Physician On-Call Payments: Compensation in a Transitional Market

American Health Lawyers Association

Physician and Hospital Law Institutes
Miami, Florida
February 24-25, 2010

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Physician On-Call Payments: Compensation in a Transitional Market

- Market forces affecting physician coverage arrangements
- Health care statutes, regulations and agency advice affecting on-call coverage and compensation
- Structuring of and strategies regarding coverage and related compensation arrangements
- Determining fair market value of physician availability
- Effects of health care reform (of lack of it) on ED call and fair market value of remuneration
- Hypothetical case study
Market Forces Affecting Physician Coverage Arrangements

- History of payment for on-call services
  - Physicians voluntarily served on the medical staff
  - Compliance with active medical staff by-laws related to emergency department ("ED") on-call coverage was considered necessary to build a practice and was a physician’s community service
  - EMTALA’s enactment, other physician concerns have encouraged on-call payment expansion

- Market forces affecting physician availability and uncompensated care
  - Tort climate
    - Malpractice premiums, inflation-adjusted, are at nearly the lowest rates in 30 years
    - Malpractice risk is higher for patients first seen in ED
    - Estimates of the annual cost of defensive medicine range from $50 billion to $100 billion
Market Forces Affecting Physician Coverage Arrangements, cont’d

- Uncompensated care
  - 46 million non-elderly persons are uninsured
  - Access to care is affected for the uninsured
  - Half of uninsured adults are twice as likely to delay or forego care

- Quality of life for physicians
  - Call rotation causes a disruption of private practice or other professional and personal activities

- Physician shortages
  - Shortage of physician residents exists, particularly in certain subspecialties
  - The number of sub-specialists who limit patients, injuries, and illnesses treated is increasing
  - A growing number physicians drop out of call rotation
Market Forces Affecting Physician Coverage Arrangements, cont’d

- Fewer emergency departments and increasing utilization
  - Nationwide ED closures and other problems in access to care create an over-utilization of EDs, resulting in:
    - Increased intensity and risk in on-call coverage, and
    - Negative impacts on payer mix and physician reimbursement

- Financial implications
  - From 2006 to 2009, median expenditures by trauma centers for physician on-call compensation increased by 141 percent
  - From 2006 to 2009, median expenditures by non-trauma centers for on-call coverage increased by 546 percent
Health Care Statutes, Regulations and Agency Advice Affecting On-Call Coverage and Compensation

- EMTALA on-call requirements
  - Statutory and regulatory requirements
  - Physician on-call list
  - Community call plan
  - Issues of:
    - Elective surgery during call schedule
    - Simultaneous on call duties
    - Call response time
    - Failure to respond
    - Frequency of call
- 42 U.S.C. §§ 1395cc,1395dd; 42 C.F.R. §§ 489.24(a),(j), 489.20(r); State Operations Manual (CMS-Pub. 100-07), Appendix V, Interpretive Guidelines § 489.20(r)
Health Care Statutes, Regulations and Agency Advice Affecting On-Call Coverage and Compensation, cont’d

- Federal anti-kickback statute and regulations
  - The statute – 42 U.S.C. §§ 1320a-7b(b)
  - Safe harbor provisions – 42 C.F.R. §§ 1001.952(d) and (i)
    - Employment exception and safe harbor
    - Personal services and management contracts safe harbor
- Advisory Opinions
  - Advisory Opinion 04-09
    - Employed physicians’ arrangement met safe harbor
    - Independent contractor arrangement would not
    - Compensation tied to referrals
  - Advisory Opinion 07-10
    - Tax-exempt entity, ER call arrangement, fixed fair market value (FMV) compensation
Advisory Opinion 07-10, cont’d

Critical inquiries:
- FMV compensation in arm’s length transaction for needed services
- Not related to volume/value of referrals or other business generated

Problematic compensation structures:
- “Lost opportunity” or similarly designed payments that do not reflect bona fide lost income
- Payment structures that compensate physicians where no identifiable services are provided
- Aggregate on-call payments that are disproportionately high compared to the physician’s regular medical practice income or
- 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 essentially being paid twice for the same service
Advisory Opinion 07-10, cont’d
- Low risk of fraud:
  - FMV payment for necessary services
  - No relation to volume/value of referrals/other business generated
  - “Legitimate, unmet need”
  - Arrangement offered to all physicians in needed specialties
  - Call divided equally as possible
  - Requirement for follow-up care lessened “cherry picking” of lucrative patients

Advisory Opinion 09-05
- Overall on–call compensation structures
- Per diem payment methods
- “Lost Opportunity” payments
- Fair market value
Advisory Opinion 09-05

Non-profit hospital program, fixed fee on-call arrangement per ED consult, inpatient professional service, surgical procedure, endoscopy procedure

- “Eligible patients” – uninsured
- “Eligible physicians” – no hospital-based physicians
- Specific Claims filing/documentation requirements
- Medical staff bylaws revised

Includes AO 07-10 OIG’s key inquiries

- Determination of compensation
- Problematic compensation
- Individual evaluation of arrangements based on totality of facts and circumstances
Advisory Opinion 09-05, cont’d

OIG’s Findings

- No square fit in personal services and management contracts safe harbor
- Low risk of fraud as hospital certified fmv compensation, payment was for tangible services, no “lost opportunity” payments existed, payment to uninsured reduced risk of duplicate payments
- Hospital had “legitimate rationale” for changing on-call coverage policy
- Arrangement was offered uniformly to all medical staff
- Arrangement imposed “tangible responsibilities” promoting physician “transparency and accountability” and was equitable to “staunch…defections from on-call duties, and [to] forestall additional on-call shortages”
Advisory Opinion 09-05, cont’d

- Questions raised by commenters:
  - Why were hospital-based physicians excluded?
  - Are per diem payments still viable option?
  - If OIG was expressing a bias in favor of flat fees?
  - Would the OIG consider a physician to be receiving “duplicate payments” if the physician also received payment from a patient or a payor?
Health Care Statutes, Regulations and Agency Advice Affecting On-Call Coverage and Compensation, cont’d

- Advisory Opinion 09-05, cont’d
- Non-Official OIG Guidance: Spencer K. Turnbull, Esq. – AHLA Teleconference
  - “[M]ore than one way to structure call compensation”
  - “[C]arefully tailored payment structure[s]” and “tangible responsibilities,” uniformly administered are important
  - “OIG analyzes different fact patterns using the same, consistent principles”
  - “What is the level of risk that one party is paying another for its referrals?”
  - “[O]pinions are based on the totality of each arrangement’s facts and circumstances”
  - “[P]er diem model is still viable”
  - “Lost opportunity” payments neither bad nor good; issue whether physicians receive windfall
  - OIG wants logical inputs into payment formula; determines if referrals being factored into formula
Advisory Opinion 09-05, cont’d

- Reasonable Assumptions Based upon Formal and Informal Guidance
  - Documentation and identification of need to pay physicians for call coverage is important
  - Indications that arrangement and payments are compliant:
    - Overall plan for on-call coverage vs. ad hoc arrangements
    - Structured/tailored arrangements, perhaps including multiple specialties and targeted populations
    - Physicians must perform real services
    - Additional services helpful such as following patient through discharge, follow up care, participating in quality and outcomes initiatives, providing consults in ED, furnishing pro bono days or shifts of coverage and performing services over and above medical staff bylaw requirements
Health Care Statutes, Regulations and Agency Advice Affecting On-Call Coverage and Compensation, cont’d

- State anti-kickback laws
  - Applicability to state Medicaid services
  - Limitations of violations, duty to report, specific behavior
  - Availability of safe harbor protection

- Federal and state Stark laws
  - Stark statute – 42 U.S.C. § 1395nn
  - Stark exceptions – 42 C.F.R. § 411.351 et seq.
    - Personal Service Arrangements – 42 C.F.R. § 411.357(d)
    - Bona Fide Employment Relationships – 42 C.F.R. § 411.357(c)
    - Fair Market Value Compensation Arrangements – 42 C.F.R. § 411.357(l)
    - Indirect Compensation Arrangements – 42 C.F.R. § 411.357(p)
Health Care Statutes, Regulations and Agency Advice Affecting On-Call Coverage and Compensation, cont’d

- Stark issues
  - Set in advance
  - Fair market value
  - No violation of Federal or state law
  - Variance in compensation based upon the “volume or value of referrals” or “other business generated”
  - Commercial reasonableness
  - No anti-kickback violation

- State Stark laws
  - Applicable to specific payor or unlimited by payor type
  - Applicable to broad “practitioner”
  - Targeted to specify health care entities
  - Disclosure of financial relationship requirement
Civil Monetary Penalties Law

OB Malpractice insurance subsidy – Anti-kickback safe harbor and Stark exception

- Anti-Kickback Safe Harbor – 42 C.F.R. § 1001.952(o)
- Protects only insurance subsidies to obstetricians
- Broad applicability to payors of subsidy
- Limited to physician recipients practicing in primary care HPSAs

Stark Exception – 42 C.F.R. § 357(r)

- Alternative 1:
  - Mirror of Anti-Kickback safe harbor
- Alternative 2:
  - Expansion of geographic area
  - Limited to types of entity whose payments protected
Medicare payment issues

Allowability of payments for “physician availability” on hospital cost reports

- Cost reports of acute care hospitals – 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. §§ 415.60(f), 415.70
  - Requires written allocation agreement
  - Compensation must be reasonable
  - Allowable unless “unnecessary in efficient delivery of services”

Provider Reimbursement Manual, Part 1, Chapter 21, § 2109

- Hourly or salary-based compensation or minimum guarantee arrangement
  - Must be no feasible alternative coverage methods

PRRB and Administrator Decisions

- Payments for physician assistant coverage not allowed
- Costs of payments to psychiatrists on standby at psychiatric hospital allowable
Medicare payment issues, cont’d

Allowability of costs for “physician availability” to critical access hospitals

- Allowable when physicians, PAs, NPs, CNSs are not on premises but only if not taking call for another provider or performing professional services
- Costs of standby CRNAs allowable
- Must be written agreement requiring presentation on site when called
- Location of CAH determines time frame for presentation (e.g., frontier area)
Anti-markup rule – 42 U.S.C. § 1395u(n)(1); 42 C.F.R. § 414.50

- CY 2009 Physician Fee Schedule Final Rule
- Prohibition of markup of technical and professional components
- Alternative 1 – “Substantially all of physician’s professional services performed for billing physician or other supplier (75%)”
- Alternative 2 – Modified site-of-service approach
  - Physician is owner, employee or independent contractor of billing physician/supplier
  - Physician supervises TC or performs PC of diagnostic test
  - In the same office as the billing physician (the space in which the ordering physician provides substantially full range of patient care services that ordering physician routinely provides)
    - Single street address; not lawn, driveway, parking lot, interior loading dock or garage
    - Not Stark centralized building, mobile vehicle, van or trailer
Reassignment rules – 42 U.S.C. § 1395u(b)(6); 42 C.F.R. § 424.80(b)

- Exception for payment to entity under contractual arrangement
- Carrier jurisdictional rules – Medicare Claims Processing Manual, Chap. 1, § 10.1.1.3
Tax issues
- Issues for federally tax-exempt entities
  - Inurement /private benefit
  - Excess benefit transaction
  - Private activity bonds
- Worker classification – tax issue for both for-profit and tax-exempt entities

Corporate practice of medicine issues
- HIPAA business associate agreement requirements – 45 C.F.R. § 160.103
Structuring of and Strategies Regarding Coverage and Related Compensation Arrangements

- Unrestricted on-call and restricted coverage arrangements
  - Blended arrangements
  - Combined unrestricted and restricted coverage
  - Blended on-call and patient care services
  - Blended on-call and other personal services, such as administrative or medical directorship services

- Common payment arrangements
  - Hourly, shift or daily rates
  - Activation fee
  - Subsidized or guaranteed arrangements
  - Deferred compensation
  - Subsidy for uncompensated care
  - Group practice internal income distribution arrangements
Structuring of and Strategies Regarding Coverage and Related Compensation Arrangements

- Methods not considered valid
  - Opportunity cost
    - On-call pay may not be the equivalent of clinical compensation
- Other considerations: “stacked” arrangements
  - Compensation for multiple arrangements are often “stacked” atop one another
  - Patient care, administration, on-call services, etc.
  - Stacking of on-call pay with employment compensation
    - Employment compensation likely includes pay for indigent or uncompensated care
    - On-call pay must only consider pay for availability
Determining Fair Market Value of Physician Availability

- Valuation theory applicable to on-call compensation
  - Cost-based approach
    - Examples of methods used in valuing on-call arrangements under the cost-based approach include:
      - Avoided cost-to-replace method
        - Physician staffing firms
        - Locum tenens firms
      - Avoided cost-to-recreate method
        - A build-up of costs associated with the creation of the service being purchased
  - Income-based approach
    - Examples of methodology under the income-based approach are often limited in unrestricted and restricted arrangements
    - Subsidy arrangements can be valued using the income-based approach
      - Quantifying revenue or compensation shortfalls associated with uncompensated care
Determining Fair Market Value of Physician Availability, cont’d

- Market-based approach
  - Examples of methods applicable to valuing on-call arrangements using the market-based approach
  - The use of published surveys is widespread, but should be applied with care, because:
    - Many surveys do not report on-call compensation, and the value of availability often does not equate to the value of clinical duties
    - Although improving, some survey data contain low numbers of respondents
    - Because of the variety of arrangements, duties, specialties, intensity and many other factors, an inherent difficulty exists in comparing survey data to on-call arrangements
    - Some experts have concerns that data may be tainted by physician-hospital referral relationships
Percentage-of-compensation method
- The proportion of aggregate physician compensation that constitutes on-call compensation
- Adjusted for factors described below
- Some proprietary methods are designed to mitigate tainting by referral relationships

Nurse call pay method
- The proportion of nurses’ on-call pay to total pay
- Generally only relates to unrestricted coverage
- Does not consider the uncompensated care element
- Mitigates the risk of tainted referral relationships
Determining Fair Market Value of Physician Availability, cont’d

- Factors impacting the value of call coverage
  - Availability vs. uncompensated care
  - Unrestricted call or restricted coverage
  - Length of shift
  - Rotation
  - Time of day/week
  - Facility trauma level
  - Payer mix
  - Physician supply and demand
  - Specialty-specific factors
  - Intensity and frequency
  - Concurrent call
  - Methods not considered valid
  - Other considerations
Effects of Health Care Reform (of Lack of it) on ED Call and Fair Market Value of Remuneration

- Recent trends and health care reform measures
- Increased governmental restrictions
- Continuing payment reductions
  - Physicians
  - Hospitals
- Closing of hospital EDs
- Potential physician defections from Medicare and Medicaid
- Increase in hospital and physician integration
- Consequences for on-call arrangements
Hypothetical Case Study

- The cast:
  - Hospital A: Level II trauma center located in a rural area, providing a full range of patient care services, including full emergency services; federally tax-exempt, non-profit hospital
  - CEO: Chief Executive Officer of Hospital A
  - Physician N: a neurosurgeon in a two-physician practice; on the active medical staff of Hospital A
  - Dr. S: a general surgeon on Hospital A’s active medical staff
  - Interim CEO: Replaces the CEO on an interim basis
  - CFO: Chief Financial Officer of Hospital A
  - Outside Counsel: Attorney in private practice, representing Hospital A
  - CPA: A Certified Public Accountant with physician compensation experience
  - Dr. O: An orthopedic surgeon, employed by Hospital A
Hypothetical Case Study, cont’d

- Physician N learns that a competing hospital now provides compensation to physicians volunteering to contract with the hospital for ED call coverage.
- Physician N approaches the CEO of Hospital A, requesting that Hospital A begin a similar approach to paying for ED call.
- The next day, Hospital A’s CEO receives a call from Dr. S, a surgeon on the medical staff of the hospital. Dr. S provides Hospital A’s CEO with a similar ultimatum.
- CEO resigns as a result of an offer from a hospital in a community nearer to family and land owned by the CEO. An interim CEO is named.
- The interim CEO begins a process of addressing the payment for call. Through discussions with the CFO, the two hospital officers conclude that the hospital should begin paying for call.
- The interim CEO discusses dollar amounts with both physicians, and reluctantly agrees to pay $1,500 per day to the neurosurgeons and $1,000 per day to the surgeons.
Hypothetical Case Study, cont’d

- Interim CEO contacts outside legal counsel to begin the process of preparing contracts for these physician specialties.
- Hospital A’s outside counsel insists on a meeting with the interim CEO, during which counsel educates the interim CEO on the compliance risks of on-call compensation and recent OIG guidance on the subject.
- Interim CEO instructs counsel to proceed with the contract development, noting the crisis in ED call coverage and the need to urgently complete this process.
- Counsel contacts a CPA with experience in physician compensation to provide an opinion as to the fair market value of unrestricted on-call compensation in the marketplace.
- Interim CEO is met by demands from an Dr. O, an orthopedic surgeon, for payment for ED call. The orthopedic surgeon is an employee of hospital A, paid per work relative value unit for his personally performed productivity. Again, the CEO meets with the orthopedic surgeon and agrees in principle to an amount of $1,000 per shift covered by the physician.
Upon discovery of this meeting, legal counsel and the CPA meet with the interim CEO and CFO to explain the problems associated with paying an employed physician for taking ED call.

CPA receives several separate pieces of requested information by email, and is concerned about the timing of the receipt of data and the impending deadline.

The CPA’s analysis of the neurosurgery and general surgery call rates include a review of the documentation requested and received from Hospital A and the neurosurgery and general surgery groups.

The CPA interviews lead physicians from both specialties.

The CPA attempts a cost-to-recreate method, considering other alternatives to paying these specialties for call.
By using the CPT production data from the neurosurgery group, the CPA is able to see clearly that the physicians receive nearly no compensation for cases first seen in the ED.

The CPA also studies market survey data, including two widely published surveys on on-call compensation.

Outside counsel notes for the CFO the statements made by the OIG in Advisory Opinions 07-10 and 09-05, and describes how some of the provisions in the requestors’ plans included additional safeguards to ensure that the physicians were not compensated based on the volume or value of their referrals.

The CPA studied other market data, including developing a method that determined the percentage of compensation that is actually attributable to taking call.
Hypothetical Case Study, cont’d

- Because of the high levels of call frequency, intensity, patient acuity and uncompensated care, the CPA opined on a rate that approximated the 75th percentile for neurosurgeons, or an amount not to exceed $1,200 per day.

- Because there was a significant absence of documentation for the general surgeons, the CPA opined that a rate not to exceed $500 was representative of fair market value for the general surgeons.

- The CPA, like the attorney, recommended methods of compensation that ensured that the physicians were paid for identifiable services, were not paid twice for the same service, and were not paid based on the volume or value of referrals. The CPA also advised that the hospital consider guidance from recent OIG Advisory Opinions.

- Outside legal counsel completed the contracts for the physicians’ signatures, including as compensation the maximum amounts opined on by the CPA, $1,200 for the neurosurgeons, and $500 for the general surgeons.
The interim CEO presented the contracts to each of the physicians. The neurosurgeons signed the contracts without significant concerns.

The general surgeons, however, refused the contracts and again demanded $1,000 per day, and refused to cover the ED until their demands were met.

The interim CEO contacted a staffing firm and another practice of general surgeons and was able to secure interim coverage to replace the ED coverage given up by the prior surgeons.

After six months into the arrangement, Dr. S contacted his own counsel, who communicated with the local U.S. Attorney’s office, alleging that Hospital A paid the neurosurgeons remuneration in exchange for referrals of Federal health care program beneficiaries.

The U.S. Attorney launched an investigation into the neurosurgery on-call coverage arrangement and referred the arrangement to the U.S. Department of Justice and the Internal Revenue Service investigative division.
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