"Breaking Down the Valuation of Physician Call Coverage: Trends, Challenges, Critical Elements, and the Future"

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Abstract - Paying for call coverage is not just tied to trauma centers – every type of hospital is now working to secure physician coverage after hours, weekends, and holidays. As professional payment for emergent and inpatient physician services continues to decline, hospitals often struggle to develop and communicate compensation plans that are consistent, compliant, and market driven. This article provides some background on call coverage, explores the nuances to valuing the support services, compliance considerations, and identifies trends that could impact the way hospitals and physicians perceive call coverage in the future.

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Organizations are required to have physicians available to respond to the emergency department ("ED") in order to comply with The Emergency Medical Treatment and Labor Act of 1986 ("EMTALA"). Under EMTALA, hospitals are required to stabilize patients that present in the ED of a participating hospital and provide treatment for the patient or transfer the patient to a facility to provide the necessary care for that patient. Since patients with certain ailments present to the ED in an unorderly fashion, hospitals generally do not have the specialists required to readily treat the ailment on site at all hours of the day. Accordingly, hospitals will enter into agreements with specialists for their availability when the need for their services arises. The industry has defined the services as unrestricted ED call coverage ("Call Coverage"). This standard applies to all hospitals accepting government payment and the need for call continues to increase and be more formal as hospital trauma designation moves from undesignated to levels 4, 3, 2, and then 1 (the highest).

Historically, physicians provided call coverage in the ED without the expectation of being compensated through a separate stipend. This occurred largely due to the fact that hospital medical staffs accepted the responsibility to provide call coverage as an "all-specialty" commitment associated with working in a general hospital, and because the physician community typically provided free call coverage in exchange for hospital privileges and/or to help build or maintain their own practices.

Whether due to benevolent participation, pressure from medical staff leadership, or better reimbursement in their clinics, the medical staff community generally accepted this arrangement. However, more recent studies and evidence from the marketplace indicate that the willingness of physicians to take uncompensated call has been on the decline. Since the early 2000s, the market trends indicate that physicians have been increasingly less willing to provide these services without additional financial support from the hospitals.

As a result of this change, more and more physicians have been receiving payments for call coverage. It is not unusual for hospitals to pay in excess of $5 million per year for coverage contracts. This observation is nationwide and prevalent regardless of whether an organization is not-for profit or for profit; or located in a rural or urban environment.

High level observations in the industry related to call payments include the following:

- Payments are related to the preferences of the organization / medical staff leadership and their position on whether or not they want to pay a separate stipend for call (whether through employment requirements or medical staff by-laws).
- In some instances, payment for call is already supported through the contracted rate for services (i.e., not separately carved out but assumed to be included – e.g., base compensation, independent contractor rates) and aligned with the terms / expectations of a broader agreement such as employment or PSA.

- Organizationally, if hospitals / health systems decide to pay a stipend for call coverage, a third-party valuation company helps to calculate and support a FMV rate to guide compensation payments.

Many organizations approach contracting and compensating for on-call coverage differently. This next section identifies observations on the rationale for either paying or not paying additional stipends for call coverage. When evaluating on-call payments, it is important to work through a progression of questions to identify factors that support compensating for call.

Several questions that may be relevant to an organization's process to understand expectations and contributions might include the following:

1. What are the legal and trauma designation requirements for the hospital?

2. Is there a position on call coverage requirements documented by the medical staff bylaws? For example, as part of having hospital medical staff privileges there is an expectation of taking call coverage for unassigned patients.

3. What are the quality and medical risk issues driving the need for call coverage?

Additionally, the following list outlines important call coverage elements to understand for contracting and valuation purposes:

Frequency	Higher frequency of call response results in increased burden on the physician responding to call. Increased frequency can impact the physician's practice, resulting from leaving scheduled patient visits to treat cases at the hospital, increased exposure to malpractice risk, lifestyle issues (taking call on nights and weekends), etc.
Burden (Frequency of calls / activations during the contracted coverage period)	An increased percentage of calls resulting in full activations translates to higher burden on the covering physician. A larger number of full activations (compared to partial, consult or non-trauma activations) suggests that the covering physician is more likely to be required to respond on-site and / or perform a more complicated case when contacted.
Distribution Among Physicians	Fewer providers participating in a rotation increases the burden of coverage for that service because an individual physician will be required to cover more shifts in a given time period.
Physician Specialty	Consistent with the differences in annual survey / benchmark compensation levels of the respective physician specialty, specialization increases the rate of call coverage pay with higher-compensated specialties earning more per coverage shift. Market conditions can also impact coverage rates and scarcity of physicians in a specific specialty / recruitment challenge in certain areas can result in higher rates of pay for trauma coverage.
Acuity of Patients (Trauma Designation)	The burden and complexity of coverage increases as patients present with more severe injuries. One such measurement is the average Injury Severity Score ("ISS") from trauma registry data.
Time Contracted/Required	Understanding the time required is an important element (24 hours, 16 hours, 12-hour shifts, etc.). Physicians with contractual expectations that overlap with the coverage period (e.g., daytime clinic) could be a consideration for the parties to evaluate when establishing pricing to avoid a scenario where the physician is receiving renumeration for both services at the same time.

Process	First call or support (APP, residents, fellows, etc.) – Resident, Fellow and advanced practice provider ("APP") support may reduce the burden of trauma coverage. These on-site or "first line of call" personnel could be the first provider contacted and determine whether a physician phone call / activation is necessary. This support is provided primarily for patient safety purposes but lowers the burden of coverage because the physician may be contacted less frequently. Specific operational processes (e.g., when an APP is called first vs. when the physician is contacted) and the level of resident support (e.g., number of residents, specialty, PGY training of residents / fellows, etc.) varies by specialty and by hospital. We would suggest any adjustment would need to be on a case-by-case basis as some proceduralists have commented that depending on training / competency of the front line individual and surgeries performed, the structure can create more work, not less.
Response Requirements (time to facility)	The requirement to respond within 15 minutes or the next day can have a profound impact on the burden and frequency of call.
Collections (OIG Opinion)	Physicians providing call coverage realize direct income from the professional fees generated from patient care in the scenarios where they bill and collect. It is understood that often the contracted physician independent may bill and collect for professional fees depending on the terms of individual arrangements. The professional fee income should be considered in the calculation of overall payments to the physician providing coverage, and to the extent that hospital retains the right to bill and collect professional fees associated with on-call coverage, it is appropriate to pay higher rates for trauma on-call coverage than if the physicians were to bill and collect. Depending on the facts and circumstances of a particular arrangement, the FMV may be impacted depending on which party bills and collects for professional fees. Similarly, hospitals with a less favorable payer mix will increase rates of pay to compensate physicians for conditions outside of their control.
WRVU Consideration (an extension to the point above)	Physicians receiving payment per work relative value unit ("WRVU") under their compensation plan would receive similar benefits to those that bill and collect professional fees for services rendered while on-call. A downward adjustment to the payment rate should be applied if a contracted physician receives WRVU credit for activities performed during the coverage period to avoid double-counting.
Multiple Facilities	What consideration or adjustments should be considered if the physician is covering multiple facilities? Depending on the trauma designation and specialty this may not be feasible, or back-up coverage would need to be coordinated. Generally, coverage of multiple facilities simultaneously would increase the burden and likely the value of the coverage. The value / contribution level of concurrent coverage does not necessarily result in doubling the value, but there are additional factors to consider when assessing FMV (e.g., is back-up provider required, does it increase activations or calls).
Multiple Services	(e.g., general surgery and vascular call) – What consideration or adjustments should be considered if the physician is covering service line requirements? Depending on the trauma designation and specialty this may not be feasible, or back-up coverage would need to be coordinated. Similar to covering multiple facilities, covering multiple service lines will have an impact on the burden and overall value of the call arrangement. Parties should consider these aspects when assessing the value of call coverage for concurrent service lines.
Malpractice Insurance	What, if any, additional indemnification is needed for call coverage arrangements? If so, how is the economic value of the insurance considered in the overall payment?
Continuity of Care	Who is responsible for the care of the patient after the on-call physician sees a patient? Follow up clinics for global care for unassigned patients. Is there a need and how is the clinic staffed, paid for and organized?

Challenges in the Industry - Limitations of Survey Data Utilized for FMV Opinions

The market data valuation firms utilize in broader FMV analyses (both published surveys and market comparable data) likely include some payment for call (e.g., many surveys include call pay in the definition of total cash compensation), especially when profiling compensation above the median statistics. To complicate the issues, this may not be a categorical issue that can be applied to all specialties and may have more of an implication on some specialties more than others. This industry observation has been acknowledged as a risk by the major salary surveys organizations utilize when establishing FMV.

As physicians increasingly have been receiving compensation for call coverage, it is probable the annual compensation figures reported to the surveys include payment for some call (e.g., medical staff by-law, employment requirements). In many arrangements (independent contractor or employment), there is an expectation that the providers will be required to provide some level of call (e.g., 7 to 10 days per month) for which there is no distinct and separate payment arrangement. For employed physicians under such arrangements, payment for this level of call is likely included in the base compensation rates agreed upon, whether specifically / separately identified or not. Any additional payment would be for what is deemed to be excess or disproportionate call. As such, when these organizations report the individual physician's base compensation to the national surveys, it by nature includes consideration for general on-call coverage (since it is part of the terms of the compensation arrangement). This aspect is also applicable to much of the market comparable data valuation firms utilize to perform FMV analyses.

Arguably, there is a similar stance that could be supported for independent physicians that report compensation statistics to the surveys. An independent group or physician may receive a broader payment from the hospital for the services rendered that might include consideration for call coverage. At the practice level, when determining annual compensation for the individual physician, the base rate could include consideration for the call services provided by the individual physician on behalf of the practice and might not be clearly separated or delineated in the physician's individual compensation plan. Therefore, when salaries are reported to the surveys from the practice, there is a risk that the base compensation reported already includes consideration for general call coverage provided.

Several on-call specific surveys exist in the market as well and can add additional insight with regards to structuring and paying for call coverage. Sullivan Cotter and Associates ("SCA"), Medical Group Management Association ("MGMA"), and BuckheadFMV, LLC ("Buckhead") all publish compensation surveys for on-call coverage services. In addition to providing data with regards to the compensation rates for on-call services, they also provide additional insight and perspective into how on-call pay strategies and reporting may differ across the country – which can validate some of the challenges identified in the preceding paragraphs.

In each of the surveys, they report that the responding physicians represent a mix of both employed and independent physicians, yet the rates reported for payment are not often delineated by this classification – which would have an impact on appropriate compensation rates for a variety of reasons (overhead considerations, billing and collecting from third-party payors, etc.).

Additionally, the reports also indicate there are a large number of respondents (50% at the median in one survey) that suggests they do not provide additional compensation for on call coverage. Furthermore, the surveys report that many organizations compensate physicians at an hourly or case rate if they are activated during the call coverage period. In the independent contractor scenario, many on-call providers are able to retain professional collections in addition to being compensated for on-call coverage services.

All of the elements outlined in the section above can create challenges when determining the appropriateness of compensation terms related to on-call compensation. Similar to any financial arrangement with healthcare providers, call coverage arrangements should be structured based on the specific facts and circumstances of the arrangement. Parties should take caution utilizing and applying the survey data when determining appropriate compensation arrangement for call coverage. Valuators should look at the totality of the circumstances when providing FMV opinions for on-call coverage arrangements.

Rationale for Not Paying Additional Call Stipends

Many organizations across the country limit the specialists or types of call arrangements (e.g., trauma call coverage) eligible for receiving call stipends using their medical staff bylaws. In these instances, the organizations do not pay an additional baseline stipend for call, unless it is for a disproportionate burden (i.e., providers are taking on additional days above the expectations outlined by medical staff bylaws) on the individual physicians. On the contrary, there are other organizations paying a stipend for ED call to their physicians in addition to the calculated base rates - though the two payments must be reconciled against FMV considerations for total FMV compensation. Organizations must take caution when determining whether to create additional stipends for on-call pay due to the unique compliance environment regarding on-call arrangements as well as the appropriate use of benchmark information given some of the uncertainty on what is included in the reported data.

Rationale for Paying Additional Stipends for Call

When determining whether to pay for call, organizations should not only ensure that the payment terms represent FMV, but also whether the arrangements are commercially reasonable. Assessing the commercial reasonableness addresses the underlying question of whether the organization has a legitimate business purpose for the service.

Several reasons might exist to support payment for call coverage, some of which include:

- Ability to provide specialty services and appropriate responses to the ED.
- Provide emergency services outside of regular clinic hours; maintain community services with limited physician resources available.
- Risk of losing a service or physician in the community; and support quality of care issues and registry outcome reporting (door to balloon rates, stroke responses, etc.).
- Demand by the physicians in the market – In some instances, private practice physicians have left the medical staff at organizations because they were not being reimbursed for call. It is important to document the need for the services when determining whether or not to pay for call.

There are also arrangements in which the on-call physicians are paid an activation rate rather than a daily stipend for call. Using a reasonable activation payment can make sense from both an economic and compliance perspective. Paying for a reasonable activation fee can result in significantly less overall compensation for the services than paying a daily rate stipend for unrestricted call. It is important to note that activation fee arrangements can present some risk of providing an incentive for the physicians to respond on-site, even when it is not necessary. The parties must monitor the application of the activation fee model to ensure that the physicians are only responding to consults that require on-site clinical services. An activation fee can also take the place of professional collections (e.g., stipend plus activations).

Compliance and Compensation for Call

Despite this increased trend in compensation for call, it is important to recognize that payments for call coverage continue to be scrutinized by the Office of Inspector General ("OIG"). The OIG has stated that on-call compensation presents considerable risk because physicians may demand this compensation as a condition of doing business at the hospital. Moreover, the OIG has historically expressed concerns that the payments may disguise kickbacks or exceed fair market value for the actual services provided. See Advisory Opinion (No. 12-15). The OIG did recognize that in some instances a hospital might need to compensate physicians for call. It outlined several characteristics that might "justify" paying for this call. See Advisory Opinion (No. 12-15).

Future Issues to Keep in Mind

Change is inevitable in healthcare and there are two major drivers of change occurring across the country that physician, leadership, and board members will need to understand the impact on call coverage.

- Telemedicine and virtual care – What does on-call look like in an environment where telemedicine services is more prominent? It is likely that virtual care may not be an option in truly emergent scenarios, but can serve as a buffer to address / triage less acute issues and reduce the burden / need for some call panels (e.g., similar to impact urgent care market has had on emergency room). Whether hospital / system sponsored or direct-to-consumer based models, patients are gaining greater access to care through virtual platforms to help assess / diagnose ailments and assess the appropriate level of care needed. Again, in a traditional trauma or acute setting, virtual care may not have a significant impact but is worth consideration.

- Shifts to Value-Based Care models – How do call panels fit in and align with value-based care models? As organizations are shifting towards more of a risk and value-based care model, who should be responsible for paying for these services? Again, trauma and emergent type encounters will truly need to be assessed outside this lens, but what about acute issues that are a result of chronic conditions (e.g., heart failure, chronic kidney disease)? How should these panels be funded going forward given the desire to transition to more of a patient panel management and risk-based model? Going one-step further, should they be separately funded or are these services already contemplated for a risk-based payment model?

Conclusion and Best Practices

Organizations risk non-compliance with healthcare regulations if they do not carefully structure, document, and monitor their call coverage arrangements. The following provides an overview of best practices for healthcare organizations in structuring said arrangements for the purposes of securing coverage while remaining compliant:

- Determine whether there is a legitimate, unmet need for the call coverage.

- Determine whether the coverage can be secured without pay through medical staff requirements or contractual employment obligations.

- Understand OIG Opinion guidelines and FMV and commercial reasonableness considerations.

- Identify high-risk arrangements (total dollars paid or payment per day).

- Structure the call coverage arrangement after assessment of compliance considerations, trauma level designation, market dynamics, and organization needs.

- Select an appropriate payment structure, documenting factors supporting burden of the coverage.

- Carefully review and assess the applicability of data that is publicly available for call coverage arrangements.

- Understand the impact these arrangements can have on your organizations risk-based and value-based care arrangements.

- Establish an internal process and / or engage a valuation professional to review the arrangement – both from a duration (every two to three years) or if there is a material change in the facts and circumstances that were applied to the value of the call coverage service.

The points outlined above are factors to consider when evaluating the compliance issues related to payments for call. It is important to note that call coverage continues to be an important part of the health care delivery system. Call panels are a necessary and important for patient care and hospital-physician relations.

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