

Ensuring Adequate On-Call Backup in the ED

Problems With On-Call Coverage Contribute to Treatment Delays and Rising Hospital Costs.

Under the Emergency Medical Treatment and Labor Act (EMTALA), a hospital that operates an emergency department is required to provide, within the specialty capability of its medical staff, an on-call panel of backup physicians in a manner that best meets the needs of its patients. However, physicians are only required to provide this coverage when they agree to serve on the emergency department call roster or when they are required to do so under the medical staff bylaws. While hospitals understand that they have an ethical and a legal responsibility to provide specialty coverage, the problem lies in getting physicians to agree, and in paying for those services.

Traditionally, medical staff have volunteered for call panels. However, as the number of uninsured, underinsured and out-of-plan patients in most EDs have increased, the ranks of call panel volunteers have thinned in the face of the financial and legal risks involved.

“The problem of on-call coverage has grown worse over time based on the growth and demand for emergency services and the accompanying lack of funding—just as ED overcrowding has grown,” said Loren Johnson, MD, President of Health Access Associates, Inc.; Director of Emergency Services, Sutter Davis Hospital, Davis, Calif.; and Chief Medical Officer, Sutter Emergency Medical Associates, Sacramento.

As with other EMTALA mandates, there are no provisions for funding on-call services. Physician participation is assumed as an ethical and legal duty. So the statute provides a healthcare safety net for the uninsured and underinsured without providing any funds to pay for those services. And this lack of funding has seriously damaged the backup infrastructure in the ED, so that these services, which were once provided willingly, have in many situations become scarce as well as costly.

“EMTALA is an unfunded mandate. And unfunded mandates don’t work very well because they tend to drive out service—if you don’t pay for something, it’s difficult to get someone to provide it,” Dr. Johnson said. In addition, the more time on-call physicians spend caring for unassigned ED patients, the less time they have available to spend caring for paying patients with whom they have established relationships.

Even when funds are available to pay for on-call physician services, collecting payments can still be a problem. The patients treated by an on-call physician may be covered by a number of different and unfamiliar insurance plans, which means that even those in large group practices may find it inefficient to bill for services. And when they do bill, payments

may be denied or significantly reduced retrospectively because of the stringent utilization review processes practiced by many plans.

The other major factor affecting on-call services is malpractice. “ED backup is a high-risk, 24/7 service that is considered a high liability and, therefore, as the professional liability crisis deepens around the country, the call-panel infrastructure continues to erode,” Dr. Johnson said.

As the on-call problem continues to grow, it threatens adverse effects on patient care. Specialized treatment is sometimes not available because doctors won’t come in when called, won’t volunteer to be on-call in the first place, or simply are not available. And emergency physicians know all too well what delayed treatment can mean for patient outcomes.

“The on-call issue is the most critical issue affecting emergency care,” Dr. Johnson said. “Call panels are the weak link in the chain of survival, and it’s getting worse.”

The California Crisis

In 2001, the joint Emergency On-Call Task Force of the California Medical Association (CMA) and CAL-ACEP published a report concluding that many California hospitals do not have adequate backup for their EDs. The report included several recommendations for funding backup services. However there is little consensus in California, and many other states, on how to pay for these services, and none of the recommendations have been adopted by the state legislature, said Dr. Johnson, who co-chaired the task force.

Then, in 2002, the California Senate Office of Research (SOR) published another report, “Stretched Thin: Growing Gaps in California’s Emergency Room Backup System.” At the top of the list of findings was this statement: “Problems with access to emergency room on-call services in many specialties in many areas of the state are adversely impacting the quality of patient care and forcing hospitals, physicians, patients and, in some cases, medical groups and health plans to incur significant costs.” The SOR report further noted that problems with reimbursement are reducing the willingness of call panel specialists to provide on-call services.

And the problem is getting worse. In a recent statewide survey conducted by the CMA, 75 percent of hospitals responding to the survey reported that the issue of on-call coverage is either a very serious (33 percent) or a somewhat serious (42 percent) problem.

While California does have an EMS fund for uncompensated care, it covers just about 15 to 20 cents on the dollar, Dr. Johnson notes. “We have Proposition 67 on the November ballot. It would expand the scope of the California EMS fund by about \$250 million by means of a 3 percent surcharge on 911 calls. But the proposition is receiving significant opposition from the phone companies,” said Dr. Johnson, who is chair of Californians for Proposition 67.

Mandated vs. Volunteer Coverage

On-call policies vary from hospital to hospital. Some hospitals have bylaws that require call panel participation as a condition of affiliation. Others rely on voluntary or paid voluntary arrangements.

Mandating that medical staff participate in on-call panels ensures coverage without adding costs for the hospital. The problem is that forcing physicians to provide ED backup as a condition of medical staff membership may create bitterness over the financial risks those physicians must assume. This can result in lowered morale, as well as resentment, and may lead to physicians resigning from hospitals that mandate call panel participation and choosing instead to practice at hospitals that don't have such mandates.

Some hospitals compensate physicians for on-call duty by offering annual stipends or per diem payments. These types of programs are intended to ensure physicians' voluntary participation on call panels. The problem is that stipends do not completely cover the physicians' cost of providing care, so they still face financial risks and are still under-reimbursed for caring for uninsured patients. Additionally, competition among specialties and hospitals can result in demands for larger and larger stipends, which add significant costs for the hospitals. Often, despite a hospital's costly investment in a stipend plan, call panels shrink and the remaining participating physicians face increasing financial risks.

Stipends can also provide an incentive for physicians to spend less time with patients because no matter how much care they provide, they are not paid any more.

"In order for on-call reimbursement programs to be successful, quality assurance and proper alignment of incentives have to be part of the plan. For example, it's better to consolidate resources toward the actual provision of service rather than to just provide stipends for being on call," Dr. Johnson said.

A Fee-for-Service Solution

Known as the EA program, Emergency and Acute Care Medical Corporation (EACMC), which is based in San Diego, California, designs and implements fee-for-service compensation agreements that improve call panel coverage. Founded in 1991, EACMC currently has programs in 47 hospitals in nine states, including 22 in California. The Clinical Advisory Board has recognized the EA solutions as a "best practice for ensuring adequate specialty ED call coverage."

EA programs compensate on-call specialists at a fixed rate per RVU (relative value unit) for treatment of unassigned patients. The dollar amount per RVU is negotiated between the hospital administration and the medical staff. It must be large enough to encourage physicians to participate on the ED call panel, but also economically feasible for the hospital.

"The RVU rate is determined by looking at both sides of the equation. On one side is the administration and its budgetary restraints; on the other side are the physicians, who basically have an amount they're willing to work for. We help them find common ground," said Art Gruen, MD, CEO of EACMC and Medical Director of the Emergency Department at Sharp Memorial Hospital in San Diego, which is the site of the first EA program.

"What we find works best is if the guaranteed set dollar amount per RVU of service is the same for all specialties across the board. This prevents any so-called sibling rivalry among specialists within a hospital. Under this plan, doctors will make more or less based on the procedures they perform. For instance, a neurosurgical procedure could have 30 RVUs, while a pediatric evaluation might have only three RVUs. So a difference in pay is inherently built in," Dr. Gruen said.

“Frequently, the best solution we offer is a hybrid, which is a combination of stipends to pay doctors for their availability, plus the fee-for-service component, which guarantees payment for services provided. This gives them the best of both worlds,” Dr. Gruen said.

EA program participation is voluntary for members of the hospital medical staff, but guaranteeing reimbursement does encourage physicians to participate on ED backup panels. “The advantage of the EA program for on-call physicians is that they’re compensated for treating unassigned patients, guaranteed regular payments based on their RVUs of service, and they don’t have to do the coding, billing or collecting,” said Bradley Zlotnick, MD, Director of Strategic Development for EACMC.

Each participating physician receives a monthly explanation of benefits listing CPT codes for all of the patients they treated, the corresponding RVUs, and the amount the physician will be paid.

EACMC guides an EA steering committee, which includes members of the medical staff and administration, through the process of developing and implementing a site-specific EA plan, then maintains the program, billing and collections, and also generates detailed financial and utilization reports on program performance.

The hospital takes responsibility for the shortfall, which is the difference between what’s collected and what’s paid out to the doctors.

“But because of faster response times on the part of on-call physicians in EA plans, the average length of stay in the emergency department decreases, as does the average length of stay for those admitted to the hospital. So, the resulting cost savings partially offset the amount the hospital must pay to make up that shortfall,” Dr. Zlotnick said. “Moreover, EA accesses dollars previously left uncollected. These cost savings help offset hospital shortfall outlay. The shortfall may be considerably less than the hospital’s prior or proposed stipend expense.”

An Ethical Responsibility

In February 2000, ACEP’s Emergency Medicine Practice and Federal Government Affairs committees issued a policy statement regarding on-call coverage titled “Hospital, Medical Staff and Payer Responsibility for Emergency Department Patients.” The first statement in the policy is: “Hospitals and their medical staffs share an ethical responsibility for the provision of emergency care.” The policy statement also notes that “Physician services ... should be compensated in a fair and equitable manner.” And therein lies the problem. What should be the source of that compensation?

Hospitals and medical staffs do have an ethical and a legal obligation to provide on-call backup services for their emergency departments. But there is also a societal responsibility to provide payment for that medical care, notes Dr. Johnson.

“On-call coverage is still primarily covered by goodwill and many doctors still see it as an ethical obligation,” he said. “But the longer it takes to solve the reimbursement issues, the more that good will is eroded.”