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Different Economics, Different Payment: Call Coverage Stipends for Employed vs. Independent Physicians

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Physician employment agreements now commonly include compensation for services beyond basic clinical services; they may also provide compensation for medical directorships, teaching, on-call payments, and so on. We have found that physicians transitioning to hospital employment are generally accepting of clinical compensation models that include a base salary coupled with productivity and quality incentives. However, they may not be as accepting of changes in compensation for emergency department ("ED") call coverage, a highly-sensitive component of physician employment arrangements.

Consider the following example:

> Dr. Smith is an independent orthopedic surgeon who is on call for Community Hospital's ED every third day. For this coverage, Community Hospital compensates her $1,000 per day of call coverage and she can bill patients for any professional services rendered.
>
> She is approached by Community Hospital with a proposed employment package under which she will receive $75 per personally performed WRVU, full benefits and malpractice coverage, and $850 per day of call coverage *in excess of the hospital's one-in-five standard.*[1] These rates were developed by the hospital and its healthcare valuation consultant in consideration of many factors including fair market value and commercial reasonableness.

[1] The one-in-three coverage provided by Dr. Smith translates to approximately 121 shifts per year while the hospital's one-in-five coverage standard is equivalent to 73 shifts per year. The difference between these two figures is 48 shifts per year of *excess* call coverage.

Dr. Smith looks at the decrease to the daily stipend and the decrease in the number of paid shifts and understandably feels that the hospital is asking her to provide the same call coverage for a lot less pay.

Putting aside federal and state regulations (Stark Law, Federal Anti-Kickback Statute, etc.), the economics themselves change fundamentally when an independent physician becomes a hospital employee. Dr. Smith, and many other physicians in her position, needs to be helped to understand this. These compensation changes were required to achieve a compensation package that meets Fair Market Value requirements.

A valuator would explain the two key factors driving the difference in call coverage compensation between independent and hospital-employed physicians as indicated below.

Factors	Before: As an Independent Physician	After: As a Hospital Employee
Professional Collections: As an independent physician, Dr. Smith could bill patients to whom she provided professional services while on call, though she may often receive little or no reimbursement depending on the patients' insurance or lack thereof. As an employee, she will be compensated via WRVUs generated for providing clinical services, regardless of the patient's ability to pay.	At risk	Not at risk
Excess Call: According to industry data, the median orthopedic surgeon takes ED call every fifth day and many of those surgeons are paid for that call coverage. The underlying survey data used by Community Hospital to set the clinical compensation rate for Dr. Smith ($75 per WRVU) represents total cash compensation and thus therefore already includes some level of call coverage stipends paid to physician respondents.	The physician receives a $1,000 per day stipend from the hospital for call coverage, and no other compensation	The physician is already being paid by the hospital for some call coverage through the clinical compensation rate, so she only gets additional compensation when the amount of call exceeds that "built in" amount

Similar principles apply to medical directorships and services provided by an employed physician to an outside organization.

It is important for both parties to understand that when a hospital employs a physician, the hospital "owns" that physician's time. While there are many ways to structure compensation, it is best for both parties to consider *all of the services* and *all of the compensation* instead of focusing on any single piece, such as ED coverage, because ultimately the hospital needs to pay fair market value for the *entire bundle* of services for which a physician is being compensated.

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