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the call conundrum

Agreements to compensate physicians for defined call coverage in the emergency department (ED) can be effective tools for health system leaders to solidify necessary clinical coverage for core programs and service lines. Unfortunately, the current and projected strategic and financial impact of physician call pay arrangements can be difficult to assess given how they have been historically developed. In many instances, existing call arrangements have been developed reactively as a result of issues raised by individual physicians or groups.

When analyzed on an individual-agreement basis, call pay arrangements tend not to be perceived as a high-priority issue, and from a practical standpoint, senior leaders may be inclined to shelve the issue while they address more pressing concerns. However, given the current trend toward specialization, call pay is an emerging and evolving concern that shows no signs of abating. This trend raises two questions that are of paramount importance: How does the continued trend toward physician-hospital alignment impact physician call-pay costs? And are there strategies to reverse the current cost trend?

AT A GLANCE

Physician pay for being on call to provide emergency department coverage has long been a headache for health systems, but a few careful steps can help mitigate future challenges:

- Proactively develop strategies and adhere to them consistently.
- Promote integrated specialty groups/departments.
- Pursue payer contracts that include key quality and total cost-of-care incentives.

The Unfortunate Truths of Physician Call Pay

Before discussing potential strategies to address call pay, it is helpful to have a clear understanding of current realities and inherent challenges in this area.

Physician call pay costs may ultimately be much greater than the amount of the initial request. The fact that physicians have requested call pay is much more significant from a strategic standpoint than is the specific dollar amount attached to such a request. In many instances, management feels pressure to respond to a time-sensitive request made by a key physician or group practice, which must be addressed quickly to maintain key service access and coverage. The possibility of losing critical call coverage places management in a difficult short-term position. Moreover, although the potential cost of a single call request from individual physicians or a group practice may fall within management's defined scope of

decision-making responsibility, in many cases a single call agreement can cause a chain reaction of related requests and costs that, if reviewed in totality, would have triggered a more rigorous decision-making process including board approval. Thus, the impact of an individual decision can set off a ripple effect that can be ongoing and significantly increase total expenses going forward.

Physician call pay arrangements come in many shapes and sizes. Unfortunately, call pay arrangements and structures can't be compared on an apples-to-apples basis. Lessons learned in one instance are not necessarily applicable to another. It is critical for leaders to understand what type of call is being discussed. Independent physician groups will value call differently depending on whether the value is developed from an internal perspective (i.e., the dollar amount they would attach to call if a physician within their group wanted to buy his or her way out of the call schedule) or an external perspective (e.g., the daily or hourly rates a health system offers to compensate them for excess or uncompensated call responsibilities). The exhibit below illustrates two methods for how an independent cardiology group with five FTE interventional cardiologists might assign a value to call—in this case, to respond to a request by one of the physicians, referred to here as Physician A, to buy his way out of call.

For this purpose, the group's administrator develops two methods for valuing the physician's call, with the physician's annual income estimated at $600,000.

The internal method consists of a simple poll of the group physicians to determine the economic point at which the group would be willing to approve the request to drop out of call and use the corresponding compensation decrease to fund the excess call responsibility picked up by the remaining four physicians. The group concludes that about 27 percent of estimated annual compensation, or roughly $160,000, is an appropriate value for call with five physicians in the pool. Given that Physician A had taken 73 days of call responsibility per year, the group calculates a per-day value of approximately $2,192 for physicians picking up the excess coverage.

In the case of the external method, the group administrator also knows cardiology groups in other markets receive excess call payments ranging from $900 to $1,100 per day. For analytical purposes, the administrator uses a call rate of $1,000 per day and backs into an annual call value per physician of $73,000 (73 days × $1,000). The net result is a significantly lower relative value for call, which is not realistic because it is likely that a physician would be willing to reduce his or her compensation by $73,000 in return for not taking call.

The group therefore approves Physician A's request to discontinue call responsibilities using the internal method. The remaining four interventional cardiologists will be content to pick up the additional call responsibilities for an additional $2,192 per day for about 18 days (73 ÷ 4), or approximately $40,000 per physician on an annual basis.

Call pay may be the right solution to the wrong problem (or the wrong solution to the right problem). In some instances, a request for call pay support may suggest that an independent physician group model is no longer sustainable given multiple factors, including regional payment rates, an inability to attract and

ANNUAL COMPENSATION BREAKOUT BY ESTIMATED WORK EFFORT: TWO METHODS FOR VALUING A PHYSICIAN'S CALL RESPONSIBILITIES

	Estimated Annual Compensation			Percentage Total		
Work Effort Description	**Internal Method**	**External Method**	**Difference**	**Internal Method**	**External method**	**Difference**
Not Call-Related	$440,000	$527,000	–$87,000	73%	88%	–15%
Call-Related	$160,000	$73,000	$87,000	27%	12%	15%
Total	$600,000	$600,000	$0	0%	0%	0%

retain the next generation of physician shareholders, or essential cost issues (e.g., professional liability insurance). Requests from employed physician groups may suggest a need to revisit the physician group model and compensation methodology (e.g., a revenues-less-expenses model that does not support competitive physician compensation rates). In such instances, a renegotiated call pay arrangement may simply delay a critical need for fundamental strategic and structural realignment.

Requests for increased call pay will inevitably rise with the trend toward increased subspecialization.
As physicians in key specialties continue the trend toward increasing subspecialization (e.g., spine surgery as a subspecialty of orthopedic surgery), hospitals are certain to see a rise in requests for incremental increases in call pay as call pools decrease in size. Historically, larger, integrated specialty groups have been relatively successful in internally managing the call issue. Meanwhile, the individual physicians in these groups have been encouraged to subspecialize and then, in exchange for support and referrals from their fellow physician shareholders, to participate in the group's physician compensation model and take an appropriate share of call responsibilities.

The exhibit above right demonstrates a hypothetical scenario of how two different orthopedic groups might approach the call question for the subspecialty of spine surgery. Group A is an independent group practice, and Group B is a hospital-employed group.

In Group A, the spine surgeon is included in the overall call rotation of four physicians, based on a conclusion that spine coverage is not necessary on a 24/7 basis given the elective nature of large, complex spine cases. Thus, each of the four physicians, including the spine surgeon, provides call on about 80 days per year, and none of them has a claim to providing excess call days relative to his or her colleagues.

By contrast, Group B was formed by the hospital, which recruited four physicians with no past history of functioning together in an independent group practice. In this instance, after setting the original rates of call pay for the four physicians, the hospital has determined that spine call coverage is necessary on a 24/7/365 basis and that, therefore, spine surgery should be regarded as a separate call group. Because this determination results in the spine surgeon being on call for 240 more days than any of the other three physicians in the group (each of whom has 80 days of call), the spine surgeon negotiates excess call pay at a rate of about $1,000 per day (about $240,000 annually).

HYPOTHETICAL SCENARIO: TWO ORTHOPEDIC GROUPS' APPROACH TO CALL PAYMENT FOR SPINE SURGERY

	Independent Group A	Hospital-Employed Group B
Physician FTEs in Call Rotation		
Orthopedic Surgery	3.00	3.00
Spine Surgery	1.00	1.00
Total	4.00	4.00
Excess Call Days per Year		
Orthopedic Surgery	0	0
Spine Surgery	0	240
Total	0	240
Excess Call Payment Daily Rate		
Spine Surgery	No excess call rate	$1,000
Excess Call Payment		
Orthopedic Surgery	$0	$0
Spine Surgery	$0	$240,000
Total	$0	$240,000

This scenario also raises the potential for future excess call payments for the general orthopedic surgeons, given that there are now three physicians in this group and under the original agreement, the amount of call pay for each physician was calculated based on the premise that the group had four physicians. This example shows the spillover impact of revising call pay agreements based on subspecialization, and how a solution for one problem may inadvertently create another.

Potential Solutions

Although the examples outlined above are simplified for illustrative purposes, they are based on real-life

circumstances and demonstrate a real, ongoing problem for health system leaders. The obvious question is, What can be done about it? If physician call pay is an unavoidable expense that also is likely to increase for the foreseeable future, how can health systems minimize this expense while maximizing the value of physician call and maintaining high levels of physician satisfaction? Putting a lid on physician call pay expenses may be difficult, given current trends, but health systems have several options they should consider pursuing.

Proactively develop and utilize consistent guidelines/strategies for physician call pay. At a minimum, health systems should define and implement a consistent approach for analyzing requests for call pay and assigning related decision-making responsibilities. Decision-making criteria in which the total estimated expenditure determines the level of governance responsibility (e.g., board approval required for any operating expense increase estimated at or above a certain amount annually) may not be effective for physician call pay issues, which frequently cause additional, unanticipated call cost issues in the future. In reality, it is helpful if management and boards can address call issues, to the extent possible, in total (versus each issue being addressed as a single, stand-alone pop-up issue). Ideally, call pay guidelines and strategies should be integrated into the health system's overall strategic plan.

Promote increased physician-physician integration. As demonstrated in the cardiology and orthopedic group call examples, larger, more integrated physician specialty groups or departments with more developed decision-making and compensation structures are better positioned to internally manage key call question issues. This is true regardless of whether the group is independent or employed. Unfortunately, the formation of larger, health-system-employed physician groups has not always led to the concomitant development of highly functioning, integrated specialty groups and structures necessary for managing complex call issues. Indeed, some of the best parts of independent practice (including the ability to effectively manage complex call issues) have been lost in the transition to employment. To the extent possible, health systems should pursue the development (or reconstruction) of large integrated specialty groups that allow for subspecialization while also allowing for effective management of overhead (including physician call pay).

Continue to pursue a higher number of payer contracts with key quality and total-cost-of-care incentives for assigned patient populations. To the extent that significant physician compensation performance bonuses are directly tied to key value-based incentives, it is likely that physician groups will have incentives to aggressively manage ED utilization (given that the ED will be ground zero for key patient population management strategies). A discussion of the specific specialties responsible for providing ED call coverage and how they should be compensated for this coverage will depend on each organization's overall structure for allocating bonus surpluses and, as such, is beyond the scope of this article. The good news is that, at the global physician organization level, the need for excess call pay may decrease as the level of value-based payer contracts increases. Conversely, incremental call pay, to a significant extent, may already be "baked" into the compensation data and surveys that a significant number of large healthcare organizations have used to determine their baseline physician compensation models.

Although the trend toward subspecialization will continue to exert upward pressure on call pay expenses, trends toward patient population management and continued intra- and inter-specialty integration offer the best options for both maximizing investments in physician call pay and developing highly functioning, fully aligned single and multispecialty group practices (as opposed to a collection of individual physicians and groups flying a single corporate banner). However, fully realizing these strategies will require a significant investment and thoughtful approach to group practice building. ■

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