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On-Call Arrangements—Selection of the Appropriate Structure in light of OIG Advisory Opinion 07-10

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I. Background and History of On-Call Arrangements

Historically, physicians provided call coverage to hospital emergency departments (ED) on an uncompensated basis. Frequently, hospitals' medical staff bylaws and/or specific departmental rules and regulations required physicians to take emergency department calls as a condition (1) of membership on the medical staff, or (2) of the granting and renewal of clinical privileges at the hospital or in a particular department. Junior physicians joining the medical staff of a hospital often would be obligated to provide the majority of the hospital's on-call coverage, and many junior physicians regarded the obligation as a privilege that would allow them access to new patients and aid them in building their medical practices.

Over the last several years, and throughout the country, a confluence of factors have reduced the willingness of physicians to serve on emergency department call panels without some form of compensation. These factors include, to varying degrees depending on the specific geographic market:

• Increasing numbers of uninsured patients who receive their only care in emergency rooms;

• Aging active-staff physicians who have met or exceeded the service and age requirements to opt out of call-coverage as mandated by hospital bylaws;

• Rising malpractice insurance premiums;

• Falling reimbursement for physician services; and

• A perceived increase in the risk of lawsuits, particularly with respect to uninsured or poorly insured patients who present in the emergency room.

Against this backdrop, hospitals have struggled to ensure adequate physician call coverage in accordance with the requirements of the federal Emergency Medical Treatment and Labor Act (EMTALA) and state hospital licensing requirements. As a result, there has been a marked increase in the willingness of hospitals to pay physicians to provide call coverage for emergent patients.

II. OIG Advisory Opinion 07-10: New Guidance

In an Advisory Opinion issued on September 27, 2007 (the Advisory Opinion), the Office of Inspector General of the U.S. Department of Health and Human Services (OIG) warned that the practice of paying physicians to provide on-call coverage may implicate the federal Anti-Kickback Statute (AKS). Specifically, the OIG warned that an agreement under which physicians are paid *per diem* compensation for providing call coverage *does not* fit within the safe harbor for personal services and management contracts under the AKS when the total payments to physicians may vary from month to month, such that the aggregate of such payments is not "set in advance," as required by that safe harbor.

Although the Advisory Opinion warns that compensated call arrangements that do not fit squarely within an AKS safe harbor may be subject to scrutiny, it also suggests that an arrangement under which physicians are compensated (1) at fair market value (FMV), (2) for actual and necessary services, and (3) without regard to the volume or value of referrals or other business generated between the parties, will generally withstand such scrutiny. After considering the "totality of facts and circumstances," the OIG concluded that, notwithstanding that the contemplated arrangement does not fit within a safe harbor, the OIG would not seek to

impose sanctions. The proposed call coverage arrangement incorporated safeguards against fraud and abuse, including some key assurances that the compensation to be paid to the physicians was FMV for the services to be performed.

The Advisory Opinion is significant for a variety of reasons, particularly the useful guidance it provides with respect to an acceptable methodology for determining FMV for on-call services. In a statement suggesting "what not to do," the Advisory Opinion makes clear that the OIG views as suspect any on-call compensation methodology based on:

1) "Lost opportunity" (i.e., any payments that do not reflect bona fide lost income);

2) Payment structures that compensate physicians when no identifiable services are provided;

3) Aggregate on-call payments that are disproportionately high compared to the physician's regular practice income; and

4) Payment structures that compensate the on-call physician for professional services for which he or she receives separate reimbursement from insurers or patients, resulting in the physician being paid twice for the same service.

On the other hand, the Advisory Opinion "blessed" the specific on-call arrangement that was submitted for consideration, noting that the methodology used to determine on-call compensation took into account: (1) the actual burden on the physician in providing call coverage, based on consideration of call on weekdays versus weekends, and the likelihood of a physician having to respond when on-call for the emergency department; (2) the actual likelihood that the physician will have to provide uncompensated treatment; and (3) the likely extent of that treatment. The OIG noted that the FMV of the compensation to be paid under the arrangement was determined by an independent third party experienced in valuing the types of services to be provided under the arrangement. Furthermore, the third party focused on the reasonableness of the proposed compensation, utilized both publicly available and proprietary data concerning practices and pay rates at a number of healthcare facilities, and set out the considerations and methodology for calculating FMV in an opinion letter that was provided to the OIG for purposes of review. The OIG noted the value of an objective opinion on reasonableness, coupled with use of a well-developed and well documented methodology for determining FMV, as a prudent practice to assure that a compensated on-call arrangement will withstand scrutiny.

III. Selection of Appropriate Coverage Structure

As suggested in the Advisory Opinion, determining the FMV of on-call coverage requires consideration of the specific characteristics of the hospital and specialty in question. Individually and in tandem, patient demographics (including both clinical case mix and payor status) often affect both the call frequency and the call burden for the on-call physician. Specifically, the severity and urgency of illness typically encountered by a physician of the specialty treating a patient in the emergency department, the likelihood of having to respond to a call when on-call for the emergency department, and the likelihood of having to treat patients who are uninsured or whose care is poorly reimbursed, each influences the burden on the on-call physician and, in turn, the FMV of physician compensation for on-call services. Accordingly, FMV compensation for on-call services may vary widely based on both the on-call physician's specialty, and differences in hospitals' emergency department patient demographics. As a result, the FMV for on-call compensation sometimes varies widely among hospitals located in the same city, vicinity, or even zip code.

Hospitals have various options for structuring on-call compensation arrangements, and the structure of a particular compensation arrangement may warrant consideration in FMV assessment, both as a cause and a reflection of the burden on each physician taking call. The most common structures for on-call compensation arrangements, along with a summary of various considerations relative to each one, are set forth below:

1. *Per Diem*/Shift Compensation. In our experience, this is probably the most common payment structure for compensated on-call arrangements. Typically, compensation covers a twenty-four-hour period, but coverage periods may be twelve-hour shifts (e.g., to split day and night call coverage) or sixteen hour shifts (to cover evening hours). In some cases, and consistent with the arrangement considered by the Advisory Opinion, compensation may be higher for an on-call period occurring on weekends or holidays, although it is more common for on-call compensation to be the same for all shifts, during all time periods (for ease of administration). For very high volume specialties, we have recently observed on-call arrangements where the physicians are paid *per diem* compensation *solely for availability to provide telephone triage*. The availability of one physician to answer telephonic triage calls serves to reduce the remaining call burden for other physicians on the hospital's medical staff, resulting in better patient flow within the hospital's ED.

Advantageous For: Specialties with more "predictable" weekly on-call burden (such as cardiology, gastroenterology, general surgery, etc.), and for cases where the hospital wants a methodology that is easy to administer.

2. Fee-For-Service Payments for Care to Unfunded Patients. Hospitals may provide fee-for-service payments to physicians who provide care to unfunded patients presenting in the emergency room. The fee-for-service payments may be a percentage of the Medicare allowable rate for the services rendered (adjusted for the hospital's region) or may be hourly based on time spent providing the services (although the latter is very uncommon due to the complexities of determining appropriate collections). In certain cases, a "pool" of funds is created and distributed to all on-call medical and surgical specialists on a quarterly basis and in proportion to the amount of unfunded care that each physician has provided. The major benefits of compensating from an "unfunded pool" are (1) the hospital has the ability to budget the total cost of call coverage; and (2) the program compensates physicians of all specialties in an equitable manner.

Advantageous For: Specialties and hospitals serving patients with generally poor reimbursement for services.

3. *Per Diem*/Shift Plus Fee-For-Service Payments for Care to Unfunded Patients. Some hospitals are electing to provide a combination of *per diem* payments and fee-for-service payments for care to unfunded patients. When a hospital provides both forms of payment, it is critical to consider the existence of the separate fee-for-service payments when determining the FMV of the *per diem* payments, since *per diem* payments often include "embedded" compensation for providing unfunded care. Accordingly, this type of combined compensation structure is generally characterized by reduced *per diem* compensation. The reduced *per diem* compensation is offset by the fee-for-service payments for actual care rendered to unfunded patients, which are generally calculated as a percentage of the Medicare allowable reimbursement for the particular care that has been provided.

Advantageous For: Hospitals for which the "poor payor" mix is less certain, and therefore, physicians are willing to accept a lower *per diem* in exchange for compensation for actual unfunded patients seen and treated.

4. Activation Fees. Hospitals may elect to compensate physicians *only* for those on-call days when the physician is actually required to present at the hospital to respond to an on-call event. If the physician is on-call but is not required to present at the hospital in response to an on-call event, then the physician receives no compensation for the on-call day. An "Activation Fee" is payable only once per day, regardless of how many times a physician has had to present at the hospital in response to on-call events. Accordingly, all things being equal, the FMV of a single Activation Fee payment will generally be higher than a *per diem* payment for a specialty and hospital having low to moderate call frequency. However, to help control hospital costs and to minimize the danger of exceeding the FMV of aggregate payments for on-call services, hospitals may: (1) seek to negotiate Activation Fee payments that are below the upper limit of the FMV range for such payments; and/or
(2) cap monthly Activation Fee payments at the upper limit of FMV for aggregate monthly *per diem* payments. **Advantageous For:** A hospital or specialty where the call frequency (i.e., frequency of on-call events requiring the oncall physician to present at the hospital) is low—less than once per day, for example.

5. *Per Diem Plus* Activation Fee. Some hospitals elect to provide *per diem* compensation *plus* an Activation Fee. For this payment structure, the *per diem* rate is generally set well below the rate that would apply under a common *per diem* only arrangement, and the Activation Fee is also slightly lower than in the typical Activation Fee only structure. Physicians may be more receptive to this compensation structure than an Activation Fee structure without *per diem* payments, since they receive some compensation for each day of call coverage, regardless of whether they respond to an on-call event during the day. The major disadvantage of this payment structure, from the perspective of the hospital, is that the *per diem* payment component may result in costs that are higher than under a model where the hospital pays only an Activation Fee.

Advantageous For: A hospital or specialty where the frequency of emergent call events requiring the physician to present at the hospital is low.

6. Hospitalist Programs used to Reduce Coverage Needs. Hospitals may utilize a combination of employed and independent contractor hospitalists to assist in meeting and "triaging" the need for call coverage. In most cases, the hospitalists provide on-call coverage for appropriate specialties during periods when other physicians are unavailable without compensation (e.g., nights and weekends).

As an alternative to traditional (internal medicine) hospitalists, some hospitals utilize an employed or contracted specialist panel to provide call coverage outside of normal business hours or during generally less busy times. For example, a surgical team may be utilized to triage

emergent surgical events, just as the hospitalist team may be used to triage emergent medical events.

The use of employed or contracted hospitalists or specialty panels may assist a hospital by reducing costs for on-call coverage, while at the same time assisting the hospital's physicians by reducing their overall call burden and interruptions from their core clinical practices during business hours.

Advantageous For: Hospitals for which on-call events are predictably concentrated in certain specialties (e.g., cardiac or trauma).

7. Paying for Concurrent Coverage of Multiple Facilities. Hospitals that have multiple campuses in close proximity to each other may elect to have a single specialist provide call coverage simultaneously for multiple campuses. This model allows certain hospital systems to provide on-call coverage for all emergency patients without having to maintain multiple call panels for each of their facilities, and may result in hospital cost-savings. Additionally, since this model requires a smaller pool of physicians to be on-call in a community at any given time, it may contribute to improved perceptions of physician work-life balance, and a reduction in the scarcity of physicians willing to take call.

On the downside, concurrent call arrangements may significantly increase the probability of any particular physician having to respond to an on-call event, thereby commensurately increasing the burden associated with on-call responsibility. The increased call burden may drive up the *per diem* or other pay for on-call physicians, as FMV for call coverage is reasonably tied to the burden of taking call coverage. Typically, however, even with this increase in the *per diem*, the "net outlay" by the hospital is still considerably lower.

Advantageous For: Multi-campus hospital systems having patient mix and geographic proximity such that a single oncall physician may be available to respond to call events at multiple campuses, and may travel to see emergent patients at each campus during the same twenty-four-hour period.

IV. Conclusion

In light of Advisory Opinion 07-10, many hospitals are carefully considering the structure of call coverage arrangements to ensure that payments to physicians appropriately reflect the relative burden of call coverage at the particular facility and in the specialty. Hospitals have various options to accomplish their call coverage objectives in an efficient and cost-effective manner. However, there is no "one size fits all" option. Each arrangement must be valued independently, with consideration given to the unique character of the hospital, and the combination of factors that influence the burden on the physician.

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