

MARCH 2013

diagnostic

Beyond the Benchmarks: Quantifying the True Value of Call Coverage Services

Hospitals across the nation are increasingly turning to call coverage compensation arrangements as a means of providing vital medical services and remaining in compliance with federal law. While the

.....
KEY TAKEAWAYS:

- *Call coverage benchmarks can be misleading, causing hospitals to overpay or be unnecessarily restricted from paying an appropriate stipend.*
 - *Call pay is far more variable than clinical compensation. As a result, hospitals must understand what drives call stipends to be higher or lower so they can set the appropriate payment.*
 - *Data-driven approaches are available that more accurately account for the variation in coverage arrangements.*
-

number and complexity of these agreements have grown, many healthcare organizations are entering into such contracts despite uncertainty that the terms are both legally defensible and financially prudent. This Diagnostic addresses some of the most pressing and frequently asked questions about call coverage arrangements and suggests a robust, thoroughly vetted methodology for arriving at payments that are individually tailored to a given arrangement and remain within the appropriate market range.

Key questions discussed in this article include:

- *Why is it so important for these agreements to be specific and supported by data?*
- *Can we use the national median payment for this specialty and consider it fair market value (FMV)?*
- *Why aren't the surveys alone sufficient?*
- *What are the factors that should be considered in calculating call coverage payments?*
- *What does the future of call coverage arrangements look like, and how can hospitals prepare themselves for the changes ahead?*

Why is it so important for these agreements to be specific and supported by data?

Healthcare systems are under more pressure and scrutiny than ever before in paying for call, with the threat of harsh penalties ranging from large fines to the loss of Medicare status if even a single contract fails to meet increasingly complicated and strict governmental regulations. The level of uncertainty and the high stakes involved have prompted the Office of Inspector General to release

..... three opinions on call coverage in the past several years, sending a message to hospitals that even seemingly minor or unintentional transgressions in this area can result in investigation and possibly civil and criminal penalties.

While most health systems rely on legal counsel in drafting agreements...the terms of the contracts themselves demand an additional level of analysis to ensure that payments do not exceed FMV and are commercially reasonable.

This situation has, naturally, prompted proactive hospital administrators to explore methods to protect themselves as they enter into the business arrangements necessary to continue providing the critical services their communities require. And while most health systems rely on legal counsel in drafting the actual agreements to ensure that these documents are appropriately protective and binding to the parties involved, the terms of the contracts themselves demand an additional level of analysis to ensure that payments do not exceed FMV and are commercially reasonable (CR).

Can we use the national median payment for this specialty and consider it FMV?

The most basic FMV analyses rely almost exclusively on national surveys of physician compensation, using median values or some otherwise specified range to determine “market” payment levels. Unfortunately, this approach, while easy to understand and execute, is extremely imprecise and may either restrict a hospital’s payments unnecessarily or create substantial risk of overpayment. Since regulators do not provide a methodology for arriving at FMV or meeting CR criteria, it is possible to use multiple processes in assessing the appropriateness

of a given contract. However, while there may be more than one acceptable way to approach the evaluation, there are also many methodologies that lack sufficient

Appropriately detailed analyses must be performed on a true case-by-case basis, using a methodology that considers more than just national benchmarks.

..... depth and market understanding to withstand being challenged in a regulatory context. As such, appropriately detailed analyses must be performed on a true case-by-case basis, using a methodology that considers more than just national benchmarks. Rather, the valuation process should take into account the relevant facts and circumstances in each arrangement.

Why aren’t the surveys alone sufficient?

The use of on-call compensation benchmarks as the sole indicator of FMV is problematic for several reasons, including small sample sizes, wide variations among benchmark sources, reliance on dated information, and, most importantly, limitations of the benchmark data collection process.

- **Sample Sizes:** Participation for these surveys has grown slowly over the past decade but remains quite small, and even specialties with a high number of physicians are generally not well-represented. The surveys classify these already-small groups of responders into still smaller subclassifications by practice type or geography, rendering the subsequent samples so small as to be statistically nonrepresentative. Further, the surveys group multiple specialties into a large data set, such that the commingled data’s applicability to the analysis becomes questionable at best.
- **Wide Variations Among Benchmark Sources:** Even the two most well-conducted and widely cited national call coverage surveys (MGMA *Medical Directorship and On-Call Compensation Survey* and Sullivan, Cotter and Associates, Inc., *Physician On-Call Pay Survey Report*) frequently exhibit significant differences in the percentile ranges they report for comparable specialties. For example, the 2012 MGMA survey reported that the 25th to 75th percentile range of daily payments for

Family Medicine was between \$100 and \$125 (six practices), while Sullivan Cotter reported a range of \$300 to \$750 for family practice physicians (five practices). Thus, one survey suggests that the payment range is three to six times higher than the other. While the surveys do not always conflict to such an extent, similar levels of variation do not exist among the clinical compensation surveys from the same publishers.

- **Reliance on Dated Information:** Call coverage is still an emerging trend, with notable variations each year. However, the most recently published coverage surveys often utilize data that is 2 to 3 years old.
- **Limitations of the Benchmark Data Collection Process:** The factors that influence the level of stipend required are not adequately measured in the survey because they are frequently not tracked by the survey respondents.

What are the factors that should be considered in calculating call coverage payments?

In early iterations of FMV analyses, the burden of call coverage was largely perceived as a dichotomy, dependent simply on whether call shifts were to be *restricted* or *unrestricted*. However, physicians and hospitals have clearly demonstrated that even within these two broad categories, there exists a wide variation in how significantly a physician’s lifestyle is likely to be impacted during an on-call shift. These variables should be accounted for in the payment mechanism.

The table below provides a summary of the key considerations in FMV assessments for call coverage arrangements.

FMV CONSIDERATION	RATIONALE
Local market physician supply.	The value of a provider increases in light of scarcity of physicians in a given specialty and/or documented difficulties in recruiting within the geographic area.
Burden of carrying a beeper.	On-call duty negatively impacts a physician’s lifestyle (even if he or she is not called in while on duty) and merits a base level of compensation.
Frequency and timing of beeper activations.	Undesirable factors, such as a high volume of pages, overnight calls, or frequent trips to the hospital, increase the lifestyle impact and should be compensated accordingly.
Post-activation procedures and follow-up requirements.	Call-related patient care provided subsequent to a shift often adds to a physician’s existing workload and effectively extends the burden of call responsibility.
Revenue generated by the physician as a result of activations.	Most, but not all, call coverage arrangements enable physicians to retain professional collections earned while on call. Quantifying the total compensation earned is an important step in making a FMV determination.
Payor mix.	An undesirable payor mix increases the percentage of uncompensated care a physician must provide and potentially increases the level of compensation that may be offered by a hospital.

Other lifestyle factors may be evaluated, such as the time distribution of pages received during a shift, particularly the level of disruption when pages are received outside of standard business hours.

Finally, it is important to gather data related to the professional fees collected by physicians as a result of these interactions in order to avoid double payment for the same services. If third-party reimbursements retained by physicians adequately compensate for all relevant burden factors, it may not be appropriate for the hospital to offer any stipend.

Although this level of detail is necessary to illustrate the tangible burden of being on call, for a truly thorough analysis of the proposed arrangement it is crucial to look beyond the characteristics of a single on-call episode and also consider larger system factors that may influence the overall burden.

What does the future of call coverage arrangements look like, and how can hospitals prepare themselves for the changes ahead?

Given the increasing number of call coverage arrangements being implemented nationwide, with no indication that this trend will change anytime soon, we believe our clients will continue to rely on these agreements to maintain adequate medical staff coverage. National surveys are slowly catching up to this market shift but remain limited, and the high degree of variability inherent in these types of arrangements makes it unlikely that any survey will ever adequately capture the myriad factors that influence the true value of call coverage services. As such, the independent third-party FMV opinion relying on client-specific data will remain a fixture among prudent hospital leaders who wish to both shield themselves from legal concerns and ensure the execution of a fair professional arrangement. But rather than viewing FMV analyses as little more than a box to be checked in physician compensation dealings, healthcare administrators are encouraged to view these reports as a component of their overall business and to benefit from the insights an appropriately rigorous FMV analysis can provide.

About ECG

ECG offers strategic, financial, operational, and technology-related consulting services to healthcare providers. As an industry leader, ECG provides specialized expertise to community and children's hospitals, health systems, medical groups, academic medical centers, and schools of medicine. For 40 years, ECG has played an instrumental role in developing and implementing innovative and customized solutions that effectively address issues confronting healthcare providers. ECG has more than 115 forward-thinking consultants who are focused on delivering the highest-quality services to exceed our clients' expectations.

This *Diagnostic* was written by Sean Hartzell, Senior Manager (shartzell@ecgmc.com), Christine Frauenhoffer, Senior Consultant (cfrauenhoffer@ecgmc.com), and Adam Klein, Senior Manager (aklein@ecgmc.com). To learn more about ECG's healthcare valuation practice, please contact:

SAN DIEGO

Tel 858.436.3220

Adam Klein, Senior Manager
aklein@ecgmc.com

WASHINGTON, D.C.

Tel 703.522.8450

Sean Hartzell, Senior Manager
shartzell@ecgmc.com



ecgmc.com 800.729.7635

Boston San Diego San Francisco Seattle St. Louis Washington, D.C.