the system, then the waits are not going to get shorter.

Again, I do appreciate your leadership and would really like to help you work on this.

Dr. ROSWELL. Thank you, Mr. Boozman.

Mr. SIMMONS. Mr. Ryan.

Mr. RYAN. Thank you, Mr. Chairman. Dr. Roswell, I am told that in 2000, there were some reforms that were made for the special pay for dentists. Can you just talk a little bit about that, for those of us who were not here in the year 2000?

Dr. ROSWELL. There were some adjustments in the special pay compensation. Let me ask Ms. Horak to address that with more specificity.

Ms. HORAK. Thank you. Public Law 106–419 resulted in significant increases to most of the seven components of special pay under the current system for dentists. In many cases, these changes offered increases of over 100 percent in the amount of special pay that some of our dentists were able to receive. That was very helpful and was significant in assisting our facilities in being able to recruit and retain dentists.

As you know, we have a much smaller number of dentists. We only have about 765 versus the 14,000 physicians. However, if you look at the ADA net private practice income, they are showing now that general and specialty dentists earn more than some physician specialties. That legislation was very helpful in remedying a severely non-competitive pay situation for our dentists.

Mr. RYAN. Great. Thank you.

Mr. SIMMONS. Thank you very much. If there are no more questions——

Ms. BERKLEY. Mr. Chairman, may I submit my opening statement for the record?

Mr. SIMMONS. Absolutely.

Ms. BERKLEY. Thank you.

[The prepared statement of Congresswoman Berkley appears on p. 57.]

Mr. SIMMONS. If there are no more questions, I want to thank our panelists, and now welcome the second panel. For our second panel, we have Dr. Thomas Joseph Lawley, the Dean of Emory University School of Medicine, with the Association of American Medical Colleges.

We also have Dr. Lactancio D. Fernandes, who is President of the American Federation of Government Employees, Local 1045, representing nearly 1,200 doctors, nurses, allied health care workers and other hospital staff at the VA facilities in Biloxi and Gulfport, MS, Mobile, AL, and Pensacola and Panama City, FL.

I will note for the record that Dr. Fernandes is also a major in the U.S. Air Force, 919th Medical Squadron, and recently completed his annual tour in support of Operation Iraqi Freedom. I just returned yesterday from Iraq. I was in Kuwait City, in Baghdad and also up in Mosul. We thank you very much for your service.

I also have listed Dr. Stephen Rosenthal, the President of the national Association of VA Physicians and Dentists.

I welcome all of you gentlemen to the panel. Dr. Lawley, please proceed.

STATEMENTS OF THOMAS JOSEPH LAWLEY, DEAN, EMORY UNIVERSITY SCHOOL OF MEDICINE, REPRESENTING THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES; LACTANCIO D. FERNANDES, PRESIDENT, LOCAL 1045, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES; AND STEPHEN ROSENTHAL, PRESIDENT, national ASSOCIATION OF VA PHYSICIANS AND DENTISTS

STATEMENT OF THOMAS JOSEPH LAWLEY

Dr. LAWLEY. Mr. Chairman, ladies and gentlemen, good afternoon. I am Dr. Thomas Lawley, Dean of the Emory University School of Medicine, and I am speaking on behalf of the Association of American Medical Colleges.

The AAMC represents the Nation's 126 accredited allopathic medical schools, over 400 major teaching hospitals and health systems, including over 70 VA hospitals, 92 academic and scientific societies representing nearly 100,000 faculty members, and the Nation's medical students and residents. I currently also serve as the chair of the AAMC VA-Deans Liaison Committee.

The issue the subcommittee is debating today, reform of the VA physician compensation system, is an important one for both the VA and academic medicine.

Since the affiliation agreements began in 1946, the VA Health Care System has been intentionally intertwined with academic medicine to the benefit of both parties, with the VA gaining access to a higher quality of medical care than could be obtained with a wholly full time VA medical service, and with the affiliated medical schools gaining valuable opportunities for medical education and research.

Under the current system, both full time and part time VA physicians receive additional salary from medical school affiliates. Full time physicians can receive stipends for their contributions to the medical schools' educational programs, and part time physicians receive salary for the academic portion of their appointment.

In recent years, there has been a growing concern that the physician compensation schedules in the VA have fallen behind the market. The recruitment of promising physicians to the VA is often made possible only by the existence of a joint appointment in an academic affiliate.

Through such arrangements, the VA gains access to the full range of medical specialties and expertise that is generally available only at an academic medical center.

There is general consensus that without joint appointments, the VA would have difficulty recruiting and retaining physicians in the highest income specialties in virtually all locations. Part of the reason is the amount of specialty pay has not increased since 1991, and the cost of living and inflation increases for Federal employees apply only to the base portion of their salary, meaning that a VA

physician's total compensation has been falling even further behind his or her private sector colleagues.

As a result, there is anecdotal evidence that the agency is having difficulty and is sometimes unable to recruit and retain individuals in scarce specialties and subspecialties, even with the academic salary subsidy.

These difficulties are most severe in the disciplines with the highest pay disparities, such as certain surgical and medical subspecialties, radiology and anesthesiology.

This is a historic opportunity to implement a compensation system that is responsive to market forces. The proposal calls for a three tiered approach that would be benchmarked to the 50th percentile of the AAMC's associate professor salary. It would incorporate performance based pay as well as geographic, specialty and productivity measures, to bring VA physician salaries in line with those in the non-Federal workplace.

While such a change would certainly improve the VA's competitiveness in recruiting and retaining physicians in the highest paying specialties, the AAMC is concerned that the proposal does not go far enough.

We believe that a system that benchmarks to the 75th percentile of the AAMC's associate professor salary level would better ensure that the VA remains on the cutting edge of medicine, and is able to compete for the best and brightest physicians.

Implementation of such a proposal would significantly increase the ability of the VA and the affiliate to recruit high quality physicians.

While the AAMC is supportive of the intent of the proposal to increase the salaries of VA staff physicians, we are concerned about the provisions in the legislative language to prohibit VA chiefs of staff from receiving compensation of any type from the affiliate. Chiefs of staff are the primary liaison between the VA and the medical school, and indeed, often hold the title of associate dean.

While I understand the VA's concern that chiefs of staff need to function as the VA's independent representatives without conflicts of interest, limitations on the benefits and compensation that a chief of staff can receive from an academic affiliate will serve as a disincentive for the most qualified individuals to pursue such a leadership position. The ability to receive funds through NIH grants or for teaching or clinical work during non-VA time should be viewed as enhancing an individual's career, not a conflict of interest.

Chiefs of staff generally do not make business decisions for the VA. That is the responsibility of the director, and conflicts of interest should already be covered by the Ethics in Government Act. Academic affiliates should be viewed as partners, not as a negative influence.

The AAMC therefore believes that the provision could be counterproductive.

The VA academic affiliations have been a major reason that the VA Health Care System is a world leader. The Department of Veterans Affairs Health Care Personnel Enhancement Act of 2003 will improve the ability of the VA to recruit and retain the best and brightest physicians, and will result in better care for the Nation's

veterans through access to the latest clinical research and cutting edge technologies.

Thank you for your attention.

[The prepared statement of Dr. Lawley appears on p. 113.]

Mr. SIMMONS. Thank you for that testimony, Doctor, and I would ask the other two witnesses to summarize their testimonies as well. We have time limitations. Your full statement will be introduced into the record. When you see that little red light go on, that means summarize quickly.

Gentlemen, thank you. Dr. Rosenthal.

STATEMENT OF STEPHEN ROSENTHAL

Dr. ROSENTHAL. Thank you, Mr. Chairman and members of the subcommittee, for the opportunity to address you this afternoon on behalf of the physicians and dentists who practice in the Veterans' Health System.

I am Dr. Steve Rosenthal. I have practiced in the VA for more than 28 years, and I am currently Acting Chief of Nuclear Medicine at the Miami VA Medical Center.

However, today I am here to testify in my capacity as president of the national Association of VA Physicians and Dentists, which is the only organization which represents solely physicians and dentists.

We are here today with three messages, to thank this Administration for recognizing the need for an adjustment in the direction of competitive pay for the front line medical staff who serves our Nation's veterans.

Secondly, to support the paradigm shift in compensation that is suggested in the proposal offered by the Department, a shift which we believe lays the groundwork for Title 38 physicians and dentists to keep pace with similar practitioners in the private sector, and thirdly, to suggest changes to the proposal that we believe will produce a statute that is simple, equitable, understandable, self-adjusting, and more easily administered than the proposed Health Care Personnel Enhancement Act of 2003.

Some 13 years ago, we came before the Congress asking that the compensation of VA doctors be adjusted upward because we were falling woefully behind our colleagues in the private sector. You heard us and enacted legislation which brought us briefly in line with the private sector.

Since that bill was signed into law a dozen years ago, save for cost of living increases, VA physicians have not received any increase.

While the time for action is long overdue, we are appreciative that Secretary Principi and Under Secretary Roswell are now acting to change the system out of a genuine desire to provide the quality of health care our country's veterans deserve.

The Department of Veterans Affairs is facing a critical juncture in the compensation system for physicians and dentists. The VA can no longer recruit and retain highly qualified and experienced physicians and dentists, and not just in the categories where scarce medical and surgical subspecialties are required.

Historically, it has been necessary for VA physicians and dentists to come to Congress with a request for increases in compensation

through the addition of specialty pay categories or higher pay bands for existing specialty pay brackets. This has meant VA physicians and dentists pay has approached the private sector only briefly, only to be left behind again shortly thereafter.

Now, we have a proposal on the table that suggests review and parity on a regular basis, without the need to change the law of the land each time, which we believe is a prudent change in thinking that will have a positive impact on recruitment and retention of quality physicians and dentists. However, as is usually the case, the devil is in the details.

The Department of Veterans Affairs' proposal is vague and complex, and, NAVAPD believes, impossible to fairly administer.

NAVAPD also believes that the Department's proposed legislation is limited in scope, is intended to benefit only a small minority of front line medical staff, provides few details regarding implementation, and has the potential to be manipulated in ways that were not originally intended.

Further, the legislation proposed by the Department is not in concert with either the most recent presidentially mandated quadrennial report or even the Department's own taskforce interpretation of that report.

Again, I wish to thank you for the opportunity to share NAVAD's thoughts on this critically important legislation.

I would be happy to answer any questions you may have.

Thank you.

[The prepared statement of Dr. Rosenthal appears on p. 117.]

Mr. SIMMONS. Thank you, Dr. Rosenthal.

I noticed from reading over your statement that there are substantial recommendations that are made as part of that, and I want to assure you that the whole statement and the recommendations will be inserted into the record as if read.

Dr. ROSENTHAL. We appreciate it.

Mr. SIMMONS. Thank you very much.

(The information follows:)

Insert A

Additional Oral Remarks of Dr. Stephen P. Rosenthal

The stated purpose of this legislation is to provide salaries that will be competitive with the private sector…which will in turn keep the professionals we have and attract high-quality recruits to the VA. However…as proposed… this legislation would have a positive compensation impact on only about 30% of the fourteen thousand-plus physicians and dentists currently in the VA. It is difficult to see this as a "moral booster" for the other 70% or a recruiting tool for new-hires.

It is even more difficult to see how this will help VA meet overall operational and clinical objectives. The front line medical staff is more than just "foot soldiers" in achieving these objectives. They are the face of the VA…they are the decision makers…the team leaders… the clinical thinkers…the quality managers…the innovators. They are very much the pilots of this highly technical…highly complex machine that is the modern health care system, managing life and death decisions…entrusted with the care and comfort of vulnerable and suffering human beings. They are under constant public scrutiny…relying upon their many years of education, training and experience…their intuition and art…and their humanity to guide their clinical actions in helping veterans and their families face the most complex, intimate and difficult choices of their lives.

In this regard…**quality does matter**…and not just for the 20 or 30 percent of the most difficult to recruit and the highly paid sub-specialists…but perhaps of equal or greater importance…also for the journeyman VA physicians and dentists…the folks who are the heart and soul of this system and the ones who make it run day in and day out. The cost of neglecting this talent is never addressed in the proposed bill and…in our estimation…the cost is incalculable. If this item remains
un-addressed when the bill is passed this
human asset will almost certainly give way to expensive contract services.

Using precious taxpayer dollars for costly contracts with affiliated universities or private groups to retain the services of needed and rare sub-specialists must be significantly reduced… if not eliminated. We agree with the department that it is vexing and galling…perhaps even ludicrous…to pay more to retain specialists on contract…while losing the benefit of a loyal full time VA employee in the process. To "pretend" to not pay them more than the prohibited salary levels by retaining them "On Contract" is a lose-lose proposition for the VA…the veterans… and the taxpayers. One of the stated purposes of this legislation is to address this issue.

The Department understandably wishes to improve efficiency and spend wisely. However, we are here to let you know that cutting dollar costs by limiting the pay of the front line medical staff comes with its own special costs…ones not addressed or even acknowledged by the language in the Department's proposal. It is true that the VA needs to remain competitive with academic institutions in order to recruit their best and brightest academic performers. However, there may be a vested interest on the part of AAMC in ensuring that the VA remains less than competitive in this arena.

Therefore...I must add that NAVAPD is **very** concerned about the use of AAMC salary data as a benchmark for VA physicians.

Since the vast majority of frontline VA physicians are practicing clinicians...it stands to reason that the VA must compete directly against the private sector for the recruitment and retention of quality physicians...just as is the case with dentists. For this reason we strongly believe that other sources of comparative physician income data, such the Medical Group Management Association (MGMA) survey, should be used to benchmark the salaries of VA physicians.

The proposed legislation describes "Performance Pay" as..."a variable pay band linked to a physician's or dentist's achievement of specific corporate goals and individual performance objectives." It goes on to say..."The amount payable to a physician or dentist for this component may vary based upon individual achievement, and may not exceed $10,000." The proposal later states that..."no physician or dentist will be paid less the day after the implementation than he or she was being paid the day before implementation." How is it possible to determine performance pay prior to implementation? At a minimum, this provision...**as written**...is vague and open to abuse.

Physicians and dentists are further placed at risk of negative pay adjustments when budget pressures may force cost cutting measures. This is partially the result of the statutory provision that prohibits negative pay adjustments for the largest professional group in the VA...nurses. We implore you not to allow an accounting bulls-eye to be placed on our backs...and adopt the same **no negative pay adjustment standard and sick leave retirement credit** for physicians and dentists in this legislation as currently exists for nurses.

As I mentioned earlier...the current proposal will positively impact only 30% of the physicians and dentists in the VA. This is the result of three factors:...the percentile used to calculate the benchmark for pay...the use of all three tiers to reach the benchmark sum...and the local flexibility of Base Pay.

We recommend that Base Pay be standardized at the GS 15, step 10 level...**including** locality adjustments for all physicians and dentists.

We recommend that the benchmark sum of Base Pay and Market Pay only, for physicians be set at 90% of the 75th percentile of the Medical Group Management Association (MGMA) compensation level. And...we recommend that the benchmark sum of Base Pay and Market Pay only, for dentists be placed at 90% of the 75th percentile of the American Dental Association (ADA) net private practice income.

We recommend that Performance Pay be granted for higher than standard work achievement...and that the range be expanded to $20,000.

We also recommend a "Dedication Pay" tier be added based upon years of service as a retention inducement for both physicians and dentists.

If this legislation is going to be the vehicle that moves the recruitment and retention of high quality physicians and dentists into the 21st century…then we must address the leave policies that are unintentionally punitive in their effect...the so-called 24/7 leave policy. While private sector practices are offering newly minted physicians and dentists between six and eight weeks of annual leave…as well as paid time for continuing medical education…we have remained trapped in a system that discourages normal vacations by charging us leave for Saturday and Sunday if we take leave on the preceding Friday and the following Monday…regardless of whether or not we see patients or perform other duties on that Saturday and/or Sunday. We believe that the department has the authority to make the necessary adjustments to correct this situation. We have been trying to work with them for over two years on this issue. However, we have been unsuccessful. We now turn to you for help. Please include in this legislative package the directive necessary to allow us to take our thirty days of annual leave without the penalty of being charged for our non-duty days.

Mr. Chairman, we have taken the liberty of including suggested substitute language in our written testimony on these and other relevant subjects for your consideration. We believe this alternative compensation proposal will provide the roadmap necessary for VA professionals to know where our careers stand and what the future will hold for us. We hope this will contribute to your deliberations.

Mr. SIMMONS. Dr. Fernandes.

STATEMENT OF LACTANCIO D. FERNANDES

Dr. FERNANDES. Chairman Simmons and members of the Subcommittee, I am Dr. Lactancio Fernandes. I have worked as a Board certified pulmonary care physician at the VA Gulf Coast Health Care System for 13 years.

I am here today as president of Local 1045 of the American Federation of Government Employees, to testify on behalf of our union.

Pay and benefits are important but doctors do not come to the VA to become millionaires. We work at the VA to make a difference in the lives of veterans. It is the freedom to practice medicine with quality as the primary focus, not profit and volume, which draws a doctor to the VA.

Doctors like myself joined our union to have an organized voice in decisions that impact our freedom to practice quality medicine. We are frustrated that administrators make unilateral policies and workplace decisions that impact how we practice medicine with little or no input from front line physicians.

Be it designing a computerized medical patient record system or rules for prescribing costly atypical antipsychotic drugs, the views of front line staff need to be a part of that decision making process.

Current law constrains our ability to sit down with VA administrators to deal with challenges in delivering high quality medical care. We ask that you clarify the law to expand and invigorate the opportunities for front line doctors to be at the decision making table. This will boost morale, enhance productivity, and attract dedicated medical professionals to the VA.

With respect to pay, I urge you not to throw the baby out with the bath water. The objective and guaranteed pay component in the current system are sound, recognizing a full time career commitment to veterans, encouraging a stable doctor/patient relationship through guaranteed length of service pay, and awarding Board certification is important to an equitable and creditable pay system.

I also urge you to be cautious in listening to the soaring song of flexibility and pay for performance. Giving administrators carte blanche discretion may give VA flexibility but it will also increase the risk of favoritism and outright discrimination.

Absent from these proposed legislation are safeguards and accountability mechanisms to prohibit waste, fraud and abuse.

VA's pay decisions should be able to withstand independent scrutiny from a neutral third party that the salary decisions are reliable, valid, and equitable.

VA wants to be able to decrease a doctor's pay and leave him or her with no recourse to an independent review to question the legitimacy of such a punitive action.

Congress has already prohibited the VA from doing this to nurses. We urge you not to give VA authority to target doctors for decreases in pay.

Noted business experts warn against promises of pay for performance. In practice, pay for performance never achieves its desired results, yet it eats up enormous managerial resources and makes everyone happy.

They promote a zero sum gain where political intrigue and ingratiating personalities are rewarded rather than team work, collaboration, and focus on the veteran.

VA's so-called corporate goals may create reverse incentives for doctors to restrict access to effective but costly consultations, diagnostic tests, medical treatments, and prescription drugs.

The potential pitfalls of VA's corporate goals to veterans' care leaves us to urge the Subcommittee to proceed with the utmost caution in giving VA pay for performance authority. Pay for performance is the wrong answer to the wrong question. It is not that VA physicians and dentists do not perform well, and will only do so if their annual raise depends on it.

Reallocating existing money so that you solve the problem for 30 percent of doctors and make things worse for 70 percent of doctors under the banner of performance is dishonest and will do lasting damage to veterans' health care.

Thank you very much. I will entertain any questions.

[The prepared statement of Dr. Fernandes appears on p. 126.]

Mr. SIMMONS. I thank the witnesses for their testimony, and again, I assure each of the witnesses that their complete statements will be entered into the record.

Dr. Fernandes, you raised the issue of pay for performance and you made the statement about political skills and ingratiating personalities might be rewarded rather than performance. I do not necessarily disagree with that. I think that is a concern.

How do we structure the performance of our professionals? Let's say that we separate that from the issue of pay. Are there other administrative mechanisms that are useful in guaranteeing excellent performance other than this pay for performance scenario?

Dr. FERNANDES. I think there are methods and systems in place right now. We have peer review, which at my facility is close to non-existent. Peer review is a way that you can look at how physicians do as far as quality and reward that. Elevating the whole GS level salaries rather than tying it to the AMC will achieve the same goal.

I think it is important that we have both parties at the table, because too often, we have administrators choosing arbitrary points as items to be rewarded.

Let me give you an example. Right now, CPRS has used an example to estimate a physician's productivity, so in one day, I can put in 50 CPRS notes that have one line in it, and I'm rewarded because some administrator is saying wow, this physician is real productive, he has 50 notes, whereas another physician may only have 20 notes, but the 20 notes say a lot more and actually examine the patient and take care of the patient, but that physician with 20 notes is not rewarded. He is looked at as not producing.

Mr. SIMMONS. Thank you for that. Peer review obviously is one mechanism. It also occurs to me that patient satisfaction might be an useful measurement to take.

I also have a question for Dr. Rosenthal. We have heard testimony today on the issue of providing incentives to attract and keep VA doctors. It is my understanding you have been in the system for 30 years. What kept you there?

Dr. ROSENTHAL. There are a number of factors that have kept me in the system. One is we did have reasonable pay bills several years ago which encouraged me to stay, and I'm here, and this is my career.

These are our patients. These are my colleagues. These are my co-workers. I enjoy what I am doing. I like being where I am.

I would have needed to go back and do additional training if I wanted to go elsewhere, but I was comfortable where I am, and I decided to stay.

Such cannot be said for many of my colleagues. I have one colleague that was in anesthesiology, the former Chief of Anesthesiology at the VA Miami. He left for a position that paid him twice as much when he left. I have a friend that was a radiologist at the Tampa VA who went across the street and started making more than twice as much as what he was.

I would think that we are really competing with the private sector. I do not know of any VA physicians or dentists that are leaving to take an university position. I think they are all leaving to take a community, private practice opportunity.

Mr. SIMMONS. Thank you for your testimony. Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman. Dr. Fernandes, thank you for your testimony, and since I assume Dr. Roswell is sort of your boss, I appreciate your courage and your candor.

Dr. FERNANDES. Thank you. I have no problem in dealing with bosses. That is why I am in the union. (Laughter.)

Mr. STRICKLAND. Also, thank you for your service in Iraq, sir.

Dr. FERNANDES. I was state side providing troops to mobilize to Iraq.

Mr. STRICKLAND. Thank you for your service to our country.

During my last round of questioning, I had asked Dr. Roswell about the 20 percent flexibility, and I think when he answered me, he indicated that the intention was not to reduce anyone's salary but to perhaps use this discretionary capability to accommodate people who may come into the VA in mid-career, and make sure their prior work and experience was adequately recognized.

What I did not get to say because my time was expired, I was going to ask the good Doctor what guarantees there might be to prevent bias or the kind of prejudicial decision making that you seemed to have described as a possibility from occurring, so I will ask you.

Is it your understanding that there are provisions in this legislation that would prevent favoritism, bias, or that kind of decision making from occurring under the proposed legislation?

Dr. FERNANDES. Thank you for that opportunity to answer that question. I do not see any proposals to prevent that. I would ask Committee members here to look right now at any one VA and look at how the special pay is practiced. You will see, even at my VA, where I have personal experience, there is a wide range of how the special pay is given to physicians with equivalent education and experience.

It really depends on whether the boss likes you or not, whether you get a certain amount of special pay. There is a wide variability within a VISN, and I happen to be on several VISN committees, and have seen that there is a wide range of pay. In our own VA,

there is a wide range of pay. There are physicians with very little experience and very little training who are making more because of this special pay, the boss happens to like them, and they get more special pay.

We have experience right now that you can look at and you can imagine now if this proposal goes into effect, how much more authority and discrimination will occur.

Mr. STRICKLAND. One more question quickly, and thank you for your answer, sir. The AFGE suggests that while physicians do want appropriate compensation, they are also concerned about other things, involvement in clinical policy development, such as establishing safe staffing ratios, making effective use of the computerized patient record system, and certain quality of care goals.

Currently, in your judgment, how involved are the rank and file or non-management physicians in such decision making within the VA?

Dr. FERNANDES. It is almost at zero percent. Any involvement, I think, is minimal and I would say at a de minimis level.

Mr. STRICKLAND. Thank you, sir. Thank you, Mr. Chair.

Mr. SIMMONS. Thank you. I will next recognize Mr. Boozman, but before I do, I want to thank the witnesses in advance. I have to go to another meeting at this moment. Before I vacate the chair, and I have asked my colleague, Mr. Boozman, to assume the gavel, I would like to recognize Michael Ebert, who is the Chief of Staff of the Connecticut VA Health Care System. Are you here today, Michael? Please stand up. Thank you for coming. (Applause.)

Mr. SIMMONS. As we know, all politics is local. Good to have you here. Thank you, gentlemen. I thank the members, and I thank Mr. Boozman for assuming the chair.

Mr. BOOZMAN (presiding). Practicing in the VA, it really is an unique situation in the sense that as opposed to being out in regular practice, you do have the advantage of not having to worry about personnel problems, if you really just want to practice whatever your specialty is. Certainly, you do not have to worry about not being included in the HMO that opens up down the street or whatever. Regular vacations. I think the call, I think, is not quite as tough as private practice sometimes. There really are some unique things.

Is there a specialty in VA medicine?

Dr. FERNANDES. No, there is not, that I am aware of.

Mr. BOOZMAN. I guess there are people that because of the things I just mentioned, that does make it attractive to them. I think many of the people that are involved in your system again like being able to practice medicine and not have to worry with a lot of extraneous things.

Is that a crazy idea? Is that something that we need to think about doing? The practice of VA medicine is unique in itself, and the demands that you are doing there, it is an unique population.

Dr. FERNANDES. What you just stated is probably one of the reasons I joined the VA 13 years ago. However, that statement is not entirely true now. Since that time, we do have a lot of personnel problems. They are not the kind of personnel problems that you have in a private practice. The personnel problems now are admin-

istrative problems. Every week, we get mandates to do this and do that with no more resources and less time.

Primary care. We are being told at our facility that you only have 30 minutes and you have to see the patient in that period of time, regardless of the fact that now we have to enter all the data using CPRS, the computerized system, and most of us physicians didn't grow up learning typewriter skills. The administrative problems are there.

As far as the HMO type problems, I have heard VA administrators say we are an HMO, and in fact, if you look at the latest things that are happening in the VA, with pill splitting, choosing the hoops that are put in doctors' way to make it difficult to prescribe antipsychotics, antihypertensive medications, we have the same number of hoops, if not more hoops, than HMOs.

All the things that you stated that made VA attractive a decade ago are no longer true. That is why a lot of physicians are leaving the VA, and that is why new physicians are not coming in, because that was the VA 10 years ago, 13 years ago, when I joined. It is not the VA now.

Mr. BOOZMAN. Dr. Lawley, at the end of World War II, the VA and universities married in order to care for the wounded vets of the war. Is the kind of reform that we are talking about a separation or even a divorce?

Dr. LAWLEY. No, not at all. In my mind, serving as a dean and also at the AAMC, dealing with our VA on a very regular basis, the single biggest problem that the VA is facing today is the inability to recruit physicians. The single biggest reason that they cannot recruit physicians is they cannot pay them enough.

In my estimation, this pay bill is absolutely necessary. In my estimation, it is not strong enough in the sense that it asks for comparability at the 50th percentile of the AAMC. I believe it needs to be at the 75th percentile.

My life is spent recruiting physicians for Emory and for the Emory VA, the Atlanta VA, and it is very clear that a major drawback is the amount of salary that we can offer, and as you pointed out previously, the ability of these individuals to go into private practice and earn large sums of money is something that we have to contend with on a daily basis.

No. I think this is not a divorce. In fact, I think it will strengthen the system.

Mr. BOOZMAN. Very good. Dr. Fernandes, in your testimony, you sound like you had problems with merit pay. Is that correct?

Dr. FERNANDES. No, special pay.

Mr. BOOZMAN. Do you have a proposal for awarding those that are doing a better than average job?

Dr. FERNANDES. I sure could come up with one. I have not been asked about that.

Mr. BOOZMAN. That is really what we are talking about.

Dr. FERNANDES. It is special pay. It is not merit pay.

Mr. BOOZMAN. Whatever. Again, I would be interested in your views for the guy that really is doing an outstanding job versus the person that is just there.

Dr. FERNANDES. Yes.

Mr. BOOZMAN. You mentioned the notes, the 50 notes versus the 20. You might have the guy that was actually writing 50 good notes and the other guy's 20 notes might not have been any good at all.

Dr. FERNANDES. Which begs the question, in order for any system to be put in place, you have to have the front line providers at the table. You cannot have administrators who never see patients making decisions because you will not get a good system.

This proposal, for instance, puts the pay band at about $140,000 for the 50th percentile for the general practitioner, and yet if you look at what they quote for the chief of staff, it's $225,000 to $250,000. Guess what? I'm going to apply for that job as chief of staff. You are going to lose more people on the front line and nobody is going to come to the front line from the outside.

This proposal was written by executives, by managers for themselves, not to recruit front line physicians and dentists.

Mr. BOOZMAN. Thank you. Ms. Berkley.

Ms. BERKLEY. My husband is a nephrologist in Las Vegas, and he could be sitting there talking to you about the regulations coming down from CMS right now that doctors had absolutely no input in, and yet he is saddled with them very much to his chagrin, and I think he would quite frankly envy the fact that you may have a full half hour with one of your patients. I am not sure he has had a full half hour with any one of his patients in a long time.

I am very sympathetic, as you can imagine, to your concerns and your interests. I believe the front line doctors do need a seat at the table when their destinies and the way they deal with their patients are decided by the administrators. I think that is very important.

Dr. Lawley, I appreciated your comments. We do need to adequately compensate physicians or we are not going to have any in the VA. My husband just recruited two new physicians for his practice, and they are practically fresh out of school, and I can tell you, the VA couldn't possibly compete with the compensation package that he offered these people to get them to come to Las Vegas.

For a community like mine, it is difficult enough to recruit qualified doctors. It is almost an impossibility for the VA to do it, and compensation is certainly an important part of that.

I understand the love of the practice, and the pleasure of dealing with a particular segment of the population, but you still have to feed your families. If you can go down the street or across the street and make twice as much as you are making now, I think you have responsibility to your family to take that job.

I think our responsibility is to make sure that the VA is in a position to adequately compete so that does not happen.

We have in Las Vegas a new dental school that is just getting off the ground, and a medical school that has been primarily located in Reno, but now will be coming down to Las Vegas in large part. I am looking forward to the day that we are able to marry all three of those facilities. It seems like a no brainer to me. I am anxious to make that happen, and would be delighted to work with all of you and the VA to make sure it does happen.

I want to thank you all for being here and for helping to educate us on an issue that is very important, and in my opinion, a crisis,

and I cannot even say a crisis waiting to happen. It is a crisis, and it will only get worse if we do not make it better.

Thank you very much for sharing your thoughts with us.

Dr. LAWLEY. You are welcome.

Dr. FERNANDES. Thank you.

Mr. BOOZMAN. Do you all have any other comments that you would like to make?

[No response.]

Mr. BOOZMAN. One thing that I would like for you to do for the panel in general, we talked about the incentive pay or however you referred to it, I really would like to know your thoughts in a formal way, as to how you would propose that, and submit that for the record for us.

Dr. LAWLEY. I just wanted to say that the notion of incentive pay, of course, in medical schools has been out there for a number of years, and we do have a whole series of methods that we employ that we think are rigorous, that the troops, if you will, the front line troops are involved in formulating, and there are all sorts of different ways, but the key there is to incent the best behavior that allows for the best care for veterans, and I believe that is absolutely possible.

Mr. BOOZMAN. Very good.

Ms. BERKLEY. There was something that was stated, and Dr. Fernandes, you are right when you talk about this almost being a personality contest. I have a doctor in Las Vegas that the veterans think walks on water, and the administrators have been trying to get rid of him for years. I cannot figure out what is what.

It would seem that the fact that the veterans love this doctor so much and he seems to work very hard and closely with them, it makes me feel that he has tremendous value.

Dr. FERNANDES. Let me give you some insight into that. Usually, because there are inherent weaknesses in every system, the VA has inherent weaknesses, too. When a physician who is obsessive about his work, his or her work, encounters those weaknesses, there are two options. One, turn a blind eye to it and continue and let the veterans suffer. The other one is to bring it to the attention of the administrator.

I would also like to set the record straight as far as physicians receiving compensation for their university affiliation. I have been affiliated with the University of South Alabama since I started at this VA, and also intermittently with Tulane. I have never received one single penny from either place. Just because you are affiliated with an university, it does not mean that you get compensated for it.

Ms. BERKLEY. How would you like to move to Vegas?

(Laughter.)

Dr. FERNANDES. Talk to me. I saw you at our convention.

Mr. BOOZMAN. Thank you all again so much for coming. I know that you traveled extensive distances just to get here. Again, we appreciate your taking the time out of your very busy schedules. I do appreciate your testimony.

Also, we might have further questions in the future, if that is okay. Thank you very much.

We will now have our last panel. Jacqueline Parthemore, Chief of Staff/Medical Director of the VA San Diego Health Care System; Richard Bauer, Chief of Staff, South Texas Veterans' Health Care System; Ms. Sheila Cullen, Medical Director, San Francisco VA Medical Center; Michael Ebert, Chief of Staff, VA Connecticut Health Care System; Michael Lawson, Director, VA Boston Health Care System; and Michael Simberkoff, Executive Chief of Staff, VA New York Harbor Health Care System.

We will start with Dr. Parthemore.

STATEMENTS OF JACQUELINE PARTHEMORE, CHIEF OF STAFF/MEDICAL DIRECTOR, VA SAN DIEGO HEALTH CARE SYSTEM; RICHARD BAUER, CHIEF OF STAFF, SOUTH TEXAS VETERANS' HEALTH CARE SYSTEM; SHEILA CULLEN, MEDICAL DIRECTOR, SAN FRANCISCO VA MEDICAL CENTER; MICHAEL EBERT, CHIEF OF STAFF, VA CONNECTICUT HEALTH CARE SYSTEM; MICHAEL LAWSON, DIRECTOR, VA BOSTON HEALTH CARE SYSTEM; AND MICHAEL SIMBERKOFF, EXECUTIVE CHIEF OF STAFF, VA NEW YORK HARBOR HEALTH CARE SYSTEM

STATEMENT OF JACQUELINE PARTHEMORE

Dr. PARTHEMORE. Thank you and good afternoon. Mr. Chairman and members of the Subcommittee, thank you for the opportunity to appear before you to discuss physician and dentist compensation issues, and the impact of the current pay structure on our ability to provide health care to veterans.

The provisions of the bill represent a major step forward in providing adequate competitive pay for physicians, dentists, and nurse executives at VHA. I am pleased that the Secretary has proposed it. It represents a major effort to redress the pay gap that exists between VHA and the private sector, as well as VHA's academic affiliates. I hope that you will make every effort to advance it.

Let me first address nurse executive pay and flexible hours. Present law permits us to adjust nurse pay in relation to local market pay at least annually, which helps us to remain competitive. It certainly forestalls nurse resignations for pay. But nurse executive pay in VHA remains a significant problem. It lags far behind local market pay, and private sector benefits provided to those in similar positions. The addition of 10 to $25,000 will be very helpful in many markets.

Given the anticipated retirement in the next 5 to 10 years of many of the VHA nurse executives, it would be wise for VHA to enhance its competitive edge, especially in urban, high cost markets. Nurse executives with vision and leadership ability are sorely needed, now more than ever, to serve as partners in administering our hospital systems.

Relative to dentist pay, dental chiefs are distressed that VHA has not implemented locality pay, such that VHA employees enjoy salary parity with other government employees of similar grade in their locales.

This country is graduating an even smaller number of dentists, and young dental school graduates entering practice are making the rational choice to enter the lucrative private sector. Many VHA

dental residencies in the past academic year were not filled, even in locales where they always had been.

Our ability to recruit top notch dentists, especially in specialty fields, such as dental surgery and orthodontia and prosthodontia is particularly problematic.

For physicians, it has been a very long time, 13 years, since physician pay was last addressed. I am delighted the legislation before you now does so. I hope that the bill can proceed quickly to passage, since a multitude of physician vacancies exist across VHA, and most often leading those of us in facility management to engage in extremely costly contracts or send our patients to the community.

As I understand it, the bill should provide greater equity for our part time physicians, who lose a considerable amount of pay under the current pay law. It is important to realize these physicians provide facilities much greater flexibility in staffing, and expanded coverage pool for night and weekend call, especially in tertiary care centers, and they provide highly specialized sub-subspecialties skills, for which there is a clinical need, great difficulty in hiring, but not the need for a full time physician.

Those facilities in which recruitment has been most difficult will see the largest improvement in pay. However, there are several groups which will not see a substantial change in salary, such as primary care physicians, most other medical specialists, neurologists, psychiatrists, pathologists, and physiatrists.

I hope that the bill continues to move forward. It has in it much to applaud with respect to greater parity with our communities, academic and private, and the flexibility to reward truly outstanding performance, targeted to VHA goals in clinical care, education, research and administration.

It will further motivate career VHA physicians, dentists and nurses to an even greater degree than they are now motivated.

VHA's ability to become a leader nationally in performance outcomes, decreased waiting times, patient satisfaction and other measures, to implement a computerized patient record and ordering system, to respond to patient safety initiatives, and to achieve many outstanding accomplishments in research and education, are testaments to the quality of its physicians, dentists, and executive nurses, as well as all of its employees.

It is our privilege to care for American veterans.

Thank you for permitting me to share my views, and I will be happy to answer any questions you might have.

[The prepared statement of Dr. Parthemore appears on p. 136.]

Mr. BOOZMAN. Dr. Bauer.

STATEMENT OF RICHARD BAUER

Dr. BAUER. Mr. Chairman and members of the Committee, with your permission, I will summarize my written statement.

You have heard testimony today about the adverse impacts on care of veterans caused by the current physician and dentist salary pay structure. I would like to cite several examples in which this has caused difficulty in delivering quality care in South Texas.

Recently, we were in a salary negotiation with a neurosurgeon, who was leaving private practice and wanted to work in a teaching

environment, caring for veteran patients. I said, we could not pay you more than the annual salary of a Supreme Court justice. He said, how much is that. I said, about $190,000. He just smiled.

For neurosurgical care, we resorted for a brief time to a locus tenens contract, which resulted in costs exceeding $20,000 per week, nearly three times the cost of a full time neurosurgeon.

To get around the salary limits, we have for some years established sharing agreements for these services with our affiliated medical schools. These arrangements are less feasible away from tertiary care facilities.

In South Texas, attempts to hire or contract for specialties in urology, orthopedics and general surgery, in Corpus Christi, McAllen and Laredo, sites where we deliver primary care successfully, have been largely unsuccessful. These cities are between 120 and 250 miles from San Antonio, and patients must travel inordinate distances in order to receive appropriate medical care.

I believe choosing an alternative market based rate benchmark for salaries will greatly enhance recruitment in these cities.

This new bill introduces an incentive component to pay. I agree with this proposal. We have initiated an incentive program using special contribution awards, which are an incentive above current salaries. These awards have been limited to $5,000. I find that these awards do incentize providers to meet institutional goals, which include assuring that all of their patients are offered flu shots, that patients are appropriately screened for prostate, colon, cervical and breast cancer, and that patients with diabetes, hypertension and heart failure are provided effective treatments.

In sum, I believe this bill constructively addresses recruitment and retention difficulties we now have and will enhance care delivered to veterans.

Mr. Chairman, this concludes my testimony. I will be pleased to answer any questions you may have.

Thank you.

[The prepared statement of Dr. Bauer appears on p. 139.]

Mr. BOOZMAN. Ms. Cullen.

STATEMENT OF SHEILA M. CULLEN

Ms. CULLEN. Mr. Chairman, thank you for the opportunity to present testimony regarding compensation issues for VA physicians and dentists.

The San Francisco VA Medical Center is a tertiary academic medical center with a strong and mutually beneficial affiliation with the University of California San Francisco School of Medicine.

One of the benefits of that affiliation has been our ability to recruit and retain top flight clinicians who provide high quality medical care to our veteran patients.

We are proud to be the home of five VA Centers of Excellence in cardiac surgery, post-traumatic stress disorder, dialysis, epilepsy, and HIV, all of which are relevant to the population we serve.

Adjunct to the excellent treatment we provide, we host the largest research program in the Department of Veterans Affairs, with over $55 million in funded projects during the current year.

We are located in the heart of the San Francisco Bay area, which unfortunately has one of the highest costs of living of any region in the country. The Data Quick Real Estate News Service, which monitors local housing costs, reported that as of August 2003, the median price of a home in San Francisco was $556,000, and in our two nearest neighbor counties, San Mateo and Marin, it was $566,000 and $627,000, respectively.

Our experience has been that this fact alone, the inability to afford a home, has been the single most important reason cited by potential physician recruits for declining to accept offers of employment with the VA. Because of these factors, recruitment and retention of outstanding clinicians is a major challenge.

Under the current pay structure, the process of recruiting physicians is difficult, time consuming, and often not fruitful. For example, we recently conducted a national search for an additional interventional cardiologist. Ads were placed in major professional journals, and we received a large number of applicants. However, most were non-citizens.

The search committee interviewed ten applicants and narrowed the field to three who were highly qualified. After wining and dining them, introducing them to the local real estate market, and a final assessment of their qualifications, an offer was made to an extremely qualified applicant. However, the salary level was inadequate for him to accept.

In the past few years, we have often been unable to find qualified U.S. citizens, and have hired non-citizens in several specialty areas. Even they, however, are leaving for more lucrative opportunities in the private or academic sectors.

We fully expect that these problems of recruitment and retention will accelerate in the next decade. Thirty percent of the employees at the San Francisco VA Medical Center will be eligible to retire in the next 5 years, and many members of our current physician cadre are senior, with many years of experience.

Other VISN–21 VA facilities in the San Francisco Bay area also report difficulties recruiting physicians in a number of specialties. For example, the VA Northern California Health Care System, serving much of the East Bay and the Sacramento Valley, up to the Oregon border, has had severe problems recruiting specialists in orthopedic surgery, radiology, anesthesiology, dermatology, gastroenterology, ophthalmology, and ENT surgeons.

To fill the clinical gaps caused by these recruitment and retention difficulties, VA facilities typically must contract at very high rates for these specialized services.

In San Francisco, during fiscal year 2003, we expended nearly $1.8 million for 7.8 full time equivalents for physician services in neuroradiology, interventional radiology, general radiology, and anesthesiology.

At Palo Alto, the problem is even more severe, where they have been forced to spend approximately $6.8 million for 22.7 full time equivalent physicians.

If VA medical centers are to remain first class institutions, we need to have the flexibility to compensate our physician staff in a way that realistically addresses the market conditions within which we operate.

The new salary bill will permit us to increase the pay we can offer, especially in scarce specialties where recruitment problems are the greatest.

Overall, we believe that the proposed legislation will improve our ability to recruit and retain highly skilled clinical staff, to provide the best possible care to our veteran patients.

The annual review will allow physician salaries to remain competitive with the local market rate, and with the productivity component, it will permit us for the first time to reward performers who exceed expectations.

Thank you for the opportunity to present this information.

[The prepared statement of Ms. Cullen appears on p. 141.]

Mr. BOOZMAN. Dr. Ebert.

STATEMENT OF MICHAEL EBERT

Dr. EBERT. Mr. Chairman and members of the Subcommittee, I appreciate the opportunity to appear before you today to discuss the compensation of physicians in the Veterans Health Administration.

Recently, the VA Health Care System has been widely recognized as a leader in health care with regard to safety, patient information systems, delivery of primary care, and prevention of disease. A significant part of this success story is due to the group of talented and dedicated physicians that staff our VA facilities throughout the country, many of which are affiliated with our medical schools.

As they mature in their careers, many of these physicians simultaneously contribute to several missions of the VA, at local or national levels.

It is imperative for the VA to retain its most talented and hard working physicians rather than have them migrate out of the VA at the time they have become most valuable to the VA mission.

You have heard testimony today on the current compensation system for VA physicians and how it developed, and the problems that it currently creates for recruiting certain physicians and retaining a larger group of physicians. I would like to comment on two aspects of the problem.

The first is the recruitment of physicians in highly compensated specialties, and the second and equally important, is the retention of highly skilled and accomplished physicians, who are making their careers in the VA.

The legislation under discussion today provides a solution for the compensation problems created in both scenarios. It provides salary benchmarking to a reasonable standard. The AAMC statistics on the compensation of academic physicians are the most reliable database that I am aware of to indicate what large academic medical centers pay their clinical medical faculty. This database indirectly provides a reasonable and a moderate benchmark for market based pay of physicians. Secondly, the legislation provides flexibility to recognize seniority of physicians, national recognition, and market competition for their services based on their accomplishments.

Let me share with you the difficulties that we have encountered in recruiting and retaining physicians in highly compensated specialties.

The VA Connecticut Health Care System is a large tertiary medical care system spanning the State of Connecticut and affiliated with Yale and the University of Connecticut. We have an active surgical program, and require subspecialized surgeons and anesthesiologists on our medical staff. We have had great difficulty recruiting and retaining academic surgeons in urology, ENT, ophthalmology, orthopedic surgery, as well as anesthesiologists, because of our pay structure.

If we were not affiliated with two academic medical centers, this problem would have been even worse.

Because of these difficulties, we have had to turn to contracting for clinical services in these disciplines, and contracting for doctors' services is a fundamentally more expensive means of providing specialty and surgical care.

Furthermore, the contract physician does not have the same investment and involvement in the health care system. This is a hidden additional expense when you think about organizational change, continuous quality improvement, and day to day administration.

The second and equally important problem is retention of extremely talented and nationally recognized physicians in the VA Health Care System, whose compensation slips behind their peers as they mature in their VA careers.

These individuals bring substantial productivity, prestigious academic accomplishments, and national leadership in health care to their VA facilities.

We have a number of such individuals in the VA Connecticut Health Care System. Many of them are internationally recognized medical scientists. Many of these individuals are also very clinically productive. They often assemble and lead state-of-the-art clinical teams in specialized areas of diagnosis and treatment, such as spinal cord injury, interventional cardiology, PTSD, alcoholism, and infectious disease. Their research is focused on discoveries that improve the health care of veterans. We have lost several of these leaders in recent years to other medical schools, where the salary differential was a significant factor in their recruitment.

I would be pleased to respond to the Subcommittee's questions.

[The prepared statement of Dr. Ebert appears at p. 144.]

Mr. BOOZMAN. Mr. Lawson.

STATEMENT OF MICHAEL M. LAWSON

Mr. LAWSON. Thank you, Mr. Chairman.

I am sure you are aware that the Boston metropolitan area is one of the premier centers of medical excellence in the United States. In a recent *U.S. News and World Report* feature, many Boston facilities were ranked at or near the top in many categories.

Facilities such as Brigham and Women's Hospital, Massachusetts General Hospital, Boston Medical Center, Massachusetts Eye and Ear Infirmary, Dana Farber Cancer Institute, and Beth Israel Deaconess Hospital, were all prominently mentioned. These are all af-

filiates of the Boston Health Care System, and their expertise are available and accessible by VA patients throughout New England.

Veterans expect, as do I, that the care provided by the VA Boston Health Care System will be the equivalent of that practiced in those prestigious institutions.

We have met those expectations, but parity has become very difficult to maintain as competition for the best and the brightest clinicians has been severely hampered by pay limitations that do not reflect the realities of the competitive clinical marketplace.

The attrition rate for physicians in the radiology specialty for fiscal year 2003 at the Boston Health Care System was 50 percent. These losses were clearly salary driven. Whereas, the average VA salary of these radiologists was approximately $170,000 to $190,000, all left for compensation in the range of $250,000 to $300,000.

For the last 3 fiscal years, physician losses at VA Boston have out paced our physician gains, primarily due to pay disparity. In addition, a growing number of physicians are converting to part time or reducing their part time hours in order to obtain additional compensation from secondary employment. This has the potential of adversely affecting the continuity of care to our patients and reduces the commitment, I believe, that accompanies full time clinicians.

When recruiting attractive prospects, our typical pay offering is invariably at the top step of the top grade available to us.

This in combination with all flexibilities authorized by law and regulations, including retention allowances, may allow us to offer a salary package in the approximate range of $130,000 to $190,000.

If the proposal exceeds $190,000, the Secretary would need to approve, which hinders rapid action. Although approval is rarely denied, it cannot be assumed during the recruiting phase.

In reviewing the proposal, I commend VA's efforts to address these impediments. Perhaps the most exciting feature of the proposed bill is the market pay aspect, which would now offer us a vehicle to respond to local market forces, as well as offer us an ability to remain competitive. It would also have the benefit of stabilizing our workforce in the future and would serve to minimize the emotional conflict that physicians experience, having to tradeoff a true commitment to veterans, versus earning compensation commensurate with their educational level, training, and skill.

This bill would also prohibit senior clinical staff at or above the chief of staff level from receiving any compensation from the affiliates. While this prohibition on supplements is understandable in light of the proposed provisions to substantially upgrade the remuneration for chief of staff, there are physicians holding these positions who have unique skills that are invaluable to the community that should be allowed to continue these activities.

I am pleased that the draft bill includes waiver authority for the VA to consider these and other unique situations. I am also pleased that the proposal would allow physicians in leadership positions to continue interactions with the medical schools, to participate in research and involvement in academic activities on a non-compensated basis. Such activities should be promoted, assuming of

course, the existing rules and regulations involving ethics and conflict of interest are respected.

It has been my experience that the chief of staff involvement in the many levels of the medical schools has been crucial in preserving the interests of the VA, and maintaining the synergy necessary for growth.

With respect to the proposal for increasing the compensation for nurse executives, I feel the proposal is well thought out, and I heartily endorse it.

With respect to the proposed flexibility regarding nurse schedules, employee satisfaction surveys indicate that the lack of flexible tours ranks at or near the top of employee dissatisfaction.

In conclusion, I strongly support initiatives that provide us the tools to attract and retain competitive medical staff.

I thank you for the opportunity to address the Committee, and I would be glad to answer any questions.

Thank you.

[The prepared statement of Mr. Lawson appears on p. 147.]

Mr. BOOZMAN. Thank you. Dr. Simberkoff.

STATEMENT OF MICHAEL S. SIMBERKOFF

Dr. SIMBERKOFF. Mr. Chairman, thank you for allowing me to testify in support of the Department of Veterans Affairs Health Care Personnel Enhancement Act of 2003, on behalf of my colleagues in VISN–3.

It is my opinion that passage of this bill is essential to help us recruit and retain qualified physicians needed to care for veterans in our facilities.

Please allow me to support this statement by providing you with some background and examples of why we need this bill.

As you may know, I am the Chief of Staff of VA New York Harbor Health Care System. New York Harbor was formed by the merger of the Brooklyn and New York VA Medical Centers in 1999.

We care for approximately 60,000 unique veterans each year and operate ambulatory, acute and tertiary care facilities at our Brooklyn campus in the Bay Ridge section of Brooklyn, ambulatory, acute and tertiary care facilities at our Manhattan campus on East 23rd Street, and ambulatory, long term, and domiciliary unit at our St. Albans campus in Queens. We also operate community based outpatient clinics in four of the five boroughs of New York City, including a rapidly expanding one that is soon to be relocated in Staten Island.

VA New York Harbor currently has critical shortages, and is experiencing great difficulty in recruiting qualified physicians to care for veteran patients in several medical specialties, including anesthesiology, diagnostic radiology, and interventional radiology.

Because VA's salary structure for specialty physicians is noncompetitive, we already have a contract to provide radiation oncology, diagnostic and interventional radiology services at our Brooklyn campus. It is likely that we will be forced to enter into a similar contract for diagnostic and interventional radiology services at Manhattan. We plan to enter into a contract to provide critical care medicine/intensivist care for our SICU in Manhattan, as per Leapfrog Group's standards for patient safety.

In addition, we need to find a new Chief of Neurosurgery, and additional cardiac surgeons in the very near future. It is likely that we will be forced to enter into a contract for these specialty physicians as well.

Under existing regulations, compensation for physicians and dentists is computed from a combination of basic and special pay rates. The basic pay rate for most physicians is fixed at approximately $110,700, way below the current market rate. Special pay rates include components for full time status, Board certification, years in government service, scarce specialty pay, geographic locality pay, and exceptional qualifications, the latter requires approval by central office.

At present, the maximum salary that we in New York Harbor can offer a diagnostic or therapeutic radiologist is $169,000. At our affiliates, these physicians, often right out of training, earn $275,000 to $325,000. Anesthesiologists at New York Harbor can be offered approximately $160,000, while at the affiliates, they earn well over $300,000.

Critical care medicine/intensivists can be offered approximately $1450,000 at our facility, but are paid $280,000 at our affiliates.

A full time neurosurgeon would be paid $160,000 at our facility, while even as an assistant professor, would earn over $340,000 at the affiliate. A full time cardiac surgeon would earn $162,000 at our facility, and between $350,000 and $450,000 at the affiliates.

The only means that we have available to hire highly qualified scarce specialists is through contracts. These are expensive and in many ways, destructive. Contract physicians are employees of the contractor. Their loyalty is to their employer, not to New York Harbor.

The proposed legislation should do much to reduce the differences in pay between VA and non-departmental physicians that currently exist. By establishing a higher band for minimum base pay, indexing market pay to salaries outside of the Department, based on geographic area, specialty, assignment, personal qualifications and individual experience, and establishing an option for up to $10,000 annual performance pay, we can compete for and retain quality physicians in scarce specialties, and establish a culture that ensures constantly improving service for our patients.

Thank you for allowing me to testify.

[The prepared statement of Dr. Simberkoff appears on p. 150.]

Mr. BOOZMAN. Thank you.

Dr. Parthemore, your testimony speaks to concerns for pay issues for nurse executives, dental chiefs, several groups of physicians that you believe are not covered by the current proposal.

It is clear that you believe a remedy is needed, but do you have a solution?

Dr. PARTHEMORE. I do not think they are covered by the present proposal. I think that the present proposal addresses many of our problems, but not necessarily all.

In some markets, such as mine, the band for nurse pay is probably not sufficient. If there was a greater ability, for instance, for the Secretary to create a broader pay band, addressing market forces and the complexity of the institutions, I think it would be more helpful to some of us.

I think that some of our physicians, as mentioned by Dr. Roswell, only 30 percent, given the present proposal, will see a significant increase. Many will see little to no increase.

Mr. BOOZMAN. Ms. Cullen, I guess for a guy from Arkansas, the cost of living in your area of the country, it sounds more like monopoly money than real money.

Ms. CULLEN. It does to us as well.

Mr. BOOZMAN. I really cannot imagine how the VA can compete for the physicians' compensation in your area. I guess the question is how do the other health care providers manage? They are faced with the same inability, I am sure. How do they handle it?

Ms. CULLEN. Well, our greatest strength in recruiting VA clinicians is our affiliate, our strong partnership with the University of California at San Francisco, and most of our physicians do have salary supplementation from the school.

Recruiting is also a challenge for university positions, and there is an awful lot of recruiting within the San Francisco Bay area. We realize that trying to get people who are already here and used to the currency of monopoly money is one of our most successful strategies.

It is incredibly difficult to try to recruit someone from a much lower cost of living area to come to our area.

Mr. BOOZMAN. Dr. Simberkoff, I guess you would have a similar problem in New York.

Dr. SIMBERKOFF. New York is a very high priced neighborhood; yes. We certainly have problems. The universities have problems as well, but I think one cannot over estimate the lure of the teaching institution. Our physicians come to us because they like caring for veteran patients, and also are attracted by the opportunity to participate in teaching and research. I think the partnership that we have with our affiliates in teaching medical students and residents and having our faculty participate in research, both sponsored by the VA and NIH and others, is a very strong attraction. Thus far, it has served us well.

Mr. BOOZMAN. Again, being from Arkansas, being from a rural state, and yet from a part of the country that really does have a lot to offer, we are having the same problems that you are having, in the sense that it is very, very difficult. Again, I live in the third fastest growing area in the country, in the third fastest growing county, the sixth fastest growing region.

The Milliken Foundation has ranked it in the top ten to retire in. They also ranked it as the number one area to go and work and make a living right now. There is a lot of opportunity, yet we have tremendous problems recruiting physicians.

I guess the question is will this legislation help the doctor shortage in the country, or do we need as a Congress to kind of address the underlying problem that is causing that problem, along with the problems that you are having?

Dr. SIMBERKOFF. I will start. I do not think it addresses the doctor shortage at all. I think that is another much more fundamental issue.

I think it will help attract physicians to the VA system, and I think for those of us who are in the system and have been in it for a long time, our first commitment is the care of veteran pa-

tients, so I think that is for the moment, our priority, and what this bill addresses.

The issue of increasing the attractiveness of medicine as a profession and nursing as a profession, and even dentistry as a profession, compared to others which are much more lucrative, is something which I think Congress needs to look at.

Dr. BAUER. May I add that I think the fact that it does respond to the market is also beneficial. We have seen cycles as far as salaries of professionals go. Right now, radiology is a very much in demand discipline. They can put tubes everywhere. It shortens hospital stays. Every hospital wants one. The price goes up.

Two years ago, it was anesthesiology, and we are still sort of suffering from that.

I think the fact that this does respond to the market fairly quickly, it does allow us to make adjustments to those fairly rapid market changes.

Dr. PARTHEMORE. I think by the same token, there is a shortage of 6,000 radiologists according to the American Radiological Society. In part, that is because there was an effort to shape what people entered as far as specialties versus primary care. In trying to create a good, we created a problem.

I think when you asked the question about the problem of people entering the practice of medicine, that is an issue we need to address at the grade school level. We have to start getting our kids to think that being a physician is an interesting job, a challenging job, something that grabs their imagination for their future. By the time they reach high school or even college, it is often too late. We have to do a better job of doing that.

Mr. BOOZMAN. Counsel.

Ms. EDGERTON. Thank you, Mr. Chairman.

I wanted to explore the issue a little bit more of whether we reward full time status. Dr. Parthemore, your statement seems to say that you appreciate the flexibility that this proposed legislation would give you. Others have said there is some value to having full time physicians in the system.

I just wondered if you would comment on whether this legislation, legislation that we would consider, should have a component that rewards full time status. Can each of you comment on that briefly?

Dr. PARTHEMORE. I do not know if you are talking just about full time status or tenure status also in the VA.

Ms. EDGERTON. Full time right now.

Dr. PARTHEMORE. I personally think we should pay a similar amount of dollars for the hours worked. That raises the question for folks as to whether or not we should pay on call salary or not. For many of our physicians, we do not—for most of our physicians, except perhaps contract doctors, we do not pay on call pay. This is an issue for some.

The universities have not paid on call pay, and we have sort of followed their lead. Even so, it may not be appropriate these days, not to reward on call pay.

Again, beyond that, I think that what we should be doing is paying an equivalent amount of money for time worked to achieve the outcomes of the job hired for.

Ms. CULLEN. I would make the comment that in some areas, we need full time VA physicians, while in others, we need part time VA physicians. It would be preferable to have our needs determine which we hire. Right now, in some cases, it is the salary that determines which we hire.

That is the case particularly for us in surgery, where we have a number of part time physicians saying they need to be making up the difference in the salary that we do not provide, and they can only afford to work for us part time. In some areas, we would much prefer having full time physicians to meet the surgical needs.

It will vary. The advantage of this pay bill is that market forces will help determine what the salaries are that we can offer.

Dr. EBERT. It depends partly also on geography. You sometimes need to have more part-time physicians in some locations.

Mr. LAWSON. In Boston, it is legendary traffic problems, and having part time staff leads to non-productive time for both participants in the shared responsibilities. In fact, I would have them consider the VA as a career and not a temporary transitional period.

We have, along with Mike Simberkoff, one of the most dynamic affiliations in the United States with Harvard University and Boston University School of Medicine. When we need continuity of the staff, they are there, not just for 2 weeks or 2 months, but in fact, around the clock.

I am very much a fan of full time physicians, assuming, of course, you have enough clinical work and academic research work to require a full time physician.

Dr. BAUER. In San Antonio, we depend very much on part time physicians, and we do that because we have a very tight affiliation with our school. When this affiliation was created some 20 years ago, it was felt that we did not desire an us and them mentality that sometimes happens when you have full time VA and full time university staff.

In this affiliation agreement, we decide jointly what it will take as far as staff to run the two facilities, and enough FTE are allocated then to run the two facilities. Independent of whether the physician is a full time or part time staff, he is expected to take evening call and weekend call and so forth, as appropriate to deliver all the clinical services that are necessary.

Dr. PARTHEMORE. I think also in some specialties, it is important for physicians to be able to work in more than one place, in order to keep their skills across the board. In scarce specialties in particular, it is difficult for physicians to always get the full gambit of cases at the VA. Neurosurgery, would be one example. We do not have trauma and other sorts of things at the VA. To keep them truly at the cutting edge, it helps them to be able to work in more than one locale.

Ms. EDGERTON. Thank you, Mr. Chairman.

Mr. BOOZMAN. Dr. Roswell earlier said that the VA contracting for specialists has grown from $190 million in 1995 to $850 million in 2002. I think you all mentioned, Ms. Cullen and Mr. Lawson also mentioned it.

The CARES proposal predicts that contracting in the future—they predict 25 percent increase themselves.

I guess the question is is contracting bad in its face? Are these numbers out of line, are they in line?

Dr. SIMBERKOFF. I think the problem with contracting is that it is inherently more expensive, and because you are adding costs such as malpractice, which the VA does on its own, and in addition, the loyalty of the employee, as I said, is to the contractor, not to the facility.

When the facility wants to improve in a certain area or change some directions, the employee may say, you know, so long.

I think we can do better. We at New York Harbor will be entering into many contracts if there is not some relief in the pay bill because of our need for scarce specialists, but I think we could do much better in terms of both the dollar value that we would get, as well as building loyalties to the VA patients, and facilities, if we were able to hire these individuals, with the university, but as primarily VA employees.

Mr. LAWSON. If I might clarify, Dr. Roswell's testimony was about an increase in contracting for personal services. Most of the CARES contracting is for total services. It is for hospital care and care in remote areas. They are different kinds of contracts. The fact is the CARES contracting would be when it is the best modality available, either that or VA construction is unreasonable or untenable or in fact, it is in some areas of the country where it would not be practical to do so.

Dr. PARTHEMORE. Just as an example, we have a new chair of radiology at our university. Once he had the opportunity to examine his books, he made an appointment to see me, to tell me that he is currently supplementing the radiologists at the VA to the tune of about $600,000.

I am sure that is going on in several other academic disciplines at my VA.

I believe that we can, with this pay bill, meet his needs, or come close enough to have him back off, and I have asked him to wait for the pay bill. If we do not have the pay bill, I am certain that he will be back asking for a contract to make up the monies that he is losing, and once he asks, other scarce specialties will begin to ask also.

We have sort of spent 2 years at our place holding them off saying wait for a pay bill, wait for the pay bill, it will get fixed. We are going to be looking at big changes in the way we have done business if we do not move in this direction.

Mr. BOOZMAN. Dr. Roswell, would you like to comment about that? You are certainly welcome to, if you wish.

Dr. ROSWELL. Thank you, Mr. Chairman. I agree that contracting for physician services is not a desirable feature.

Let me point out that when we have to contract for physician services through an affiliated medical school, our contracting regulations require indemnification at the amount of a minimal of $1 million, which means that medical malpractice insurance must be included in the contract, and we are paying for something that is already paid for for VA employment through the Federal tort claim protection.

So, contracting not only detracts from physician loyalty to the VA mission and purpose, as the panelists have pointed out, it also is a much more expensive way to acquire physician services.

In contrast, contracting for hospital services in a comprehensive fashion, as noted in CARES, is something that in fact may allow us to be more cost efficient, because it avoids the need for capital infrastructure/acquisition costs, and allows us to maximum current hospital capacity and then contract for services when we go over that.

Clearly, when it comes to individual physician services, the ability to be competitive in the marketplace, whether that is at the 50th percentile or the 75th percentile, or some other mechanism, it is absolutely essential for us to be good stewards of the taxpayer dollars.

Mr. BOOZMAN. Thank you very much. Counsel, do you have anything else?

Ms. EDGERTON. No, Mr. Chairman.

Mr. BOOZMAN. Thank you. Again, I want to thank the panel so much for making the long trip in many cases, and spending time with us. Your testimony certainly was very, very beneficial.

The Committee will consider today's testimony and other materials and information prior to moving forward with legislation, so late in this session, as was noted, nearly 13 years have elapsed since Congress last reformed the VA physician pay.

The Chair intends to carefully craft our eventual proposal in close consultation with Chairman Smith and Ranking Member Evans, because once a bill is reported and enacted into law, it likely will be the law of the land for a number of years, and it will affect thousands of VA physicians and many thousands more of other VA staff, and literally, millions of veterans in a way that we may barely be able to imagine today.

In fact, I think Dr. Parthemore alluded to that, in the sense that we crafted a bill for primary care, as far as physician specialties several years ago, and I think now we are reaping the benefit of that. Certainly, we need to be very prudent and very careful as we go along this track.

Thank you all again very much for being with us today, and we certainly do appreciate your testimony.

The meeting is adjourned.

[Whereupon, at 4:10 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN SIMMONS

Good afternoon. Please come to order.

The Subcommittee, at the strong suggestion of the Department of Veterans Affairs, is holding this legislative hearing to review VA pay and staffing matters dealing primarily with its physician workforce.

Doctors traditionally have been called "the engines" of medicine and health care, which I believe is an indicator of their importance to the diagnosis and treatment of illness and injury, and efforts at reducing human misery and easing pain and suffering. Given the advent of primary care, physicians are said to promote health and improve health status of the population they serve. This suggests that we are all destined to live forever, but I think in VA, given its aged and sick enrolled population of veterans, much of VA physicians' energies are devoted to the diagnosis and treatment challenges rather than the health maintenance ones.

In any event, physicians are one of the most important professions in human affairs across human history. Healers are very precious to us. Also, with rare exceptions in Western Civilization, physicians are very highly compensated compared to any other profession or occupation. In this country, physicians are the highest paid profession—even above plumbers and trial lawyers. However, even given their very substantial remuneration for services rendered, our society occasionally experiences shortages and mal-distributions of physicians, especially those in the highest demand—members of the surgical teams, specialists in rare diseases, experts in brain diseases, anesthesia, or organ transplantation. There are others, dependent on location or the issues of the moment.

Congress has preoccupied itself over the years to ease physician shortages and improve their distribution across the country, with legislation that altered reimbursement in Medicare and other federal programs, creating certain incentives that influence decisions on where to live or how to specialize, provided direct subsidies, including tuition reimbursement and loan programs, and the like. In fact, during an acute shortage of VA physicians in the early 1970s at the peak of the repatriation of Vietnam wounded into the VA system, and based on a idea germinated by this Committee, Congress enacted legislation that established five new State schools of medicine to address specific geographic shortages of physicians in West Virginia [at Marshall University], South Carolina [at the Medical University of South Carolina], Texas [at Texas A&M], Ohio [at Wright State University] and Tennessee [at East Tennessee State University]. These schools have been successful academic and clinical ventures, producing thousands of new doctors, who practice at least for a time at their host VA medical centers, raising the quality of care for veterans and later furnishing some improvements in those States' availability of physicians to the general populations.

Also, from time to time, this Committee has played a pivotal role in resolving reported recruitment and retention difficulties encountered in VA in the Department's efforts to provide first-class health care to America's veterans. The most recent accomplishment dealt with reforming the VA nurse pay system to permit locality-based pay increments, and guaranteed annual comparability increases, also [incorrectly] called COLAs.

We also raised pay for VA dentists, psychologists, pharmacists and social workers just two years ago to stem their losses from VA and to aid recruitment of these valuable and hotly-contested staff members.

The Committee awaits the report of VA's national Commission on Nursing which this Committee authorized in law, and whose report is due here next year, to advise Congress of the state of VA nursing, including recruitment and retention, staffing mix, tours of duty, education matters and other areas of concern to VA and the Committee. I note for the record that VA's proposals on dealing with some of its

current nursing staffing problems as detailed in its recent proposal are based on work of an internal task force but do not reference the national Nursing Commission's deliberations or any of its preliminary conclusions or coming recommendations.

VA employs about 6,000 physicians, and reports about 950 physician vacancies that it presumably would fill were it able to recruit these professionals.

Recently VA submitted a legislative proposal to the House and Senate that would dramatically reform the way VA compensates its "engines of medicine." The Committee will consider today's testimony and other materials and information prior to moving forward with legislation so late in this session. Nearly 13 years have elapsed since Congress last reformed VA physician pay, the Chair intends to carefully craft our eventual proposal with assistance from my friend the Gentleman from Texas, Mr. Rodriguez, in close consultation with Chairman Smith and Ranking Member Evans, because once a bill is reported and enacted into law, it likely will be the law of the land for a number of a years and will affect thousands of VA physicians and many thousands more of other VA staff, and literally millions of veterans, in ways we may barely be able to imagine today. Thus, we will be very prudent in considering all of the likely implications before moving any bill with such large potential to both do good and possibly otherwise.

We have good panels of witnesses for today's hearing, representing VA, its practicing physicians, facility leaders, professional associations and labor unions, to promote a thorough ongoing discussion of this matter. We also have invited veterans organizations to provide written testimony. Let us begin with panel 1 and the VA Under Secretary for Health. Dr. Roswell, please introduce your colleague and proceed.

Panel 2—For our second panel, we welcome Dr. Thomas Joseph Lawley, M.D., the Dean of Emory University School of Medicine Association of American Medical Colleges. Dr. Lactancio D. Fernandes, M.D., who is the President of the American Federation of Government Employees Local 1045 representing nearly 1,200 doctors, nurses, allied health care workers and other hospital staff at the VA facilities in Biloxi and Gulfport, Mississippi, Mobile, Alabama, and Pensacola and Panama City, Florida. Dr. Fernandes is also a Major in the United States Air Force Reserve, 919th Medical Squadron, and recently completed his annual tour in support of Operation Iraqi Freedom. We thank you Dr. Fernandes for your service in both capacities. And Dr. Stephen Rosenthal, M.D., the President of the national Association of VA Physicians and Dentists.

Panel 3 There are six participants on our third and final panel for today's hearing. Representing nearly 6,000 of their medical colleagues are Dr. Jacqueline Parthemore [PAR-the-more], M.D., the Chief of Staff and Medical Director for the VA San Diego Health Care System; Dr. Richard Bauer, M.D., the Chief of Staff at the South Texas Veterans Health Care System in San Antonio, Texas; Dr. Michael H. Ebert [EE–bert], M.D., Chief of Staff at the VA Connecticut Health Care System; and Dr. Michael S. Simberkoff, M.D., Executive Chief of Staff of the VA New York Harbor Health Care System. Ms. Sheila M. Cullen, Medical Director of the San Francisco VA Medical Center and Mr. Michael M. Lawson, the Director of the VA Boston Health Care System are also participants on this panel, addressing the challenges faces by VA's medical facility leadership.

I want to thank our witnesses, and our Subcommittee Members, for their participation and attention to this matter of interest to VA in its ongoing efforts to provide high quality health care services to our Nation's veterans. We will take this legislative proposal under advisement.

STATEMENT OF CIRO RODRIGUEZ
RANKING DEMOCRATIC MEMBER
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS

Health Oversight Hearing on Veterans Affairs
Physician and Dentist Compensation Issues
October 21, 2003

Thank you Mr. Chairman. I know the issue of compensation for physicians and dentists is of extreme importance to VA. Dr. Roswell, I am aware that you and the medical center directors and chiefs-of-staff who are here with you today are particularly invested in this matter as you continue to prepare a workforce that can meet the challenges of the VA health care system in the 21st Century.

I think we will find that this issue is confronting medical centers in every region and at every level, including my hometown of San Antonio. I want to welcome Dr. Richard Bauer, the chief of staff of the South Texas Health Care System who will tell us what issues we're dealing with there.

While there is more controversy about the physician supply than about the nursing shortage everyone acknowledges, some believe that we will also face a physician shortage—particularly for specialists—in the near future.

If we are facing a physician shortage, it may hit VA hard. There can be no doubt about it. VA physicians are underpaid compared to their counterparts in the private sector, including in the academic medical centers in which many of them are also privileged. We have not revisited pay legislation in 13 years.

In its fiscal year 2004 budget submission, VA estimates that it will hire more than 900 physicians over this fiscal year. This is a comparable number to one in Dr. Roswell's statement that cites a survey of VA facilities identifying 900 vacancies—about 10% of its full-time physician workforce—for which VA would recruit if it could offer competitive salaries. I understand that the contracts for specialists VA often uses as an alternative may be more expensive than just hiring the specialist at a decent salary. This is a situation we must address.

While we can acknowledge that current law guiding physician pay may be an impediment to recruitment and retention, other personnel-related issues may also need to be re-assessed to make VA an employer-of-choice. In my view, however, even with new legislation, VA could have a challenge given the inadequate budget they may have to work with. So, Dr. Roswell, I hope that VA and the Administration are giving thoughtful consideration of the funding you will request in fiscal year 2005 to successfully implement your legislative proposal.

The Administration's proposal purports to address many of the challenges VA believes it is confronting in providing a competitive benefits package to its physician workforce. I am eager to ensure that we give VA the tools it needs to be an employer-of-choice for all of its clinical staff. I am also eager to hear the views of our witnesses—all of whom seem to agree about the need for payment reform, but may disagree about what exactly needs to be addressed in these reforms.

Mr. Chairman, again, I appreciate you calling this hearing today and look forward to hearing from our witnesses.

Statement of Congresswoman Shelley Berkley
Subcommittee on Health
Oversight Hearing VA Physician and Dentist Compensation Issues
October 21, 2003

Thank you, Mr. Chairman. As you know, southern Nevada has one of the fastest growing veterans populations in the country. Currently, the southern Nevada veterans health community is struggling to meet the needs of the population growth, which has been compounded by the evacuation of the Addeliar D. Guy III Ambulatory Care Clinic, and its replacement of several temporary health care sites. According to the CARES draft plan released by the VA, southern Nevada's veterans need a new medical facility, including a new outpatient clinic, hospital and long-term care facility.

The VA has projected that the number of enrolled veterans needing health care services in Las Vegas will increase by 18% from 2001 to 2022. Due to this growth, the Las Vegas Valley's demand will also increase for VA physicians, nurses, and dentists to care for the men and women who have sacrificed for our nation.

Nevada is already facing a health care crisis, which will make it increasingly difficult for the VA to recruit and retain doctors. Currently, there are 91full-time and part-time doctors in southern Nevada serving the health

care needs of our 160,000 veterans. Currently, there is not a significant shortage of general practitioner doctors in southern Nevada's VA facilities, yet we are finding it harder and harder to find oncology, hematology, and pulmonary specialists to treat our veterans. As well as in many communities around the nation, nursing shortages have affected our patients care in our hospitals, long-term care facilities, and public health clinics.

We all agree that veterans' access to quality health care is a priority. However, in order for veterans to have access to quality health care they not only need buildings, beds and medical equipment, but they need experienced and hard-working physicians, nurses, and dentists. Therefore, we must ensure that VA health care professionals are adequately compensated. If the significant pay disparity between VA doctors and private doctors continues, we will not have physicians to care for VA patients and once again we will break another promise made to our veterans.

I look forward to hearing from the witnesses regarding the VA's plan to update the compensation to doctors and dentists. Thank you, Mr. Chairman.

STATEMENT OF
THE HONORABLE ROBERT H. ROSWELL, M. D.
UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U. S. HOUSE OF REPRESENTATIVES

October 21, 2003

Mr. Chairman and Members of the Subcommittee, I am pleased to be here to discuss our legislative proposals that will greatly enhance VA's ability to recruit and retain the highest quality physicians, dentists, and nurses to care for the Nation's veterans.

Mr. Chairman, VA is having increasing difficulty recruiting and retaining a number of physician specialties. This is because the maximum salaries that VA can pay for some physician specialties are non-competitive with the private sector.

The VA compensation structure for physicians and dentists has not changed since 1991. The current system is extremely complex and does not provide the flexibility to respond to the changing competitive market for many medical specialties, especially for the highest paid medical subspecialties. Also, national shortages of many physician specialties critical to our health care mission further affects our ability to fill critical vacancies. In these shortage specialties, VA total compensation lags behind the private or academic sectors by as much as 67 percent.

VA is facing a critical situation because of our outdated pay system. If we are to maintain our tertiary care capability and ability to offer a full range of health services to veterans, we must be able to offer competitive salaries. For several specialties our turnover rate far exceeds our hire rate, i.e. we are losing these specialists faster than we can hire them. Also, many facilities are not actively recruiting to fill some vacancies due to unavailability of candidates at current VA salary rates. Earlier this year, facilities reported over 900 such vacancies that they would fill if candidates could be found. The effects of noncompetitive pay and benefits are also reflected in dramatic increases in our scarce specialty, fee basis, and contractual expenditures. These expenditures increased from $180 million in 1995 to $851 million in 2002. Additionally, we increasingly must hire non-US citizens under J-1 visa waiver authority and international medical

graduates – currently almost 30% of our workforce. Also, although Congress increased special pay for dentists in 2000, those increases did not bring VA pay up to the levels in private dental practice.

The problems with the current system are clear: special pay rates are fixed in statute, so over time their values are eroded by inflation, and VA pay eventually falls behind the market. We already are paying the maximum authorized amounts for scarce specialists; there is no discretion under existing statute to pay more to retain these mission-critical employees.

As you know, increased enrollment by veterans of all ages for VA health care and the need for more comprehensive care to aging veteran patients is increasing workloads across the system. At the same time, current trends indicate a steady decrease in the number of physicians and dentists VHA will be able to employ. This decrease will result from increased retirements, losses to the private sector, a shrinking dentist labor supply, and increasing difficulty in recruiting replacements. These factors will combine to create significant gaps between VHA's staffing needs and available resources for most physician specialties. Without the flexibility to adjust pay in response to market pressures we will be unable to meet the demands of our increasing workload. We will be forced to rely more heavily on scarce medical specialist contracts and fee basis care, which often cost more than using VHA physicians. Thus it is critical that we be able to offer more competitive compensation for physicians and dentists.

Proposed New VA Physician/Dentist Pay System

Mr. Chairman, our bill would completely revise the VA physician and dentist pay system to allow VA to adjust physician and dentist compensation levels according to market forces. Under our proposal, the system would have three bands: base pay, market pay, and performance-based pay. VA would benchmark the sum of all three bands to the 50th percentile of the Association of American Medical Colleges (AAMC) Associate Professor compensation (for physicians) and 75 percent of American Dental Association (ADA) net private practice income (for dentists). The base pay component would be increased by the annual comparability adjustments to Federal pay authorized by Executive Order. The system's simplicity and flexibility would ensure that VA physician and dentist compensation levels and practices do not become outdated over time due to statutory limits.

First Tier – Base Pay. A uniform base pay band will apply to all positions in VHA, without grade distinctions. The proposed range is Chief grade, step 10 of the VA Physician/Dentist Schedule to Level V of the Executive Schedule, from roughly $110,000 to $125,000. This change will dramatically simplify hiring and

employment and facilitate reassignments and position changes. Placement in this band would be based on the individual's qualifications.

Second Tier – Market Pay. The second tier, the market pay band, will be determined according to geographic area, specialty, assignment, personal qualifications and individual experience. It would be indexed to the salaries of similarly qualified non-Department physicians, dentists, and health-care executives at the entry, mid-career, and senior levels. The flexibility of this tier allows VA to keep pace with the market, both on upward and downward trends. VA would link the market band for clinicians to AAMC faculty compensation. For executives at the Chief of Staff (COS) level and above, the benchmarks would be hospital and HMO executive compensation levels. For dentists, the benchmark will be American Dental Association (ADA) net private practice income. Our primary competition in the marketplace is private practice income.

Third Tier – Performance Pay. The third band will be linked to performance, and would be paid for discrete achievements in quality, productivity, and support of corporate goals. The measures will be flexible and generally set locally; we could also mandate national objectives. VA facilities could authorize performance pay of up to $10,000 for physicians and dentists below the Chief of Staff (COS) level. For managers at the COS level and above, ten percent of their benchmarked pay would be at risk, and would be payable to the extent that performance goals are met. This will address a concern that has been raised by the General Accounting Office and others of a disconnect between employees' performance and their pay.

The draft bill also would prohibit senior title 38 officials at the Chief of Staff level and above from receiving any compensation, whether from employment or contract, and from accepting any offers of future employment, from medical schools affiliated with their respective VAMCs. This prohibition will reduce the risk of potential conflicts of interest, and will ensure that the Department's interests in agreements with affiliated medical schools are adequately protected. It is highly desirable to have an independent senior clinical official at each facility.

Details of VA's Implementation Plan

- Salary benchmarks will be set at the national level and communicated to networks. Local facilities would set pay levels within a range (± 10 percent of the benchmark) according to local circumstances. Any decision to set pay outside the 10-percent band will require higher-level approval.

- Benchmark salaries will be set for each specialty and location, at entry, mid-career, and senior levels. Increments and graduated benchmarks will be set to reflect varying levels of experience and to provide for reasonable income growth over a period of time.

- We will use ADA net private practice income to set VA dentist salary benchmarks.

- Specific amounts of each tier and the total payable for each clinician will be set at the local level. This continues the VA practice of local pay setting based on national policy (used for physician and dentist special pay, nurse locality pay system, and special salary rates).

Our proposed physician and dentist pay would be effective on the first day of the first pay period on or after the later of April 1, 2004, or six months after the date of enactment. We estimate the 2004 cost would be $48 million.

Other Critical Proposals

Mr. Chairman, our pay bill also includes important provisions allowing more flexible tours for nurses and an executive pay proposal for nurse leaders. I request that the committee also act on these proposals. I have already noted the projected increase in the number of aging veterans and increased enrollment in the VA healthcare system by veterans of all ages over the next several years that will increase workload across the VA healthcare system. At the same time, national nursing leaders and healthcare organizations are projecting a national shortage of registered nurses. The proposals in our bill will help VA remain a competitive place of employment for nurses and to meet current and future healthcare needs.

We also request that the committee act on a draft bill we recently forwarded to Congress that would clarify the authority of the Secretary to promulgate regulations relating to staff adjustments of title 38 employees and to clarify the exclusion from coverage under general civil service laws of title 38 personnel laws and regulations. As you know, exclusive title 38 authority was provided by Congress to help assure that VA would have the ability to assure quality of care is provided to the Nation's veterans. A recent Federal Court decision has diluted the Secretary's authority to prescribe the "conditions of employment" for all title 38 medical professionals. This decision would have us make decisions regarding staffing of particular facilities without regard to the individual's professional competencies and patient care needs. This consideration is critical to staffing a health care system in which staff members'

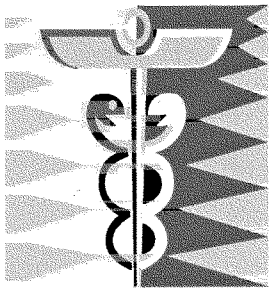
particular competencies dictate the quality of care a facility can provide.

Mr. Chairman, we very much appreciate your scheduling this hearing to address the need for reform of VA's Physicians and Dentists pay authority. We are in a critical situation with increasing needs of veterans for health care while our current pay system leaves us in a very non-competitive position for recruiting the staff we need today and into the future.

This concludes my prepared statement. I would be pleased to answer any questions you may have.

UNDER SECRETARY FOR HEALTH'S REPORT TO THE SECRETARY OF VETERANS AFFAIRS

2002 QUADRENNIAL REPORT TO THE PRESIDENT ON PHYSICIAN AND DENTIST PAY



SUBMITTED BY THE QUADRENNIAL REPORT REVIEWING COMMITTEE

June 2002

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PREFACE

This report contains the results of a 2-1/2 day meeting and recommendations of the 2002 Quadrennial Report Reviewing Committee.

The Committee met in Washington, DC, on May 20-22, 2002. The membership of the Reviewing Committee is provided in Appendix A. The agenda for that meeting is provided in Appendix B.

The Reviewing Committee was impressed with the information and depth of data provided in the Quadrennial Report, and found its conclusions and recommendations helpful in developing its own recommendations. The Committee provides its recommended disposition of the contractor's recommendations in Appendix E.

The members of the 2002 Quadrennial Report Reviewing Committee thank the Under Secretary for the opportunity to participate in this important endeavor. We believe that VA faces a critical challenge in how to attract and retain clinicians. We have an historic opportunity to develop a modern compensation structure that is responsive to market forces, while encouraging and rewarding the desired behaviors and actions needed to support VA's strategic direction.

EXECUTIVE SUMMARY

There has been no change in the amounts of physician special pay since the current amounts were enacted in 1991. When first implemented, the amounts were generally adequate to recruit and retain all specialties. However, the amounts are now 11 years old, and the rise in many physician specialties' incomes is significantly outstripping VHA's ability to compete for the most highly paid specialists. As a result, VA is experiencing increasing difficulty and, in some cases, inability to recruit and retain more and more scarce specialties. The Reviewing Committee notes that VA is experiencing severe noncompetitive pay, as measured by the AAMC benchmarks and reports of staffing difficulties, for about one-quarter of the VA workforce.

For dentists, there was virtually no increase in special pay in 1991. The increases in November 2000 in dentist special pay provided some relief, but they were considered only a stopgap measure pending the recommendations of the Quadrennial Report.

There is a clear consensus among the Reviewing Committee members that VA is experiencing increasing difficulties recruiting and retaining physicians and dentists, particularly in certain specialties and locations. There is no shortage of anecdotes of the difficulty to hire and retain clinicians in many specialties. The difficulties are most pronounced in a few specialties where the pay disparities are most severe. While the recommended pay system would apply to all physicians and dentists, the Committee believes that the increased maximum pay flexibility will be used for only a small portion of the VA clinical workforce.

Recommendations:

The Reviewing Committee members offer the following proposals:

General Proposals

1. Recruitment

- VA should continue to consider international medical graduates (IMGs) for employment. Almost one quarter of all first-year medical residents are IMGs, the vast majority of those individuals are non-citizens. In the cases where U.S. citizens are unavailable, particularly in hard-to-fill locations and specialties, VA needs to be able to employ IMGs, with appropriate visas.

- VA should do a better job of marketing itself as a desirable employer. VA offers numerous features that are attractive to many clinicians. VA should establish a national physician and dentist recruitment office to publicize VA employment opportunities and to handle employment inquiries.

2. Benefits

- VA should consider improving certain features of the benefits package, such as offering disability insurance, increasing the amount individuals can contribute to the Thrift Savings Plan and deduct from taxable income, crediting sick leave for additional service credit in retirement, and offering group dental insurance. These issues are complex and require further study and cost analysis, as well as close coordination with other Federal agencies to develop any future proposals.

- Where VA's benefits package is competitive with the community, VA should publicize the positive aspects of its benefits, including malpractice insurance coverage, paid time off, national portability of licensure, and education debt repayment.

3. Other Issues

- Receipt of salary stipends from affiliates by VA Chiefs of Staff are a matter of concern. Currently, appointment to a paid position with the university affiliate is needed to recruit and retain the desired caliber of clinical leader. VA should be able to offer competitive salary levels to these senior clinical leaders. Once VA's pay system is competitive for senior clinical leaders, such arrangements should be unnecessary except for the most unusual situations.

- VA has restructured itself into a Primary Care system. This system now treats twice the number of patients as were treated just 10 years ago. This system has dramatically increased the number of referrals, but without the necessary increase in specialist employment.

- The changing demographics of the veteran population will force further realignment of the VA workforce. The influences will be both geographic, with population shifts, and clinical, with greater demands for certain age-related specialties. VA needs to look closely at how we support and influence graduate medical education.

- The number of full-time dentists in the VA system has declined from 804 in FY 1991 to 665 in FY 2001, while the workload and eligibility for dental care have increased. At the same time, the number of dentists entering the workforce is at an all-time low. Projections are that there will be a shortage of dentists through the year 2010 and beyond due to the declining number of dental schools. Although two new schools are scheduled to open within the next two years, this falls far short of addressing the shortage created by the six closures in the past 15 years.

New Pay System

The Reviewing Committee proposes a three-tiered pay system benchmarked to, for physicians, the 50th percentile of the Association of American Medical Colleges (AAMC) Associate Professor income, along with any other significant local salary factors. For dentists, the benchmark would be no more than 75 percent of the average of dental private practice net income. A tier of the system will be linked to the achievement of specific performance objectives and measures. This promise of competitive, market-based compensation is conditioned on achievement of specified performance levels and support of organizational goals.

These tiers would replace the current graded structure, incorporate a performance-based pay element for all clinicians, and tie VA compensation to the non-Federal marketplace. This proposal would keep VA compensation competitive with the overall market, through upswings and downturns.

Tier 1. This basic pay band would offer a guaranteed minimum rate of pay to all physicians and dentists. It would be adjusted annually by the amount of the Federal annual comparability increase. The minimum rate would be Chief grade, step 10; the maximum would be the rate for EL-V.

Tier 2. This pay band would be based on either clinical specialty (for direct patient care assignments) or administrative responsibilities (for management positions).

A. The clinical pay band would be determined locally, according to geographic area, specialty, and individual experience. This band would be targeted to the appropriate AAMC level, as follows:

VA Level	AAMC Level
Staff Physician	Associate Professor
Service Chief or Equivalent	Professor
National Program Director	Chair
Dentist	Linked to private practice income

B. Other management positions would be benchmarked to non-Federal healthcare positions, and would be delinked from the clinical specialty pay bands.

VA Level	Non-Federal Benchmark
Chief of Staff	Medical Director, Vice President for Medical Affairs
Facility Director	Hospital Administrator
Chief Medical Officer	Clinical Manager, HMO

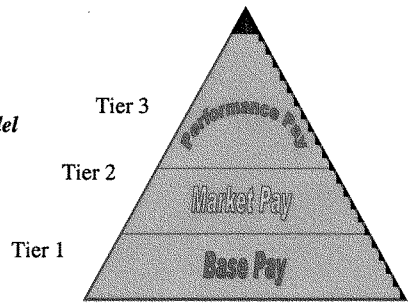
C. Recommendations for determining pay of top executive assignments were more varied in source of benchmark. The group notes that VHA leadership positions,

whether clinical or SES, could demand significantly higher salaries in the private sector for managing budgets of hundreds of millions of dollars.

Tier 3. This band would offer an incentive for enhanced productivity and performance. This component would be paid in amounts up to $10,000 for activities that support corporate goals and VA strategic objectives, such as memberships on committees, PSBs, and IRBs; teaching and supervision of residents; serving as medical staff; performing C&P exams or taking call; achieving compliance with billing requirements, etc. A set of measures with guidelines for application would be developed at the national level to ensure understanding of intent. The measures selected for each individual or work group would be determined locally, so that specific desired outcomes can be supported and rewarded. This system would ensure that areas supporting designated corporate goals are targeted with these incentives. The performance component would apply to all positions not currently included in the VHA Incentive Pay Plan for senior executives.

Total Pay. The combination of these three bands would be targeted to achieve average compensation targeted to the applicable reference point. Individual income levels would vary according to seniority, clinical experience, and productivity. The system should offer the potential for senior staff to achieve income parity with average AAMC physician associate professor salaries and net dental private practice income. The ceiling on physician pay would be an absolute maximum of 75 percent of the AAMC Professor benchmark (for direct caregivers and first level supervisors) or $400,000, whichever is lower. For dentists, the cap would be the average net dental private practice income.

Proposal for a Three-Tiered VA Physician and Dentist Compensation Model



Cost Estimate

These proposals for market-based pay would cost an estimated $1.5 billion over 10 years (assuming half-year costs in first year of implementation). The cost is based on full parity with the proposed benchmarks as of FY 2001. These costs would be offset by an estimated $0.9 billion is savings from reduced contract and fee basis expenditures over 10 years. The net total cost estimate is $636 million over 10 years.

2002 QUADRENNIAL REPORT REVIEWING COMMITTEE

REPORT FOR THE QUADRENNIAL REPORT TO THE PRESIDENT ON PHYSICIAN AND DENTIST COMPENSATION

Introductions and Group Goals

The Committee met at 8:00 a.m. on Monday, May 20, 2002.

The meeting started with a general review of objectives for the next 2-1/2 days. The Committee was to review the contractor's recommendations and make recommendations for a new pay system for VA physicians and dentists. The Committee also considered specific issues of recruitment and retention, benefits, duty and leave, and the relationship of VA staff to affiliates.

The group outlined the following problems with the current pay system and the desired changes:

- The current pay structure, in which the annual cost-of-living adjustment is granted only on the basic pay, causes VA salaries to fall behind the rate of inflation. Physicians and dentists receive only the basic pay increase, not the locality component, so their increase is smaller than the rest of the Federal workforce. And, because the increase is computed only on basic pay, not special pay, the actual net increase is even smaller. For the average VA physician who is making about $145,000 per year (approximately $100,000 in basic pay and $45,000 in special pay), a 2.3 percent increase is diminished to 1.6 percent.

- The method of determining the amount of increase in physician and dentist salaries also causes noncompetitive pay. The annual pay increase is determined by a formula linked to the overall US Employer Cost Index. This measure does not reflect changes in healthcare salaries, which have increased more quickly than U.S. average wages overall. Through most of the 1990s, the relative stagnation of private healthcare compensation enabled VA pay to maintain its relative position and minimize the gap with non-Federal salaries for an extended period. But, when specialist incomes started to climb dramatically in the late 1990s, the limitations of the current pay system and the adjustment formula became all too apparent. For dentists, the enactment of P.L. 106-419 restored some parity to the VA salary structure. The result of that legislation was to more than double the total amount of special pay received by VA dentists, but many felt that it did not provide the impact or flexibility needed to recruit many of the dental specialists.

- Due to the limitations in the current system, there is insufficient flexibility to respond to regional variations in income for individual specialties. Because VA salaries are so

uncompetitive for many specialties, the geographic location component of special pay is used universally in order to make competitive salary offers to these specialists. Thus, VA must pay the same maximum amounts possible to invasive cardiologists, radiologists, and surgical sub specialists alike across the country in an attempt to compete.

- VA's ability to recruit and retain these healthcare professionals would benefit from a pay system that is responsive to market forces and provides more regional variance. The historical benchmark for VA pay setting is the American Association of Medical Colleges (AAMC). There is fairly significant regional variance in AAMC compensation. VA should have a pay system that better tracks its benchmark and partner in medical education.

- There are and will be physician and dentist shortages, most analysts agree. What is at issue is how large the shortages will be. The shortages will be most noticeable in the specialties, at least in the short term. Additionally, the shortages will vary significantly by region. The availability of labor and the salaries will be unique to each area of the country, so VA's system must be flexible enough to respond appropriately.

- The benchmarks that VA uses for pay setting and the system itself must be sufficiently flexible to address compensation needs in extremely rural and isolated locations, community-based outpatient clinics, major tertiary care medical centers, and staff to provide future mandates in dental and other medical care.

- An additional recruitment issue is the amount of education debt accumulated by physicians and dentists. Many professionals now come out of residencies with over $100,000 in education debt. VA must be able to fully fund and use its student loan repayment program to compete with the private sector.

- Along with any change in the physician and dentist pay system should come increased emphasis on linking pay to performance. A key outcome and benefit of changes in the system is performance-based pay, which will support organizational performance improvements, such as, reduced waiting times, sensibly increased productivity, and customer satisfaction. Quantitative and qualitative measures are available for many programs – research, panel size, VISN 12's mental health measures, CMS reimbursement rates, etc. There are a number of initiatives and locations where such a system could be piloted.

History of Physician and Dentist Pay System

The current base pay structure for VA physicians and dentists has its roots in a law enacted in 1946. Prior to that time, VA physicians and dentists were employed under the Medical Servic pay system and were compensated according to their level of professional responsibilities and rank within the organization. Extensive hearings and investigations of the quality of

medical care provided concluded that this system was the primary deterrent to recruiting and retaining the caliber of physicians with the professional capability to provide quality medical care. With the passage of P.L. 79-293, January 3, 1946, the "Organic Act of 1946," the Department of Medicine and Surgery was created and base salary rates set equal to the then-existing statutory pay rates for professional employees. The range of pay was as follows:

Grade		Professional		General Schedule	1945 Salary
Junior	=	P-3	=	GS-9	$3,640
Associate	=	P-4	=	GS-11	4,300
Full	=	P-5	=	GS-12	5,180
Intermediate	=	P-6	=	GS-13	6,230
Senior	=	P-7	=	GS-14	7,175
Chief	=	P-8	=	GS-15	8,750

In addition, the Act provided for a 25 percent specialty allowance for physicians in addition to the rates of basic pay. The limitation on total pay was $11,000.

Rates were adjusted over time, with a 10 percent statutory pay increase in 1958, which was offset by a reduction in the specialty allowance from 25 to 15 percent. The maximum payable rate at that time was $16,000.

The "Federal Salary Reform Act of 1962," P.L. 87-793, eliminated the 15 percent specialty allowance for physicians, and formally linked the VA physician pay scale to the General Schedule and Foreign Service pay rates. By that year, the minimum hiring rate for VA physicians was $8,045, with a maximum payable rate of $18,405.

VA's physician pay structure was then totally inadequate to recruit and retain qualified staff. A 1966 Task Force recommended a complete salary overhaul, which was not pursued because of the requirement for separate legislation. By 1970, the maximum payable rate for a staff physician was $29,752, with no additional pay provided.

Finally, in 1975, special pay was reinstated by the "Veterans' Administration Physicians and Dentists Comparability Act of 1975," P.L. 94-123. Prior to enactment, there was great debate about the need to extend special pay to VA dentists, given the less severe staffing difficulties, fewer foreign-educated dentists, and the lower vacancy, turnover, and part-time employment rates for that profession. The decision in Congress was to include dentists in the special pay provisions, but at only 50 percent of the amounts proposed for physicians, in order to prevent a deterioration of the staffing situation to the depths then experienced for physicians. This law provided special pay of up to $13,500 for full-time physicians ($6,750 for full-time dentists), which, when added to the maximum base pay permitted of $36,000, enabled VA to pay salaries approaching those offered by other Federal agencies. These amounts of special pay were increased again in 1980 to a maximum payable amount of $22,500 for physicians ($10,000 for dentists), where they remained until the enactment of P.L. 102-40 in 1991.

The maximum payable amount of physician special pay increased from $11,000 in 1946 to $22,500 in 1990, an increase of 204 percent. During that same period, the Consumer Price Index increased 622 percent.

Current Physician and Dentist Pay System

With the enactment of P.L. 102-40 in 1991, the amounts of special pay authorized were significantly increased for physicians with a modest increase for dentists. However, this law did not modify the base pay amounts.

The base pay amounts of VA physicians and dentists are linked to the General Schedule grades of GS-11 through GS-15, and the old GS-16 to GS-18 grades (superseded by the establishment of the Senior-Level and Scientific and Professional pay scales in the "Federal Employees pay Comparability Act" of 1990. All pay rates, except for that of the position of Deputy Under Secretary for Health are capped at the rate for Executive Level V (EL-V), currently $121,600.

Thus, although a number of the title 38 statutory grades are comparable to the Senior Executive Service, their pay is not. The Senior Executive Service base rates are capped at EL-IV, currently $130,000.

The effect of this limitation is to compress significantly and, in many cases, eliminate the pay distinctions among the grade levels for physicians and dentists. At the field level, the difference in base pay between a staff physician and the Chief of Staff, the senior clinician for a facility, is only $6,621, or less than 6 percent. This is less than the Title 5 and 38 systems guarantee individuals on promotion from one grade to a higher level. The difference between a staff dentist's base rate and that of a national clinical program director is just $14,243, or 11.7 percent.

VA base rates offer little incentive for physicians and dentists to take on increasingly complex and responsible assignments. Further, this pay compression serves as a significant impediment to the recruitment of scarce specialists. The base pay for all specialties -- radiologists and internists, general dentists and oral surgeons – is the same. This base pay system is completely delinked from the prevailing practice elsewhere in the health care industry, which determines compensation levels by clinical specialty.

Despite the low levels of inflation in the 1990's, compensation for VA physicians and dentists did not keep pace with inflation. The primary reason for this is that the annual comparability adjustment is computed on basic pay only, while special pay constitutes approximately one-third of physician and dentist total compensation. Further, these individuals did not receive the annual locality comparability payment, which has accumulated to over 10 percent on average since its inception in 1994.

The current system of special pay also erodes VA's competitive position over time. The amounts of special pay authorized for physicians have not been adjusted since 1991 and are

no longer competitive for many specialties and categories of physicians. After 1991, physician staffing stabilized or improved in most medical categories. However, VA's current competitive situation is eroding in many areas of the country and will continue to erode due to the current limits on special pay amounts. The amounts of special pay have increased only fractionally since their inception in 1975.

Special pay has followed a saw tooth pattern of steep adjustments, stagnation and decreasing value due to inflation, followed by another jump that only temporarily provides adequate compensation.

It is proposed that the VA pay system be changed to provide long-term viability and competitive compensation, and to more accurately reflect the varying income levels of the different medical and dental specialties, and to provide meaningful financial incentives for quality and performance.

New Pay System

The Reviewing Committee supports the contractor's statement that VA does not recruit for a physician or a dentist. Rather, VA recruits for individuals with specific clinical training, whether it is prosthodontics, general surgery, or whatever. However, the Committee did not believe that variable base pay, essentially special salary rates for each clinical specialty by location would be an efficient option. The proliferation of nurse pay schedules under the Locality Pay System, with 600 different pay scales throughout the Nation, is a clear example of the complexity that would result. The multitude of multiple physician pay scales that would be required, according to duty location, clinical specialty and subspecialty, would become a burden to maintain and administer.

Instead, the Committee proposes a pay system with three tiers:

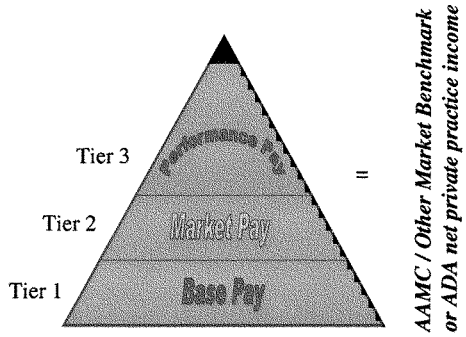
- A single pay range for basic pay

- A local comparability band indexed to the AAMC salaries for staff physicians and first level supervisors (see below for the proposal for dentists)
  -- OR --
  A local comparability band indexed to healthcare employers (ACHE and ACPE) for facility, Network, and VA Central Office executive assignments

- Performance pay component tied to achievement of specific corporate goals and individual performance objectives

Total Compensation Target. The overall target for total compensation from these three tiers would be the 50th percentile of the AAMC Associate Professor salary for experienced physicians. The maximum payable rates would be $400,000 or the 75th percentile of the AAMC Professor salary, whichever is less. No VA physician compensation could exceed that level.

Proposal for a Three-Tiered VA Physician and Dentist Compensation Model



A portion of AAMC total compensation includes practice income and is directly impacted by individual productivity. Also, the rate of increase in average incomes is quite steep as individuals progress through the academic hierarchy from Instructor to Assistant to Associate and finally Professor. It was noted that VA pay progression over one's career is relatively small. Thus, VA pay is very attractive at the entry levels when compared to academic compensation. However, the rate of growth in VA income over time is much flatter than the rate in the AAMC and private sector salary surveys.

The goal of this new system, then, is to offer the potential for more substantial increases in compensation in the early stages of employment. The contractor's report noted this threat to departure by physicians and dentists early in their careers. The critical juncture point in employees leaving is at 5 to 7 years of service, and, to a lesser extent, at 11 years of service. The VA compensation structure should be more flexible to offer the financial incentives to retain individuals at these critical decision points.

The overall objective is to offer a compensation system that is fair and equitable, market- and performance-driven, and flexible enough to address current and future needs. The AAMC salary data, along with other benchmarks like HMO, ACPE, ACHE, etc., would be procured, developed, and disseminated from a central source.

Special Consideration for Dentists. It is noted that the American Dental Education Association (ADEA) compensation data are not valid benchmarks for VA dentist compensation. Over 90 percent of all dentists are employed in private practice, and that setting is what VA must compete with. It is suggested that the more appropriate measure and target for VA compensation should be net private practice income for dentists. The maximum payable level would be 75 percent of the net dental practice income.

First Tier – Basic Pay

The first tier of the new pay system would be a pay band ranging from a minimum of roughly equivalent to Chief, step 10, with a maximum of Executive Level V, currently $121,600.

This base pay tier would consist of a single grade. Once an individual's base pay is set, there could be no reduction.

Upon initial employment, staff and service chief physicians and dentists would be evaluated for employment against a basic qualifications standard that establishes the requirements for appointment to VA: licensure, English language proficiency, etc. The rate of basic pay would be recommended by a Professional Standards Board (PSB) according to an assessment of the individual's training, education, and experience.

The basic pay band will offer the added potential for individuals to progress through the range and receive longevity increases. Individuals would receive increases to their rates of basic pay based on a supervisory request and PSB recommendation for advancement to a higher rate. These evaluations would be conducted when deemed appropriate, with an assurance of consideration after two years.

An advantage to a single grade level of basic pay for all assignments and positions is the flexibility to reassign and move people as needed. As noted earlier, VA faces significant workforce stresses, and this flexibility to reassign people without impacting their rates of basic pay will facilitate restructuring.

This pay range for all physician and dentist assignments would cover every position except the Under Secretary for Health and Deputy Under Secretary for Health -- positions that are currently authorized rates of basic pay equivalent to the rates of EL-III and EL-IV, respectively. Because rates of basic pay for all other assignments and grades are currently limited to EL-V, this would be no change from current practice.

Individual basic pay rates and the pay bands would receive the statutory annual cost-of-living increases as mandated by Congressional action and Executive Order.

Second Tier – Market Pay for Clinicians and First Level Supervisors

The second tier of pay would be the market component. The Reviewing Committee recommends that this component of pay be based on clinical discipline and duties. This component would be determined according to location, specialty, experience, education and qualifications, etc. This portion of physician and dentist pay offers the possibility for best capturing position-specific and practitioner-specific total pay.

This second tier would not receive automatic COLA adjustments; there would be no automatic inflation protection. Instead, the amounts paid to each specialty at each location would be reviewed and adjusted annually based on local market changes. This tier would be sensitive to changing compensation levels in the reference community. When the community and specialty incomes increase significantly or decline, this tier would reflect those changes.

The concern for how to deal with decreases in average compensation levels in the relevant indices, which would be reflect in turn in the market tier, was discussed at length. On one hand, there should be equal opportunity for gain as well as risk of loss in a downturn, that a balance of benefit and risk should be present in the new system. On the other hand, no other Federal pay system holds the threat of reductions in pay. The preference is that competitive market forces would hold sway and cause adjustments – whether positive or negative -- to the locality tier.

It was also noted that the Federal sector is not like the private sector, and that this difference is what attracts many individuals to Federal employment. The group was very sensitive to retaining the features of VA employment that are attractive to candidates – a certain cushion from the most severe market forces, while also offering the potential for more market-sensitive pay.

The concern, then, is how to implement decreases in the market component of pay: One option is to place a limit on the size of increase and decrease from year to year, perhaps in the range of a 10 percent cap. Another option is to freeze the individual amounts of the market tier for current employees, and set reduced market payments for new hires only. There was no consensus on this question.

The primary benchmark for setting the market or second tier of pay for physicians will be the AAMC salaries, in recognition of the fact that an estimated 75 percent of VA physicians hold faculty appointments. In areas where HMO penetration and large practices are a significant portion of the local market, those salary benchmarks should be used as well. For dentists, the primary benchmark for determining the amounts of this market tier is will be net private practice dental income.

Determining Payable Amounts in the Second Tier. The Group discussed the various options and methodologies for setting and adjusting the payable amounts in this second tier. It was generally agreed that a uniform, rigid system of automatic increases based on seniority was not in VA's interests, but that there should be recognition of years of experience by factoring career growth into the second tier. Just as there is clear income growth within the AAMC data as individuals progress from junior faculty to Assistant and Associate and then full Professor rank, there should be appropriate increases in income as individuals gain in experience. This benchmark would apply to staff clinicians and their first level supervisors. The group felt that it is at this level that the duties are most directly comparable to AAMC positions.

First level supervisors at the service chief and equivalent level are working supervisors and continue to perform significant amounts of clinical work. The group proposes that these individuals continue to be paid under the market system, with some factor added in for their supervisory responsibilities. Chiefs of larger and more complex services would be expected to receive greater credit for their supervisory responsibilities because of the larger and frequently more complex responsibilities.

The Reviewing Committee recommends, just as is the case under the current system of physician and dentist special pay, that the market tier is locally determined according to individual qualifications and experience, academic achievements, teaching performance, research grants and overall funding, publications, professional accomplishments, membership in professional societies, and other achievements.

The members offer one option for how this system might be implemented at the local level:

- A Professional Standards Board (PSB) evaluates each candidate for employment, just as is currently done. The PSB evaluates the individual's qualifications and experience against established criteria, much like the current qualifications standard. From this evaluation, the PSB recommends a basic pay amount within the pay band, as well as an amount of market pay, if appropriate, according to the assignment, specialty, individual qualifications, and geographic location, as related to the AAMC regional pay data. The distinctions in pay amounts would be based on education, training, achievements, duties and proposed scope of practice.

- These evaluations would be repeated when the individual's assignment or qualifications and scope of practice change significantly.

- The PSB recommendations would be submitted to the COS and facility Director for consideration. The PSB recommendation would not be binding, but the COS and facility Director would be required to advise the PSB why their recommendations were not adopted.

- Annual or periodic adjustments to the market tier would be determined by the COS or facility Director, based on an assessment of community trends in physician and dentist availability, increases or decreases in overall compensation levels for the clinical discipline, and competitive pressure to recruit and retain individuals for VA's needs.

A concern was raised over the potential for VA to inadvertently pattern its compensation structure on a biased pay system, as some members of the AAMC have had to defend their compensation practices against charges of gender discrimination. The Committee recommends that VA conduct retrospective studies of overall compensation levels within VA to guard against any potential for disparate impact.

While there would naturally be variation in compensation within a specialty according to experience, training, and privileges, real distinctions in compensation will be due to the results of the third, or performance-based, pay tier.

Second Tier for Managers and Executives

Clinicians in these leadership assignments provide benefits to the organization: they bring the clinical perspective and awareness to health care management. They bring different

values. It is understood that individuals in these executive leadership positions would earn less than the most highly compensated specialists and service chiefs involved in direct patient care. However, this pay inversion is common in the private sector, and reflects conscious career choices by clinicians to enter the management track.

For positions at the COS or equivalent level and above, the Committee agreed with the contractor that management positions should be delinked from the clinical discipline pay scales. Management assignments would use the ACHE and ACPE salary surveys as their benchmarks for pay comparability. Management positions would not receive the clinical market tier, but would receive a management component instead. Individuals electing this career path are clearly stepping off the clinical specialty track, as stated by the contractor and agreed to by the Reviewing Committee. The Committee recommends that the pay levels for these clinical management positions of COS, facility director, and network director be benchmarked to Medical Director of large institutions and Vice President for Medical Affairs, Hospital Administrator, and CEO of healthcare systems, respectively.

For COSs, there should be a policy against salary stipends except in the most unusual situations. Individuals in COS positions must be able to function fully as VA's representatives. However, that may mean that VA must pay significantly more to compete to recruit retain the caliber of individual needed for these key management positions. A pay band affording a range of up to $225,000 or $250,000 would be consistent with current salary data for Chief Medical Officers.

The pay range for clinical leadership positions should be broad enough to cover the range of facilities – from outpatient clinics to multi-site tertiary referral centers, at all locations. The amounts would be determined according to number of beds, affiliations, research activity, nursing home care units, recruiting difficulty, cost of living, etc. This broad band should provide for compensation ranging from $160,000 to the maximum noted above.

For the position of facility director, the benchmark should be a hospital CEO, as reported in ACHE and ACPE surveys. It is recommended that the center director's compensation be no lower than that of the COS. The total compensation afforded to these positions should be in the $180,000 to $230,000 range, consistent with the salary findings by HayGroup for non-physician hospital directors. Because these positions often serve as the recruiting pool for headquarters and network assignments, competitive pay to attract and retain high performers is a critical factor in VA's succession planning.

The pay bands for network assignments, such as Chief Medical Officer (comparable to a regional COS) should be benchmarked to the pay for an HMO Clinical Manager or Vice President of Medical Staff at a very large hospital.

Pay for the VISN Director position would be tied to generally the same benchmarks, with a guarantee that VISN Directors earn no less than the facility directors supervised. The VISN position is a valuable development setting for VHA's future top leaders. Retention strategies need to be key in constructing any compensation scale.

The group could not come to any consensus on a pay system for headquarters positions, given the variations in assignments. Recruiting for executive assignment in headquarters is acknowledged to be very difficult, due in large part to an expensive housing market, career uncertainties, the challenges of dealings with other agencies and branches of government, etc. With these factors and tight budgetary situations working against recruitment success, the case for change is made.

One proposal is to benchmark pay for clinical program directors at the AAMC national mean for Chairs by specialty. VA could then use as benchmarks for the higher positions in the organization the AAMC salaries for Presidents, Deans, and Associate Deans of medical educational facilities for other headquarters assignments. Alternatively, the pay setting could flow from the top down, with the pay level for the Under Secretary for Health setting the start point, with pay for the other positions cascading from there. A third approach would be to link headquarters pay levels to the salaries established for field assignments of facility and VISN directors, with incremental increases according to the rank of the positions. A final approach is to simply continue the current system, but provide for full cost-of-living protections through annual COLA increases on all components of pay.

These benchmarks are suggested, but there is no consensus among the group. The Committee was very sensitive to the political considerations over the levels of compensation needed to reach a reasonable percentage of the benchmark, and was concerned not to make a recommendation that would jeopardize the larger proposal of pay reform for field clinicians. The group defers to the Under Secretary on this difficult and politically sensitive issue. The total number of positions under consideration here is no more than 250.

Determining Payable Amounts in the Second Tier. The proposal is that Network Directors, in consultation with the Chief Medical Officer for their networks, evaluate and set the COS pay.

For physician and dentist facility directors, the members suggest a structure for the pay bands like the pay system for SES facility directors – four levels within the band, determined according to the facility complexity. The level within a band would be proposed by the Under Secretary and approved by the Secretary.

Second Tier for Other Assignments

The Reviewing Committee considered how to deal with other types of assignments and positions that do not involve direct patient care or clinical management, such as research, QA, evaluations and assessments, informatics, teaching, etc. For these assignments that have little or no direct patient care responsibilities, the salary benchmarks could be based on the industry compensation for the skill, without regard to whether the benchmark is for a physician or dentist or not. Amounts in the Market tier for individuals in these assignments would be determined in the same manner as for clinicians and first level supervisors. For those individuals in these kinds of assignments performing only some clinical patient care duties, their market component would reflect a portion of their clinical discipline.

Third Tier – Performance-Based Pay

The results of the 2001 All-Employee Survey showed that the majority of employees were dissatisfied with current award and recognition practices, and do not believe there is appropriate recognition of high level performance. This proposal will, we believe, address many of these concerns.

This third tier of performance-based pay would be offered to all employees and managers through the COS level. (Individuals in facility director and Network assignments participate in a performance awards pool comparable to the Senior Executive Service awards.) Each individual's performance goals would be defined at the beginning of the year, and linked to specific corporate goals and objectives, quality, cost effectiveness, revenue generation, patient satisfaction, and productivity measures. The achievements would be discrete and measurable. The goals could be changed annually according to the desired achievements.

The Committee proposes that there be guidance provided from the national level on suggested measures and performance standards and how to use them. However, the manager and employee would decide jointly the specific goals established for each clinician. The group believes that this proposal offers a unique opportunity to cascade the national and Network performance goals down to the individual clinician. This vertical symmetry linking individual employees' efforts to VA's corporate goals and strategic objectives can serve as a model for the rest of the Federal Government.

The Committee expects that the targeted organizational performance elements will change over time, as data systems improve and as organizational objectives change. To illustrate this, as waiting times are brought down to acceptable levels, another corporate goal will become the focus. This feature is one of the strengths of the system. It provides flexibility to adapt the incentives to changing corporate goals and permits adding in new measures according to evolving forces and issues. This ensures the continued vertical alignment of the organization's strategic goals and performance systems.

There is a great potential for motivating and rewarding desired behaviors and achievements. However, the group also recognized the potential for unintended consequences: if the bonus is based on increasing the numbers of patients seen to reduce waiting times, there could be an effect from primary care physicians increasing panel size and creating bottlenecks elsewhere in the system through unrestrained growth. Therefore, there needs to be careful balance of appropriate measures, careful selection of what activities are measured, and analysis of how those behaviors will impact other portions of the system. VA has shown that clinical practice guidelines change behaviors. It is expected that performance standards tied to productivity pay will have a similar effect.

VA can learn from the current experience with network director performance contracts. There is an effort in FY 2002 to build corporate goals in the areas of physician order entry and compliance. To this effort VA should add discipline-specific sample measures,

developed jointly by VHA's Performance and Quality Office and the individual clinical offices. These prototype performance standards would be adopted and modified locally, as appropriate, in response to the local drivers of access, quality, and satisfaction. The VHA-wide corporate competencies in the High Performance Development Model (HPDM) could be included as basic universal performance standards. However, given the reliance on subjective evaluations of these 'soft' skills, they should be included only as pre-conditional performance elements that clinicians must pass to be eligible for the third tier bonus payout.

It is suggested that VA immediately begin testing performance measures to assess data systems, appropriate performance goals, and the results of targeted performance measures on the system. Another element that could be studied during this test phase is to evaluate how individual clinicians' performance can be rolled up into performance elements and a third tier payout for first-level supervisors and Chiefs of Staff. These performance results could be further aggregated to assess performance of facility and network leadership positions. A trial period will facilitate the assessment of measurement systems, performance standards, and will help eliminate any unintended outcomes.

One consideration in any performance-based system is the limitation in current data gathering technologies and statistics. The validity of VA data at the individual clinical level is a major concern for the Committee, which recognizes that support for this proposal will come only with reliable, impartial metrics and methodologies. The current limitations in data collection for specific data elements may impact what is measured and how the behavior is rewarded. For example, the issue of waiting times is an important performance element, but the data are available only to the facility level, and may not be able to be linked to individual clinicians in a meaningful way. One response to this sort of impediment is to establish group performance pools for some or all of the targeted organizational goals. This practice would reward teamwork and acknowledge that organizational success can be achieved only through the cooperation and efforts of all employees.

It is acknowledged that factors beyond the individual practitioner's control can impact productivity and performance. For instance, third party reimbursements may depend as much on the competence of the coding clerk as on the physician's patient notes. The experience and number of support staff also impact productivity of service providers. The group recognizes that clinicians' performance is directly affected by the actions of others. A long-term goal should be to expand the productivity bonus pools to entire teams of caregivers, including physician extenders, support staff, etc., whose work performance is critical to achieving organizational improvement.

Finally, VA values many actions, such as resident teaching, committee memberships, and other corporate goals that need to be included in any balanced scorecard of individual performance. The Reviewing Committee believes that any performance system must include all these elements to truly add value.

It may be appropriate to exclude new hires from participation in the third tier in their first year of employment. It is expected that the supervisor would have difficulty establishing reasonable performance objectives for individuals in their first year, and that the clinicians

would have little opportunity to achieve those performance goals during their period of adjustment, orientation, and settling in. It is noted that AAMC Instructor salaries for new hires (less than 1 year) are significantly below those for Assistant and Associate Professor positions.

There was a question whether the clinical quality and performance measures should be absolute or relative. The group believes that the standards cannot be absolute. For instance, it is well understood that patient satisfaction correlates to health outcomes – patients in poor health are generally more dissatisfied with their care, despite no deficiency in the quality of that care. The group agreed that any clinical quality measures should be tied to the relative risk in the patient populations. In these instances, patients are unhappy with their health situation, and that dissatisfaction may extend to the caregivers. So, it is important that the measures and standards recognize and be sensitive to the individual patient circumstances.

The Committee proposes the following implementation strategy for the performance tier: that the performance negotiations cascade to the next level of the organization. That is, the Network Director negotiates specific performance goals with the facility directors and COSs, who in turn cascade these performance expectations to and develop specific targets for the next level in the organization, the service chiefs. Service chiefs and first level supervisors then negotiate individual performance contracts with the clinicians under their direct supervision. Such a system will require supervisory training in how to establish valid performance measures, negotiate performance expectations, and evaluate and explain results to employees.

Determining Amounts of the Third Tier. The Reviewing Committee was very concerned about making the performance component large enough to provide a meaningful incentive and distinction in performance among practitioners, but not so large as to create financial distortions within the system or undue administrative burdens. The members discussed various amounts, in both relative percentage and absolute dollar amounts. While a performance bonus of 15 percent or more would certainly focus employees' efforts on achieving specific outcomes, it might also lead to increased employee complaints and disputes over performance measures. Also, whether the target bonus amount is stated as a dollar or percentage figure will affect the significance of the bonus to practitioners depending on their overall income levels. A uniform percentage amount would result in potentially very large productivity bonuses for the most highly paid specialists. The final consensus was to set the target performance amount at no more than $10,000 per individual.

The group believes that this amount will provide sufficient reward and motivation, while keeping the amounts in question within reasonable comfort levels. This amount will be part of the overall compensation target, and will be truly at risk, paid only for clear, measurable achievements. The members believe that, over time, the amounts of pay in the third tier can be increased, with the guaranteed portion of pay becoming a smaller and smaller part of the VA compensation package, to create incentives to drive desired behaviors and outcomes.

There is the potential for concern about the influence of a financial competitive incentive on the VA social system. The transition to this new incentive system could prove difficult in a

large system like VA's. This underscores the need to pilot and test measures before full implementation. VA must ensure that the structure is there to support the performance measures and assessment.

The timing and mechanics of the bonus distribution need to be worked out, especially for individuals who come and go throughout the year. One option is to pay out the bonus at the end of each fiscal year. Another option is to make quarterly assessments and regular payments throughout the year. However, the more frequent payout could be potentially disruptive to the workforce and create additional administrative burdens. In any event, there should not be a financial incentive for clinicians to stay simply for the bonus payout, especially when their services are no longer required. And, individuals who decide to leave during the year should not lose out on any bonus they've earned simply because of the timing of their departures.

This third tier of performance-based pay is a radical departure in Federal compensation systems. However, the members believe that this proposal can achieve the motivational success through an assurance of a certain income level, with the potential for an additional amount based on personal performance.

A number of measures and performance objectives are offered by the Committee members as suggestions for the guidance that would be issued from headquarters as part of the implementing instructions for this new pay system. The Committee recommends that there be some agreement on typical measures, that they be tied into corporate goals and objectives, and that they be publicized as examples. But the specific measures agreed to for each clinician will be negotiated locally. The members recommend that every award be tied to the performance, quality of care, and productivity of each practitioner. The Committee's suggested measures can be found in Appendix C of this report.

Transition to the New Compensation System

The Reviewing Committee recommends that, as part of the enactment of this proposal, there will be a guarantee that no current employee's pay will be reduced as a result of conversion to the new system. As was provided in P.L. 102-40 setting up the current special pay system, the legislation for this new system should carry a statutory protection for physicians and dentists employed at the time of enactment from any future reduction in their total compensation level. Their current base and special pay amounts would be guaranteed to them. In addition, they would be eligible for any increased pay that the new system may provide, as well as participation in the third tier of performance pay.

It is projected that this guarantee will apply to the majority of VA physicians and dentists, at least at first. For most physicians and dentists, current compensation levels are generally competitive, especially when balanced with VA's provision of malpractice coverage, paid leave, employer-sponsored health insurance, continuing education support, reasonable work hours and minimal call rotations for some, and opportunities for teaching and research. All individuals, including those not receiving additional compensation under this new system,

would participate in the performance-based third tier, offering them the potential of increased compensation based on performance achievements.

All new hires would be paid according to the new system's rules.

Cost Estimate

This proposal offers market-based pay to all physicians and dentists. It will increase pay for only some VA clinicians, however. These costs will be offset at least partially by savings in contract and fee basis expenditures due to improved efficiency and productivity, as well as improved ability to recruit and retain providers through more competitive salaries, which cost less than the scarce specialty contracts. While some of these savings and reductions in other expenditures can only be estimated, they will definitely occur.

The direct costs of this proposal are estimated at $69.4 million in the first year, based on implementation in third quarter of FY04. That cost represents $62.2 million for the current physician clinical workforce, $2.5 million for the dental clinical workforce, and $2.2 million for the management/executive cadre.

Offsetting these costs are an estimated savings of $20.9 million in the first year. That figure is based on an estimate of $14.5 million in productivity savings, which is computed as 25 percent of the difference between the costs of staff and contract services, by specialty. Additional savings of $9.9 million in contract expenditures (half-year) are based on 10 percent of the physician scarce specialty contracts *only for the specialties that are estimated to receive higher salaries.* An additional $4.7 million would be saved in physician fee basis and consultant expenditures. This figure reflects 5 percent of the on-station expenditures for fee and consultant and attending services. A lower percentage is used because the fee basis accounts include nursing expenditures. The savings for dentists are estimated at $0.7 million for reductions in fee basis expenditures. There are no contract or fee expenses associated with management positions, and thus no savings estimated.

The net total annual cost is estimated at $48.5 million in the first year, and $636 million over 10 years. Refer to Appendix D for a detailed cost estimate.

Other Elements of a New Compensation System

Benefits. The broad topics are mentioned here as side notes only. Specific proposals to change employee benefits and services to enhance recruitment and retention will be addressed in separate legislation. Some of these issues were noted earlier in the discussion of recruitment and staffing issues. Additional issues include:

- Rules for crediting physician and dentist pay to retirement. The rules in Title 38 governing vesting of all income only after 15 years and the 8-year phase-in for full vesting of pay are disincentives to recruitment.

- Cafeteria-style benefits. The opportunity to select from a menu of options, and pay for them with pre-tax income, is more and more common throughout the non-Federal sector. VA needs to offer a similar package to be competitive.

- Employee retirement savings. Because the pay system for physicians and dentists will be dramatically different from the rest of the Federal workforce's, and because they defer income-producing employment longer than most other professions, it is proposed that they should receive a different benefits package. One area in which VA practices are noncompetitive with the private sector is retirement savings. The issue of income replacement in retirement is a critical difference between the VA and non-Federal physician and dentist retirement plans. Social Security income and FERS annuities will represent only a fraction of these individuals' pre-retirement incomes. VA employment would be more competitive if these employees could make larger personal pre-tax contributions to their personal retirement savings accounts, as is generally permitted in the academic and private sector. The employer match would not increase, but physicians and dentists would be permitted to place a larger share of their pre=tax income in TSP-type investments.

- Equitable employer share of health premiums. The Federal Health Benefits Program is a major recruitment tool for these individuals, who, in the private sector, generally purchase their own health benefits. However, the Federal Government unwittingly subsidizes the premiums of certain part-time employees. The Reviewing Committee recommends that the employer share of health insurance premiums be proportional to the individual's work time of all part-time physicians and dentists, including those with tours of less than 16 hours or more than 32 hours per week.

- Dental insurance. The Federal Employees Health Benefits Program should offer group dental insurance as a separate purchase option for employees, whether or not there is an employer contribution to defray the costs of premiums.

- Disability insurance. The Federal Government does not currently offer any disability insurance program to its employees. Employees must qualify for and elect disability retirement (with eligibility limited to individuals with a minimum number of years of service).

Hours of Duty and Leave. The members offer a number of recommendations to improve the utilization of physicians and dentists, and to recognize the different work situations in which employees now find themselves.

Charging full-time physicians and dentists for absences on non-duty days is a deterrent to recruitment and retention. The system creates coordination difficulties for full-time employees with appointments at the medical schools, which operate under a different leave system. It serves as an impediment to recruitment of new employees. In recognition of the likely reduction in the amount of leave charged to these employees as a result of this change, VA should consider reducing the annual leave accrual rate from 30 days to 26 days.

Another significant impediment to efficient VHA operations and use of staff are the current rules and requirements for scheduled part-time tours. While VHA should retain the option of regular part-time tours for some clinic operations, greater flexibility in scheduling is needed to promote the efficient use of proceduralists, to accommodate seasonal workloads, and to recognize the significant time demands of resident supervision/rotations. The group recommends that a second option for part-time service be established, whereby individuals contract with VA for a level of service, an annual time commitment. These individuals would then receive a regular biweekly payment equal to 1/26th of the negotiated compensation. VHA would maintain attendance records accumulating the hours worked to assure that VA is receiving the services paid for. This approach would significantly enhance recruitment and retention of part-time employees: VA would pay for the work to be performed, according to a specified level of service, not according to time. Under this scenario, on-call coverage could be established in the performance contract and the negotiated level of service. Those hours would not be counted in the total work commitment. This change will enable VA to offer regular income to part-time physicians and dentists, while maximizing VA's ability to meet varying patient care demands.

This proposal would standardize the pay for all individuals, full-time, part-time, and seasonal. Because there would no longer be special pay as we know it, the issue of appointments in excess of 1 year for receipt of special pay would become moot. Also, this proposal would address the problem of part-time employees whose work demands fluctuate significantly over time due to resident supervision or duty as MOD. One example of how this would work would be that a part-time gastroenterologist is hired for 2/8ths. The individual might be called on to work extensively providing resident supervision for a period of weeks, coming in to perform additional specific procedures as needed, and taking a weekly clinic of an hour, with the sum of these responsibilities equaling 520 hours over the year.

The members also suggest that VA might benefit from converting from a system that counts work time in eighths to the decimal system. This change in salary and work hour computation will offer greater flexibility in scheduling and work hours.

The Reviewing Committee members also recommend that there should be recognition of the additional time commitments that many physicians and dentists – whether full-time or part-time -- provide to veteran care by taking holiday, evening, and weekend call, and serving as MOD and Admitting Physician. Rather than establishing a separate pay component for this service, the frequency and extent of on-call coverage should be a factor in the setting of the market/specialty tier of pay.

VA's Relationship with Affiliates. Dr. Stephanie Pincus, Chief Academic Affiliations Officer, presented information regarding the relationship between VA and its academic affiliates.

- The relationship between VA and the affiliate appears to be highly variable and dependent upon the medical school, the clinical discipline involved, and, most importantly, the "local culture."

- The frequency of full-time VA employees also having faculty appointments with the affiliates is generally in inverse proportion to the number of part-time staff holding faculty appointments.

- No specific data are available for the prevalence of faculty appointments throughout VA.

- VHA executives polled concerning the advantages and disadvantages of faculty appointments for VA physicians were universally supportive of the practice, and felt that the advantages to VA were significant. Most commonly mentioned as the major benefit to VA was the enhanced ability to recruit and retain physician staff, especially in the highest income specialties. Without faculty appointments, the consensus opinion is that VA would be unable to recruit full-time staff in the scarce specialties in virtually all locations.

- VA also derives benefits from its relationships with medical schools through support for VA's academic mission and teaching activities, with access to information on state-of-the-art practices and cutting-edge technology.

- No particular problems were identified concerning physicians' dual appointments at VA and the affiliates, with few concerns noted. The few concerns expressed included such issues as the need for careful definition of and time allocation for duties outside the scope of the VA position.

- In conclusion, the consensus opinion was that the relationship with affiliates "keeps people at VA." VA is most competitive when hiring at junior faculty levels, especially in primary care. However, this advantage disappears with higher academic ranks and in highly paid specialties.

The Committee then addressed the question of whether there is any problem created by payment of stipends by the affiliates to full-time VA staff. The extent of the practice is unknown, because there is no longer any requirement for reporting of outside professional income. There's no one pattern or practice, based on awareness of the different relationships extant throughout VA. The competition for time for research activities or time outside employees' administrative tours of duty for responsibilities at the affiliates is great. There is a growing concern that, as in the 1980s until the enactment of the current special pay provisions, that VA is again not paying its 'fair share.'

It is important that all employees be fully aware of the potential conflicts and rules governing these dual appointments, so that individuals can manage the competing demands and keep appropriate separation between the two positions. Bottom line, however, the use of affiliates'

stipends in order to attract individuals to VA highlights VA's inability to recruit and retain staff in many locations and for many specialties.

Based on an estimate of 15 percent of full-time physicians receiving stipends from affiliates, VA could have as many as 1,200 physicians (15% x approximately 8,000) receiving some amount of stipend.

Given the scope of this practice, VA could do certain things to facilitate the dual appointments of VA employees at the affiliates without any compromise in quality of care to veterans. VA should have flexible work rules to accommodate changes to tours of duty for teaching and academic rotations. VA timekeeping systems should be improved to facilitate the identification of time spent at VA. The dual appointments and responsibilities can be a challenge to employees, and the VA time and attendance systems must clearly document the time spent in the VA portion of the two roles.

In summary, VA receives great benefit from the relationship with the affiliates – through enhanced recruitment and access to the latest in clinical research and treatment advances.

The issue of academic stipends is not an issue for most VA dentists. Over one-third of VA's dentists provide resident supervision and teaching support, most without compensation from the affiliates. Those who receive compensation from the affiliates receive it for teaching performed outside their VA tours of duty.

There was an issue that the Reviewing Committee identified, and it is receipt of stipends by VA Chiefs of Staff (COSs). The current VA compensation system does not enable VA to offer a competitive salary level to attract the caliber of clinical leader needed. There was universal agreement among Committee members that a paid appointment with the university affiliate posses a potential conflict for COSs. Given the leadership position and responsibility of the COS for managing clinical operations in VA facilities, the members noted that VA must be able to offer more competitive compensation for its COSs. This will help ensure the integrity of decisions the COS makes with respect to contracts and other agreements with the affiliate.
VA salaries for COSs are lower than the amount paid by the smallest private hospital to its Medical Director, a position equivalent in responsibility to the VA COS. Compensation surveys reported by ACPE and ACHE also show significantly higher salaries for physician executives. The group felt strongly that VA needed to be able to pay more to COSs. The widespread vacancies and long recruitment times are indicative of the pay-related staffing difficulties.

Recruitment and Staffing Issues

Affiliate Support. The group noted difficulties with VA's current recruiting methods. They acknowledged that VA advertisements don't always generate responses. So, VA capitalizes on the allure of the affiliates and lets the universities do the recruitment. This maximizes one of VA's key staffing benefits, which is the opportunity for teaching. VA

benefits by using the universities to help publicize openings. The members felt this was essential for successful recruitment of the best-qualified staff. This is a win-win for both parties. And, because of VA's role in the Nation's education of health-care professionals, the close partnership is necessary.

Non-U.S. Citizen Employment. The Committee recognizes that VA is sometimes able to meet its staffing needs only through the recruitment of J-1 visa applicants. These non-U.S. citizens come to VA because of VA's ability to sponsor visa holders to remain in this country after their education is completed. VA is committed to employing U.S. citizens as the first goal of any recruitment action. However, the members acknowledge that these candidates are sometimes the only applicants that VA can attract to certain hard-to-fill locations and in certain specialties. This employment option is useful to VA in attracting physicians to rural sites and to appointing stellar academic performers. These individuals generally apply for and obtain their U.S. citizenship, and sometimes stay with VA for their entire careers. They serve as a valuable source of clinicians to provide patient care.

For the most recent period available, 23 percent of first-year residents are international medical graduates (IMGs). If VA is to be able to employ adequate clinical staff to treat veterans, this pool of candidates needs to be available for employment when circumstances warrant. On balance, the program is valuable to VA and should be continued. The members noted that if VA pay were more competitive with the non-Federal community, there would be more citizen applicants and less need for J-1 visa applicants.

VA Workforce Utilization Patterns. VA has created a system based on primary care, with community-based outpatient clinics (CBOCs), doubling the number of veterans seeking care in the VA system. However, this increase in patient load has not translated into an increase in the number of specialists. The number of referrals has increased, creating a bottleneck in waiting times for specialist care. With the most severe recruitment and retention difficulties now being experienced in the subspecialty ranks, VA needs to ensure that systems support the maximization of these subspecialists' productivity.

One strategy for improving utilization of specialists' time is to ensure adequate numbers of support staff, purchase of appropriate equipment, redesign of facilities and clinics, etc. This point also applies to optimizing the productivity of dentists.

Some additional strategies that would ensure most efficient use of specialists' time are the use of registered nurses and trained technologists to perform some procedures, to follow up with patients, perform telephone contacts with patients, conduct pre-visit interviews, take health screenings and histories, etc. VA could also look at how to make better use of physician extenders and allied health professionals like optometrists, podiatrists, nurse practitioners, etc. Unfortunately, there are often staffing shortages in many of these extender specialties as well.

A clear protocol on referrals from the primary care providers and the CBOCs could yield efficiencies. One technique would be to provide education to the primary care providers in such areas as back pain, diabetes management, urologic disorders, dermatology cases, etc., so that there is reduced need for referrals to specialists.

Another technique would be to rethink the process for specialist referrals. The first consult should be with a specialist, but follow-up appointments could be evaluated for assignment to the appropriate clinician. VA could explore a team approach, whereby the primary care provider would provide the follow-up care. The specialist would decide the treatment plan and protocol for care, and consult with the primary care provider throughout the follow-up care at the CBOC or primary care clinic.

VA Workforce Projections. The group agreed that the most severe recruitment and retention difficulties are in the clinical specialties. It was agreed that the VA workload is changing. Due to the demographic changes in the veteran population, the amounts of certain kinds of care will change: VA will need to employ more orthopedic specialists for arthritic and aging joints, more urologists for prostate troubles, and more ophthalmologists for diseases of the aging eye. These specific clinical demands, along with the restructuring of the way in which VA delivers health care – from a hospital-based system to a network of primary care clinics – will force continued realignment of the workforce.

The Committee members foresee continued shortages in most specialties. They noted that the current practice of utilizing advanced practice nurses and physician assistants as partial substitutes for general internal medicine physicians has avoided widespread shortages in this specialty.

These changing needs should impact the numbers and kinds of physician residencies funded by VA. One suggestion was to decentralize the decisions concerning the funding of graduate medical education slots. There was no consensus on this point.

Ultimately, VA's workforce needs will change because of the change in numbers and demographics of patients, technological changes, market forces, availability of certain clinical disciplines, treatment modalities. Virtual treatment centers will evolve: patients will be contacted by phone and providers will consult telephonically. Electronic imaging will enable consults from almost anywhere in the world.

As for dental staffing, the projected dentist shortages in the U.S. workforce were outlined as part of the legislative hearings in support of P.L. 106-419. The number of dental schools is declining; dental school enrollments are not sufficient to meet the projected demand. VA will face an increasingly difficult time attracting and retaining dentists. The steep and steady increases in net practice income will continue to pose significant competition to VA's staffing efforts.

Improved Recruitment Strategies. VA needs to change the way we recruit for physicians and dentists. VA has many employment features that make us an attractive choice. However, many of these features are not well publicized. VA should market itself

for careers, showing the potential for advancement, lifetime professional development through education and research.

VA needs to dedicate staff to recruiting physicians, just as facilities have dedicated staff to nurse recruitment. This service could be centralized and delivered from a single site. VA must compete with private sector physician recruiting firms through a systematic, centralized, knowledgeable sales force.

It was noted that the New Orleans Healthcare Staff Recruitment and Development Office provides an inventory of physician and dentist vacancies and interested applicants, but is not intended to market VA careers. Further, in a tight labor market such as currently exists for most physician and dentist specialties, there are very few candidates looking for employment, and many of those are less than ideal.

The Committee offers a number of suggestions for improving VA's marketing position:

- VA should widely publicize its self-insurance for malpractice. With the recent crises in insurance availability in New Jersey and Texas, VA's ability to eliminate this headache and expense from individuals' practice considerations should be exploited as an aid in recruitment efforts.

- VA should also emphasize the opportunity for personal mobility within the system. Because VA accepts a valid state license for practice anywhere in the system, physicians and dentists have the ability to relocate without the burden and expense of obtaining new licenses in new states.

- VA should be able to offer more flexible relocation packages. VA should be able to negotiate first move reimbursements, as well as current staff moves. The current system of all-or-nothing funding of relocations is potentially so expensive as to work as an impediment to paid moves. The arcane and restrictive reimbursement rules also serve as disincentives to attracting well-qualified candidates and offering competitive relocation packages. *[A similar proposal was included in the VHA Succession Planning Report recommendations. The Deployment Group is working with VA program offices and the General Services Administration to implement these changes. A legislative proposal has also been submitted for the 108th Congress as VHA Legislative Proposal #20.]*

- VA has implemented the Title 38 education debt repayment program, which provides for up to $40,000 in student loan repayments. This amount is too low to be an incentive for physicians and dentists who complete their educations with up to $150,000 in debt. VA should be able to offer more generous repayments of student loans over longer periods of time.

- VA has an opportunity to enhance retention of personnel who choose VA for its lifetime development opportunities. VA should follow through on this promise with better funding for medical and dental continuing education, more funding for

conferences and travel, and increased authorized absences and sabbaticals for professional development to ensure that all personnel possess the latest in clinical skills.

- VA should establish a Physician/Dentist Recruiting Center. This centralized, virtual function would have staff who are knowledgeable of VA benefits, and able to offer actuarial projections of the value of Federal savings and retirement programs. This way, the benefits of a career with VA are understood and marketed to prospective employees.

- VA could improve its recruitment efforts with a consistent image for all its advertising. There should be a centralized advertising budget that regularly runs ads in all the major journals, creating and nurturing the VA image. These advertisements would publicize a single 1-800 number, a single web site, so that there would be centralized recruitment for physicians and dentists and all health-care vacancies.

- This recruiting office would be responsible for the purchase of display booths at all specialty conventions. This public recruitment effort is essential to compete with other Federal and private employers who regularly attend these gatherings. VA's recruitment center needs to be confidential and reliable, as many practitioners do not want it known that they are looking for new employment.

- VA should conduct exit interviews to understand why individuals choose to leave, what are the demotivators to employee satisfaction and retention. This way, VA can engage in continuous improvement by addressing the impediments to employee retention. *[An identical proposal was included in the VHA Succession Planning Report recommendations. This initiative is currently being developed by the Office of Human Resources Management with assistance from the Veterans Health Administration and other offices.]*

- VA should consider whether there would be a significant recruitment and retention benefit if we were able to offer paid memberships in professional societies as a recruitment incentive. Many private sector employers offer this perquisite.

APPENDIX A

Membership of the Reviewing Committee

Madhulika Agarwal, M.D., Associate Chief of Staff for Ambulatory Care, VA Medical Center, Washington, DC

Stephen F. Bergen, D.D.C., Chief of Dental Service, New York Harbor Healthcare System, New York, NY

C. Richard Buchanan, D.M.D., Deputy Director, Office of Dentistry, VHA Headquarters

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Mark A. Enderle, M.D., Chief of Staff, VA Medical Center, Fayetteville, AR

M. Elon Gale, M.D., Chief of Radiology Service, VA Boston Healthcare System, Boston, MA

Thomas J. Hogan, Director, Management Support Office, VHA Headquarters

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Brian J. O'Neill, M.D., Chief of Staff, VA Northern California Healthcare System, Martinez, CA

Stephanie J. Pincus, M.D., Chief Academic Affiliations Officer, VHA Headquarters

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William T. Schmeling, M.D., Ph.D., Consultant Care Division Manager, VA Medical Center, Milwaukee, WI

Rose C. Trincher, M.D., Spinal Cord Injury Service Line Executive, VA Medical Center, Augusta, GA

Louise Van Diepen, Executive Assistant, Office of Quality and Performance, VHA Headquarters

APPENDIX B

AGENDA
2002 Quadrennial Report on Physician and Dentist Pay
Meeting of the Reviewing Committee

Monday, May 20, 2002
State Room, Washington Hilton Hotel

8:00 a.m.	Introductions
8:15 a.m.	Review agenda
8:30 a.m.	Overview of charge
9:00 a.m.	Break
9:15 a.m.	VA's relationship with academic affiliates Stipends for full-time staff Conflicts of interest for Chiefs of staff Recruitment efforts
10:30 a.m.	Break
10:45 a.m.	Non-U.S. citizen appointments
11:30 a.m.	Lunch (on your own)
1:00 p.m.	Additional staffing issues Recruitment process Workforce predictions – availability of physicians and dentists and VA's needs
2:30 p.m.	Break
2:45 p.m.	Pay -- Base pay Front-line clinicians Researcher Non-clinical assignments Management ranks
3:30 p.m.	Break
3:45 p.m.	Base pay (continued)
5:00 p.m.	Adjourn

Tuesday, May 21, 2002
Jackson Room, Washington Hilton Hotel *(Note room change)*

8:00 a.m.	Reconvene
8:15 a.m.	Review previous day's progress
8:30 a.m.	Pay - - Special pay Review 8 components Can the system be simplified? How do the base pay decisions impact the need for special pay?

10:00 a.m.	Break
10:15 a.m.	Special pay (continued)
11:30 a.m.	Lunch
1:00 p.m.	Performance-based Pay How much What measured Scope of coverage
2:30 p.m.	Break
2:45 p.m.	Performance-based pay (Continued)
3:30 p.m.	Break
3:45 p.m.	Performance-based pay
5:00 p.m.	Adjourn

Wednesday, May 22, 2002
Jackson Room, Washington Hilton Hotel

8:00 a.m.	Reconvene
8:15 a.m.	Review previous day's progress
8:30 a.m.	Duty and leave for full-time, part-time physicians and dentists
9:30 a.m.	Break
9:45 a.m.	Need for additional pay authorities On-call pay
11:00 a.m.	Adjourn

APPENDIX C

SUGGESTED PERFORMANCE ELEMENTS AND STANDARDS

The elements shown below are suggested as a starting point for development of performance measures for the third their of compensation. The Reviewing Committee recommends that work groups from each clinical discipline be formed to develop model performance elements and suggested measures.

Universal Measures Applicable to All Clinicians

- Frequency of notes in physician order entry, CPRS, and BCMM (to capture resident supervision through attending notes, billing, and tests and medications ordered, as well as case management)
- Service on committees, Medical staff, Professional Standards Boards, Internal Review Boards, peer review, and root cause analysis teams
- Membership and elected positions in professional societies
- Teaching (noon conferences, etc.)
- Resident supervision and timeliness of pupil evaluations
- Compliance with clinical reminders and clinical practice guidelines
- Performance of C&P and special benefits exams
- Improvement in waiting times for initial and follow-up appointments, use of advanced access, reductions in number of cancellations/no-shows
- Cost effectiveness improvements
- Improvements in scheduling efficiency, utilization of time
- Reductions of number of unbillable cases, and successful resolution of such cases
- Proficiency in documenting patient records consistent with CMS/HCFA standards (The Reviewing Committee suggest that required elements and a billing template be built into CPRS to facilitate improved performance)
- Revenue generation
- High levels of patient satisfaction, closely correlated to specific clinical service
- High scores on NSQIP, Prevention Index, Chronic Disease Index, and other quality of care measures
- Results of JCAHO audits for specific clinical service area
- Number of patients seen, number of clinics performed, number of outpatient visits
- Frequency of taking call
- Funded research (number and size of grants, internal and external funding,

Anesthesiology

All of the Universal Measures, as applicable, plus:

- Compliance with OR and patient safety measures
- Successful results on OSHA inspections
- Pain clinics

- OR turnaround times

Dentistry
All the Universal Measures, as applicable, plus:
- Level of CTVs or RVUs based on national Dentistry Performance Guidelines
- Program Director responsibility
- Accreditation issues

Hospitalists
All the Universal Measures, as applicable, plus:
- Patient safety measures
- Service as Medical Officer of the Day and Admitting Physician

Mental Health
All the Universal Measures, as applicable, plus:
- Percentage of unvested patients

Pathology
All the Universal Measures, as applicable, plus:
- Turnaround time from when specimen is received to recorded lab result

Primary Care
All the Universal Measures, as applicable, plus:
- Percentage of unvested patients
- Panel size
- Supervision of physician extenders (advanced practice nurses, PAs)
- Management of panel size and waiting times (number of visits per hour, visits per patient per year)
- Use of tools and techniques to maximize customer care and personal productivity, e.g., telephone care, reduced numbers of cancelled and missed appointments
- Disease management
- Productivity and effectiveness measures
- Timeliness of care

Radiology
All the Universal Measures, as applicable, plus:
- Number of procedures
- Compliance with Nuclear Regulatory Commission regulations and procedures
- Turnaround time from imaging to recorded interpretation

Spinal Cord Injury & Disease
All the Universal Measures, as applicable, plus:
- Percent of patients completing EPRP standards, for whom the SCI physician is the primary care provider

APPENDIX C

Surgery

All the Universal Measures, as applicable, plus:

- Billing, as tracked through RVRS components of reimbursement
- Reductions in overtime costs through efficient scheduling of elective procedures, improved OR turnaround times
- Number of procedures, factored for complexity
- Compliance with OR and patient safety measures
- O/E ratios

APPENDIX D

COST ESTIMATE

Physician Cost Estimate

For physicians, the contractor's report suggested a correlation of AAMC faculty ranks to VA staff according to years of service/experience. To develop a weighted average benchmark salary for the current VA workforce, we used the 2001 AAMC national average compensation levels for Instructor, Assistant Professor, and Associate Professor at the 50th percentile for each physician clinical discipline. These salaries were weighted according to VHA physician tenure as follows:

AAMC Rank	Years of VA Service	% VA Physicians
Instructor	Less than 1 year	9.7%
Asst. Professor	1 – 9 years	49.0%
Assoc. Professor	10+ years	41.3%

Once the weighted average benchmark AAMC salary was derived by specialty, that target salary was compared to the weighted average VA salary, including special pay, for each clinical discipline. If the AAMC benchmark salary was higher, the difference was weighted by the VA FTEE in the specialty to derive the cost to bring VA salaries up to the benchmark.

This calculation resulted in an estimated cost of $124.5 million to bring clinical staff salaries of 3,098.12 FTEE up to the AAMC benchmark. Under these assumptions, VA would increase salaries for about 30 percent of its physician FTEE. A significant portion of the cost estimate (16.6 percent) is attributable to the costs of parity for general surgeons, who represent only 4.8 percent of VA's total physician FTEE. It is noted that a careful assessment of the scope of surgical practice would be done to equate VA surgeons to the AAMC compensation figures for individuals with full surgical practices. For individuals who are providing limited surgical services, their benchmark will be a factor of less than 1.0 of the AAMC target.

The total amount spent on scarce contracts in FY 2001 was over $375 million; of that total, $328.6 million was attributable to physician clinical services. We believe that VA will, through this enhanced compensation system and the performance-based pay element, increase its success in recruiting and retaining physicians and will motivate improved productivity and performance. As a result, we believe that the amount spent on contract costs will decline.

We believe that the performance element, which will apply to all clinicians, will result in efficiencies in every clinical area. However, for purposes of estimating savings, we counted savings only in the specialties where VA compensation is currently below the AAMC benchmark. We assumed a 10 percent savings in contract costs for all clinical

specialties that are currently below the AAMC benchmark, yielding a conservative savings estimate of $18.9 million (full year projection).

In FY 2001, VA spent a total of $189.2 million for on-station fee basis and consultant and attending services for Medical and Nursing costs. Of this total, $164 million are attributable to on-station Medical and Nursing fee services. Because there is no immediate way to differentiate between fee basis expenditures for nursing vs. medical services or to allocate the fees among the medical specialties, we estimated savings from reduced use of medical fee personnel at only 5 percent. That assumption yields an additional $9.4 million in savings.

To these savings from current expenditures ($18.9 million plus $9.4 million), are the savings that are projected from improved productivity. These figures are based on the difference between the constructed cost per FTEE of contract expenditures and the proposed average VA salary for that specialty. It is projected that VA will be able to replace more costly contracts with in-house personnel, whether employed on a full-time, part-time, or intermittent basis, this achieving over time significant savings over the current contract expenditures. The total possible savings is $112.0 million. It is projected that VA could initially achieve 5 percent savings, with increased cost avoidance and savings over the coming years. The first year savings (based on a full year) are projected at $5.6 million.

Thus, the first year total savings estimate for physicians is $28.3 million in productivity savings, and $5.6 million in savings from reduced reliance on more expensive contracts. These savings would offset a portion of the increased salary costs, yielding a net annual cost for physicians of $90.5 million.

Dentist Cost Estimate

The Reviewing Committee acknowledges that the American Dental Education Association (ADEA) salary reports are not complete: they report only that portion of income from the part-time faculty assignments, and do not include income from private practice and other sources.

Instead, the Committee proposes to use the ADA net private practice income for general and specialty dentists as the benchmark. The VA average salary will aim for the mean net private practice income, less the cost of VA employee benefits (currently 25.56 percent). The Committee notes that there is a significant difference between the average incomes of non-owner dentists (employees and associates) and owners. The benchmark that VA uses should find a way to reflect these two salary metrics. Also, the group notes that the average number of hours worked by private practice dentists is shorter than the hours worked by VA dentists.

The ADA private practice income data were tabulated for general practice and specialist dentists, using the trend in cost inflation in the CPI-Medical to extrapolate a 2002 figure. Those figures were reduced to 74.44 percent to determine the benchmark for the target VA salaries. The costs to bring current VA compensation for VA dentists up to the benchmarks are estimated at $5.0 million per year.

In FY 2001, VA spent $374,918 for contract dental services. In addition, the Department spent $13.3 million for on- and off-station dental fee services. We believe that VA will, through this enhanced compensation system and the performance-based pay element, motivate improved productivity and performance and increase its success in recruiting and retaining dentists. As a result, the amounts spent on fee and contract services will decline. Assuming that there would be a 10 percent reduction contract and a 5 percent reduction in fee basis expenditures through increased productivity and performance, a total of $0.7 million in costs would be avoided each year.

These savings would offset a portion of the increased salary costs, yielding a net annual cost for dentists of $15.7 million.

Management Cost Estimate

The Reviewing Committee proposes that the salaries of management and executive positions be benchmarked to clinical executives in hospitals, clinics, and healthcare organizations.

The Committee suggests that salary determinations for VA positions that are primarily executive or managerial in scope should have their pay determined other than by AAMC clinical faculty compensation. This group of VA positions would consist of Chiefs of Staff, facility and Network executives, and VA Central Office (VACO) assignments. For those individuals who continue to perform clinical duties along with their management assignments, some factor of the Market Tier for Clinicians could be factored in, as appropriate. To develop the cost estimate, we compared average VA compensation for the following positions to salary data from a number of healthcare employers.

VA Position	Benchmark Position
Chief of Staff	Medical Director
	Vice President for Medical Affairs
Facility Director	Hospital Administrator
Chief Medical Officer	Clinical Manager for an HMO
	Vice President for Medical Affairs (multi-site hospital system)
Network Director	Chief Executive Officer for a Healthcare System
National Program Director	Chair of a Clinical Department, AAMC
Headquarters assignments	Associate Dean, Dean, or President, AAMC

VA total compensation would be targeted to 75 percent of these benchmarks. The total number of positions under consideration here is no more than 250.

Using the data provided by the HayGroup in its September 2000 report on VA Medical Center Leaders Cash Compensation and the Physician Executive Management Center's 2001 Survey of Chief Medical Officers, as well as AAMC executive salary data, we estimate a cost of $4.4 million per year to bring total compensation for these individuals to 75 percent of the benchmark. The salary figures used from these sources are consistent with salary reports from other surveys.

Consolidated Cost Estimate

This proposal is estimated at $138.8 million per year in direct salary costs, with an estimated $31.9 million in savings annually, for a net annual cost in the first year of $96.9 million. It is assumed that this system will be implemented in the third quarter of FY 2004, resulting in a half-year cost of $48.5 million

Projecting the costs and increased savings over a 10-year period with a 3.9 percent annual inflation factor results in a total net cost projection of $636.2 million.

Cost Estimate

Savings Estimate

Physician Cost Estimate

Clinical Specialty	'01-'02 AAMC Instructor	'01-'02 AAMC Asst. Professor	'01-'02 AAMC Assoc. Professor	Weighted AAMC Salary (1)	VA FTEE a/o 9/30/02	VA Salary	Difference	Cost of 100% Parity for Current Staff	FY 2001 Contract Costs	FY 2001 Fee Basis Costs	10% Estimated Savings (2)	Target New Total Pay	Wtd New Total Pay
Allergy/Immunology	$85,000	$116,000	$135,000	$120,840	16.0	$134,629	$0	$0	$393,353		$0	$134,629	$2,156,754.52
Anesthesiology	$195,000	$211,000	$228,000	$216,469	335.9	$168,072	$48,397	$16,254,904	$18,040,153		$1,804,015	$216,469	$72,705,172.44
Cardiology (3)	$130,000	$176,000	$206,000	$183,928	315.5	$154,120	$29,808	$9,404,570	$17,556,339		$1,755,634	$183,928	$58,029,284.00
Dermatology	$125,000	$160,000	$201,000	$173,538	91.0	$146,297	$27,241	$2,478,023	$19,411,073		$1,941,107	$173,538	$15,786,318.02
Emergency Medicine	$163,000	$168,000	$186,000	$174,949	79.7	$139,820	$35,129	$2,800,465	$8,322,130		$832,213	$174,949	$13,946,934.28
Endocrinology	$101,000	$111,000	$135,000	$119,942	108.6	$133,695	$0	$0	$186,985		$0	$133,695	$14,513,974.78
Gastroenterology	$129,000	$143,000	$179,000	$156,510	203.1	$145,894	$10,616	$2,156,201	$1,902,181		$190,218	$156,510	$31,787,376.64
General Internal Medicine	$118,000	$127,000	$146,000	$133,974	3872.3	$136,250	$0	$0	$113,586,127		$0	$136,250	$527,600,180.45
General Surgery	$106,000	$183,500	$228,000	$194,361	487.0	$151,844	$42,517	$20,706,684	$12,232,562		$1,223,256	$194,361	$94,658,666.03
Geriatrics	$107,000	$123,000	$148,000	$131,773	105.1	$132,003	$0	$0	$5,300,674		$0	$132,003	$13,877,433.94
Gynecology (OB/Gyn - Other)	$132,000	$161,000	$205,000	$176,359	20.1	$141,488	$34,871	$700,438	$2,646,880		$264,688	$176,359	$3,542,390.96
Hematology/Oncology	$102,000	$131,000	$160,000	$140,164	173.5	$136,166	$3,998	$693,713	$3,604,702		$360,470	$140,164	$24,319,154.82
Infectious Diseases	$93,000	$109,000	$135,000	$118,186	132.3	$135,196	$0	$0	$597,046		$0	$135,196	$17,881,040.65
Nephrology	$103,000	$128,000	$162,000	$139,617	134.4	$132,247	$7,370	$990,857	$4,561,735		$456,173	$139,617	$18,770,807.57
Neurology	$78,000	$114,000	$140,000	$121,246	304.3	$133,314	$0	$0	2182568.7		$0	$133,314	$40,562,491.91
Neurosurgery	$75,000	$240,000	$302,000	$249,601	42.0	$149,583	$100,018	$4,201,015	$3,786,867		$378,687	$249,601	$10,483,866.00
Ophthalmology	$70,000	$160,000	$208,000	$171,094	143.5	$149,585	$21,509	$3,086,924	$4,315,444		$431,544	$171,094	$24,555,410.88
Orthopedic Surgery	$110,000	$242,000	$275,000	$242,825	136.7	$158,811	$84,014	$11,482,677	$6,600,581		$660,058	$242,825	$33,188,410.41
Otolaryngology	$71,000	$181,000	$230,000	$190,567	90.7	$150,813	$39,754	$3,604,471	$962,887		$96,289	$190,567	$17,278,709.89
Pathology	$102,333	$129,667	$156,667	$138,166	347.8	$145,778	$0	$0	$10,832,884		$0	$145,778	$50,706,577.47
Physical Medicine & Rehab (4)	$139,000	$137,000	$151,000	$142,976	314.8	$137,860	$5,116	$1,610,461	$969,748		$96,975	$142,976	$45,009,738.40
Plastic Surgery	$122,000	$190,000	$287,000	$223,465	30.9	$145,580	$77,885	$2,404,310	$840,228		$84,023	$223,465	$6,898,364.55
Preventive Medicine	$1,000	$103,000	$131,000	$104,670	9.3	$145,807	$0	$0			$0	$145,807	$1,348,710.68
Psychiatry	$113,000	$120,000	$139,000	$127,168	1607.4	$146,887	$0	$0	$4,350,983		$0	$146,887	$236,112,404.93
Pulmonology	$95,000	$125,000	$151,000	$132,828	224.9	$138,667	$0	$0	$1,162,023		$0	$138,667	$31,185,955.24
Radiology (5)	$160,000	$213,000	$244,000	$220,662	555.9	$171,202	$49,460	$27,493,654	$64,119,853		$6,411,985	$220,662	$122,661,592.56
Rheumatology	$93,000	$112,000	$133,000	$118,830	66.3	$133,563	$0	$0	$165,564		$0	$133,563	$8,858,700.29
Thoracic/Cardiovasc Surgery (6)	$173,500	$216,000	$302,500	$247,602	70.4	$160,622	$86,980	$6,119,788	$15,826,215		$1,582,621	$247,602	$17,420,967.22
Urology	$70,000	$185,000	$250,000	$200,690	169.6	$151,739	$48,951	$8,299,682	$3,597,512		$359,751	$200,690	$34,026,989.50
TOTAL					10,188.82			$124,488,837	$328,055,298	$189,191,261	$18,929,709		
Net Cost					3,098.12			$96,099,565		$9,459,563.05		New Average Salary:	$156,041.01
													$43,885.01

(1) - AAMC rank weighted by VA seniority: Instructor = 9.7% of VHA physicians @ <1 year; Asst. Prof. = 49.0% @ 1-9 years; Assoc. Professor = 41.3% @ >10 years.

(2) - Savings based on improved productivity through performance-based pay.

(3) - VA data includes Cardiology and Cardiovascular Diseases

(4) - Includes Physical Medicine & Rehab, Physiatry, and Paraplegia (SCI)

(5) - Salary reported for AAMC includes both Diagnostic and Therapeutic. VA data includes Nuclear Medicine

(6) - VA data includes Cardiothoracic, Thoracic, and Cardiovascular Surgery

Dentist Cost Estimate

Clinical Speciality	VA FTEE (1)	Current VA Salary (1)	Average Change in CPI-Med	Median Net Income, 2000 (G) 1998(S)	Projected Net Income, 2002 (2)	Benchmark @ 74.44%	Difference	Cost for Current Staff
General Dentist	479.2	$130,627	4.35% (2000-2002 only)	$166,460	$181,257	$134,928	$4,300	$2,060,879
Oral/Max. Surgeon	55.5	$153,075	3.83% (1998-2002 only)	$238,150	$276,731	$205,999	$52,924	$2,935,801
Other Specialists	129.8	$144,900	3.83% (1998-2002 only)	$165,790	$192,649	$143,408	$0	$0
TOTAL	664.5							$4,996,680
	Average VA Salary:	$135,289				$142,517		

	FY 2001 Costs for Outside Services	Estimated Savings (3)
Contracts	$374,918	$37,492
Fee Basis	$13,313,478	$665,674
Total Cost, Outside Services	**$13,688,396**	
Estimated Savings		**$703,166**
Net Cost	**$4,293,514**	

(1) - Employment as of 9-30-2002
(2) - Figures aged to 2002 estimates by amount of change in CPI-Medical.
(3) - Savings based on improved productivity through performance-based pay: 10% of Contract costs and 5% of fee basis expenditures.

VA Position	Non-Federal Benchmark	Base Income (1)	Bonus
Chief of Staff (3)	Chief Medical Officer (CMO)- All	$230,340	19.0%
	CMO (Hospital)	$210,447	15.0%
	CMO, <250 beds	$204,165	15.0%
	CMO, 251-400 beds	$221,964	14.0%
	CMO, 401-600 beds	$235,575	17.0%
	CMO, 601+ beds	$251,280	27.0%
	CMO, Academic Health Center	$261,750	unk
	Medical Director (MGMA)	$188,956	unk

VA Position	Non-Federal Benchmark	Base Income (1)	VA Target	VA FTEE (2)	VA Salary	Difference	Cost for Current Staff
COS, Complexity I	Medical Director (MGMA)	$188,956	$188,956	40	$167,074	$21,883	$875,308
Complexity II	CMO, <250 beds	$204,165	$204,165	36	$167,074	$37,091	$1,335,291
Complexity III	CMO (Hospital)	$210,447	$210,447	38	$167,074	$43,373	$1,648,190
Complexity IV	CMO, 251-400 beds	$221,964	$221,964	26	$167,074	$54,890	$1,427,151
TOTAL, COS							$5,285,940
Chief Medical Officer (3)	CMO, Integrated System	$251,280	$225,000	21	$174,282	$50,718	$1,065,078
Facility Director (4), (5)	CEO (Small Hospital)	$208,754	$225,000	10	$174,282	$50,718	$507,180
	CEO (Large Hospital)	$241,204					
	CEO, Academic Hhealth Center	$343,992					
	Physician CEO-President (MGMA)	$311,000					
Network Director (4), (6)	CEO (Large Hospital)	$327,665	$235,000	10	$185,600	$49,400	$494,000
	COO (Multi-Hospital System)	$439,176					
	Non-Physician CEO (Health System)	$228,954					
	Physician CEO (Health System)	$271,130					
	CEO, HMO (PwC, November 2000)	$300,291					
National Program Director	AAMC Chair of Medical/ Clinical Department (7)	$324,000	$235,000	10	$177,572	$57,428	$574,277
Chief Consultant			$235,000	8	$177,572	$57,428	$459,421
Chief Officer			$235,000	8	$177,572	$57,428	$459,421
Associate USH			$235,000	7	$180,600	$54,400	$380,800
Assistant Deputy USH			$235,000	1	$185,600	$49,400	$49,400
Deputy Under Secretary			$240,000	1	$199,000	$41,000	$41,000
Under Secretary			$250,000	1	$212,200	$37,800	$37,800
TOTAL				**217**			**$9,354,318**

(1) - Compensation data aged to 2002 by rate of change in CPI-Medical.
(2) - Average number of Title 38 incumbents in SES positions
(3) - 2001 Physician Executive Compensation Report, Physician Executive Management Center, ACPE
(4) - VHA Leader Compensation, Hay Group, September 2000: Data for Hospital CEO (regardless of degree)
Data aged to 2002 by rate of change in CPI-Medical
(5) - Association of Academic Health Centers, 2001-2002 Salary Survey, CEO, Academic Health Center
(6) - Healthcare Executive Compensation Survery, Witt/Keiffer, November 2000
(7) - Average of all MD Clinical Science chairs, AAMC, 50th percentile. 2001-2002 Salary Report

VA Position	Employees	Target Pay	10% At-Risk *	Guaranteed Net Base + Market	VA Pay, 2002	Avg Bonus, 20
COS, Complexity I	40	$188,956	$18,896	$170,061	$167,074	unk
Complexity II	36	$204,165	$20,417	$183,749	$167,074	unk
Complexity III	38	$210,447	$21,045	$189,402	$167,074	unk
Complexity IV	26	$221,964	$22,196	$199,768	$167,074	unk
Chief Medical Officer (3)	21	$225,000	$22,500	$202,500	$174,282	11563
Facility Director (4), (5)	10	$225,000	$22,500	$202,500	$174,282	8625
Network Director (4), (6)	10	$235,000	$23,500	$211,500	$185,600	17889
National Program Director	10	$235,000	$23,500	$211,500	$177,572	20000
Chief Consultant	8	$235,000	$23,500	$211,500	$177,572 \	
Chief Officer	8	$235,000	$23,500	$211,500	$177,572 \	
Associate USH	7	$235,000	$23,500	$211,500	$180,600 }	13760
Assistant Deputy USH	1	$235,000	$23,500	$211,500	$185,600 /	
Deputy Under Secretary	1	$240,000	$24,000	$216,000	$199,000 /	
Under Secretary	1	$250,000	N/A		$212,200	N/A

* Secretary would reserve right to exclude these personnel from eligibility for other performance-based awards.

Consolidated Cost Estimate

	Direct Costs for Current Staff	Savings from Productivity
Cost for Physicians	$124,488,837	$28,389,272
Cost for Dentists	$4,996,680	$703,166
Cost for Management	$9,354,318	$0
TOTAL	$138,839,835	$29,092,438

10-year projections
(First year cost projections assume implementation in 3rd quarter of FY 2004)

Assuming annual rate of inflation of 3.9 percent:

	COST	PRODUCTIVITY SAVINGS	CONTRACT/FEE SAVINGS *	NET COST
FY 2004	$69,419,917	$14,546,219	$6,405,709	$48,467,990
2005	$144,254,588	$30,227,043	$19,217,127	$94,810,419
2006	$149,880,517	$31,405,898	$32,028,544	$86,446,075
2007	$155,725,857	$32,630,728	$44,839,962	$78,255,168
2008	$161,799,166	$33,903,326	$57,651,380	$70,244,460
2009	$168,109,333	$35,225,556	$69,656,718	$63,227,060
2010	$174,665,597	$36,599,352	$80,855,976	$57,210,269
2011	$181,477,556	$38,026,727	$92,055,235	$51,395,594
2012	$188,555,180	$39,509,769	$103,254,493	$45,790,918
2013	$195,908,832	$41,050,650	$114,453,752	$40,404,430
TOTAL	$1,589,796,546	$333,125,267	$620,418,896	$636,252,382

*** Savings based on difference between cost of providing services in-house vs. contract and fee basis.**
See attached sheet for calculation of estimated total contract savings ($112 million over 10 years).
Savings in contract expenditures based on realizing 10% of total savings per year.
Savings in fee basis expenditures ($8.05 million) based on 5% reduction per year over 5 years.
NOTE: Savings in 2013 do not equal total due to crediting only half-year savings in first year.

Potential Savings Through Improved Staffing Success

Clinical Specialty	Current Active Vacancies	FY 2001 Contract Costs	New VA Pay	Estimated Average Contract Cost per FTE (1)	Estimated Contract FTE (2)	Estimated Savings from Contract Replacement (3)
Allergy/Immunology	2.4	$393,353	$134,629	$265,724	1.48	$194,061
Anesthesiology	89.5	$18,040,153	$216,469	$387,500	46.56	$7,962,388
Cardiology	58.1	$17,556,339	$183,928	$423,031	41.50	$9,923,087
Dermatology	18.125	$19,411,073	$173,538	$352,366	55.09	$9,851,230
Emergency Medicine	20	$8,322,130	$174,949	$216,824	38.38	$1,607,245
Endocrinology	6.1	$186,985	$133,695	$181,776	1.03	$49,458
Gastroenterology	45.4	$1,902,181	$156,510	$329,111	5.78	$997,592
General Internal Medicine	191.225	$113,586,127	$136,250	$160,058	709.66	$16,895,004
General Surgery	31.25	$12,232,562	$194,361	$277,702	44.05	$3,671,108
Geriatrics	11.375	$5,300,674	$132,003	$167,694	31.61	$1,128,177
Gynecology (OB/Gyn - Other)	1.9	$2,646,880	$176,359	$206,943	12.79	$391,181
Hematology/Oncology	29.625	$3,604,702	$140,164	$385,606	9.35	$2,294,428
Infectious Diseases	18.505	$597,046	$135,196	$199,761	2.99	$192,972
Nephrology	7	$4,561,735	$139,617	$275,311	16.57	$2,248,366
Neurology	22.25	$2,182,569	$133,314	$212,216	10.28	$811,484
Neurosurgery	7.175	$3,786,867	$249,601	$502,913	7.53	$1,907,405
Ophthalmology	17.1	$4,315,444	$171,094	$301,451	14.32	$1,866,135
Orthopedic Surgery	22.875	$6,600,581	$242,825	$444,105	14.86	$2,991,556
Otolaryngology	11.55	$962,887	$190,567	$304,389	3.16	$360,058
Pathology	24.875	$10,832,884	$145,778	$289,235	37.45	$5,372,989
Physical Medicine & Rehab	20.575	$969,748	$142,976	$234,605	4.13	$378,752
Plastic Surgery	5.125	$840,228	$223,465	$472,475	1.78	$442,828
Preventive Medicine	1		$145,807	N/A	N/A	N/A
Psychiatry	110.175	$4,350,983	$146,887	$161,440	26.95	$392,213
Pulmonology	16.975	$1,162,023	$138,667	$236,298	4.92	$480,114
Radiology	100.2	$64,119,853	$220,662	$450,000	142.49	$32,678,042
Rheumatology	9.4	$165,564	$133,563	$212,183	0.78	$61,347
Thoracic/Cardiovasc Surgery	10.375	$15,826,215	$247,602	$375,385	42.16	$5,387,326
Urology	34.75	$3,597,512	$200,690	$337,144	10.67	$1,456,039
TOTAL	**944.905**	**$328,055,298**				**$111,992,584**

(1) - Estimated unit FTE cost based on MGMA Physician Compensation Report, 2002 (based on 2001 data); actual contract FTE costs may be higher.
(2) - Contract FTE constructed by dividing total contract expenditures by estimated unit FTE cost.
(3) - Savings based on difference between contract costs per contract FTE and VA employee costs for same FTE, or actual contract expenditures, whichever is lower.

APPENDIX E

RECOMMENDED DISPOSITION OF CONTRACTOR'S RECOMMENDATIONS

The contractor provided a number of recommendations concerning recruitment and marketing, a new pay system, and employment administration for physicians and dentists. Many of the recommendations formed the basis of the recommendations of the Reviewing Committee. As such, the majority of the contractor's recommendations are incorporated into the Reviewing Committee's recommendations.

The Committee recommends the following courses of action on each of the specific recommendations from the contractor:

Recommendations 1 – 5, 7 - 8. The new pay system that incorporates longevity, geographic area, and other characteristics into specialty base pay rates.

These specific recommendations are not proposed for adoption. They would perpetuate the current system of numerous discrete components of pay, resulting in a jigsaw puzzle of compensation bits for each candidate and undue complexity of administration. Rather, the Reviewing Committee has proposed a simpler system of a three-tiered pay system, including a performance-based component of at-risk pay.

Recommendation 6. Create funded honorary positions for exceptional researchers and clinicians.

The contractor proposes that VA create positions for exceptional researchers and clinicians like Chaired Professors at Doctoral-level Universities. These positions would be centrally funded and offer compensation and supporting staff for exceptional individuals, such as Nobel laureates, etc.

VA has a program of Distinguished Physicians, whereby senior individuals may be placed in these honorary positions in recognition of their seniority and years of contributions to the Department. A separate program does not appear to be necessary and is not recommended for adoption.

Recommendation 9. VA should improve its data reporting system to facilitate workforce planning.

We acknowledge the shortcomings in the current PAID system, and the need for improved employee information to support workforce planning. However, the proposal is beyond the scope of this report.

Recommendation 10. VA should improve its marketing and recruitment and target individuals at risk of leaving at certain junctures in their careers.

VA adopts the proposal for a specialized recruitment office focusing on recruitment of physicians and dentists. The Reviewing Committee has included a broad outline of the responsibilities and functions of such an office, to include recruitment, marketing, and employment referrals.

The proposal to target individuals at key points in their careers, at 5 – 7 years and, to a lesser extent, 11 years of service, requires further study to better understand who is leaving, and why. If many of those leaving are the senior clinicians who come to VA after leaving private practice or academe, their departures may be appropriately timed for their retirements. Also, it may not be possible to identify who is likely to leave. The majority of employees stay past these key service points. It will take careful analysis to see if there is any way to identify who is likely to leave and should be targeted for retention incentives.

To facilitate such a study, VA is working to implement an automated exit interview to gather valuable information on why employees leave for reasons other than retirement.

S T A T E M E N T

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On

VA Physician Compensation Issues

Presented by

Thomas Lawley, M.D.
Dean
Emory University School of Medicine

Before the

Subcommittee on Health
Committee on Veterans Affairs
United States House of Representatives

October 21, 2003

Good Afternoon. I am Thomas Lawley, M.D., dean of the Emory University School of Medicine. I am here this afternoon speaking on behalf of the Association of American Medical Colleges (AAMC). The AAMC represents the nation's 126 accredited allopathic medical schools, over 400 major teaching hospitals and health systems – including over 70 VA hospitals –, 92 academic and scientific societies representing nearly 100,000 faculty members, and the nation's medical students and residents. I currently also serve as chair of the AAMC's VA-Deans Liaison Committee, which provides a forum for medical school deans with strong VA affiliations to discuss important policy decisions with VA leadership.

The issue the subcommittee is debating today, reform of the VA physician compensation system, is an important one for both VA and academic medicine. Since the affiliation agreements began in 1946, the VA health care system has been intentionally intertwined with academic medicine, to the benefit of both parties. This relationship, by all counts, has been mutually beneficial, with VA gaining access to a higher quality of medical care than could be obtained with a wholly full-time VA medical service, and with the affiliated medical schools gaining valuable opportunities for medical education and research. The VA maintains approximately 8,600 full-time residency positions, and is the nation's largest provider of graduate medical education. However, that figure alone does not illustrate the full impact of the VA on academic medicine. Over 30,000 medical residents rotate through the VA system every year, in addition to over 20,000 medical students. And these figures do not even begin to address the other types of health professionals that provide services to, and receive educational training from, the VA.

Following the end of World War II, leaders of the Veterans Administration faced the problem of providing care to a large number of veterans while facing a shortage of qualified VA physicians. Simultaneously, medical schools were looking for ways to expand opportunities for graduate medical education to accommodate all the returning physicians who had gone into the armed services without completing specialty training.

Paul B. Magnuson, M.D., who chaired the department of orthopedic surgery at Northwestern University Medical School at the time, was one of the people called upon to help resolve this dilemma. He found that the VA shortage of physicians was caused in part by bureaucratic red tape and the poor reputation of VA medicine. Dr. Magnuson suggested that affiliations between medical schools and VA hospitals would solve VA's problem by allowing medical school deans to staff VA hospitals with top-notch medical school faculty physicians, residents and interns. The affiliated VA facilities, in turn, would provide medical schools with new venues in which to educate young physicians. Public Law 79-293, enacted on January 3, 1946, provided the legal basis for affiliating with schools of medicine, and established the VA Department of Medicine and Surgery, the predecessor of the Veterans Health Administration. Later that same month, VA published Policy Memorandum No. 2, the "Policy on Association of Veterans' Hospitals with Medical Schools." The memo made clear that the VA would retain full responsibility for the care of its patients, and the school of medicine would accept responsibility for all graduate education and training. The affiliations were intended to afford "the veteran a much higher standard of medical care than could be given him with a wholly full-time medical service." Policy Memorandum No. 2 still guides the VA-medical school affiliations today.

The architects of the affiliations saw benefits in integrating the clinical care team at the VA with the medical school and its teaching hospitals. This led to a construction policy of favoring sites near existing medical schools, and for the same reasons of cooperation and efficiency, medical schools often built facilities near existing VA hospitals. In fact, under the 1972 VA Medical School Assistance and Health Manpower Training Act, VA provided grants to expand existing medical education programs and facilities, as well as to establish five new medical schools (Marshall University, Wright State University, East Tennessee State University, Texas A&M University, and the University of South Carolina) for which the nearby VA medical centers would serve as their principal teaching hospital facilities. Such agreements led to the establishment of joint appointments and shared compensation for physician faculty, two hallmarks of the current affiliation agreements.

Under the current system, both full-time and part-time VA physicians receive additional salary from the medical school affiliate. Full-time physicians receive stipends for their contributions to the medical schools' educational programs. Part-time physicians receive salary for the academic portion of their appointment, but because the VA's physician compensation schedules have fallen so far short of market standards, a physician with a fractional VA appointment typically receives more than the proportionate share of his/her salary from the academic partner.

In recent years there has been growing concern that the physician compensation schedules in the VA health system have fallen even further behind the market. The recruitment of promising physicians to VA is often made possible only by the existence of a joint appointment at the academic affiliate. By accepting a joint appointment, individuals often receive research space and eligibility to apply for VA research funding. The VA also uses the joint appointment process as a recruiting tool, offering the opportunities (e.g., career advancement) afforded by an academic appointment as incentive for providing care at the VA. In fact, approximately 70 percent of VA physician staff members have some level of joint academic appointments, and some deans report the extent of joint appointments in their affiliations is over 90 percent. In addition to those with formal employment agreements, many full-time medical school faculty members maintain Without Compensation (WOC) appointments at the VA, which allow them to see and admit patients, educate medical students and residents, and conduct research within the VA medical center. Through such arrangements, the VA gains access to the full range of medical specialties and expertise that is generally available only at an academic medical center. In addition, interns and residents, supervised by attending physicians, participate in the care of countless veterans at VA medical centers.

Although it is unclear exactly how many full-time VA physicians with joint appointments receive stipends from the affiliated medical school, there is general consensus that without joint appointments, the VA would have difficulty recruiting and retaining physicians in the highest income specialties in virtually all locations. Part of the reason is that the amount of specialty pay has not increased since 1991, and cost of living and inflation increases for federal employees apply only to the base pay portion of the salary, meaning a VA physician's total compensation has been falling even further behind his/her private sector colleagues. As a result, there is anecdotal evidence that the agency is having difficulty and sometimes is unable to recruit and retain individuals in scarce specialties and subspecialties even with the academic salary subsidy.

These difficulties are most severe in the disciplines with the highest pay disparities, such as certain surgical and medical subspecialties, radiology and anesthesiology.

This is a historic opportunity to implement a compensation system that is responsive to market forces. The proposal calls for a three-tiered approach that would be benchmarked to the 50th percentile of the AAMC's Associate Professor salary. It would incorporate performance-based pay as well as geographic, specialty, and productivity measures to bring VA's physician salaries in line with those in the non-federal workplace. VA estimates that such a change would increase the salary of approximately 30 percent of VA physicians at a cost of $124 million in the first year, and $636 million over 10 years when the savings from a reduction in contracts and fee-based services is taken into account. While such a change would certainly improve the VA's competitiveness in recruiting and retaining physicians in the highest paying specialties, the AAMC is concerned that the proposal does not go far enough. We believe that a system that benchmarks to the 75th percentile of the AAMC's Associate Professor salary level would better ensure that VA remains on the cutting edge of medicine and is able to compete for the best and brightest physicians. Such a change is estimated to cost an additional $244 million in the first year, and would increase salaries for over 99 percent of VA physicians. Implementation of such a proposal would significantly increase the ability of VA and the affiliate to recruit high quality physicians.

While the AAMC is supportive of the intent of the proposal to increase the salaries of VA staff physicians, we are concerned about provisions in the legislative language to prohibit VA Chiefs of Staff from receiving compensation of any type from the affiliate. Chiefs of Staff are the primary liaison between the VA and the medical school and, indeed, often hold the title of Associate Dean. It is essential that persons so appointed have academic credentials and credibility, as well as linkages with the affiliate. While I understand the VA's concern that Chiefs of Staff need to function as VA's independent representatives without conflicts of interest, limitations on the benefits and compensation that a Chief of Staff can receive from an academic affiliate will serve as a disincentive for the most qualified individuals to pursue such a leadership position. The ability to receive funds through NIH grants or for teaching or clinical work during non-VA time should be viewed as enhancing an individual's career, not a conflict of interest. Chiefs of Staff generally do not make business decisions for the VA; that is the responsibility of the Director, and conflicts of interest should already be covered by the Ethics in Government Act. Although it is my understanding that the proposed compensation prohibition would not affect a large number of Chiefs of Staff, the AAMC believes that the provision could be counterproductive and inhibit recruitment.

The VA academic affiliations have been a major reason that the VA health care system is a world leader. Since the affiliations began in 1946, mutually beneficial policies such as shared appointments and adjacent construction practices have provided the VA with access to the full range of high-quality medical care, and the affiliates with valuable education and research opportunities. The "Department of Veterans Affairs Health Care Personnel Enhancement Act of 2003" will improve the ability of VA to recruit and retain the best and brightest physicians, and will result in better care for the nation's veterans through access to the latest clinical research and cutting edge technologies, as well as an enhanced academic environment.

National Association of VA
Physicians and Dentists

Testimony of Dr. Stephen P. Rosenthal
President
National Association of VA Physicians and Dentists

Before
The U.S. House of Representatives
Subcommittee on Health
of the
Committee on Veterans Affairs

344 Cannon House Office Building
Washington, D.C.
October 21, 2003

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Thank you Mr. Chairman for the opportunity to address your sub-committee this afternoon on behalf of the physicians and dentists who practice in the Veterans Health System. I am Dr. Steve Rosenthal. I have practiced in the VHA for 28- plus years and I am currently Acting Chief of Nuclear Medicine at the Miami VA Medical Center. However, today I am here to testify in my capacity as President of the National Association of VA Physicians and Dentists. NAVAPD is the only national organization whose sole mission is enhancing the professional working conditions, and incentives, that increase VA physicians and dentists ability to provide accessible, high quality health care for our Veterans.

We are here today with three messages: 1.) To thank this administration for recognizing the need for an adjustment in the direction of competitive pay for the front line medical staff who serves our nation's veterans. 2.) To support the paradigm shift in compensation that is suggested in the proposal offered by the Department. A shift which, we believe, lays the groundwork for Title 38 VA physicians and dentists to keep pace with similar practitioners in the private sector, And, 3.) To suggest changes to the proposal that we believe will produce a statute that is simple, equitable, understandable, self-updating and more easily administered than the *"Health Care Personnel Enhancement Act of 2003."* Our proposal has flexibility, is market responsive and maintains in harmony with the American economy.

Some thirteen years ago, we came before Congress asking that the compensation of VA doctors be adjusted upward because we were falling woefully behind our colleagues in the private sector. You heard us and enacted legislation that brought us more in line with the private sector. Since that bill was signed into law a dozen years ago, save for cost of living increases, VA physicians have not received one dime in increased compensation. While the time for action is long overdue, we believe that Secretary Principi and Undersecretary Roswell have acted out of genuine desire to provide the quality of health care our country's veteran population deserves.

The Department of Veterans Affairs is facing a critical situation in its compensation system for physicians and dentists. The VA can no longer recruit and retain highly qualified and experienced physicians and dentists, and not just in the categories where scarce medical and surgical sub-specialties are required. Many VA professionals remain employed in the VHA out of respect for and loyalty to the men and women "who shall have borne the battle." However, these professionals also desire opportunities to do research that cannot be done elsewhere and to educate future healthcare providers. In so doing, they build careers and provide unique care-giving knowledge for the special needs of our veterans. These professionals want to be treated fairly and be compensated commensurate with their knowledge and skill levels.

Because the Department of Veterans Affairs is not meeting these professional career goals, recruitment and retention of physicians and dentists is a critical, and worsening, problem for the Department. In addition, generational attitude shifts of many young professionals have redirected their focus away from institutionalized medical care, medical education, and research. There is a rapidly shrinking pool from which to select replacement physicians and dentists with the requisite knowledge base and specialized skills.

Historically, it has been necessary for VA physicians and dentists to come to Congress with a request for increases in compensation through the addition of "specialty pay" categories or higher 'pay bands' for existing specialty pay brackets. This has meant VA physicians and dentists pay has approached private sector standards for a snapshot in time. We have then had to "wait our turn" for the next legislative opportunity...all the while slipping further and further behind our private sector colleagues. Now we have a proposal on the table that suggests review and parity on a regular basis, without the need to change the law of the land each time, which we believe is a prudent change in thinking that will have a positive impact on recruitment and retention of quality physicians and dentists. However, as is usually the case...the devil is in the details.

The Department of Veterans Affairs proposal is vague and complex and, NAVAPD believes, impossible to fairly administer. NAVAPD also believes that the Department's proposed legislation is limited in scope, is intended to benefit only a small minority of front line medical staff, provides few details regarding implementation, and has the potential to be manipulated in ways that were not originally intended. Further, the legislation proposed by the Department is not in concert with either the most recent Presidentially mandated Quadrennial Report or even the Department of Veterans Affairs' Task Force Interpretation of that Report.

The stated purpose of this legislation is to provide salaries that will be competitive with the private sector, which will in turn keep the professionals we have and attract high-quality recruits to the VHA. However, as proposed, this legislation would have a positive compensation impact on only thirty-percent (30%) of the fourteen thousand-plus physicians and dentists currently in the VHA. And that assumes total pay would include base pay, market pay AND performance pay. It is difficult to see this as a "moral booster" or recruiting tool.

It is even more difficult to see how this will help VA meet overall operational and clinical objectives. The front line medical staff is more than just "foot soldiers" in achieving these objectives. They are the face of the VA, they are the decision makers, the team leaders, the clinical thinkers, the quality managers, the innovators. They are very much the pilots of this highly technical, highly complex machine that is the modern health care system, managing life and death decisions, entrusted with the care and comfort of vulnerable and suffering human beings. They are under constant public scrutiny, relying upon their many years of education, training and experience, their intuition and art, and their humanity to guide their clinical actions in helping veterans and their families face the most complex, intimate and difficult choices of their lives. In this regard, quality does matter, and not just for the 20 or 30 percent of the most difficult to recruit and the highly paid sub-specialists, but perhaps of equal or greater importance, also for the journeyman VA physicians and dentists, the folks who are the heart and soul of this system and the ones who make it run day in and day out.

In addition to the goals which have already been described, and which are primarily addressed by the proposed legislation – the ability to recruit and retain extremely high paid rare sub-specialist - we ask that you keep another objective in mind as well the importance of returning the VHA to those who have the interest of the organization most at heart, the career physicians and dentists.

Wasting precious taxpayer dollars through the use of expensive contracts with affiliated university or private groups to hire needed and rare sub-specialists must be significantly reduced, if not eliminated. We agree with the department that it is vexing and galling, perhaps even ludicrous, to pay more to hire these specialists on contract while losing the benefit of a loyal full time VA employee in the process. To "pretend" to not pay them higher than the prohibited salary levels by hiring them "On Contract" is a lose-lose proposition for the VA, the veterans and the taxpayers. One of the stated purposes of this legislation is to address this issue, it is only a part of story from our perspective.

The Department understandably wishes to improve efficiency and spend wisely. However, we are here to let you know that cutting dollar costs by limiting the pay of the front line medical staff comes with its own special cost, one not addressed or even acknowledged by the language in the Department's proposal. It is true that the VA needs to remain competitive with the academic institutions in order to recruit their best and brightest academic performers. However, there may be a vested interest on the part of AAMC in ensuring that the VA remains less than competitive in this arena. Therefore, I must add that NAVAPD is very concerned about the use of AAMC salary data as a benchmark for VA physicians. Since the vast majority of frontline VA physicians are practicing clinicians, it stands to reason that the workforce that VA competes against for recruitment and retention are private practicing physicians, just as is the case with dentists. We strongly believe that other sources of comparative physician income data, such the Medical Group Management Association (MGMA), should be used to benchmark salaries of VA physicians.

The value and contributions of sub-specialty providers are generally well understood; but less well understood perhaps are the contributions of another class of VA physicians and dentists – the full time, clinically based medical staff providers. These are the folks for whom the quality of the organization matters, who are loyal not only to their patients and their colleagues, but also to their organization and the mission of the VA. We represent and are concerned about the "bread and butter" of the medical staff, the doctors who come to work each day with the intent to make their facility a better place and who are committed to working in a health care environment which is world class and second to none in their community in the standards and quality of care. The cost of neglecting this talent is never addressed in the proposed bill and in our estimation the cost is incalculable. If this item remains unaddressed when the bill is passed this asset will almost certainly gradually be lost to expensive contract services.

The proposed legislation describes "Performance Pay" as, "a variable pay band linked to a physician's or dentist's achievement of specific corporate goals and individual performance objectives." It goes on to say, "The amount payable to a physician or dentist for this component may vary based upon individual achievement, and may not exceed $10,000." The proposal later states that "no physician or dentist will be paid less the day after the implementation than he or she was being paid the day before implementation." How is it possible to determine performance pay prior to implementation. Is this provision, in fact, a "lack of performance" pay that potentially will be held over the heads of physicians and dentists like the sword of Damocles? At a minimum, this provision, as written, is vague and open to abuse. We recommend that a clear and distinct benchmark be used for evaluating the performance of Medical Center and VISN Directors to ensure

that performance pay is equitably administered across the country and not just a means for individual Directors to balance their budgets.

Additionally, this assurance of no negative pay adjustments appears to be negated by subsection 7431 (B) (d) which states, "Any decrease in pay that results from an adjustment to the market or performance component of a physician's or dentist's total compensation does not constitute an adverse action," and by the proposed language for subsection 7431, which states, "the functions of the Secretary and other officers of the Department of Veterans Affairs under this chapter are vested in their discretion." This provision appears to remove the due process rights of physicians and dentists and is reported to be in response to the unfair termination case of Dr. Elizabeth Von Zemensky in which the courts upheld her reinstatement.

Physicians and dentists are further placed at risk of negative pay adjustments when budget pressures may force cost cutting measures. This is the result of the statutory provision that prohibits negative pay adjustments for the largest professional group in the VHA, nurses. We implore you not to allow an accounting bulls-eye to be placed on our backs, and adopt the same no negative pay adjustment standard for physicians and dentists in this legislation as currently exists for nurses. Similarly, we urge you to favorably consider the deletion of the aforementioned change to subsection 7431.

As I mentioned earlier, the current proposal will positively impact only thirty percent (30%) of the physicians and dentists in the VHA. This is the result of three factors, the percentile used to calculate the benchmark for pay, the use of all three tiers to reach the benchmark sum, and the local flexibility of Base Pay. We would recommend that Base Pay be standardized at the GS 15, step 10 level...including locality adjustments for all physicians and dentists. We would recommend that the benchmark sum of Base Pay and Market Pay only, be set at eighty percent (90%) the 75th percentile of the Medical Group Management Association (MGMA) compensation level for physicians and that the benchmark sum be placed at eighty percent (90%) the 75th percentile of the American Dental Association (ADA) net private practice income for dentists.
We would recommend that Performance Pay be granted for higher than standard work achievement and that the range be expanded to $20,000. We would also recommend that a "Dedication Pay" tier be added based upon years of service as a retention inducement.

If this legislation is going to be the vehicle that moves the recruitment and retention of high quality physicians and dentists into the 21st century then we must address the leave policies that are unintentionally punitive in their effect. While private sector practices are offering newly minted physicians and dentists between six and eight weeks of annual leave, as well as paid time for continuing medical education, we have remained trapped in a system that discourages normal vacations by charging us leave for Saturday and Sunday if we take leave on the preceding Friday and the following Monday...regardless of whether or not we see patients or perform other duties on that Saturday and/or Sunday. We believe that the department has the authority to make the necessary adjustments to correct this situation. We have been trying to work with them for over two years on this issue. However, we have been unsuccessful, even though other groups have changed leave and other benefits without this type of difficulty. We now turn to you for help. Please include in this legislative package the directive necessary to allow us to take our thirty days of annual leave without the penalty of being charged for our non-duty days.

Mr. Chairman, we have taken the liberty of including suggested substitute language in our written testimony on these and other relevant subjects for your consideration. We believe this alternative compensation proposal will provide the roadmap necessary for VA professionals to know where our careers stand and what the future will hold for us. We hope this will contribute to your deliberations.

The following is a brief statement that we received from one of our rank and file that speaks to the points we are addressing here that I would like share with you:

> I'm a full time VA employee, board certified in three specialties, with eleven years of post-graduate training before beginning my practice at the VA, where I've remained for the last eight years. I am an Intensivist, a specialist in critical care medicine and take care of patients who are severely ill in the intensive care unit. During that time I'm on call 24 hours a day, seven days a week. It is demanding and stressful work. When I'm attending in the ICU, four months out of the year, I work on average 70 hours a week, including weekends, for which I receive no additional compensation. When I'm not in the ICU, I work about 50 hours a week. I'm also a co-director of the ICU and I spend long hours working on quality and safety improvement efforts, which have helped to make our ICU among the best in our community. My VA salary, which is my only source of income, is $134,000 dollars a year, admittedly a good income. By contrast, however, according to the Medical Group Management Association (MGMA) data base, the median national income for a Critical Care Intensivist in 2001 was $203,000, the mean salary income nationally was $218,747, and for the third quartile was $277,564. In all likelihood a competitive salary in my particular market area is more than double my current income.
> The VA has an asset in both its academic and clinical front line staff, which it seems, it does not fully recognize and which this bill absolutely does not recognize. The cost in loyalty, in efficiency, in quality improvement to the VA, in letting this asset remain under-recognized, and not aggressively competing to retain this asset is immeasurable and vastly exceeds that for recruitment and retention of high end, rare sub-specialists. I agree with the effort to compete for these high end sub-specialists but believe that it misses the real mark, if that is the main intent of the bill, in terms of providing real and lasting value not only to the veterans but to the health and future of the VA itself.

Again, thank you for the opportunity to share NAVAPD's thoughts on this critically important legislation. I would be happy to answer any questions you may have.

ELEMENTS OF THE NAVAPD PROPOSED SUBSTITUTE COMPENSATION LEGISLATION

The alternative compensation plan described below will address the tremendous pay disparities between VA physicians and dentists and those in private practice and academia. Although this plan would not match current private practice incomes, it would stem the rapid drain of these professionals from the system. The proposed compensation plan will provide assurance to Veterans that this Nation will maintain a Veterans' Health System that is second to none.

1. All pay of every category, past and future, will immediately count for calculations of retirement annuities and for calculations of lump sum retirement settlements.
2. Retirement lump sum settlement calculations will be based on total salary at the time of retirement.
3. No dentist or physician will receive less than his or her current salary on the day before enactment of this statute.
4. Judicial review will be maintained for all administrative levels as now dictated by Title 38 and Title 5 statutes.
5. There will be no written employment contracts or specified retirement dates.
6. There will be no vesting periods for any category of pay.
7. Federal Locality Pay will be included for all Department of Veterans' Affairs physicians and dentists according to current Federal statutes for each geographic location.
8. The most recently available American Dental Association (ADA) and Medical Group Management Association (MGMA) data shall be used in calculating the Market pay guidelines, adjusted each year by the fluctuations of the most recent Medical Index component of the Consumer Price Index. An oversight committee including field physicians and dentists will determine the formulation of the Market pay guidelines each year.
9. Market pay tier guidelines will be updated every year on November 1 and the new guidelines will become effective on the first day of the first full pay period in the subsequent January.
10. Total compensation will be the sum of Base and Market Pay. Performance Pay will be calculated and addressed separately.
11. VA dentists and physicians will earn thirty days of annual leave per year. Non-duty days (weekends and holidays) will not count against that leave.
12. VA dentists and physicians will earn fifteen days of sick leave per year. Non-duty days (weekends and holidays) will not count against that leave.
13. All language referencing benchmarking salaries must be included in the actual legislative language, including all references to specific sources of income data as well as levels at which benchmarks will be set.
14. This statute will become effective immediately upon enactment.
15. The legislative language must specifically state that salaries of VA physicians and dentists will not be reduced, consistent with all other categories of VA employees.

The stated goals by the Department of Veterans Affairs are listed below and are clearly met by NAVAPD's alternative proposal:

Compensation structure is simpler
Compensation provisions are improved
VA's ability to retain and recruit is enhanced
Market forces are incorporated into the proposal
Statutory limitations will not be outdated by time
Compensation levels should not fall drastically behind those in the private sector and academia

In addition the NAVAPD alternative proposal addresses physicians' and dentists' goals as follows:

There are guaranteed base salaries
Individual formulation and calculation of salary structures are easily understood
Updates are accomplished yearly
Administrative abuse is largely prevented
Already earned retirement benefits are protected
All pay is used to calculate retirement benefits
Leave schedules are aligned to more nearly mirror the private and academic sectors
Provides inclusion of Federal Locality Pay
No physician or dentist will lose pay
Current judicial protections are retained
Written employment contracts and vesting periods are eliminated
Retirement only on specified anniversaries is eliminated

COMPENSATION COMPONENTS

A) <u>Total Pay:</u>

This will consist of two components: Base Pay and Market Pay

1. **Base Pay--**Base Pay for VA physicians and dentists will be the equivalent of GS 15/10 including appropriate Federal Locality Pay. This tier will be adjusted each January by COLAs.

2. **Market Pay--**

   a) Medical and surgical specialists and sub-specialists will receive 90% of the Medical Group Management Association (MGMA) level in the same specialty at the 75th percentile.

   b) Primary care physicians will receive 90% of the family practice physician level of the Medical Group Management Association (MGMA) at the 75th percentile.

c) Dental specialists will receive 90% of the American Dental Association (ADA) average of private practice net income for dentists in the same specialty at the 75th percentile.

d) General practicing dentists will receive 90% of the American Dental Association (ADA) average of private practice net income for general dentists at the 75th percentile.

B) Performance Pay:

VA physicians and dentists will be paid up to $20,000 per annum for achievements in quality, productivity and support of corporate goals. A national panel to include physicians & dentists from the field will recommend definitions and pay levels for quality, productivity and corporate goals.

STATEMENT BY

LACTANCIO D. FERNANDES, M.D., F.C.C.P

PRESIDENT LOCAL 1045
OF
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

BEFORE

THE HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON HEALTH

REGARDING

DEPARTMENT OF VETERANS AFFAIRS
PHYSICIAN AND DENTIST SALARY AND BENEFIT ISSUES

ON

OCTOBER 21, 2003

Chairman Simmons and members of the Subcommittee, I am Lactancio Fernandes. I am a fellow of the American College of Chest Physicians and I work as a pulmonary care physician at the VA Gulf Coast Health Care System.

American Federation of Government Employees, AFL-CIO
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As a Major in the United States Air Force Reserve, 919th Medical Squadron, my most recent annual tour was spent in support of Operation Iraqi Freedom. As President of Local 1045 of the American Federation of Government Employees, AFL-CIO, I represent nearly 1,200 doctors, nurses, allied health care workers and other hospital staff at the VA facilities in Biloxi and Gulfport, Mississippi, Mobile, Alabama, and Pensacola and Panama City, Florida. I am honored to present my union's views on issues confronting VA's ability to retain and recruit needed medical providers.

Addressing VA's ability to retain and recruit needed primary care and medical specialty providers is essential if the VA is to meet the current and future demand for veterans' medical care. Our members are frustrated and deeply concerned that hundreds of thousands of veterans must wait months for appointments to see us. Today's hearing is ultimately about ensuring that the VA will have the physicians and dentists it needs to provide veterans with meaningful access to high quality medical care.

Pay and benefits are key to retaining and recruiting direct care providers, but we believe that enhancing the culture of medical professionalism will also yield great strides in VA's ability to hire and keep physicians and dentists. Like other civil servants, physicians and dentists choose to work at the VA because it offers an opportunity to help people, hone and develop our professional practice, and perform meaningful and challenging work. In short, it is the nature of the work, not just the size of the paycheck, which matters.

Decisions on restructuring, staffing, administrative duties, and rationing of care affect how we are able to practice medicine. Ensuring that front-line medical providers have a voice in decisions which involve medical practice and quality of care issues is absolutely essential if the VA is to be the employer of choice for doctors and dentists and provide world-class health care.

For example:

- Front-line medical providers need to be part of VA's dialogue on developing a staffing model for primary care, long-term care, and specialty care to ensure that the methodology accounts for time spent not only on direct patient care but administrative tasks, research, coordination of care and ongoing professional development and education.
- VA's ongoing efforts to refine a computerized medical record system would benefit from extensive feedback from the very doctors who must expend patient care time entering data.
- When VISN or facility management establish additional requirements for prescribing atypical antipsychotic drugs the voice of front-line physicians is essential to ensure that cost-containment efforts do not undermine or restrict veterans access to effective treatment.

Current law creates unnecessary constraints on the ability of front-line physicians and dentists to work with VA management to address the ongoing challenges the VA faces in the delivery of direct patient care. As you consider improvements to the physician and dentist pay system we urge you to consider improving the participation of front-line physicians and dentists in decisions which affect their practice. Ensuring that direct care providers have a seat at the decision making table will create a stronger culture of medical professionalism, improve morale, and make successful implementation of new policies and procedures more likely. Giving doctors and dentists a real say in shaping workplace decisions that impact on patient care will boost VA's ability to hire and keep medical providers.

AFGE would welcome the opportunity to work with the Subcommittee to explore workable ways to expand and invigorate the opportunities for direct care physician representatives to be part of VA's ongoing dialogue on how to improve its delivery of care to veterans.

As this Subcommittee considers the VA's proposed new pay and benefit system for physicians and dentists it is important to assess what the current system offers in terms of establishing competitive salaries.

Positive components of the current system include:

- A guaranteed annual General Schedule (GS) nationwide pay adjustment,
- the recognition of the value of full-time physicians and dentists through a guaranteed pay adjustment,
- encouraging a stable patient-physician relationship and long-term commitment to caring for veterans through guaranteed length of service pay,
- incentive pay for ongoing professional learning and advanced credentials through guaranteed compensation for board certification, which recent research has shown is linked to improved patient outcomes,
- flexibility to provide additional compensation for medical specialties,
- flexibility to increase compensation to meet specific geographic challenges in recruitment and retention, and
- the ability to reward exceptional qualifications within a specialty.

This pay system is more transparent, fair, credible, and equitable because many of the key pay components are guaranteed and not discretionary. It also makes the system easier to administer and less subjective or vulnerable to bias or discrimination than a system which places all components of pay for each individual physician at the discretion of VA facility management. As the Subcommittee moves forward in refining the existing pay system we would urge you not to eliminate the guaranteed status of key objective pay components.

The values of the current special pay provisions have been diluted over the years because the statutory dollar limits are not indexed. A simple and rational approach to addressing this weakness in the pay system would be to adjust all current guaranteed and discretionary pay components upward by the same

percentage as the GS across-the-board pay increase. This would in effect index the current statutory dollar limits.

Using the GS across-the-board raise to increase both the base salary and specialty pay is rational because the GS across-the-board increase is based upon the Employment Cost Index (ECI). This Bureau of Labor Statistics (BLS) index measures the change in compensation costs for private sector, State and Local government employers. By using the GS pay increase on the full salary amount, provider salaries remain competitive. This would also be consistent with other current federal pay systems, and would not require significant effort by the VA to administer.

Discretion in VA's Current and Proposed Pay System to Set Market Based Salaries

While the current discretion in setting geographic and specialty salary rates may give VA flexibility it also makes the system vulnerable to arbitrary, inconsistent and biased compensation decisions. With this vulnerability come inconsistency, favoritism and discrimination, which erode the core merit principle of equal pay for work of equal value. The inconsistent and biased exercise of discretion hurts morale.

Having key components of the current physician pay system be based on guaranteed and objective measures has gone a long way toward preventing pay discrimination on the basis of race, ethnicity, gender, or veterans status. However, the current system's discretionary pay components in geographic pay and specialty pay have meant a return of a "good ole boy" system in some facilities. Problems with such discretion are not limited to cronyism but outright discrimination. Employment discrimination lawsuits are a costly check and balance to abuse in the pay system.

We are very concerned that VA's proposed pay system strips away any guarantees for objectively and fairly setting physician and dentist salaries. Senior front-line physicians would no longer be guaranteed compensation for their full-time status, long-term commitment to caring for veterans or board certification. These factors might be considered in placing an individual physician or dentist along the base pay band and in appraising his salary for the market pay band but the facility administrator could also ignore or discount these objective factors. Under the proposed legislation, two primary care doctors working at the same medical center who have the same years of service in the VA and are both board certified in the same specialty could have salaries that vary by $25,000 or more.

The VA's proposed legislation would also allow the VA absolute discretion to reduce the salaries of doctors and dentists. Further, the VA would contend that these reductions in pay would not be subject to review by an independent third

party. How can telling doctors that they could have their pay reduced and will have no recourse should such an adverse action occur help the VA retain and recruit highly qualified staff?

We understand that the VA would set the initial base pay amount as a salary floor. We are concerned, however, that this floor is still inadequate given the absolute discretion proposed in the legislation. For example, the VA could set two doctors' base salaries at $110,000 and over the years raise their salaries to $130,000. The VA would still have statutory authority to cut one doctor's pay by $20,000 and she would have little to no recourse.

The VA suggests that decreases in a doctor's pay will be the result of downward changes in market salary trends. The proposed legislation authorizes the VA broad authority to interpret and apply "market data." For example, the provision on the market pay band includes factors such as "personal qualifications, and individual experience." These subjective assessments would have nothing to do with market trends but would nonetheless be part of the market-based component of pay. Using these subjective non-market factors, facility administrators could cut physicians' pay.

This Subcommittee wisely put a stop to negative pay adjustments in the VA's nurse pay system. Should the Subcommittee move forward on VA's physician and dentist pay proposal we urge you not to give the VA authority to decrease a medical provider's pay.

VA's explanation of the market-based tier also makes clear that the target for pay comparability is the 50 percentile of AAMC salaries in the broad geographic area, plus or minus 10%. Facility administrators under tight budget constraints could ignore market data repeatedly to keep salaries minus 10% of the already low benchmark of the median AAMC salary levels. We have seen how facility administrators have ignored salary data to repeatedly deny Registered Nurses any pay raises. What safeguard mechanisms and accountability would be in place to ensure that facility management would not regularly set salaries at minus 10% of the median AAMC salary rates?

Should the Subcommittee allow any level of individualized pay setting we urge you to ensure that discretion in setting pay is balanced by statutory checks and balances, independent review and accountability mechanisms to ensure reliability, validity, and transparency in any both establishing the regulatory framework and for specific pay decisions.

Pay for Performance

Does a pay system that sets out to reward individual employees for contributions to productivity and quality improvement and punishes individual employees for making either relatively small or negative contributions to productivity or quality

improvement work? The data suggest that they do not, although the measurement of productivity for service-producing jobs is notoriously difficult.

Although individualized merit pay gained prominence in the private sector during the 1990's, there is good reason to discount the relevance of this experience for the federal government as an employer. Merit based contingent pay for private sector employees over the decade just past was largely in the form of stock options and profit-sharing, according to BLS data. The corporations that adopted these pay practices may have done so in hope of creating a sense among their employees that their own self interest was identical to the corporation's, at least with regard to movements in the firm's stock price and bottom line. However, we have learned more recently, sometimes painfully, that the contingent, merit-based individual pay that spread through the private sector was also motivated by a desire on the part of the companies to engage in obfuscatory cost accounting practices.

These forms of "pay for performance" that proliferated in the private sector seem now to have been mostly about hiding expenses from the Securities and Exchange Commission (SEC), and exploiting the stock market bubble to lower actual labor costs. When corporations found a way to offer "performance" pay that effectively cost them nothing, it is not surprising that the practice became so popular. However, this popularity should not be used as a reason to impose an individualized "performance" pay system with genuine costs on the federal government.

Jeffrey Pfeffer, a professor at Stanford University's School of Business, has written extensively about the misguided use of individualized pay for performance schemes in the public and private sectors. Pfeffer's research shows that performance systems never achieve their desired results, yet "eat up enormous managerial resources and make everyone unhappy."

Professor Pfeffer explains that pay for performance myths are based on conceptions that human nature is uni-dimensional and unchanging. In economics, humans are assumed to be rational maximizers of their self-interest, and that means they are driven primarily, if not exclusively by a desire to maximize their incomes. The inference from this theory, according to Pfeffer, is that "people take jobs and decide how much effort to expend in those jobs based on their expected financial return. If pay is not contingent on performance, the theory goes, individuals will not devote sufficient attention and energy to their jobs."

Further elaboration of these economic theories suggest that rational, self-interested individuals have incentives to misrepresent information to their employers, divert resources to their own use, to shirk and "free ride", and to game any system to their advantage *unless* they are effectively thwarted in these strategies by a strict set of sanctions and rewards that give them an incentive to

pursue their employer's goals. In addition there is the economic theory of adaptive behavior or self-fulfilling prophesy, which argues that if you treat people as if they are untrustworthy, conniving and lazy, they'll act accordingly.

But do pay for performance systems work? Pfeffer answers with the following:

> Despite the evident popularity of this practice, the problems with individual merit pay are numerous and well documented. It has been shown to undermine teamwork, encourage employees to focus on the short term, and lead people to link compensation to political skills and ingratiating personalities rather than to performance. Indeed, those are among the reasons why W. Edwards Deming and other quality experts have argued strongly against using such schemes.
>
> Consider the results of several studies. One carefully designed study of a performance-contingent pay plan at 20 Social Security Administration (SSA) offices found that merit pay had no effect on office performance. Even though the merit pay plan was contingent on a number of objective indicators, such as the time taken to settle claims and the accuracy of claims processing, employees exhibited no difference in performance after the merit pay plan was introduced as part of a reform of civil service pay practices. Contrast that study with another that examined the elimination of a piece work system and its replacement by a more group-oriented compensation system at a manufacturer of exhaust system components. There, grievances decreased, product quality increased almost tenfold, and perceptions of teamwork and concern for performance all improved. [1]

Compensation consultants like the respected William M. Mercer Group report that just over half of employees working in firms with individual pay for performance schemes consider them "neither fair nor sensible" and believe they add little value to the company. The Mercer report says that individual pay for performance plans "share two attributes: they absorb vast amounts of management time and resources, and they make everybody unhappy."

One further problem cited by both Pfeffer and other academic and professional observers of pay for performance is that since they are virtually always zero-sum propositions, they inflict exactly as much financial hardship as they do financial benefit. In the federal government as in many private firms, a fixed percentage of the budget is allocated for salaries. Whenever the resources available to fund salaries are fixed, one employee's gain is another's loss. What incentives does this create? One strategy that makes sense in this context is to make others

[1] "Six Dangerous Myths about Pay" by Jeffrey Pfeffer, Harvard Business review, May-June 1998, v.76, no. 3, pg. 109(11).

look bad, or at least relatively bad. In addition, competition among workers in a particular work unit or an organization may rationally lead to a refusal on the part of individuals to share best practices or teach a coworker how to do something better. Not only do these likely outcomes of a zero-sum approach obviously work against the stated reasons for imposing pay for performance, they actually lead to outcomes that are worse than before.

What message would the VA be sending to its medical providers and prospective employees by imposing pay for performance system? At a minimum, if performance-based contingent pay is calculated on an individual-by-individual basis, the message is that the work of lone rangers is valued more than cooperation and teamwork and focusing on veterans. Further, it states at the outset that there will be designated losers - everyone cannot be a winner; someone must suffer.

Apart from grave concerns about how performance pay depletes administrative resources and pits one physician against another, we also have questions about the specifics of the so-called "corporate goals" for physicians and dentists who treat veterans. We are concerned that the "corporate goals" upon which performance pay will be based will adversely impact professional autonomy to make necessary direct patient care decisions.

As part of VA's cost-cutting measures, would the VA adopt "corporate goals" which give physicians an incentive to restrict or dampen veterans' access to needed medical tests, treatments or perscription drugs? Would the "corporate goals" try to encourage doctors to see more patients but spend so little time with each patient as to undermine the quality of the doctor-patient relationship? Would the VA promote "corporate goals" that would encourage facility administrators and medical providers to erode VA's capacity to provide more costly inpatient psychiatric care, substance abuse treatment, or spinal cord injury care? Because performance pay could be based upon VA's ability to recoup money from third party payers would the VA "corporate goals" in effect reward physicians who do not treat or who spend less time treating veterans who have no insurance?

How will front-line physicians and dentists' representatives and veterans advocates be involved in developing and evaluating the performance pay "corporate goals"? Will there be effective transparency and accountability measures, including independent third-party reasonableness reviews, access to independent grievance procedures, internal assessments and regular direct care provider evaluations of the system? Such safeguards are key to minimizing waste, fraud and abuse.

Given that experts find that pay for performance systems eat up enormous managerial resources and usually make everyone unhappy we are skeptical of the possible benefits from VA's proposed third tier for pay. The added potential

pitfalls of VA's "corporate goals" undermining veterans' access to high quality medical treatment lead us to urge the Subcommittee to proceed with utmost caution in considering VA's pay for performance proposal.

Pay for performance is the wrong answer to the wrong question. It's not that VA's physicians and dentists don't perform well and will only do so if their annual raise depends on it. More money needs to be put into VA's budget to hire additional staff. More money is needed so that federal salaries are competitive with salaries paid in the private sector. Reallocating existing money so that you solve that problem for some and make things worse for others under the banner of "performance" is dishonest and will do lasting damage to the delivery of health care for veterans.

Questions with the Market Tier

VA's proposed legislation is open-ended in defining what data it will use to support its quasi-market based pay tier. Our understanding is that by regulation the VA would use AAMC data and target the combined three tiers of salary to approximate the 50th percentile of pay, plus or minus ten percent.

As previously discussed, we have grave concerns with the amount of discretion facility administrators would have in interpreting the data and applying it to individual medical providers. We also have a number of questions as to whether AAMC data is the most suitable benchmark upon which to base VA pay decisions.

Many medical schools have undergone revisions in their faculty pay that do not seem applicable to VA medical practitioners. It is my understanding that more schools are adopting a "eat what you kill" philosophy that requires faculty to essential raise 50% to 70% of their salary through outside research grants. Adopting this philosophy for full-time VA primary care and specialty doctors by proxy of the AAMC salary data does not make sense. We ask that the Subcommittee consider whether other databases or a combination of salary surveys might be more relevant to helping the VA achieve pay comparability with the private sector.

Even if the AAMC salary surveys were the appropriate database, why is the 50th percentile the magic number for ensuring that VA achieves pay comparability? Under VA's nurse locality pay system the VA cannot be the pay leader but it can go much higher than the 50th percentile to achieve competitive salaries for nursing staff, including nurse practitioners. Under the Federal Employee Pay Comparability Act, signed into law by George H. W. Bush, federal employee salaries under the General Schedule are to progressively increase over several years to reach 95% comparability with the private sector pay.

It is our understanding that the VA's proposed regulations implementing the proposed legislation would mean only 30% of VA's physicians and doctors would receive a significant pay increase at the expense of the remaining 70%.

Before proceeding with such a radical change in how VA sets pay we urge you to explore why such a limited number of physicians would benefit from this pay proposal, whether these physicians are full-time or part-time, provide specialty or primary care, front-line providers or administrators and whether there are other alternatives to addressing the unique salary demands for these physicians that do not adversely impact on the other 70% of the physicians and dentists.

Leave and Benefit Issues

The VA's proposed legislation fails to address a leave issue of concern for many full-time VA physicians and dentists -- the 24/7-availability policy. The current VA regulation governing annual leave for physicians, dentists, podiatrists and optometrists requires that these employees be charged for annual leave on weekends, even when their normal schedule is Monday through Friday. Eliminating the weekend charges of annual leave would be a significant step in improving the working conditions for VA's medical care providers. We would welcome the opportunity to work with the Subcommittee to address this problem.

In order to improve VA's retention of nurses during a national shortage, the 107th Congress changed how sick leave would be calculated for purposes of retirement annuities for Registered Nurses under the Federal Employee Retirement System (FERS). We believe that such a change for VA physician and dentists would also enhance VA's retention and recruitment efforts.

Funding to Support Hiring and Retaining Needed Staff

As long as the VA operates under a cloud of fiscal uncertainty it will not be able to plan to hire and retain needed staff in a competitive market. Without a dedicated new funding stream to allow the VA to retain and recruit physicians and dentists at more competitive rates we risk diverting funds away from retaining other needed staff to ensure safe medical care for veterans.

The Subcommittee's challenging and crucial work in addressing the ongoing fiscal uncertainty of veterans' health care funding will also help ensure the VA maintains adequate staffing levels to address current waiting lists and future demand for care.

Conclusion

Thank you again for the opportunity to share our concerns with you and to raise questions about how VA's proposed new pay system would work. I would be happy to answer your questions.

STATEMENT OF J.G. PARTHEMORE, M.D.,
CHIEF OF STAFF VA SAN DIEGO HEALTHCARE SYSTEM
BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
OF THE
U.S. HOUSE OF REPRESENTATIVES

October 21, 2003

Mr. Chairman and members of the Subcommittee, thank you for the opportunity to appear before you to discuss physicians and dentists compensation issues and the impact of the current pay structure on our ability to provide health care to veterans.

The provisions of the Bill represent a major step forward in providing adequate, competitive pay for physicians, dentists and nurse executives of VHA. I am pleased that the Secretary has proposed it. It represents a major effort to redress the pay gap that exists between VHA and the private sector, as well as VHA's academic affiliates. I hope you will make every effort to advance it.

Let me first address Nurse Executive pay and flexible hours. Present law permits us to adjust nurse pay in relation to local market pay at least annually, which helps us to remain competitive. It certainly forestalls nurse resignations for pay. But Nurse Executive pay in VHA remains a significant problem. It lags far behind local market pay <u>and</u> private sector benefits provided to those in similar positions. The addition of 10 to 25 thousand dollars will be very helpful in most markets. Given the anticipated retirement in the next 5 to 10 years of many VHA nurse executives, it would be wise for VHA to enhance its competitive edge, especially in urban, high cost markets. Nurse Executives with vision and

leadership ability are sorely needed, now more than ever, to serve as partners in administering our hospital systems.

Relative to dentist pay, dental chiefs are distressed that VHA has not implemented locality pay such that VHA employees enjoy salary parity with other government employees of similar grade in their locales. This country is graduating an even smaller number of dentists and young dental school graduates entering practice are making the rational choice to enter the lucrative private sector. Even VHA dental residencies in the past academic year were not filled in locales where they always have been. Our ability to recruit top-notch dentists, especially in specialty fields such as dental surgery, endodontia and prosthedontia is particularly problematic.

And for physicians, it has been a very long time, 12 years, since physician pay was last addressed. I am delighted the legislation before you now does so. I hope that the Bill can proceed quickly to passage, since a multitude of physician vacancies exist across VHA, most often leading facility management to engage in extremely costly contracts or send patients to the community. As I understand it, the Bill should also provide greater equity for our part time practitioners, who lose a considerable amount of pay under the current pay law. It is important to realize these physicians provide facilities much greater flexibility in staffing, an expanded coverage pool for night and weekend call, especially in tertiary care centers, and they provide highly specialized sub-subspecialty skills for which there is the clinical need, great difficulty in hiring, but not the need for a full time physician.

Those specialties in which recruitment has been most difficult will see the largest improvement in pay. However, there are several groups which will not see a substantial change in salary, such as primary care physicians, most medical specialists, neurologists, psychiatrists, pathologists and physiatrists.

I hope that the Bill continues to move forward. It has in it much to applaud with respect to greater parity with our communities, academic and private, and the flexibility to reward truly outstanding performance targeted to VHA goals, in clinical care, education, research and administration. It will further motivate career VHA physicians, dentists and nurses to an even greater degree than they are now motivated.

VHA's ability to become a leader nationally in performance outcomes, decreased waiting times, patient satisfaction and other measures, to implement a computerized patient record and ordering system, to respond to patient safety initiatives and to achieve many outstanding accomplishments in research and education are testaments to the quality of its physicians, dentists and executive nurses, as well as all of its employees. It is our privilege to care for America's Veterans.

Thank you for permitting me to share my views and I will be happy to answer any questions you might have.

STATEMENT OF
RICHARD L. BAUER, M.D.
CHIEF OF STAFF, SOUTH TEXAS HCS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
OCTOBER 21, 2003

Mr. Chairman and Members of the Committee.

I am pleased to be here this afternoon to present testimony on physicians and dentists compensation issues. I fully support VA's proposal to enhance the ability of the VA to recruit and retain professional staff and provide incentives for performance.

Since the last physician pay bill was enacted in 1991, and despite the more recent adjustment to dentist pay, the maximum salary that can be approved locally for physicians and dentists has been capped at about $190,000. Salaries of many medical specialties have exceeded this for many years.

Recently, we were in a salary negotiation with a neurosurgeon who was leaving private practice and wanted to work in a teaching environment caring for veteran patients.

> I said, "We could not pay him more than the annual salary of the Supreme Court justice.
>
> He said, "How much is that?"
>
> I said, "$190,000."
>
> He smiled.

To get around this impediment to recruitment, we have for some years established contracts for these services with our affiliated medical schools and occasionally with providers in the private sector. In tertiary care medical centers, I believe this has worked well. In San Antonio, these contracts have allowed us to include incentives to enhance productivity, supervision of residents, and quality of services.

These arrangements are less feasible away from tertiary care facilities. In South Texas, attempts to hire or contract for specialties in Urology, Orthopedics and General Surgery in the Corpus Christi, McAllen, and

Laredo areas, sites where we deliver primary care successfully, have been largely unsuccessful.

I believe choosing an alternative market rate benchmark will greatly enhance recruitment in these areas.

This new bill introduces an incentive component to pay. I agree with this principle. We have initiated incentive programs using special contribution awards, which are an incentive above current salaries. These have been limited to $5,000. I find that these rewards do incentivize providers to meet institutional goals.

I want to caution, however, that a predictable salary, even if less than the income earned in private practice, is now an aid to the recruitment of physicians and dentists in the VA. Investors in the stock market take risks because of the prospects of larger gains. I believe incentive pay can be a recruitment and productivity incentive for physicians and dentists, but there must be the prospects of some greater gain.

I support provisions of the bill giving flexibility to the scheduling of nurse duties and setting of pay for nurse executives. I chaired the search committee for the South Texas Associate Director for Patient Care Services and Chief Nurse Executive approximately 4 years ago. The nurse executive from our affiliated university hospital also served on this panel and indicated that the nurse executive pay scale was significantly less than her own pay and at least one highly qualified external candidate withdrew her application because VA pay was substantially below her current pay.

Mr. Chairman this concludes my testimony. I would be pleased to answer any questions you may have.

Statement of

Sheila Cullen, Director, San Francisco VA Medical Center

Before the

Committee on Veterans' Affairs

Subcommittee on Health

U. S. House of Representatives

October 21, 2003

Mr. Chairman, thank you for the opportunity to present testimony regarding compensation issues for VA physicians and dentists.

Our facility is a tertiary academic medical center with a strong and mutually beneficial affiliation with the University of California, San Francisco School of Medicine. One of the benefits of that affiliation has been our ability to recruit and retain top flight clinicians who provide high quality medical care to our veteran patients. We are proud to be home of five VA Centers of Excellence in Cardiac Surgery, Post-Traumatic Stress Disorder, Dialysis, Epilepsy, and HIV, all of which are relevant to the population we serve. As an adjunct to the excellent treatment we provide, we host the largest research program in the Department of Veterans Affairs with over $55 million in funded projects during the current year.

We are located in the heart of the San Francisco Bay Area, which unfortunately has one of the highest costs of living of any region in the country. The Data Quick Real Estate News Service, which monitors local housing costs, reported that as of August 2003, the median price of a home in San Francisco was $556,000, and in our two nearest neighbor counties, San Mateo and Marin, it was $566,000 and $627,000 respectively. Our experience has been that this fact alone, the inability to afford a home, has been the single most important reason cited by potential physician recruits for declining to accept offers of employment with the VA. Because of these factors, recruitment and retention of outstanding clinicians is a major challenge.

Under the current salary structure, the process of recruiting physicians is difficult, time-consuming and often not fruitful. For example, we recently conducted a national search for an additional interventional cardiologist. Ads were placed in major professional journals, and we did receive a large number of applicants, however most were non-citizens. The search committee interviewed ten applicants and narrowed the field to three who were highly qualified. After "wining and dining," introducing them to local real

estate, and a final assessment of their qualifications, a final offer was made to an extremely qualified applicant, however the salary level was inadequate for him to accept. In the past few years we have often been unable to find qualified U.S. citizens, and have hired non-citizens in several specialty areas. Even they, however, are leaving for more lucrative opportunities in the private or academic sectors. We fully expect that these problems of recruitment and retention will accelerate in the next decade; 30% of the employees at the San Francisco VA Medical Center will be eligible to retire in the next five years, and many members of our current physician cadre are senior with many years of experience.

Many of our surgeons are part-time because this allows them to earn a better salary by maintaining an outside practice at the university or in the private sector. Our current workload could support hiring additional staff in a number of surgical specialties and I concur with our Acting Chief of Surgical Service who believes that if the VA could pay higher salaries, rather than relying on part-time staff, we could hire more full-time surgeons who would be able to offer important contributions to the medical center in other clinical areas such as quality improvement and peer review on our professional standards board. At the same time, the new pay bill would also give us the ability to pay competitive salary rates for intermittent physicians in highly specialized fields who are needed only occasionally.

Our sister VA facilities in the Bay Area also report difficulties recruiting physicians in a number of specialties. For example, the VA Northern California Health Care System, serving much of the East Bay and the Sacramento Valley, has had severe problems recruiting orthopedists, radiologists, anesthesiologists, dermatologists, gastroenterologists, ophthalmologists, and ENT surgeons.

To fill the clinical gaps caused by these recruitment and retention difficulties, VA facilities typically must contract, at very high rates, for these specialized services. In San Francisco during FiscalYear 2003, we expended nearly $1.8 million for 7.825 full-time equivalents for physician services in neuroradiology, interventional radiology, general radiology and anesthesiology. At Palo Alto, the problem is even more severe, where they have been forced to spend approximately $6.8 million for 22.725 full-time equivalents in a wide variety of major specialties and sub-specialties, with the highest amounts concentrated in anesthesiology, diagnostic and interventional radiology, cardiothoracic surgery, neurosurgery, urology and vascular surgery.

If we are to remain a first-class institution, we need to have the flexibility to compensate our physician staff in a way that realistically addresses the market conditions within which we operate. The following are examples of outstanding attending physician

faculty members that we hope to retain: our chief of Cardiothoracic Surgery, who runs our Center of Excellence and is an NIH-funded researcher; our chief of Medicine, who is a nationally renowned clinical leader in care of patients with HIV/AIDS; our full-time neurosurgeon who leads the surgical unit of our Movement Disorders-Parkinson's Disease Center, a program unique within the VA; and our very experienced interventional cardiologist, who provides an important care component to a fast growing program. While we in San Francisco are indeed fortunate to have these clinical leaders on our staff, we still have difficulty recruiting anesthesiologists, radiologists, gastroenterologists, cardiothoracic surgeons, oncologists, and additional interventional cardiologists.

The new salary bill will permit us to increase the pay we can offer, especially in the scarce specialties where the recruitment problems are greatest. Although there are some specialties that may not see increases, or may actually decrease, we support the provisions in the bill that will allow current staff to maintain their present salaries as well as the greater flexibilities in setting future rates. In addition, under the current system, we must often rely on using retention pay and recruitment bonuses. However, because these are not considered pay for retirement computation purposes, they are less valuable than would be a higher base salary. We also believe that this new pay package will benefit our Dental staff. Although we have found that the current pay and benefits for dentists is competitive, this will ensure that we will continue to be able to recruit them as well.

Overall, we believe that the proposed legislation will improve our ability to recruit and retain highly skilled clinical staff to provide the best possible care to our patient population. The annual review will allow physician salaries to remain competitive with the local market rate, and with the productivity component, will permit us for the first time to reward performers who exceed expectations.

I appreciate the opportunity to present this information to the committee and I will be pleased to answer any questions you might have.

STATEMENT OF
MICHAEL EBERT, M. D.
CHIEF OF STAFF, VA CONNECTICUT HEALTH CARE SYSTEM
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
U. S. HOUSE OF REPRESENTATIVES

OCTOBER 21, 2003

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to appear before you today to discuss the compensation of physicians in the Veterans Health Administration. I am the Chief of Staff of the VA Connecticut Healthcare System and Professor and Associate Dean for Veterans Affairs at Yale School of Medicine. I recently completed an 18-year tenure as a clinical department chair at Vanderbilt University School of Medicine, where I worked closely with the affiliated VA, the Tennessee Valley VA Healthcare System. In both responsibilities, I have had substantial experience recruiting and retaining academic physicians who are working full or part time in the VA Healthcare System.

The Veterans Health Administration is the largest integrated health system in the United States. Its mission is to provide clinical care for eligible veterans, educate trainees in medicine and allied health care, and provide backup to the Department of Defense in the event of a national emergency. VA Medical Centers are affiliated with 107 medical schools, and the VA supports 10% of all graduate medical education in the United States. Recently the VA Healthcare System has been widely recognized as a leader in healthcare with regard to safety, patient information systems, delivery of primary care, and prevention of disease. A significant part of this success story is due to the group of talented and dedicated physicians that staff our VHA facilities throughout the country, many of which are affiliated with medical schools. As they mature in their careers, many of these physicians simultaneously contribute to several of the VA missions, and do it at the local, VISN, and national levels of VA organization. It is imperative for the VA to retain its most talented and hard working physicians rather than have them migrate out of VA employment at the time that they become most valuable to the VA mission, because of an overly rigid system of compensation.

You have heard testimony today on the current compensation system for VA physicians, how it developed, and the problems that it currently creates for recruiting certain physicians, and retaining a larger group of physicians. I would like to focus on two

aspects of the problem. The first is the recruitment and retention of expert physicians in certain highly compensated subspecialties. The second is the retention of highly skilled and accomplished physicians, regardless of specialty, who are maturing in their careers within the VA system. These physicians are often full time.

The legislation under discussion today provides a solution for the compensation problems created in both scenarios. It provides salary benchmarking to a reasonable standard. The AAMC statistics on the compensation of academic physicians are the most reliable database that I am aware of to indicate what large academic medical centers pay their clinical medical faculty. The database indirectly provides a reasonable and moderate benchmark for market-based pay of physicians. Secondly, the legislation provides flexibility to recognize seniority of physicians, national recognition, and market competition for their services based on their accomplishments.

Let me share with you the difficulties that we have encountered in recruiting and retaining physicians in highly compensated specialties. The VA Connecticut Healthcare System is a large tertiary medical care system, spanning the state of Connecticut, and affiliated with Yale and the University of Connecticut medical schools. We have an active surgical program and require subspecialized surgeons and anesthesiologists on our medical staff. We have had great difficulty recruiting and retaining academic surgeons in urology, ENT, ophthalmology, orthopedic surgery as well as anesthesiologists because of our pay structure. If we were not affiliated with two academic medical centers recruiting such physicians would be even more difficult. In VISN 1, Northampton and Boston, Massachusetts have had significant difficulty recruiting and retaining radiologists. Because of these difficulties, we have had to turn to contracting for clinical services in these disciplines. Contracting is fundamentally a more expensive means of providing specialty medical and surgical care. Furthermore, the contract physician does not have the same investment and involvement in the healthcare system. This is a hidden additional expense when you think about organizational change, continuous quality improvement, and day-to-day administration.

The second, and equally important problem, is the retention of extremely talented and nationally recognized physicians in the VA Healthcare System, whose compensation slips behind their peers as they mature in their VA careers. These individuals bring substantial productivity, prestigious academic accomplishments, and national leadership in healthcare to their VA facilities. They are usually full time, enjoy working in the VA, and are very loyal to the VA Healthcare System. However, once they establish a distinguished national reputation, they are often lured away by other medical schools to non-VA positions.

We have a number of such individuals in the VA Connecticut Healthcare System. Many of them are nationally and internationally recognized medical scientists. Interestingly, the majority of these scientists are also very clinically productive. They often assemble and lead state of the art clinical teams in specialized areas of diagnosis and treatment such as spinal cord injury, interventional cardiology, PTSD, alcoholism, and infectious disease. Their research is focused on discoveries that improve the healthcare of veterans. We have lost several of these leaders in recent years to other medical schools, where the salary differential was a significant factor in the recruitment.

Again, thank you for inviting me to this hearing. I will be pleased to respond to the subcommittee's questions.

Statement of
Michael M. Lawson
Director, VA Boston Healthcare System
Before the
Committee on Veterans' Affairs
Subcommittee on Health

October 21, 2003

Mr. Chairman and Members of the Subcommittee, thank you for inviting me to appear before your committee today to discuss physician and dentist compensation issues.

I am sure you are aware that the Boston Metropolitan area is one of the premier centers of medical Excellence in the United States. In a recent US News and World Report feature, many Boston facilities were ranked at or near the top in many specialties. Facilities such as Brigham and Women's Hospital, Massachusetts General Hospital, Boston Medical Center, Massachusetts Eye and Ear Infirmary, Dana Farber Cancer Institute, and Beth Israel Deaconess Hospital were all prominently mentioned. These are all affiliates of the Boston Healthcare System and their expertise are available and accessible by VA patients throughout New England.

Veterans expect, as do I, that the care provided by the VA Boston Healthcare System will be the equivalent of that practiced in those prestigious institutions.

We have met those expectations, but parity has become very difficult to maintain as competition for the best and brightest clinicians has been severely hampered by pay limitations that do not reflect the realities of the competitive clinical marketplace.

I mentioned earlier that we had met the challenge to this point. I believe we have done so, because our senior physician staff, while they have a deep-seated commitment to our veterans, choose to stay until they can exercise benefits offered them under the Civil Service Retirement System (CSRS). We have also exercised every available method and means (hiring traditional staff, contract, Fee basis, locum tenens; and supporting H1B visas) to obtain the services of physicians in critical care areas. In our critical care occupations we have two goals – to recruit quality staff and to retain the staff we have. Given the current salary rules, this presents us with significant challenges. Vacancies in certain specialties remain unfilled for many months – if not years. For example, positions in anesthesiology, infectious disease, radiology, oncology, cardiovascular surgery, thoracic surgery, gastroenterology and cardiology are often vacant for nine (9) to twelve (12) months. In anesthesiology, 62% of our physicians are on time-limited appointments due to their immigration status. While these H1-B visa holders are a good source of candidates, the number of these visas available through the Immigration and Naturalization Service are more limited than in

the past. Though committed to the VA in the short term due to their immigration status, most leave their clinical positions for more lucrative opportunities at the earliest possible opportunity. In anesthesia, our inability to recruit has also required us to meet workload demands through the use of scarce medical contracts at prevailing market rates. The disparity in compensation has become a morale issue when staff, working side-by-side, have markedly different levels of income.

The attrition rate for physicians in the radiology specialty for FY'03 at the Boston Healthcare System was 50%. These losses were clearly salary driven. Whereas the average VA salary of these radiologists was approximately $170,000 to $190,000, all left for compensation in the range of $250,000 to $300,000.

For the last three fiscal years physician losses at the VA Boston Healthcare System have out-paced our physician gains primarily due to pay disparity. In addition, a growing number of physicians are converting to part-time or reducing their part-time hours in order to obtain additional compensation from secondary employment. This has the potential to adversely affect the continuity of care to our patients and reduces the commitment, I believe, that accompanies full time clinicians.

When recruiting attractive prospects, our typical pay offering is invariably at the top step of the top grade available to us. This, in combination with all flexibilities authorized by law and regulations, including retention allowances, may allow us to offer a salary package in the approximate range of 130 thousand to 190 thousand dollars. If the proposal exceeds 190 thousand dollars, the Secretary would need to approve, which hinders rapid action. Although approval is rarely denied, it cannot be assumed during the recruitment process.

In reviewing the proposal, I commend VA's efforts to address these impediments. Perhaps the most exciting feature of the proposed bill is the "market pay" aspect, which would now offer us a vehicle to respond to local market forces, as well as offer us an ability to remain competitive. It would also have the benefit of stabilizing our workforce in the future and would serve to minimize the emotional conflict that physicians experience having to trade-off a true commitment to the veteran, versus earning compensation commensurate with their educational level, training and skill.

This bill would also prohibit senior clinical staff at, and above, the Chief of Staff level from receiving any compensation from the affiliates. While this prohibition on supplements is understandable in light of the proposed provisions to substantially upgrade the remuneration for the Chief of Staff position, there are physicians holding these positions who have unique skills that are invaluable to the community that should be allowed to continue their activities. I am pleased that the draft bill includes waiver authority for VA to consider these and other unique situations. I am also pleased that the proposal would allow physicians in leadership positions to continue interactions with the medical schools, to participate in research and involvement in academic activities on a non-compensated basis. Such activities should be promoted assuming, of

course, that existing rules and regulations involving ethics and conflict of interest are respected. It has been my experience that Chief of Staff involvement at many levels of the Medical School(s) has been crucial in preserving the interests of the VA and maintaining the synergy necessary for growth.

With respect to the proposal for increasing the compensation for nurse executives, I feel the proposal is well thought out. At the Boston Healthcare System, the nurse executive is responsible for nearly 1000 employees and a myriad of patient care issues. In and of itself, our Nursing Service is larger than many facilities in both the VA and the community.

With respect to the proposed flexibility regarding Nurse schedules, employee satisfaction surveys indicate that the lack of flexible tours ranks at our near the top of employee dissatisfaction. Implementation of a tour schedule as proposed should help stabilize employment levels on special units and prove to be a significant recruitment and retention tool.

In conclusion, I strongly support initiatives that provide us the tools to attract and retain competitive medical staff. I thank you for the opportunity to address the committee and would be glad to answer any questions.

STATEMENT OF
MICHAEL S. SIMBERKOFF, M.D.
CHIEF OF STAFF OF VA NEW YORK HARBOR
HEALTHCARE SYSTEM
(NYHHS)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
U. S. HOUSE OF REPRESENTATIVES

October 21, 2003

Mr. Chairman, thank you for allowing me to testify in support of the Department of Veterans Affairs Health Care Personnel Enhancement Act of 2003 on behalf of my colleagues in VISN-3. It is my opinion that passage of this bill is essential to help us recruit and retain qualified physicians needed to care for veterans in our facilities. Please allow me to support this statement by providing you with some background and concrete examples of why we need this bill.

As you may know, I am the Chief of Staff of VA New York Harbor Healthcare System (NYHHS). NYHHS was formed by the merger of the Brooklyn and New York VA Medical Centers (VAMCs) in 1999. We care for approximately 60,000 unique veterans each year and operate ambulatory, acute and tertiary care facilities at our Brooklyn campus in the Bay Ridge section of Brooklyn, adjacent to Fort Hamilton; ambulatory acute, acute and tertiary care facilities at our Manhattan campus on East 23rd Street; and ambulatory, long-term, and a Domiciliary unit at our St. Albans campus in Queens. We also operate community-based outpatient clinics in four of the five boroughs (counties) of New York City including a rapidly expanding one that is soon to be relocated in Staten Island (Richmond County).

VA NYHHS currently has critical shortages and is experiencing great difficulty in recruiting qualified physicians to care for veteran patients in several medical specialties including anesthesiology, diagnostic radiology, and interventional radiology. Because VA's salary structure for specialty physicians is non-competitive, we already have a contract to provide radiation oncology, diagnostic and interventional radiology services at our Brooklyn campus. It is likely that we will be forced to enter into a similar contract for diagnostic and interventional radiology services at Manhattan. We plan to enter into a contract to provide

critical care medicine/intensivist care for our SICU in Manhattan, as per Leapfrog Group's standards for patient safety. In addition, we will need to find a new Chief, Neurosurgery and additional cardiac surgeons in the very near future. It is likely that we will be forced to enter into a contract for these specialty physicians as well.

Under existing regulations, compensation for physicians and dentists is computed from a combination of basic and special pay rates. The basic pay rate for most physicians is fixed at approximately $110,700. Special pay rates include components for full-time status, Board Certification, years in government service, scarce specialty pay, geographic locality pay, and exceptional qualifications (the latter requires approval by VACO).

At present, the maximum salary that VA NYHHS can offer a diagnostic or therapeutic radiologist is $169,000.00. At our affiliates, these physicians earn $275,000 to $325,000. Anesthesiologists at VA NYHHS can be offered approximately $160,000, while at the affiliates they earn well over $300,000.00. Critical care medicine/intensivists can be offered approximately $140,000 at VA NYHHS but are paid $280,000 at our affiliates. A fulltime neurosurgeon would be paid $160,000 at our facility while, even as an assistant professor, would earn over $340,000 at the affiliate. A fulltime cardiac surgeon would earn $162,000 at NYHHS and between $350,000 and $450,000 at the affiliates.

The only means that we have available to hire highly qualified scarce specialists is through contracts. These are expensive and, in many ways, destructive. Contract physicians are employees of the contractor. Their loyalty is to their employer, not to NYHHS.

The proposed legislation should do much to reduce the differences in pay between VA and non-Departmental physicians that currently exists. By establishing a higher band for minimum base pay, indexing market pay to salaries outside of the Department based on geographic area, specialty, assignment, personal qualifications and individual experience, and establishing and option for up to $10,000 annual performance pay, we can compete for and retain quality physicians in scarce specialties and establish a culture that ensures constantly improving service for our patients.

STATEMENT OF

DENNIS M. CULLINAN, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

TO THE

COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VETERANS AFFAIRS PHYSICIAN AND DENTIST COMPENSATION

WASHINGTON, D.C. OCTOBER 21, 2003

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.6 million men and women of the Veterans of Foreign Wars of the United States and our Ladies Auxiliary, I would like to thank you for allowing us to comment on this important subject.

Members of the VFW and all veterans have a vested interest in the compensation system of the Department of Veterans Affairs' (VA) health care providers. We believe that to remain competitive with the private sector, VA must be allowed greater flexibility in setting compensation levels for its health care providers.

Unfortunately, and to the detriment of veterans, VA does not currently have this payroll flexibility and the current salary structure has been in place since 1991. Consequently, VA's physician pay lags far behind what the private sector can pay--in certain specialties by as much as 67%.

As a result, the recruitment and retention of quality health care physicians has become increasingly difficult, especially in certain critical specialties. System wide, VA is nearly 2000 full-time physicians short. Further VA is over 100 physicians short in specialties such as Anesthesiology, cardiology, gastroenterology, internal medicine, psychiatry and radiology. VA just is not able to compete with the salaries offered by the private sector.

To some extent, VA can overcome this disadvantage. Doctors at VA have a significant burden lessened in the amount of malpractice insurance they must carry, resulting in a substantial savings for them. Additionally, their affiliations with many medical schools affords their doctors

increased opportunities for research, as well as additional compensation possibilities through the school. In some areas, however, this is not enough. And in certain facilities, where there is no medical school affiliation, it is impossible altogether.

To compensate for the employment shortfall, VA must, in effect, shoot itself in the foot. VA contracts for care from local physicians at prevailing market rates. VA will not pay these rates to actually put a physician on staff, yet they will pay these higher rates to have this physician work alongside other VA staff. This does not make any sense.

When combined with the growing numbers of veterans seeking access to VA health care, the inability of VA to fill these provider positions is a contributory factor towards the access problems that plague the VA health care system. With a full health care staff, it is likely that the nearly 100,000 veterans who have been waiting six months or more for their primary health care appointments would be significantly fewer and that we would hear fewer horror stories of two-year waits for specialty care appointments.

Providing proper physician compensation is necessary to ensure that our nation's veterans receive the first-rate timely health care they earned through their service; these two issues are directly intertwined. As such, we would endorse any legislation that would increase the recruitment and retention of quality physicians and health care providers, thereby improving the quality of care our nations' veterans receive.

This concludes my testimony. I would be happy to answer any questions that you or the members of the Subcommittee may have.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CHAIRMAN SIMMONS TO THE HONORABLE ROBERT J. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH

Questions for the Record
Honorable Rob Simmons, Chairman
Subcommittee on Health
Committee on Veterans' Affairs
October 21, 2003

Hearing on Physician and Dentist Compensation Issues

Question 1: The Klemm Analysis Group's September 30, 2001, report shows that in general VA physicians and dentists are compensated at higher levels than other Federal physicians and dentists. Are VA recruitment and retention challenges more acute than those of DoD, the Public Health Service, or other federal agencies that employ such medical personnel, and in what ways?

Response: While VA is aware that DoD or HHS' Public Health Service may experience recruitment and retention difficulties, we are not aware of the specifics and thus cannot offer any direct comment on their issues. However, VA is the predominant Federal employer of physicians and dentists, and so is the largest Federal recruiter in the marketplace. Because VA must recruit and retain so many physicians and dentists to care for the millions of veterans who come to VA, staffing challenges are more acute simply due to the sheer volume. Another factor affecting VA's recruitment stance is the fact that, while the number of Federal physicians declined by 46 percent from FY 1998 to FY 2002, VA increased the size of its physician workforce by 15 percent.

VA differs significantly from these two other Federal employers in its recruitment efforts, in volume, breadth of geographic scope, and type of candidate recruited. DoD does not rely heavily on its ability to recruit civilian physicians, as it relies largely on its military staff. HHS has long maintained that it is not in direct competition with VA for physicians. HHS rightfully argues that the target of NIH's and FDA's recruitment efforts is primarily an administrative, research oriented, or regulatory/oversight physician, while VA focuses its recruitment efforts on active clinicians with an academic interest.

To indicate the magnitude of recruitment challenge that VA faces, some overall employment statistics:

- As of September 2002, VA had 15,149 physicians on staff, 71 percent of the total Federal physician employment of 21,356. HHS and DoD employed almost all the remaining physicians. HHS employed 4,942, primarily in the FDA and NIH, and DoD employed 800 physicians.

- VA must recruit physicians for all 50 states, the District, and U.S. territories; HHS has 66 percent of its entire physician workforce in Maryland; DoD employs 40 percent of its physicians at three hospitals.

- VA employed 965 (including residents and fellows) dentists as of September 2002, 70 percent of the total Federal dentist workforce. As with physicians, the overwhelming majority of non-VA Federal dentists were employed by HHS and DoD. HHS employed 342 dentists, and DoD 31.

It is important to note that both HHS and DoD have statutory authority to use certain provisions of title 38 to recruit and pay their health care workforces and have the option to authorize special pay for their physicians and dentists. HHS reported that in CY 2000 (the most recent period available), they authorized special pay for 655 physicians and 21 dentists at selected locations around the country. DoD has not yet chosen to use these pay authorities

Question 2: The Secretary's transmittal letter to the Speaker of the House on July 18, 2003, outlines several staffing challenges facing VA. In reference to these challenges: (a) To what degree does your pay reform proposal rectify the noted pay disparities between VA and the private and academic sectors? (b) Does a compensation disparity exist between the private and academic sectors? (c) If so, what is the range of that disparity? (d) How will your pay reform proposal "protect" other physicians' and dentists' pay, as indicated in your July 18 letter?

Response: We believe that this proposal will significantly improve VA's ability to address staffing difficulties caused by non-competitive pay.

(a) The VA proposal would fully eliminate the gap between VA and the average academic direct compensation, as the VA proposal specifies that VA benchmark salaries would be those currently offered at similar academic health care institutions. There would continue to be differences in the non-cash benefits offered by VA and its academic peers. There are many benefits offered in the academic community that VA cannot match, such as disability insurance, more generous retirement benefits, and free or reduced tuition for dependents.

(b) Overall, there is a disparity between levels of pay for physicians in academic health care facilities and private practice. In the private sector, there are many different employment settings and widely varying levels of income; however, the general finding is that the highest levels of physician income are found in private practice in office settings. Although the VA proposal is benchmarked to American Association of Medical Colleges (AAMC) compensation, it would also permit the collection of all available regional salary data from non-Federal employers other than AAMC members, so as to ensure that all non-VA factors are included in pay determinations.

(c) Current salary information from the AAMC and various salary studies show private practice income at the national level consistently exceeds AAMC average compensation for the Associate Professor rank by up to almost 100 percent. Comparisons of selected specialties show:

Specialty	MGMA Mean 2002 Survey	AAMC Mean '01-'02 Salary Survey	Difference
Anesthesiology	$306,878	$236,100	$70,778 30.0%
Cardiology	$430,672	$223,400	$207,272 92.8%
Internal Medicine	$160,436	$155,900	$4,536 2.9%
Ophthalmology	$301,451	$239,100	$62,351 26.1%
Pathology	$296,377	$161,600	$134,777 83.4%
Radiology (all)	$352,484	$246,500	$105,984 43.0%
Surgery, General	$283,009	$253,100	$29,909 11.8%
Urology	$337,144	$263,200	$73,944 28.1%

The MGMA (Medical Group Management Association) reports on compensation paid to members of group practices. The group practices range in size from a few physicians to over 100 physicians. These data represent provider net compensation, and are consistently higher than physician compensation in academic settings. The MGMA salary data are the highest recorded for many specialties, in part because the reported figures include all cash compensation, including bonuses, and cash contributions by the practices to retirement funds on behalf of the physicians.

Other data sources, such as Merritt, Hawkins & Associates, *Modern Healthcare*, and *Medical Economics*, report higher net incomes for physicians. There are often significant variations among the various publications, depending on their methodology, breadth of data sources, and reporting period:

Specialty	Other Non-Federal Benchmark	
Anesthesiology VA = $168,072	AMGA	$282,372
	HHCS	$242,886
	Hay Group	$265,400
	Merritt Hawkins	$290,000
	Sullivan & Cotter	$254,373
Internal Medicine VA = $136,250	AMGA	$154,979
	HHCS	$161,275
	Hay Group	$161,900
	Merritt Hawkins	$150,000
	Sullivan & Cotter	$154,369
Pathology VA = $145,778	AMGA	$235,380
	HHCS	$228,098
	Hay Group	$167,100
	Merritt Hawkins	Not reported
	Sullivan & Cotter	$236,902
Radiology VA = $171,202	AMGA	$332,160
	HHCS	$325,829
	Hay Group	$285,500
	Merritt Hawkins	$317,000
	Sullivan & Cotter	$274,357
Surgery, General VA = $151,844	AMGA (H)	$291,104
	HHCS	$274,534
	Hay Group	$237,100
	Merritt Hawkins	$242,000
	Sullivan & Cotter	$217,246
Urology VA = $151,739	AMGA	$321,669
	HHCS	$299,719
	Hay Group	$253,400
	Merritt Hawkins	$277,000
	Sullivan & Cotter	$253,903

The AMGA (American Medical Group Association) compiles compensation data from its 28,000 member-physicians. The HHCS (Hospital and Healthcare Compensation Service) includes 268 employers of 19,932 physicians; the majority of organizations surveyed are hospitals (87 percent). The Hay Group conducts a survey of 53 employers of over 9,000 physicians; the employers represent a balance of hospitals, hospital systems, group practices, and HMOs. The Merritt, Hawkins & Associates survey reports on recruitment salary packages for over 2,400 physician placements during the period of April 2002 through March 2003. Finally, the Sullivan, Cotter & Associates consultancy reports on 2003 compensation levels paid by over 165 healthcare organizations to 18,500 physicians; including hospitals, group practices, managed-care plans, practice plans, and medical foundations.

There are also rather significant regional variations. Generally speaking, physician compensation is higher in the South than elsewhere in the nation. Depending on the specialty, the difference can be as large as $30,000 per year. In the Southwest, the academic institutions are not as significantly in the physician labor market. The VA proposal would provide that VA physician compensation mirrors regional variations. However, it is not proposed that VA physician pay fully match the levels available in private practice. VA recognizes that there are non-monetary factors that offset any lower compensation levels, including its mission of service to veterans, as well as opportunities for research and academic endeavors.

(d) The VA proposal calls for protecting physicians' and dentists' pay from reduction. This protection would parallel the protections offered to Federal employees under market-based pay systems, like VA's registered nurses and blue-collar employees under the government-wide Federal Wage System, from salary reductions due to declining compensation levels within a region or specialty. Individuals whose pay would otherwise be reduced as a result of a decline in the benchmark pay rates would have their existing pay saved; the new, lower rates would apply only to new hires.

Question 3: VA has indicated that the increase in special pay for dentists granted in 2000 by Public Law 106-419 did not bring VA dentist pay up to levels comparable with dentistry practices in the private sector. (a) Was this concern reported to the Committee, either in testimony or otherwise? If not, please explain the reasons for not reporting the continuing pay disparity.

Response: It is true that the increases in the amounts of special pay for dentists provided in P.L. 106-419 do not bring VA dentist compensation levels to those found in private practice. Information obtained from the ADA (American Dental Association) shows CY 2000 median net pay of $166,460 for general dentists and $238,150 for oral and maxillofacial surgeons and $165,790 for specialists in CY 1998. These figures, although up to 4 years old, are higher than VA dentist compensation after the implementation of P.L. 106-419. In the Quadrennial Reports on Physician and Dentist Pay, the pay disparities for VA physicians and dentists have been noted. We do not argue, however, that VA pay should fully match the levels found in private practice, as individuals in private practice make trade-offs of greater demands and risk for the potential for higher pay. VA employment has non-monetary compensating features, such as the opportunity to serve veterans, conduct research, and train future dentists.

Question 4: When did VA last request increases in special pay rates under 38 USC 7431, and what was the result of that request?

Response: VA has not formally asked for any increased in special pay since the current system took effect in July 1991. However, over the past several years, VA has considered a number of proposals to modify the physician and dentist pay structure. Some of these proposals evolved from recommendations in prior Quadrennial Reports.

Although VA submitted the Quadrennial Reports to Congress for its review, VA did not submit a formal legislative proposal on physician and dentist pay until this last fiscal year.

The 1995 Quadrennial Report included recommendations to link the amounts of pay provided under the tenure/length of service component of special pay to provider productivity and performance; to expand eligibility for geographic location pay to include administrative categories of physician and dentist assignments; to increase flexibility under the statutory criteria to waive special pay refund liabilities; to clarify the statutory language governing the approval of the exceptional qualifications component of special pay; to eliminate the reductions on special pay for part-time employees (i.e., the 75 percent cap and to offset the loss of the primary special pay component); to increase the amounts of special pay for board certification; to provide greater flexibility and discretion in the amounts of executive position/responsibility pay for physicians and dentists in VACO assignments; and to equalize the executive position/responsibility pay amounts for physicians and dentists.

The 1999-2000 report did not include recommendations for adjustments to physician special pay, because VA was still generally able to match physician compensation needs thanks to policy changes made as a result of the 1995 Report and aggressive use of recruitment and retention bonuses. Also, the restructuring of the VA health care delivery system then underway was enabling VA to minimize the demand for additional specialty physicians. For dentists, the 1999-2000 Report repeated the 1995 recommendation to equalize the amounts of physician and dentist executive position/responsibility pay, and also recommended equalizing the amount paid for full-time service. Congress acted on this aspect of the Quadrennial Report, making adjustments in dentist special pay.

Question 5: According to your testimony, "The effects of noncompetitive pay and benefits are reflected in dramatic increases in VA's scarce specialty, fee basis, and contractual expenditures." What proportion of the rise in VA contractual expenditures is attributable to noncompetitive compensation versus scarcity, a competitive medical marketplace, health inflation or factors other than VA salary rates alone?

Response: It is not possible to determine what proportion of the increase in contract expenditures for physician services is attributable to an inability to fill vacancies, losses of in-house physician staff, increased patient demand, or overall inflation. However, a comparison can be made of changes in VA physician staffing, the number of unique veteran patients, contract expenditures, and the rate of inflation for medical expenses shows:

Year	MD FTEE [1]	Contract Costs	Number of Patients [2]	CPI-Med [3]
1998	11,407.1	$579 million	3.43 million	242.1 +3.2%
2001	11,897.9	$1,043 million	4.25 million	272.8 +4.6%
2002	11,913.9	$1,069 million	4.67 million	285.6 +4.7%

[1] Source: Full-time employee equivalents (not head count) PAID Report on Title 38 Employment as of September 30
[2] Source: VA Program Data, Healthcare Workload, 1997-2002
[3] Consumer Price Index (CPI) measures changes in medical expenditures, based on CPI-U (All Urban Consumers), 1982-84 = 100

Over the 5-year period, the number of patients seen in VA facilities increased by over 36 percent. To meet this increasing workload, VA was able to hire more physicians, but not enough to address the demands for primary and specialty care. Many of the additional physicians were added in the primary care/internal medicine specialties, while the number of specialists, depending on the specialty, either held steady or declined. As a result, the number of veterans on waiting lists grew. To meet this increased workload, VA had to resort increasingly to the use of contracts and fee basis providers.

We believe that the increase in contract costs is largely attributable to VA's inability to hire all the physicians due to noncompetitive pay. The increase in expenditures for medical care and supplies, as measured by the CPI-Med, increased by 21.7 percent over 5 years, or an average of over 4 percent per year. By comparison, during that same period, base salaries for VA physicians increased by only 16.5 percent, and there was no increase in VA special pay amounts, yielding an increase in total compensation for the average VA physician of only 12.4 percent, or almost half the increase in medical inflation.

Question 6: How did VA develop the benchmarks for base pay, market pay and performance-based pay that are included in your draft legislation?

Response: The benchmarks for VA's proposal for base pay, market pay, and performance-based pay were developed based on an assessment of the various data sources available. We looked for the most reliable, widely available, and consistent salary benchmark. In addition, VA considered its nearest benchmark and counterpoint from an employment setting. For these reasons, the Association of American Medical Colleges (AAMC) was selected as the overall benchmark. As stated above in response to Q3 and Q4, VA did not seriously consider benchmarking its compensation levels to private practice, for reasons of workplace comparability and cost.

Once the salary benchmark was selected, the overall compensation structure was developed. The recommended structure has three parts: the base salary component, a market component, and a performance-based component. The base salary component is proposed as a continuation from the old system for continuity, particularly for individuals not currently receiving special pay. The base pay tier would be linked to

current base pay amounts, for ease of granting the guaranteed annual comparability pay adjustments and for equity with other Federal pay systems. The market tier is a simplification from the current system of seven components of special pay, each with their own rules for payment. This component would be broad in application, and highly variable according to specialty, location, professional seniority, and personal qualifications. The third component would link a portion of each individual's pay to outcomes and specific performance measures. The proposal calls for up to $10,000 in performance pay for staff and first-level supervisors; the amount of performance pay for service chiefs and higher level executives would be 10 percent of total pay. VA included performance-based pay in its proposal in recognition of GAO and other calls for more closely linking Federal pay and performance, and based on trends in physician compensation. Variable pay based on personal performance and productivity is increasingly common, and provides a link between pay and outcomes. Based on VA's research into industry practices, the performance tier was designed to represent a substantial portion of each individual's compensation, but not so large as to distort incentives and clinical practice.

Question 7: Does your pay reform proposal contain an appeal process for individual physicians, and how would the appeal process work?

Response: The VA proposal did not specifically address the question of an appeal process for employees. However, under the current system, employees do not have a separate appeal process established to resolve disputes over the amounts of special pay authorized for them. Instead, individuals who are dissatisfied with the individual pay determinations made under the current system may file administrative grievances. Such an administrative process would remain available to employees under the new system. Any individual dissatisfied with the total compensation authorized could file an administrative appeal. A review of that complaint would assess whether the pay determinations have been made consistent with implementing regulations.

Question 8: What measures would be used to assess an individual physician's performance for pay purposes? (a) Would medical research, the level of professional commitment, or intellectual level of effort, for example, be a part of an evaluation? (b) How much weight would be attached to non-patient care tasks contrasted with direct patient care work? (c) Would seniority be a factor in such determinations?

Response: VA would assess each provider's performance (for eligibility for the performance-based component of pay) on a combination of national and individual measures. It is expected that the national measures would vary over time, according to areas of focus, and to address new areas once organizational performance has reached the desired level. For example, if a desired goal were improved timeliness in completing patient charts, compliance with clinical practice guidelines and reminders, or use of advanced clinic access, one or more of those items would be established as a national performance goal. Once the desired level of compliance was achieved, a new performance element could be set. National performance goals could also be set by clinical specialty, e.g., complexity-weighted panel size for primary care physicians or

minimum turnaround time for specimen evaluation for pathologists. Individual performance goals could be established as well, based on consultation between the employee and the supervisor. The area of focus would depend on the individual physician's program area and desired emphasis. In all cases, the intent is to have a few key performance standards that are significant to the organization's performance, and that are easily quantified. Examples of possible national performance elements for providers include:

- Timeliness of notes in physician order entry, Computerized Patient Record System (CPRS), and Bar Code Medication Administration (BCMA) to capture resident supervision through attending notes, billing, and tests and medications ordered, as well as case management
- Resident supervision and timeliness of pupil evaluations
- Compliance with clinical reminders and clinical practice guidelines
- Performance of Compensation and Pension (C&P) and special benefits exams
- Improvement in waiting times for initial and follow-up appointments, use of advanced access, reductions in number of cancellations/no-shows
- Improvements in scheduling efficiency, utilization of time
- Reductions of number of unbillable cases due to incomplete patient records, and successful resolution of such cases, as indicator of proficiency in meeting CMS/HCFA standards
- Improvements or sustained high-level performance in patient satisfaction, closely correlated to specific clinical service
- Improvements or sustained high-level performance in Prevention Index, Chronic Disease Index, and other quality of care measures
- Successful performance on JCAHO audits for specific clinical service area

The performance elements for chiefs of staff and other management positions would operate along similar lines. There would be a few key national measures, linked to the performance goals established nationally for Network Director. If appropriate, specific goals could also be established for individuals, after discussion between executive and supervisor, based on targeted areas of emphasis.

(a) Research activities are not universal throughout the system and are highly variable in scope and practice within the community, and so would not be appropriate for national performance goals. However, a research-related performance element could conceivably be added on an individual basis, after discussions between the individual physician and the supervisor.

(b) Non-patient care tasks would be part of performance plans, depending on the individual, the position, and the organizational focus. For individuals in managerial assignments who devote little time to direct patient care, their performance plans would focus on these other areas. For the majority of providers, measures that emphasize quality of care, such as safety measures or risk-adjusted morbidity and mortality rates, will be the focus of national performance goals. As each performance plan is intended to focus on only a few specific objectives and measures, it is not anticipated that a

complex weighting process will be necessary. However, the emphasis on each element would be a subject for discussion and agreement between employee and supervisor.

(c) Seniority would not be a factor in the performance plans. New hires in their first year of VA employment would not be eligible for the performance tier. For these individuals, their primary focus will be on learning the VA system and acclimating themselves to their new workplace. Once these individuals have had an opportunity to learn their way around the facility and are familiar with the VA systems (VistA, CPRS, Advanced Clinic Access, etc.), they will be in a better position to understand and achieve the performance goals set for them. They, like all probationary employees, would have performance standards, but these individuals would not participate in the performance tier of physician and dentist pay.

Question 9: In the past, VA has recognized the need to communicate with and include various stakeholders when certain major policy changes were under consideration. Have you sought advice from employee stakeholders, such as VA physicians and dentists in the field or organizations that represent then, on the transmitted pay reform proposal? (a) Please describe any such consultation and how it affected your final submission. (b) Do these stakeholders support this legislation in its current form?

Response: This proposal was developed over time by a cross-section of VA employees located in the field and headquarters, representing a broad range of clinical disciplines and management roles.

(a) The proposal was also shared informally with VHA clinical managers and clinical advisory groups to solicit their comments. VA dentists, physicians, and VISN managers were briefed very generally on the pay proposal. The conceptual outlines of the proposal were also shared with external stakeholders and interested parties, such as the Office of Management and Budget, the Office of Personnel Management, and other agencies employing physicians and dentists, such as DoD, HHS, and Justice.

(b) As the proposal went through the internal clearance process, certain elements were modified, deleted, or added. Not all of these changes were shared with employees or other interested parties until shortly before the proposal was submitted to the Committees. As you are aware, several stakeholders shared their concerns with the Committee at the October 21 hearing.

Question 10: Your written testimony states that for managers at the chief of staff level and above, "ten percent of their benchmark pay would be at risk, and would be payable to the extent that performance goals are met." Please explain hypothetically how such a concept could be put into practice and any intended outcomes in a chief of staff's salary in three VA settings: a highly-affiliated urban medical center; a VA regional system of care; and, a "critical access hospital" as you have defined this concept within your CARES criteria.

Response: For chiefs of staff (COSs) and other key executive assignments, the current proposal calls for a performance tier of 10 percent of total pay. In researching compensation benchmarks for COSs and other hospital-based executives, we found that pay distinctions are correlated to location, complexity (variety of clinical programs, tertiary care), and size of facility (number of beds). The proposal would stratify VA facilities according to these factors and set pay accordingly. The degree of affiliation would only indirectly affect pay, as highly affiliated facilities tend to be larger and more complex (more clinical programs, acute inpatient operations, etc.). Regional healthcare systems could have greater complexity due to the geographic dispersal of operations, but the size of the catchment area is not a factor in executive compensation. Similarly, whether a facility is designated as a "critical access" facility will not be a factor in pay setting.

In the course of developing the current proposal, we identified a number of possible benchmarks for management positions. The range of compensation varies widely: MGMA reports compensation of approximately $189,000 for a Medical Director (manager of group practice of up to 100+ providers). The American College of Physician Executives' Compensation Report shows compensation ranging from roughly $200,000 to $260,000 (excluding bonus) for Chief Medical Officer, depending on size and number of hospitals managed. The COS at academic hospitals earns an average of $261,000. The selection of a benchmark has the potential to significantly affect target compensation and the cost of the proposal. In the VA cost estimate, the clinical executive pay structure is based on a combination of MGMA Medical Director and the lower ACPE CMO rates.

The following illustrates how the pay structure with the proposed salary benchmarks would impact COSs at a large tertiary care facility, a mid-sized regional healthcare system, and a small facility:

Pay Component	**Large Tertiary Care Facility**	**Mid-Sized Healthcare System**	**Small Facility, Limited Acute Care**
Total Pay*	$221,964	$210,447	$188,956
Base Pay	125,400	125,400	125,400
Market Pay	74,368	64,002	44,660
Performance Pay	22,196	21,045	18,896

* Total pay not adjusted for regional cost of living.

Question 11: As an alternative to your extant proposal, could VA's recruitment and retention problems be addressed significantly with a pay plan comprised of basic and market pay, with a separate performance element that would reward outstanding leadership or other superior accomplishments? Would such a simplified system be inferior or superior to the model you have proposed, and what are your reasons for this conclusion?

Response: Although simply being able to offer more compensation would assist VA in addressing its recruitment and retention problems, higher pay without the appropriate framework will not achieve the organization's larger goals. Employees throughout the Government have voiced concerns over the disconnect between pay and individual performance. Our proposal is significant in that it provides a clear connection between a portion of each physician's and dentist's pay and the individual's performance. We believe that making a part of employees' pay contingent on achievement of a few key elements will allow us to focus energies and efforts on critical organizational goals like reducing waiting times and increasing quality of care. Our current pay system provides base pay and, through the components of special pay, market pay (limited by the statutory caps on the individual components). It does not, however, provide a clear link between individual efforts and the agency's objectives.

Under this proposal, individuals will still be eligible for cash awards for special contributions and exceptional actions in service to veterans and VA's mission, in addition to the performance pay. It is important to note that the performance pay is part of each individual's total compensation, and so should be included in each employee's benefit computations. Performance pay is not guaranteed – it is dependent on individual performance. Ideally, each individual should be able to achieve full performance expectations, receive the full amount of performance pay, and thus achieve full parity with the benchmark salaries.

Question 12: Your testimony suggested that it is difficult for VA to fill your current reported 945 physician vacancies because of the intense competition with private practice fro qualified physicians. However, your pay reform proposal uses the Association of American Medical Colleges (AAMC) salary data as the benchmark rather than another source of comparative physician income data, such as the Medical Group Management Association, a private-sector salary data source. Would you please explain the differences in such data sets and why you believe the AAMC salary data to be more appropriate for use by VA, given your basic justification of need to be competitive with the private sector?

Response: As stated above, we do not believe that it is necessary for VA to offer the highest salaries in order to be competitive in the marketplace. VA's mission is a powerful recruitment tool, but VA must ensure that the call to service does not exact a heavy financial sacrifice. In addition to the opportunity to serve veterans, VA employment also offers the opportunity to combine teaching and research with clinical duties. This employment opportunity is most directly like that offered in the academic healthcare arena. In addition, VA employment offers the opportunity to work with state-of-the-art patient safety programs, paperless patient records, electronic orders and prescriptions, and new developments such as telemedicine. We believe that VA employment, with more competitive salaries, will allow VA to address its recruitment and retention challenges.

The salaries reported by AAMC and MGMA reflect very different market forces and work environments. The AAMC salary data are based on total compensation from

teaching, research, and/or patient care for almost 70,000 full-time faculty physicians. The AAMC survey includes data from 125 of the 125 fully accredited medical schools in the United States. The AAMC survey reports the actual fixed or contractual salary, any supplemental earnings from medical practice, bonus/incentive pay, and any outside earnings. The work setting includes traditional didactic teaching, supervision of residents in academic hospitals, research activities, and time spent in direct patient care in clinics, group practices, and hospitals.

The MGMA Survey reports on physicians in group practices ranging in size from 3 physicians to over 100, with the majority of participants belonging to small and very small practices. The MGMA covers a variety of practice settings, from traditional doctor's offices to freestanding health clinics to specialty practice hospitals. Most practices are single-specialty office operations. The reports include direct compensation to partners and employees of the practices managed by MGMA. The MGMA survey reports data for over 26,600 physicians in 95 medical subspecialties, including 12,000 physicians in academic practices. Data for these individuals came from 1,545 responses (out of 10,767 distributed), with 1,300 of the responses from group practices. Because these practices tend to specialize in a single medical subspecialty, their productivity and income tend to be higher. To illustrate, a gastroenterologist in private practice may perform dozens of endoscopies each day, allowing for maximum revenue generation and efficiency. The practice environments are not analogous to a broad-spectrum healthcare operation like the VA. The MGMA respondents self-select, and there is limited continuity among respondents from year to year.

Question 13: What percentage of all VA physicians paid under 38 USC Chapter 74 would receive an increase in total compensation if your draft legislation, as proposed, were enacted by Congress? Please provide a table showing how these higher salaries, based on your bill, would be distributed across specialties and across VA's networks of care.

Response: The percentage of VA physicians receiving an increase in total compensation would vary, depending on regional adjustments to benchmark salaries and local decisions to set pay within the ±10 percent band for each benchmark.

Applying the national AAMC data for Associate Professor at the 50th, 75th, and mean (weighted average) to the VA physician workforce would yield very different results: Using the 50th percentile, approximately 3,100 FTE out of 10,200 physician FTE would be entitled to receive an increase to get to 100 percent of the target. Using the 75th percentile of AAMC compensation for the Associate Professor rank would result in increases for physicians in every specialty except Preventive Medicine (based on AAMC data for 30 faculty at this rank). Using the mean (weighted average) of AAMC Associate Professor compensation would result in increases for the majority of physician specialties representing approximately 7,600 FTE. The attached tables show the different results for each of these comparisons.

The advantage of using the quartiles (whether the 50th or 75th percentile) is that they help to minimize fluctuations in survey results over time. A statistical mean can be distorted by the introduction or deletion of a few very high or very low figures, but the quartiles reflect the overall array of observations and relative position, thus minimizing negative variations over time.

Question 14: It is the Committee's understanding that private physician income is being constrained due to restructured Medicare reimbursements, rising overhead costs, malpractice insurance premium increases and more stringent regulation compliance. (a) Is malpractice protection in itself at the Department of Veterans Affairs for its physicians an attractive recruitment tool in today's competitive health care environment, and is the Department using it for such marketing purposes? (b) Assuming you were able to estimate the costs of overhead, rent, utilities, staff salaries, malpractice and liability insurance, marketing, billing and other expenses associated with a private or group practice, what might those costs be on an annual basis in an average practice in both an urban and rural setting, compared to their availability in VA facilities? Could such information be used as a VA recruiting tool, and is the Department using such comparisons in its recruitment efforts?

Response: Efforts to restrain and even reduce Medicare reimbursement rates will certainly impact physician income. However, those reductions can be mitigated by increased effort or a focus on non-Medicare patients. In addition, other costs are increasing, such as practice overhead, malpractice insurance, and staff salaries. Despite all these factors, however, average private sector physician income is still rising overall. MGMA data show that primary care physician average income has increased in each of the past 10 years; specialty physician average income increased in 8 of the past 10 years. Also, MGMA data report that the average physician works 46.3 weeks per year, and average just over 42 hours per week. As needed, physicians in private practice can increase the amount of time they put into direct patient care (with little or no increase in practice and overhead costs). The 2002 MGMA Survey showed an average ratio of physician compensation to gross charges of 37.5 percent, that is, charges before any discount or Medicare/Medicaid charge reduction. This means that the average physician in the MGMA survey receives $0.375 for every dollar billed. As charges are discounted, the ratio of provider income to charges increases.

(a) VA does publicize its malpractice coverage in physician recruitment. We believe that VA's malpractice coverage is an effective recruitment incentive, but VA is not alone in offering this benefit. The 2003 report on physician recruitment incentives by Merritt, Hawkins & Associates found 76 percent of respondents offering free or reduced-cost malpractice insurance as a recruitment tool for physicians. When physicians can earn significantly more money outside VA, even accounting for the costs of malpractice insurance, VA is placed in a non-competitive pay situation.

(b) The Centers for Medicare and Medicaid Services (CMS) have done a great deal of work to quantify overhead and administrative costs for practices, both rural and urban. These efforts have quantified variations in practice costs as well as malpractice

expenses. The Practice Expense Index ranges from .71 to 1.458 for 92 separate geographic areas. Certainly, the costs of setting up and running a private practice are significant, but, as noted earlier, the highest average compensation levels are reported for providers in private practice. So, although there is greater risk and expense associated with private practice, the financial returns are greater. Nonetheless, VA does emphasize the benefits of fewer administrative concerns from employment in VA.

Question 15: One of your indicated goals in changing the VA pay system is to recruit and retain more full-time physicians, because VA's salary structure is out of date and is non-competitive. However, the percentage of full-time physicians employed in the VA has increased from 60% in 2000 to 65.5% in 2002, under current law. Does this mean VA is improving its ability to recruit and retain full-time physicians without any additional incentives such as the reforms you have proposed? What is your projection for the proportion of full-time versus part-time VA physicians over the next year?

Response: We expect that this new pay system will improve VA's ability to recruit both full-time and part-time physicians.

The proportion of physicians employed by VA on a full-time basis has increased over the past several years. This is attributable to a number of factors. As VA has restructured its care model from specialty-focused inpatient services (requiring a variety of specialized services on an episodic basis) to a primary care and integrated care delivery model, the requirement for more full-time primary care and family practice providers has increased. And, the current special pay amounts are competitive for these specialties in many parts of the country. So, we are generally able to compete for these primary care providers. Also, the current special pay system has certain financial disincentives for part-time employment, creating an incentive for these individuals to convert to full-time status or separate. And, the current time and attendance system for part-time physicians does not offer highly paid practitioners sufficient flexibility to efficiently utilize their time for revenue generation. Finally, as VA compensation has fallen farther and farther behind the private sector in more and more specialties (the group of physicians most likely to be employed on a part-time basis), these individuals have been more likely to resign to pursue more financially lucrative opportunities. So, while VA has been able to increase the absolute number of full-time physicians employed, there is still a need for even more providers to meet the rapidly increasing workload. It is expected that the proportion of full-time physicians will continue to increase, but should stabilize or slightly decrease as the new part-time physician time and attendance system takes effect in 2004.

Question 16: VA estimates the 2004 costs to implement this legislation for six months at $48 million. What does the cost net VA in benefits – for example, how many additional physicians, what kind of reduction in waiting times and other impacts do you anticipate would be derived from the investment of $48 million?

Response: We estimate that this increase in costs for current staff alone will yield an estimated 5 to 10 percent savings in contract and fee expenditures, due to the

performance incentive. In addition, the higher pay and reward for performance should enable VA to fill many of the vacancies that are filled with high-cost contracts and fee basis providers. Although difficult to quantify, this proposal should translate into improved access and reduced waiting times due to improved recruitment and retention. Additional productivity and performance improvements should also be achieved through shortened length of vacancies and reduced turnover. Improved staff retention will enhance continuity of care and should result in higher customer satisfaction.

Question 17: VA's ten-year projected cost to implement this legislation is $1.1 billion, which assumes savings of at least $240 million in contract and fee basis expenditures. How do the assumed savings correlate with the increase in fee basis expenditures related to the implementation of the Capital Asset Realignment for Enhanced Services (CARES) projections that call for adding even more contract care services?

Response: The CARES projections were made independently of this legislative proposal. A good deal of the increase in contract services under the CARES plan can be attributed to additional access points, such as outpatient clinics operated by contractors, and increased use of off-station fee basis services (rather than requiring veterans to travel long distances to a VA facility). Where the business case can be made to recruit and employ a VA physician, whether full-time or part-time, this proposal will provide the means to make competitive salary offers to staff these additional access points.

Question 18: The largest growing veteran demographic is and will continue to be the aging veteran population. Does this reform address the need to recruit geriatricians and gerontologists, and how so?

Response: The primary medical conditions that VA will need to treat in older veterans are age-related: heart disease, urological conditions, mental deterioration, and sensory degradation (eyes and hearing). These conditions are treated by specialties for which VA pay is noncompetitive: Cardiology, Urology, Neurology, Otolaryngology, and Ophthalmology. The fields of geriatrics and gerontology do not yet have significant numbers of faculty in AAMC organizations or large numbers of practitioners on medical practice. However, the implications and aspects of geriatric conditions are clearly significant factors in all medical specialties, whether urological or cardiac or other. As medical treatments are increasingly pharmacological, a greater understanding of and research in the effects of medications on the aged is required. VA needs a greater understanding of how the aging process affects the metabolization of medications, as well as a greater understanding of physical changes doe to aging.

Question 19: The Secretary's transmittal letter to the Speaker of the House on July 18, 2003, states that the pay reform proposals were "consistent" with the President's Fiscal year 2004 budget submission. Please provide a further explanation of the meaning of the term "consistent."

Response: The reference in the Secretary's letter to the Speaker was to the impact of this proposal on the FY 2004 budget. That budget was submitted before this proposal received Administration clearance; therefore, the Administration's FY 2004 VA budget does not reflect the added costs associated with this proposal. It was intended that the half-year costs associated with this legislative proposal would be absorbed administratively in FY 2004.

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2 Subcommittee on Health		
3 U.S. House of Representatives		
4 333 Cannon House Office Building		
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REMARKS

SUBJ: Responses for HVAC Regarding October 21, 2003 Hearing on Physician and Dentist Compensation Issues

1. Enclosed are responses from the Honorable Robert J. Roswell, M.D., Under Secretary for Health, to post-hearing questions from the Honorable Lane Evans.

2. If you have any questions, please contact Ken Greenberg at 202-273-5628.

Attachment

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Ken Greenberg
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OPTIONAL FORM 41 (Rev. 7-76)
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Questions for the Record
Honorable Lane Evans
House Committee on Veterans' Affairs
Health Subcommittee
Subcommittee on Health
October 21, 2003

Hearing on Physician and Dentist Compensation Issues

Question 1: How can the VA be an effective agent in shaping the federal physician workforce to meet veterans' needs and those of other Americans in the future? Does this bill address this challenge?

Response: The healthcare needs of the American population are expected to change dramatically over the next two decades as the population continues to age. In many ways, VA has already experienced this shift and has successfully responded to meet this change. The lessons learned on quality and performance-focused cost containment can be generalized to the larger American population. Recent publications have shown VA to be a model of cost effective healthcare management for a population that is growing older, all the while improving quality of care. Meeting the physician needs for providing this healthcare will require planning on several fronts.

Having an adequate physician workforce to accommodate changing veteran demographics requires VA to be proactive in assessing current shortfalls and predicting future deficits in patient care. The young trainees now providing clinical care in our hospitals are an excellent source of future doctors. It is clear that exposing young physicians in training to VA increases their likelihood of considering VA as a potential future employer. VA provides a significant source of clinical training for 108 of the 125 medical schools in the United States. Physician residents were more than twice as likely to consider VA for employment after their VA rotation than before, according to the Learners Perception Survey by the Office of Academic Affiliations. Dental residents and nursing students reported an even more favorable response. VA can effectively shape the physician workforce by continuing to provide excellent clinical training. The physician and dentist pay bill will help us provide the best physician mentors possible to further enhance the training experience.

VA is also responding to the special needs of the veteran population not commonly found in the general population. The VA Special Fellowship programs are two-year opportunities to learn research and provide clinical care for graduate physicians and dentists that have already completed their residency training. These fellowship programs are in areas of special interest to VA, not formally recognized by the medical accrediting bodies. Areas such as spinal cord injury, palliative care, Parkinson's disease, and psychiatric research (including PTSD) resonate to the needs of the veteran population and are not readily addressed by mainstream healthcare. These programs help ensure a supply of clinicians specifically trained to meet the needs of the veteran population.

VA has also taken a position of national prominence in two other areas that are critical to healthcare needs of the future. Patient safety has rightfully emerged as an issue of overwhelming importance, and VA has become a national leader in this area. Physicians in training are exposed daily to the patient safety efforts that VA has in place. This will have a lasting effect on them for the duration of their clinical careers. Another area of VA excellence is the impact of our information technology and electronic medical record upon clinical care and resident education. Medical residents providing care at VA are exposed to and are being shaped by the finest electronic patient record in existence. While assisting patient care, it also enables them to better integrate complex, multi-system clinical problems. Without question, it has also aided in the excellent quality improvement systems we have in place. Overall, these advances have improved educational and patient care experiences that promote a positive work environment for current and future employment opportunities.

VA is competing with other providers of "institutional" healthcare for a finite workforce of physicians and other healthcare providers interested in practicing medicine in this setting. While a VA career has rewards not found in private practice, salary must be kept competitive with academic and military medicine, and when necessary, able to compete with the private sector. In particular, a mechanism must be found to allow the local facility options to attract and retain difficult to recruit providers and reward those that are consistently performing well. It is important to allow maximum flexibility at the facility level to compensate for geographic market differences as well as local fluctuations in supply of healthcare workers. The current physician and dentist pay bill provides the facility director the option of offering salary inducements to accommodate local market requirements and gives them the ability to reward the healthcare workers with consistently high performance.

In many ways VA is at the forefront of clinical care and works to provide an adequate healthcare workforce for the future of VA as well as the American population. This new pay bill would be an effective agent in shaping the Federal physician workforce, in that it creates a market-based pay system that is dynamic and responsive to changing market conditions. The bill would also help VA continue its obligation for excellence in teaching and patient care by supplying the necessary infrastructure of healthcare workers to carry out this mission. With its open structure tied to external benchmarks, this proposal would allow VA to retain its competitive stance for all clinical disciplines, so that VA can recruit and retain the numbers and types of quality physicians needed to serve veterans. With competitive pay and the ability to recruit and retain all specialties of physicians, VA's graduate medical education programs would be able to allocate residency slots according to need, without concern for the ability to fill those positions.

Question 2: I made reference to the need for VA to seek appropriate funding for fiscal year 2005 in order to implement physician pay reforms. Does VA intend to make full funding for this initiative part of its administrative request?

Response: VA's legislative proposal assumed implementation midway through FY 2004. The President's FY 2004 budget submission request includes sufficient funding to cover the projected costs of the proposal for that year. If the proposal were to be enacted during FY 2004, the FY 2005 funding request would also include resources to cover the projected costs.

Question 3: As you know, Congress did implement some reforms for special pay for dentists in 2000. How extensively have these new special pay reforms been used? If they have not been used extensively, why do you believe this is the case?

Response: The dentist special pay provisions of 2000 have been widely implemented throughout VHA. The increases called for by P.L. 107-135 in the components of full-time, tenure, and hospital-based residency components were automatic and granted across the board. Those components resulted in increased compensation to dentists of over $10 million. In addition, the increased components of scarce specialty, geographic location, and responsibility pay were widely implemented throughout the system for a number of specialties. As of FY 2002, an analysis of these components showed that 28 percent of all specialty dentists were receiving the increased amounts of scarce specialty pay; approximately 10 percent of all dentists were receiving the increased amounts of geographic location pay; and, 50 percent of supervisory dentists were receiving the higher amounts of responsibility pay.

Question 4: Some witnesses suggest VA use a different pay scale such as the Medical Group Management Associations pay scales. They argue that the "competition" comes from offers of employment in the private sector, not the affiliate. Explain why VA believes the American Association of Medical Colleges offers the most comparable pay scales for VA physicians.

Response: It is true that VA faces competition from a number of sources in physician recruitment. The physician market today basically consists of HMO employers, group practices, academic institutions, and governmental institutions. While there are some specialties that continue to practice as independent providers in private practice (e.g., ophthalmology), most physicians, if engaged in private practice, are employed in group practices, usually as partners. VA believes that the characteristics of private sector employment are very different from institutional employers of physicians. Among the institutional employers, VA's close affiliation with academic institutions makes the AAMC a natural benchmark for our physicians. VA acknowledges that there are instances where VA must consider other salary benchmarks in addition to the AAMC, and this proposal permits the flexibility to consider such additional pressures in the pay setting. Where facilities face significant competitive pressure from non-academic institutions or group practices, those salary levels would be factored in to the facility's pay setting determination. Should that cause the necessary salary level to exceed the +/- 10% band of the AAMC benchmark, the facility would request approval to pay a rate outside that band.

Question 5: Please respond to AFGE's recommendation that VA's special pay authorities for physicians and dentists be indexed by the federal employee annual raise.

Response: The proposal from AFGE is appropriate for the current pay structure. However, VA is proposing a new, more dynamic pay system without fixed pay amounts in statute. VA's proposal includes indexing physician and dentist base pay amounts to the federal employee annual raise.

Question 6: Some believe the prohibition on chiefs-of-staff taking additional pay from affiliated schools of medicine threatens to undermine the affiliations. Will you address this concern?

Response: VA feels strongly that while an individual is serving as COS, there should be no outside relationship that impinges upon the individual's ability to fully represent and serve VA's interests. Further, it VA's intent through this proposal that a COS would not enter into an agreement for future remuneration from the affiliate negotiated while the individual was serving as COS. These provisions will ensure that the COS has no financial interests with the affiliate that can be served or harmed by the decisions made as COS for VA. These are reasonable requirements to avoid the real potential for a conflict of interest.

VA fully supports and values its relationships with the medical schools of America. VA seeks to foster and strengthen these ties, by assuring that its senior clinical representative at each facility is able to fully engage in representing VA's interests before the affiliate or other business partner. Only through a strong equal partnership can VA maintain and improve its relationships with the affiliates.

It is important to note that this proposal would not prevent a COS from holding an uncompensated appointment with the affiliate. Thus, VA's ties to the affiliates, at every level of the facility up to the COS, will be continued.

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REMARKS

SUBJ: Responses for HVAC Regarding October 21, 2003 Hearing on Physician and Dentist Compensation Issues

1. Enclosed are responses from Richard Bauer, M.D., M.Sc., Chief Of Staff, South Texas Veterans Heath Care System, to post-hearing questions from the Honorable Lane Evans.

2. If you have any questions, please contact Ken Greenberg at 202-273-5628.

Attachment

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Director, Congressional Reports & Correspondence (009)

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FPMR (41 CFR) 101-11.206

Questions for the Record
Honorable Lane Evans
House Committee on Veterans' Affairs
Subcommittee on Health
October 21, 2003

Hearing on Physician and Dentist Compensation Issues

Question 1: In the past you have suggested that financial rewards have helped you get providers to work toward institutional goals. Will you give some examples of the types of goals these rewards have helped you achieve?

Response: The South Texas Veterans Health Care System (STVHCS) operates primary care clinics throughout South Texas and has approximately 55,000 patients managed by some 61 full and part-time physicians. VA Performance goals have been promulgated for the screening and treatment of patients with hypertension, diabetes, congestive heart failure, coronary heart disease, substance abuse, cancer, vaccinations, and Hepatitis C. A total of 34 individual clinical interventions were established as performance measures under these disease groupings. A system was instituted at the STVHCS in the first quarter of FY 2003 using authorities under 5 U.S.C. Chapter 45, Incentive Awards. Individuals who met the exceptional target established for the 34 clinical interventions were awarded $200 for each target met; individuals meeting the fully successful target were awarded $100 for each target met. Fifty-three of the 61 providers received an award. Twenty-six of the 34 clinical interventions showed improvement between the first and fourth quarter of the fiscal year. This incentive paid up to $5,000 total and was awarded in addition to regular salary.

Question 2: You have cautioned this committee that a predictable salary is, in fact, a recruitment and retention tool for the VA. How would you reconcile this with a desire by VA to reward performance?

Response: Of the 61 practitioners currently providing primary care services in the STVHCS, almost 75% were recruited from private and group practice environments. A very common refrain of those leaving private practice is the oppressive burden created by insurance companies and the rapidly rising overhead of their practices. A predictable salary and retirement benefits were inducements to many of these practitioners.

I indicated previously that incentives, even small ones, can influence practitioners' behaviors. The caution about incentive systems in my written statement addresses the degree to which incentive salary displace fixed salary and affect retirement pay. The small incentives STVHCS has used are not creditable toward retirement credit, and are in addition to the current fixed pay. In the current proposal, the selected AAMC salary benchmarks indicate that 70% of VA physicians would not need an increase in their total pay. For these physicians, the bill's provisions could potentially reduce the amount of their pay creditable toward retirement. This is because the current version of the proposal excludes the *comparatively smaller* performance tier from retirement credit. Physicians, I believe, will be skeptical of a pay system that puts a significant portion of their total compensation at risk for performance goals that encompass small, although important, aspects of their overall responsibilities.

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REMARKS

SUBJ: Responses for HVAC Regarding October 21, 2003 Hearing on Physician and Dentist Compensation Issues

1. Enclosed are responses from Michael Ebert, M.D., Chief Of Staff, VA Connecticut Health Care System, to post-hearing questions from the Honorable Lane Evans.

2. If you have any questions, please contact Ken Greenberg at 202-273-5628.

Attachment

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Questions for the Record
Honorable Lane Evans
House Committee on Veterans' Affairs
Subcommittee on Health
October 21, 2003

Hearing on Physician and Dentist Compensation Issues

Question 1: Your statement says that VA tends to lose some clinicians as their careers mature. In your opinion, is there a need for physician pay to continue to reward tenure?

Response: Yes, I feel that there is a need for physician pay to continue to reward tenure. This subgroup of VA physicians tends to be full-time and to comprise individuals who are making a long-term career commitment to the VA healthcare system. In a medical school compensation system, the salary of such individuals would increase substantially over time with promotion in faculty rank. The AAMC data on faculty compensation capture this information. The VA facilities who are affiliated with medical schools would have to be able to exercise enough flexibility to compensate a full professor with many years of service to the VA and to the academic affiliate differently from an assistant professor. Similarly, physicians who are employed in a large corporate group practice such as the Mayo Clinic or the Cleveland Clinic would see their compensation increase substantially as they become more senior and accomplished members of the organization and the medical staff. As we revise and update our compensation system for physicians in the VA, we want to be sure that we do not establish disincentives for physicians to remain in the VA as their careers mature and they become increasingly valuable to our organization.

Response of Dr. Stephen P. Rosenthal, National association of VA Physicians and Dentists to the follow-up question of Rep. Ciro Rodriguez, House Committee on Veterans Affairs, Subcommittee on Health Hearing on Physician and Dentist Compensation Issues October 21, 2003.

QUESTION-There are obviously a lot of concerns about performance pay, including the fact that such pay would not be factored into consideration in retirement pay calculations. Essentially it's bonus pay. Is there any way we can do more to "standardize" this pay tier to ensure that networks can make use of it without playing favorites?

ANSWER-NAVAPD supports the basic concept of performance (bonus) pay. It makes sense to reward superior effort and outstanding clinical performance. We agree that administrators and supervisors should have the flexibility to reward hard work and individual effort to better achieve the aims of improved quality and efficiency for the organization. However, as we have stated in our testimony we do not believe that performance pay should be a component of the basic or market pay package for physicians and dentists in the VA. We are also aware of the potential for misuse of this tool. Used improperly, it has the potential to create a level of discord that could easily undermine its benefits.

Therefore, with a clear understanding that NAVAPD does not, and will not, support any performance pay proposal that is either a component of regular pay or would allow for a negative pay adjustment (creating a disincentive for quality care), we believe a performance pay plan for VA physicians and dentists should contain the following basic elements. It should serve to focus work effort on the VA itself, rather than on competing interests, such as outside employment or affiliation. Secondly it should be fair. This means that goals should be derived in a reasonable manner, they should be transparent, and should be achievable by all eligible physicians and dentists. Third, it should promote loyalty to the underlying mission of the VA and to the evolving and rapidly changing challenges faced at a national, regional and local level. To promote buy-in by the professional staff, performance goals need to be achievable with available time, space, support staff, support services, and other resources.

Bonus incentives should work to encourage not only outstanding individual effort but also cooperation between individuals, departments and medical centers in meeting the goals. Valid criteria could include the number of patients treated, desirable clinical outcomes, being on-call, seeing patients after hours, and working in excess of 80-hrs/pay period as well as time spent on committee assignments, peer review, supervising house staff, research, quality improvement, and attending to administrative issues. Further, extra effort during times of inadequate staffing and community or national emergencies should not go unrewarded. Performance awards should not be all or none. They should be proportional to the percentage of a goal accomplished, if not fully met. Performance goals should be developed at a local level, close to the front line and in association with one's immediate supervisor and colleagues. We believe that the maximum achievable performance pay should be capped at $20,000.

NAVAPD would be pleased to work with VHA and members of Congress in furthering the development of performance goals in awarding bonus pay.

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