The Burden of Call:
An Objective Approach to Determining Financial Payment

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In this article...

Discover a formulaic approach to paying for call that a health system in Tacoma, Washington, uses that quantifies, monitors and budgets the costs of call coverage.

The causes of the trend toward payment for call coverage are well documented. The aging physician workforce and the growing physician shortage, in combination with increasing physician subspecialization, have resulted in decreasing numbers of willing and able physicians available to provide call coverage.

Financial pressures have also put a strain on physicians' willingness to participate in call schedules, as they frequently disrupt efficient practice operations, and reimbursement for ED professional services is often poor. Moreover, lifestyle disruptions by call are a primary source of physician dissatisfaction.

As physicians become less willing to participate in call schedules, hospitals have found it increasingly necessary to offer payments to physicians who provide 24 hours of ED coverage, seven days a week. The data regarding on-call payments are limited, but it is clear that a significant number of hospitals in some regions of the country have programs that involve call pay for select physicians.[1] As more physicians request payment for call, hospital administrators continue to struggle with determining fair market value (FMV) payments to high call burden specialists.

The Stark regulations generally define FMV as the value in arm's-length transactions, consistent with general market value. Specifically, it is defined as the compensation that would be included in a service agreement as a result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for each other.

Another definition, based on IRS Revenue Ruling 59-60, generally defines FMV as the price that the unrestricted market would be willing to pay for services provided.[2] The health care regulatory environment historically offered little guidance regarding the application of FMV principles to call payment methodologies.

This guidance was limited to the FMV safe harbor established by the Stark regulations which outlined a methodology for fair market compensation based on commercially available compensation survey data. Realizing the limitations of the safe harbor approach, on September 5, 2007, the Centers for Medicare & Medicaid Services (CMS) published the Stark law Phase III Final Rule, which eliminated the FMV safe harbor related to physician compensation for services provided on an hourly basis.[3]

Although the formal safe harbor was abandoned, CMS still encouraged the use of multiple published salary surveys to determine FMV for physician compensation arrangements, and passing the FMV test remained a critical factor under Stark and antikickback requirements.

The first specific guidance for call coverage payment solutions was offered to hospitals by the OIG in September 2007 as Advisory Opinion 07-10.[4] This opinion was in response to a not-for-profit medical center's request that the OIG comment on its payment approach, which encom-passed the recommendations of the hospital's ad hoc committee for per diem payments for all physicians on the call panel, higher rates for more onerous call responsibilities and weekend call, and citizenship requirements for free days of coverage.

The OIG ruled favorably on the approach. As the consulting firm that provided FMV justification for the payment arrangement, ECG Management Consultants published further guidance on structuring call coverage arrangements.[5]

Call Coverage at MHS

MultiCare Health System (MHS) is a not-for-profit organization that provides health care for residents of the Greater Tacoma, Washington, region. It comprises four hospitals and

Figure 1

Relative Call Burden Formula With Example Calculations

I: (Total Number of Hospitals Covered x 365) / (Total Number of Physicians Taking Call)

x

II: (Number of Consults Per Day + Number of Admissions per Day + Mean Number of Referred Patients per Day + 4) x (Mean DRG Weight by Specialty)

x

III: (State Trauma Requirement Weight + Relative Trauma Frequency (special weight))

=

IV: Relative Call Burden

Example Specialities	Orthopedic Surgery	General Surgery Without Trauma	Infectious Disease
I	(3x365)/19	(3x365)/19	(4x365)/5
	x	x	x
II	(1.6+1.0+1.1) x 1.5	(4.3+2.0+0.5) x 1.7	(1.0+0.7+0.2) x 1.7
	x	x	x
III	3.0+0.2	1.0+0.0	0.3+0.2
	=	=	=
IV	1,037	650	480

(I) **Call Frequency** – This variable calculates the number of call days required in the regional community per physician. The relative call burden increases as physicians must cover additional facilities or as the number of physicians in the community decreases.

(II) **Call Intensity** – This variable calculates the intensity of an average day of call. The relative call burden increases as the numbers of ED admissions or subsequent consultations within 48 hours of ED admission increase. There is also a factor to account for case mix differences between specialties.

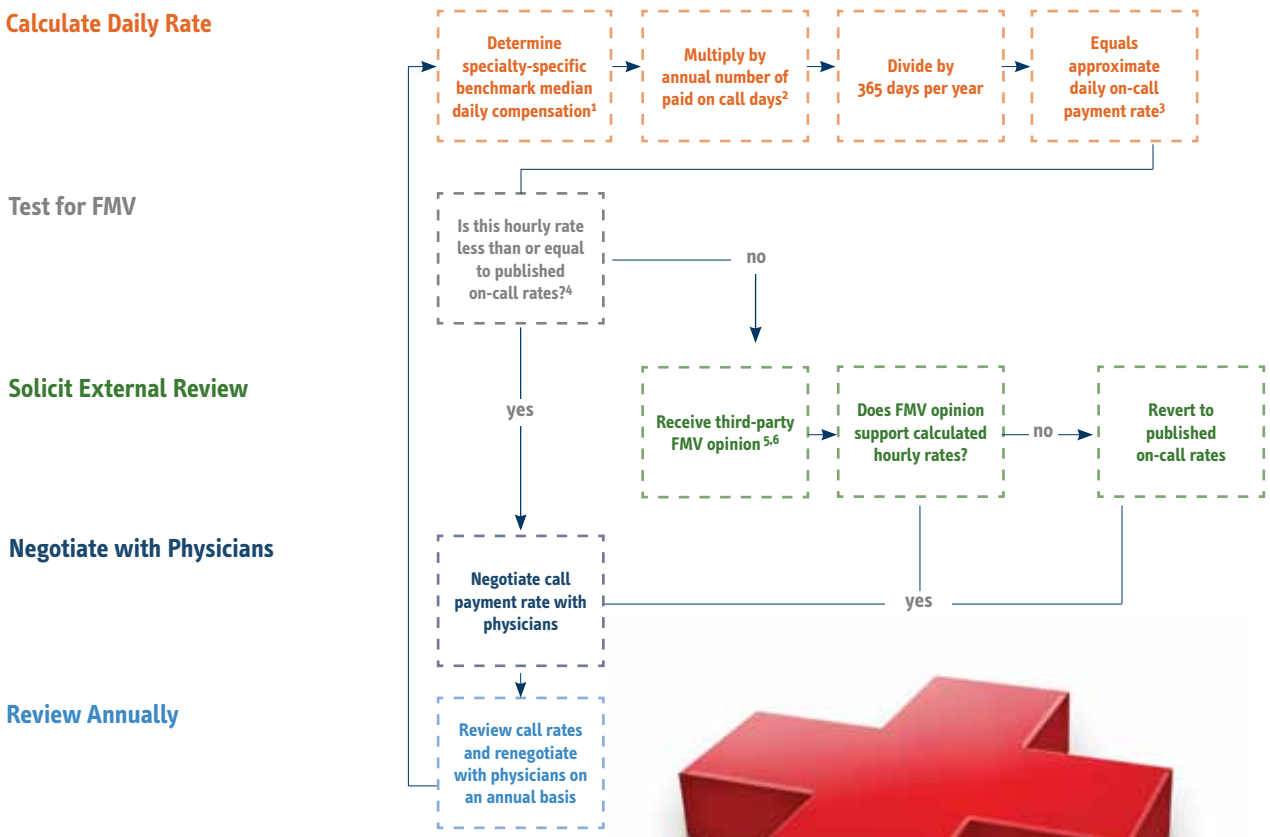
(III) **Local Geographic Requirements** – This variable accounts for specialty-specific state law requirements for trauma center certification, as well as special considerations such as local trauma frequency or other geographic factors. Additional geographic requirements may be included in this variable to reflect unique local circumstances.

(IV) **Relative Call Burden** – This number reflects a specialty's overall burden of call, which can be compared to that of other specialties. MHS considered a specialty to have high call burden if its relative call burden index was at least two standard errors greater than the mean relative call burden for all specialties. In this limited example, orthopedic surgery was determined to have a high relative call burden and be eligible for on-call payments.

NOTE: This formula accounts for characteristics that are specific to the Tacoma market. Other organizations and markets may have unique circumstances and therefore may wish to apply this equation differently.

Figure 2

Process for Determining Fair Market Call Payment Rate



The process to determine the call payment rate for high call burden specialties begins with the calculation of a daily rate that is based on physician paid call days and benchmark compensation rates. If this calculated rate is greater than published on-call rates, the committee solicits an independent third party to render an FMV opinion of the proposed rate. Once the range of fair-market payment rates is established, the committee negotiates with physicians for call coverage. The upper limit of the calculated FMV payment range is considered the maximum target rate in negotiations with physicians. Call payment rates are then reviewed and renegotiated on an annual basis to ensure adherence to FMV.

foot notes

1. Benchmark median daily compensation is based on local and regional compensation surveys, including surveys produced by MGMA, AMGA, and ECG.
2. Physicians are generally expected to provide 3 or 4 uncompensated on-call days per physician per month, based on physician age. They are paid for the additional days they are expected to provide call coverage.
3. The daily on-call payment rate assumes that physicians are paid for all obligated and non-obligated on-call days, and that all weekdays, weekends, and holidays are paid at the same rate.
4. The daily rate is converted to an hourly rate and then compared to the equated hourly rate for unrestricted call from the Sullivan Cotter Physician On-Call Pay Survey Report.
5. The third-party opinion weighs various components to determine whether the hourly rate satisfies fair market principles. Specifically, the opinion factors in:

   • Local locum tenens rates. • Comparable specialties. • Unique community circumstances (e.g., physician shortage, physician age demographics).
   • The opportunity cost for physicians taking call compared to published reports.
6. Review of the hourly rate could be performed internally, but external, third-party review is recommended for several reasons:

   • A third party will provide an objective analysis • Internal reviewers may not have sufficient resources available to adequately complete the analysis.
   • An external opinion is defensible to the OIG and the community.

numerous primary care and urgent care clinics, multispecialty centers, and home health and many other services.

In addition, MHS operates Level II trauma centers at Tacoma General Hospital and Mary Bridge Children's Hospital & Health Center. As part of Washington State's requirements for Level II trauma designation, these facilities must have a comprehensive set of surgical specialists on call and available within 30 minutes.

These required surgical specialties include, but are not limited to, obstetric, orthopedic, thoracic, urologic, vascular, gynecologic, ophthalmic, oral/maxillofacial or otorhinolaryngologic, and plastic surgery, as well as neurosurgery.

This trauma coverage is provided by a trauma team that is shared by MHS, Franciscan Health System (FHS), and Madigan Army Medical Center and that operates under the umbrella of the not-for-profit organization, Trauma Trust. Trauma Trust was established to stabilize the shared trauma system and provide the physician services necessary to satisfy the state's trauma designation criteria.

Like many health care organizations over the past several years, MHS has faced an increasingly challenging physician environment. The Tacoma region has been hit hard by the growing physician shortage, and MHS has experienced acute physician shortages in many of the subspecialties required for Level II trauma designation.

Compounding this problem is the aging of the physician population in Tacoma, with significant numbers of specialists nearing retirement. Not surprisingly, MHS has frequently experienced difficulty finding enough physicians willing to work under traditional call arrangements, thus risking violations under the Emergency Medical Treatment and Active Labor Act (EMTALA) and threatening trauma designation.

Within this environment, MHS was faced with the challenge of securing adequate call coverage for its EDs. Before deciding to pay physicians for call, however, MHS explored other forms of support that would ease the burden of call coverage (e.g., MHS considered technological solutions, such as Picture Archiving and Communication System [PACS] or electronic medical record [EMR] technologies, as well as human resources solutions, such as the hiring of additional physician assistants, hospitalists, or physicians).

Only after these options were determined to be insufficient, ineffective, or impractical did MHS offer payment for call coverage to high call burden specialties. In these cases, MHS found it necessary to pay some physicians for call coverage to maintain its trauma designation and meet the needs of the community.

As this necessity arose in some subspecialties, many other subspecialties began to demand payment for call. Recognizing the imperative to prevent these payments from spiraling out of control, MHS set out to develop a rational call payment methodology that would be objective and consistent across all subspecialties.

In response to this potential crisis, a committee was organized to tackle the call payment issue. Wishing to design a solution that best met the needs of the Tacoma community, MHS sought focus group participation from community physicians.

The focus groups were convened to shed light on the unique and shared challenges faced by different specialties. MHS also sought committee participation from the other Level II trauma center in the area, St. Joseph Medical Center of FHS.

Committee leadership was provided by MHS's vice president of medical affairs, acute care, and FHS's senior vice president and chief medical officer, while membership included legal and administrative representation from both health systems.

Between 2006 and 2008, this ED Call Committee developed and refined a robust approach to the assessment of call burden to physicians and the appropriate compensation of call coverage. This approach includes a mechanism for identifying specialties with significant call burdens as well as processes for calculating call compensation and for evaluating other support services.

Importantly, this approach also ties the level of compensation for call services directly to FMV principles.

Determination of relative call burden

Before determining how much to pay physicians for call, the ED Call Committee determined whom to pay for call. While all committee members had a sense of which specialties had the highest regional call burden, they did not have an objective way to measure or rank this burden.

Wishing to have such a measure as a basis for determining call payment, the committee used an evaluation by ECG to guide the development of an equation that objectively ranks specialties based on their relative call intensities.[6] The resulting formula contains variables to account for (I) call frequency, (II) call intensity, and (III) local geographic requirements that results in (IV) a final measure of relative call burden. This formula is presented in Figure 1, with example specialties.

By applying this formula to data from all specialties, the ED Call Committee was able to rank the specialties based on relative call burden. An objective relative call burden threshold was set to determine which specialties should or should not receive extra support or payments for call coverage. The specific threshold set for high call burden specialties may vary by community based on unique local market realities.

Determining FMV call payment

Once MHS determined who to pay for call, it determined how much to pay. To guide this analysis, MHS formed an internal committee, the Community Physician Compensation Committee. This committee was established to review FMV calculations for community physicians, maintain a common practice that meets the Stark requirements, and engage an independent third party to review FMV determinations as necessary.

This committee was chaired by MHS's vice president of medical affairs, acute care, and included representatives from corporate compliance, legal, human resources, physician leadership, and finance. The Community Physician Compensation Committee reviews call payment determinations on an annual basis in order to ensure continued FMV compensation.

Figure 2 outlines the process the Community Physician Compensation Committee went through to determine call payment rates within FMV.

To ensure market-based call coverage payment rates, the Community Physician Compensation Committee used compensation data from three to five objective, independently published, commercially available salary surveys to arrive at a median annual salary for each high call burden specialty.[7]

This annual salary was then translated into a daily rate, which was applied to the call days for which compensation was provided.[8] The payment for these days was spread over all call days, resulting in physicians' receiving payments for all 24-hour periods of call coverage.

This per diem method of compensation for 24 hours of coverage is the most prevalent payment arrangement nationwide and is recognized as a standard for call coverage in the industry. In fact, in Advisory Opinion 07-10, the OIG states that the methodologies used to establish per diem payments "lower the risk that the arrangement is a vehicle to disguise payments for referrals."

Implications

By establishing and consistently adhering to this process of using objective data and ongoing committee review to determine relative call burden and fair market call payments, MHS has realized several major benefits:

- **Minimized FMV risk**

  While hospitals and health systems try to keep their physicians satisfied, they are often challenged when sensitive physician compensation issues arise. By developing a consistent approach to the determination of call burden and payment, adhering to FMV principles, and only paying for coverage for high call burden specialties, MHS has drastically mitigated the risks of becoming noncompliant with FMV principles, violating the Stark provisions, being subject to an unfavorable review by the OIG, or losing its tax-exempt status. Furthermore, the process developed by MHS fulfills the Stark requirement of securing individual signed agreements with all physicians receiving call payments.

- **Reduced administrative effort**

  Prior to developing this methodology, MHS administrators exerted considerable effort on physician call payment issues. All call payments were evaluated on a case-by-case basis, with little standardization. As physicians began to learn of others receiving pay for call, they increasingly began to ask for call payments, which resulted in numerous reactive call payment determinations.

  With the implementation of its approach, MHS has been able to address call in a proactive manner, avoiding the "squeaky wheel" phenomenon. Furthermore, MHS now negotiates payments for call coverage with entire call groups instead of with individual physicians. Consequently, the administration of call issues has become much more straightforward and much less time-consuming.

- **Enhanced hospital/physician relationships**

  This comprehensive approach to relative call burden has improved many hospital/physician relations. The transparent and consistent application of a statistical measurement of relative call burden determination has eased many physicians' concerns that some specialties receive unfair compensation for call. This methodology has provided an objective mechanism and forum for discussing call payment requests with physician call groups who do not currently receive stipends, and it is generally considered fair by the physician community.

  As a result, physicians have now begun to trust MHS administration and view it as much more of a partner, as opposed to an adversary, in solving the call crisis. This open collaboration has helped MHS avoid physician conflicts over call coverage payments that have proven costly to other health care organizations and communities.

- **Quantified call burden as a financial expense**

  Before adopting this approach, MHS administrators did not have a complete understanding of their call coverage expenses. By adding rigor to the call burden determination and payment process, MHS has built a transparent framework for

quantifying, monitoring, and budgeting for the costs of call coverage.

Importantly, MHS now views call coverage as an objective issue and weighs the costs of call payments against the benefits it realizes from a comprehensive call coverage program, as well as against other options it considers to help mitigate the call coverage problem (e.g., surgical hospitalists, physician employment).

The economic benefits MHS has experienced from its call payment program include reducing the risk of losing its Level II trauma designation, avoiding CMS investigations for EMTALA violations that could result in loss of CMS payments, and minimizing the loss of acute care admissions due to incomplete call coverage.

The financial quantification of call burden has also allowed MHS to view call payments as more than simply a cost of business (e.g., as a reported community benefit in support of not-for-profit status). Furthermore, non-economic benefits of this call payment system have been realized through improvements in the coverage provided by the ED call system to the public (e.g., fewer uncovered days, quicker physician response times, limited between-specialty disagreements over patient care responsibility).

Therefore, as the health care environment continues to change, MHS is well positioned to not only balance the funding for call payments with the other options available for reducing call burden and the benefits it receives from providing this coverage but also allocate resources to best meet the needs of the health system and the Tacoma community.

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7. Surveys used include the MGMA Physician Compensation and Production Survey, the American Medical Group Association (AMGA) Medical Group Compensation & Financial Survey, and the ECG Provider Compensation, Production, and Benefits Survey.
8. Physicians are expected to provide a number of uncompensated call days per month (historically, 3 or 4 days per month); this number is based on physician age and decreases as the age of the physician increases. This number of unpaid call days is then subtracted from the total number of required coverage days to determine the number of days for which call coverage will be compensated.