Best Practices in Structuring Call Coverage After the Recent OIG Advisory Opinion 09-05

Co-Sponsored by the Fraud and Abuse, Hospitals and Health Systems, In-House Counsel and Physician Organizations Practices Groups

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Speaker(s):
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Agenda of Teleconference

- Introductions & Survey Results
- Overview of current climate (30 minutes)
  - OIG Opinions on Call Coverage (Spencer)
  - Hospital perspective (Lou)
  - Physician perspective (Ann)
- Group discussion of top issues (30 minutes)
- Best practices (15 minutes)
- Question and Answer Time (15 minutes)

Introductory Remarks

- Review of Survey Process
- Overview
  - Focus on current situation and issues
  - Limited discussion of relevant law (Stark exceptions, etc.)
- Speakers who have knowledge of the three stakeholder perspectives: Government, Hospital & Physician
  - Standard disclaimer applies to Spencer's remarks and slides: they are his personal views and do not represent the Government's official position.
- Valuation issues will be mixed into the conversation as warranted

CALL COVERAGE: PERSPECTIVES FROM OIG ADVISORY OPINIONS

Spencer Turnbull, Senior Counsel
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Call Compensation: Two OIG Advisory Opinions

- Why call compensation arrangements implicate the Anti-kickback statute
- Advisory Opinion **07-10** (9/20/2007)
  - Favorable opinion for *per diem* payment structure based on physician specialty
- Advisory Opinion **09-05** (5/14/2009)
  - favorable opinion for per service payment structure for uninsured patients

Call Compensation: Two OIG Advisory Opinions

- Different Fact Patterns, Same Guidance
  - Carefully tailored payment structure
  - Tangible responsibilities
  - Uniform administration
  - Circumstances giving rise to arrangement
- Take-away: there is more than one way to structure call compensation

09-05 Does Not Trump 07-10

- Advisory Opinions are not regulatory models
  - Each advisory opinion is responsive to the facts presented
  - Neither says hospitals should or shouldn't pay for call coverage
- *Per diem* payment model is still viable

Lost Opportunity Payments

- NEITHER Advisory Opinion says lost opportunity payments are good or bad
- BOTH Advisory Opinions caution that such payments can be used to disguise payments for referrals
- Each opinion's treatment of lost opportunity is fact-specific:
  - 07-10: variable per diem payment reflects logical difference between weekday vs. weekend call burden
  - 09-05: no lost opportunity payments in the proposed arrangement, thus no risk that payments for referrals are hidden there

A few words on FMV

- OIG is not authorized to opine on whether fair market value shall be, or was, paid
- BUT, OIG can and does look to see
  - Are logical inputs going into the payment formula?
  - Are referrals being factored into the payment formula?

Take Comfort…

- OIG analyzes different fact patterns using the same, consistent principles
- Our call coverage payment analysis boils down to this:
  - What is the level of risk that one party is paying another for its referrals?

…And Also Use Caution

- These opinions are based on the totality of each arrangement's facts and circumstances
  - If your arrangement has different facts, it could yield a different result

HOSPITAL PERSPECTIVE

D. Louis Glaser
Partner
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Background on 07-10

- Scope of the program – almost all specialties
- Drivers/market conditions that lead to the program:
  - Increased costs for physician, particularly malpractice premiums
  - Lack of tort reform
  - Specialties refusing to take call at all hospitals in community
  - Increasing number of indigent/uninsured patients in ED
- Response to specific market situation and breadth
- Not a response to a single group or specialty
- Cooperative development of program

Hospital's Key Structural Considerations

- Securing scope of services beyond just call:
  - ED call coverage and timely response
  - Consultations while on-call, including for indigents/uninsured
  - ED care and follow-up care through discharge for indigent/uninsured
  - Participate in quality initiatives
- Securing agreement of all needed specialties – avoiding diversion
- Consistent treatment and approach for specialties (not same payment, but consistent treatment)
- Creating system that did not exceed financial viability
- Shared commitment to indigent care (18 days of uncompensated call)

Design of Payment Methodology

- Per diem – weekday rate and weekend/holiday rate
- Based on:
  - Severity of illness typically encountered
  - Likelihood of having to respond when on-call
  - Likelihood of request for consult
  - Likelihood and degree of follow-up care in hospital for patients presenting at ED
- Hospital & physicians jointly rejected response pay or subsidy payment for indigent/uninsured

Rationale for Advisory Opinion

- Mutual commitment to transparency by hospital and physicians
- Breadth of the program (*i.e.*, covering nearly all specialties)
- Concern over response of competitors

Feedback

- Requiring physicians to do more than they are obligated to do under the bylaws
- Addressing specific market conditions
- Not differentiating among physicians or within specialties
- Logical and careful design of payment rates
- Not including payments in program costs
- Program had demonstrated improvements:
  - Increased patient satisfaction scores
  - Greater efficiencies

PHYSICIAN'S PERSPECTIVE

Ann Bittinger
The Bittinger Law Firm

Significance of 09-05 on Physicians

- A wolf in sheep's clothing, perhaps?
  - A blessing of call pay, or is it?
    - "We believe it should be possible for the parties to structure on-call payment arrangements that are consistent with this standard." (page 8)
    - But….

Significance of 09-05 on Physicians

- Has the funeral bell tolled on call pay when:
  - There is no guarantee of being called?
  - When you will be paid by payer/patient?
- Insinuation (or factual presentation/bad facts):
  - *Perhaps* call pay is not appropriate when
    - the physician is paid for services
    - the physician does not have to respond in-person

Significance of 09-05 on Physicians

- The need to call it what it is:
  - Is this a call pay AO or is it an indigent care AO?
- Types of possible “covert” payments (pg. 8)
  - Isn’t this what call is all about?

Representing physicians in call coverage negotiations post 09-05

- Main focus: Advice on how to “use” an AO
- Also:
  - EMTALA,
  - medical staff bylaws (and policies),
  - intra-group agreements,
  - other hospital agreements with physician/group.

Representing physicians in call coverage negotiations post 09-05

- Key issues in how to use the AO:
  - How “heavy” is the beeper?
    - How do you document how heavy the beeper is?
    - What is “heavy”?
  - Has the beeper just become weightless?
  - Significance of:
    - Hospital as “sole provider of acute care, inpatient services in county”.
    - Hospital having problems providing call coverage.
    - Importance of hospital certification of fmv.

To physicians, the beeper remains heavy

- Do the variables still matter?
  - Number / frequency of calls
  - Scope of service when called
    - Must respond in-person?
    - Scope of work provided when responding in-person
    - Risk
    - Likelihood of getting paid

What is “heavy”?

- Thesis:
  - Perhaps amid AO 09-05, we should be thinking outside the box.
  - Is “call” what we’re really being paid for?
    - 09-05 page 2: “hospitals receive some form of state …reimbursement for providing services to the indigent and uninsured…physicians do not have a similar mechanism for compensating them for such services. As a result, physicians generally render services to this indigent population without compensation.”

ISSUES FOR GROUP DISCUSSION

Issues for Group Discussion

General comments

- Based on Survey of Members
- Can't cover all the topics, but will cover as many as time permits
- Start with the top vote getters and work our way down the list (with recognition that fewer votes does not mean an issue is unimportant).

Top Two Vote Getters

#1 – Continued Viability of per diem/stipends in light of OIG Advisory Opinion 09-05

- Is there a concern about payment for periods when no patients are seen at all.

#2 – Other viable payment options

- Activation Fees
- Fees for services
- Deferred Compensation plans
- Subsidies/Guarantees

#3 – Determining the “burden” of coverage (vs. lost opportunity)

- Frequency of events
- Acuity Level
- Payor mix – how does it vary by specialty
- Response time

#4 – When Coverage is required by the Medical Staff By Laws

- How to account for it
- Who is in charge of the call panel?
- Payment for “excess” coverage

#5 – Competitor pays high rates

- Can it be verified?
- Is their situation the same?
- Are there other competitors? What do they pay?

#6 – Avoiding Double Payment

- If the doctors bill and collect
- If the doctors also get a fee for service
- Having too many doctors covering
- Simultaneous coverage or more than one hospital or in more than one specialty

#7 and #8 – Handling the loss of coverage or low supply of doctors

- Loss of coverage means the end of an important program
- Hospital in rural area (reducing physician supply)
- Specialty in low supply in many locations, not just rural (neurosurgery, pediatric surgery, etc.)

#9 and #10 – Contracting with Groups vs. Individual Physicians

- Who provides back-up coverage?
  - Who pays for it?
- Who can see the valuation?
  - Hospital only
  - Group
  - Individual doctors
- Negotiating leverage – when doctors form a group

#11 – Stacking coverage with other services

- Employment
- Administrative services
- Management services

#12 – Does call include follow up care?

- Can it be compensated separately?
- Any situations where call need not include follow up care?

#13 – EMTALA impact

- How has EMTALA changed the game?
  - Care for uninsured patients
  - Does EMTALA force hospitals to ensure that physician coverage is provided?
- What is not impacted by EMTALA?
  - Inpatients who develop emergent conditions
  - Is coverage still required?

The rest of the survey topics

#14 – Impact of Potential Legislative Changes

#15 – Concurrent coverage

#16 – Antitrust issues – different terms

#17 – Engaging outside valuators

#18 – Professional Liability Insurance issues

#19 – Avoiding Amorphous Services

#20 – Community Call Arrangements

#21 – Changes in the call panel makeup

BEST PRACTICES

Best Practices in Call Coverage

- Preliminary Steps – Assessing Need for Coverage
  - Determine Whether Need for Call Coverage Exists
    - Specialties with few emergencies
      - Is there a burden if the doctor can see the patient the next day?
    - Can coverage be provided by other physicians who already take call?
  - Determine Whether Coverage can be secured without any pay
    - Are physicians required to provide some coverage without any pay (under Medical Staff requirements or employment obligations, etc.)
    - Are physicians willing to provide coverage without pay
    - Is there a shortage of physicians or competitive market, etc.

Best Practices in Call Coverage

- Determining the Structure of Call Coverage
  - What is the coverage period (24 hours, nights, weekends, etc.)?
  - Is Coverage Restricted or Unrestricted?
  - What is the required response time?
  - How is the call panel schedule determined?
  - Is more than one Hospital covered by the same doctor?
    - Concurrent call
  - What services/patients are covered?
    - ED, Trauma unit, Inpatients, Labor & Delivery, Psychiatric unit, etc.
    - Indigent patients only vs. all patients
    - Adult only, Pediatric only, or both
  - What level of response is expected?
    - Telephone vs. Presence at the Hospital
  - What level of follow-up care is required?
  - Who provides backup coverage?

Best Practices in Call Coverage

- Determining the Appropriate Payment Structure
  - Per diem, Fee-for-services, Activation Fee, or combination
  - Do the physicians bill and collect from insured patients
    - For employed physicians, does response to call events count toward incentive pay (WRVUs, etc.)
  - Other types of payments
    - Deferred compensation, insurance subsidies, etc.
  - How will different specialties be handled – will all be paid, etc.?

- Determining FMV of the Payment Structure
  - Consider the specific factors that impact call
    - Burden on doctor, acuity level, etc.
  - Internal analysis vs. engaging an outside valuator

Best Practices in Call Coverage

- Consider Whether any OIG Danger Areas Apply
  - Is payment for "lost opportunity" or *bona fide* lost income?
  - Is payment for identifiable services?
  - Is payment disproportionately high compared to regular practice income?
  - Is payment duplicative of other compensation?

AMERICAN HEALTH LAWYERS ASSOCIATION

Thank you for your attention!

Question and Answer Session

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