

managing the margin

...strategies for generating new revenue and controlling costs

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Minimizing Costly Medical Staff Subsidies

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In California, hospitals are paying up to \$3,000 per night to on-call specialists to be available to take emergency department (ED) coverage. In Florida, one hospital is seeking help from the community to fund payments to specialists for uncompensated care. And on-call coverage fees are not the only subsidies hospitals are paying out. Growing numbers of medical centers across the country are paying physicians to participate in committee and board meetings and hold leadership positions, such as president of the medical staff.

Clearly, hospitals can no longer assume physicians will perform activities such as taking call or holding leadership positions simply out of a sense of good will. Instead, many physicians are demanding nonclinical sources of revenue. A variety of factors are contributing to the fairly recent practice of paying stipends to physicians:

- A shortage of specialists, especially those in most demand to cover the ED
- Increased subspecialization of physicians, which places additional burden for call coverage on traditional specialists (e.g., hand specialist versus general orthopedics)

- Migration of medical procedures to outpatient settings, making it more difficult to get gastroenterologists, nephrologists, plastic surgeons, and similar providers back to the hospital setting to cover the ED
- Increased practice costs, such as rising malpractice insurance premiums, coupled with stagnant or, in some cases, declining payment

Why Subsidies?

Payments to specialists for ED coverage have become more common for several reasons. Although most hospital medical staff bylaws require physicians to take call in order to obtain hospital privileges, some specialists are willing to suspend medical staff privileges to avoid taking call. Certain specialists in short supply, such as cardiologists, neurosurgeons, and orthopedists, may believe themselves to be overworked and underpaid, so they are no longer taking call or desire to be compensated to do so.

Also, regulations from CMS and through the Emergency Medical Treatment and Labor Act (EMTALA) place the responsibility on hospitals to ensure the availability of emergency care, which

includes having an on-call list that meets the needs of patients. Medicare-participating hospitals and physicians found to be in violation of EMTALA may be fined, and possibly excluded from participation in Medicare and Medicaid programs.

In some markets, physicians have seized the opportunity to demand payment for coverage. In one extreme case, a group of independent neurologists refused to provide call coverage for the ED unless the hospital increased fees for its call panels. At the time of publication, the hospital was considering filing an antitrust complaint.⁴

Physicians are also reluctant to participate in administrative duties, such as serving on quality assurance committees or taking the role of president of the medical staff, likely because they believe the reward for doing so is not worth the effort. Young physicians' desire to participate in these activities has declined most notably. This segment tends to place a greater value on quality-of-life goals than their senior colleagues did early in their careers. As a result, hospitals are paying stipends to many physicians to meet these needs.

Physicians are also less willing to take on teaching as part of their responsibility at teaching hospitals without receiving compensation in return. Certain medical schools throughout the country are scrambling at the last minute to try to fill teaching positions that traditionally had long lists of candidates. In some instances, medical centers are paying stipends upward of \$5,000 to motivate providers to teach.

What Can Providers Do?

The real question for hospital executives is whether these subsidies can be avoided or minimized. The likely answer is no to "avoided," and yes to "minimized." However, a balance must be struck between what is paid and what is needed. Hospital leaders understand that physicians are looking for ways to supplement their income. Physicians' desire to supplement their income, however, should not come at the expense of the hospital's bottom line.

With these concerns in mind, several strategies for improving ED coverage have proven useful.

Develop a funds pool. Distribution to physicians should be based on the

Did You Know?

Two-thirds of emergency department medical directors reported shortages of on-call specialists in a recent survey by the American College of Emergency Physicians. About 8 percent said their hospital was paying stipends for on-call commitments from specialists, while 15 percent were guaranteeing certain levels of payment for services, and 14 percent were providing some measure of medical liability coverage. Medical directors from 1,427 hospital emergency departments participated in the survey.

amount of hospital call coverage they provide. Pool amounts should consider what the market will bear, existing ED patient levels, and the funds available for the pool. The method for distribution can be on a per diem or clinical productivity basis.

Set specialty-specific thresholds or tiers that vary the amount of pay.

The formula to determine the tiers may include number of days each month the physician is on call, the number of days per month without pay, frequency of calls off-hours, and the amount of uncompensated care provided. Thresholds that define the number of days that the specialist covers for no pay should allow hospital leadership to maintain that call coverage is a part of the medical staff responsibility while compensating those physicians who take on an additional burden of call.

Develop a productivity-based payment structure.

The basis should be a

guaranteed amount per relative value unit for unassigned ED patients. This approach can cut financial risks for physicians by providing funding for uncompensated care.

Contract with a third-party entity. Outsourcing is another option. In such an arrangement, the third party recruits physicians to provide on-call services, bills for the professional services, and pays the physicians using a productivity-based methodology. The hospitals are responsible for paying a fee for the company's services in addition to the shortfall between payer reimbursement and the productivity-based payments to physicians. The advantages to outsourcing include reduced time and energy for the hospital and regular and fair payments to physicians for their services. However, this option can be relatively costly for the hospital.

Prioritize payment where it's most needed.

Some hospitals pay physicians a fair market value in the busiest call specialties, such as internal medicine and general surgery, and for staying overnight (7 p.m. to 7 a.m.).

Develop a hybrid approach.

Some hospitals are using a stipend methodology for high-volume specialties while employing a productivity-based approach for low-volume specialties.

Regardless of the methodology chosen for ED call coverage, hospital leadership must not get caught on the slippery slope. Once payments for one specialty are implemented, it may not be long until more specialists are lined up at the executive offices seeking stipends. Consistency and maintaining fair, document-

ed payment policies will help to avoid potential political fall-out and go a long way toward meeting regulatory requirements.

Methods for paying physicians to participate in clinical and medical staff leadership roles vary based on the specific duties.

Duties may encompass (among other things) oversight of a program, clinical quality assurance, interface with referring physicians, and program development. In most cases, hospitals will:

- Outline specific duties expected, such as staff management, development of protocols, attendance at meetings, and record-keeping requirements.
- Determine the amount of time necessary to fulfill the administrative duties requested.
- Develop a discounted (e.g., 50 percent) clinical value of time per hour to pay the physician on an hourly basis for duties.
- Assess the market to determine how much physicians are paid for such activities.

Subsidies in Action

A community hospital in a Southeast metropolitan city started paying physicians for ED coverage about 10 months ago. Initially, hospital executives earmarked funds to pay physicians in five specialties with tiered stipends to reflect time actually spent in the ED for call coverage. The medical executive committee believed that the pool needed to be expanded to pay tiered stipends to physicians in 12 specialties. Eventually, hospital executives agreed to provide a \$2 million pool, giving the medical executive committee the authority to divide the funds how it

wished, as long as the ED was covered. The methodology and contract with participating specialists now reflects the following:

- Twelve specialties are paid \$500 per night for ED coverage.
- Physicians taking call are required to cover the ED four nights per month without payment.
- Physicians follow policies and procedures to help decrease utilization and costs, such as using EMRs consistently.

Now 10 months into the program, the ED is covered, but there are still problems the hospital needs to address. As the hospital seeks to meet financial targets, and nursing or other departments feel the effects, it's hard to justify payments to physicians. Additionally, other specialists on staff want to get in on stipend payments. Psychiatrists want more money to be on-call because they make more when they see office patients. The hospital will continue to try to meet the needs of its community by providing ED coverage, and work with physicians in this regard, but it is actively trying to avoid the slippery slope.

Chris Howard, executive vice president, SSM Health Care (SSMHC) of Oklahoma in Oklahoma City, says medical staff subsidies are almost impossible to avoid. In the Oklahoma City market, healthcare providers avoided paying subsidies for as long as they could. Eventually, hospitals in Oklahoma City started paying stipends to physicians for ED coverage and administrative responsibilities. Regarding administrative responsibilities, SSMHC has come up with some strategies to soften the blow.

SSMHC strongly believes in providing a solid business base for physicians to practice that potentially satisfies their needs so they don't turn to the hospital for additional sources of revenue. In this vein, the organization also believes that if they need to spend money on physicians, then it should be spent on those things that will help the physicians grow their business. SSMHC has assisted in recruiting partners to existing practices and developing business plans for physicians to expand their practices.

When SSMHC does pay a stipend for a medical direc-

tor position, it is not easy money for the physician. Strict performance monitoring has helped ensure the organization is getting what it pays for and lets the physicians know from the outset that merely assuming the position is not "money in the bank."

The Future

Given the fragile financial condition of many hospitals and competing demands for scarce resources, providers clearly want to limit costly medical staff subsidies. Although all hospitals may have tried, and some are still succeeding, avoiding medical staff subsidies is not

a likely option for the future. With the right strategies in place, such as strict performance criteria and well-documented, consistent payment policies, hospitals may be able to alleviate some of the costs and maximize the values for funds expended. ■

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