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Ten questions to ask when structuring a compliant call coverage agreement

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The on-call coverage environment has seen significant changes over recent years. While call coverage was once considered to be a requirement alongside clinical services, due to the growing uninsured patient population and emphasis on physician work-life balance, it has become more common for physicians to require additional compensation for providing this coverage. As a result of these changes, hospital leadership faces the difficult task of ensuring sufficient physician coverage to handle emergent case volume, in-patient consults, and continued care for admitted patients. This challenge is further exacerbated by the low quantity of physicians willing to provide the coverage, the rising compensation amounts paid to these physicians, and the need to meet the rules and regulations of the desired trauma designations. Since the passage of the Emergency Medical Treatment and Labor Act of 1986 (EMTALA),[1] on-call compensation for physicians has become a more significant issue. EMTALA requires hospitals participating in Medicare to have adequate physician coverage to provide medical services to patients presenting to the emergency department. As a result, hospitals are confronted with determining not only the appropriate level of coverage, but also whether such coverage should be provided on a restricted (on-site) or unrestricted (off-site) basis. This discussion focuses on unrestricted (availability or beeper) coverage, during which on-call physicians must be available to report to the hospital within a set, emergent time frame.

On-call compensation regulatory environment

There are several legal regulations that must be considered when determining compensation for call coverage arrangements. Two of the most relevant laws guiding healthcare compensation arrangements are the federal Anti-Kickback Statute (AKS)[2] and the Physician Self-Referral Law (Stark Law).[3] AKS is a criminal statute that prohibits the exchange or solicitation of anything of value for the referral of services reimbursable by Medicare or Medicaid. The Stark Law is a set of United States federal civil laws that prohibit physicians (or their immediate family members) from making referrals for Medicare or Medicaid patients to any entities with which they have a financial relationship. To be compliant with these regulations and in order to limit the influence of remuneration on medical decision-making, the government requires physician compensation to be set at fair market value (FMV). In regard to healthcare transactions, FMV can be defined as "the value in arm's-length transactions, consistent with the general market value. 'General market value' means the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement."[4]

Top ten questions to help ensure compliance

When structuring call coverage agreements, hospital leadership must ensure the rates paid to the physicians are competitive enough to satisfy the required level of coverage and are financially viable for the hospital. Hospitals unable to secure adequate coverage must resort to using *locum tenens* coverage and compensate third-party staffing companies at premium rates or transfer the patient to another hospital with the appropriate resources or physicians available to treat the patients. Locum tenens physicians are usually the most expensive form of coverage and were designed for usage on a temporary, as-needed basis. As a result, hospital leadership should understand the value drivers that affect on-call pay and ask the appropriate questions to help ensure compliant call coverage agreements regardless of the staffing model being used. Although not an exhaustive list, the following key questions are crucial to consider when establishing call coverage arrangements.

1. **Is the call coverage necessary and commercially reasonable?** Considering the hospital's clinical/quality needs, operational goals, and financial concerns, would the arrangement make business sense without accounting for referrals? It is imperative to understand the "why" of the arrangement and to document accordingly.

2. **Is the call coverage compensation consistent with FMV? If so, what method was used to determine this: internal process by the hospital or independent third-party valuation?** The first method can be less expensive and thus may be preferred for compensation deemed low risk. However, the riskiness of the proposed compensation may be difficult to determine. The government has shown a preference to the latter method.[5]

3. **Is the compensation arrangement based on the volume or value of the physician's referrals, and does it comply with the healthcare laws and regulations?** Never document, tie, or track any payments to physicians with the number of referrals the physician makes to the hospital. Legal counsel should be used to ensure the arrangement is compliant with laws and regulations.

4. **What is the opportunity cost of not paying for call coverage?Will this result in inadequate coverage or the use of locum tenens coverage?**

5. **Is the call coverage required to maintain a trauma designation, be compliant with EMTALA, or fulfill a community need?** Depending on the situation, a higher rate may be warranted due to the specific need of the hospital. It is important to document the need of the hospital through a community needs assessment, trauma regulations, etc.

6. **What is the market rate (local, regional, and national) for the subject services, and how does it compare to market compensation surveys?** Understanding what other hospitals are paying is always a good starting point when structuring a call coverage arrangement. However, it is important to note that consistency with peers does not guarantee consistency with FMV, as the specific facts and circumstances of other hospitals may not be known.

7. **What are the requirements of the hospital's bylaws with regard to paying for call coverage? Are a set amount of days required to be uncompensated?** It is not uncommon for hospitals to require employed physicians to provide a set amount of uncompensated days prior to receiving an additional payment for call coverage. According to the 2018 Physician On-Call and Telemedicine Compensation Survey Report, 50% of respondents that pay stipends or hourly rates require uncompensated hours/shifts.[6] In addition, the monthly required uncompensated on-call shifts range from five to nine for all specialty groups.

8. **Will the physicians retain collections for the professional services rendered while providing the coverage?** Reimbursement risk may have a substantive effect on selecting a rate. Hospital leadership should understand the total amount of compensation to be received by the physicians.

9. **Is the physician an independent contractor or employed?** Understand which party will pay for certain expenses, such as malpractice insurance, benefits, etc., and whether/how it will affect the proposed rate.
10. **How do the value drivers, such as those listed below, affect the call coverage arrangement?**
    - Required specialty
    - Expected number of phone calls and in-person emergent responses
    - Required response time
    - Patient acuity/difficulty of case mix
    - Time required per case
    - Trauma designation of the hospital
    - Guaranteed compensation paid to the physicians
    - Payer mix and/or reimbursement risk
    - Number of physicians available to provide the coverage

Backup and concurrent call coverage

Another emerging trend that should be considered when structuring call coverage arrangements is backup and concurrent call coverage. At hospitals with a high likelihood of several in-person responses within a shift, should the primary on-call physician already be involved in a case, physicians may be included in the call panel as a backup. The hospital must determine if the physician will provide their own backup, or if an additional payment to the backup physician is required by the hospital. If the backup physician will be separately compensated, it is important to consider that these physicians typically receive reduced call rates—they are less likely to be called into the hospital and thus have a lower burden of call than that of the primary physician.

Likewise, often due to a low supply of on-call physicians or in order to reduce on-call expenses, some physicians are contracted to cover multiple hospitals or specialties simultaneously during a given shift. In these situations, hospitals must confirm that the subject physicians could realistically travel to each hospital within the emergent response time, as well as consider including backup coverage in the call panel to guard against potential lapses in coverage. Physicians providing concurrent calls typically warrant higher rates due to the increased burden of calls but should not receive the full call coverage compensation stipend for each hospital, because their availability has already been accounted for.

Common mistakes

If determining compensation internally, hospitals should be cognizant of common mistakes that may result in compensation that is not consistent with FMV. The first mistake is assuming that paying the same rate as another local hospital ensures your rate is in line with FMV. This may not be the case due to several reasons. The rate at the other hospital may not be consistent with FMV, value drivers could be substantially different between the hospitals; there may be differences in community need for the call coverage services; and the required uncompensated call shifts may differ. Another mistake is *solely* relying on market compensation surveys detailing a range of rates for specialty on-call coverage. Although these surveys are useful in theory, they include little to no specific information regarding the respondents' reimbursement risk and burden of call. In addition,

these surveys have minimal respondents and reflect only hospital-to-physician relationships. As these rates consist of data from parties with a referral relationship, they should be used cautiously. Lastly, as discussed previously, locum tenens coverage is typically the most expensive form of coverage as it includes corporate overhead and a profit margin payable to the locum tenens vendor, and it is designed to be used on an as-needed basis. Therefore, paying a locum tenens rate for non-locum tenens coverage is not advised.

Conclusion

Due to the risks associated with violations of healthcare laws and regulations and the resulting penalties, it is imperative to structure on-call compensation arrangements that are both commercially reasonable and consistent with FMV. Analyzing the economic and noneconomic factors discussed herein and seeking the assistance of an independent valuation expert should make structuring compliant on-call arrangements a much simpler process. For more information on the value drivers associated with call coverage arrangements and a more in-depth analysis of the differences between independent contractors and employed physicians, please refer to the article titled, "Should Independent Contractors be Compensated More Than Employed Physicians?" in the June 2017 edition of *Compliance Today*.[7]

Takeaways

- Understanding the underlying value drivers of unrestricted call coverage is crucial.
- Payments for concurrent call coverage are typically discounted as the availability has already been accounted for.
- Relying solely on market call coverage compensation surveys could result in compensation that is not consistent with fair market value (FMV).
- Paying the same rate as another hospital does not necessarily indicate the compensation is consistent with FMV.
- Seek an independent valuation firm to complete an FMV opinion if there are any concerns related to the on-call coverage payments.

1 42 U.S.C. § 1395dd .
2 42 U.S.C. § 1320a-7b(b) .
3 42 U.S.C. § 1395nn .
4 42 C.F.R. § 411.351 .
5 Office of the Inspector General, "Appendix A," *Corporate Integrity Agreement Between The Office Of Inspector General Of The Department Of Health And Human Services And Halifax Hospital Medical Center And Halifax Staffing, Inc.*, March 10, 2014, http://bit.ly/39EtQD0.
6 Sullivan, Cotter and Associates, Inc., *2018 Physician On-Call and Telemedicine Compensation Survey Report*, § 3, 2018, 13-14.
7 Bartt Warner, "Should Independent Contractors be Compensated More Than Employed Physicians?" *Compliance Today*, June 2017.