paying for call coverage
what you should know

If your physicians expect payment for being on call to provide emergency services, do you know how to ensure they receive a fair market value rate for their services?

Not long ago, hospitals could rely on physicians to provide call coverage in their emergency departments (EDs) without the expectation of being paid for it. But times have changed. Physicians are increasingly demanding that hospitals pay them to provide such coverage.

The reasons physicians have become less willing to provide uncompensated call coverage are many. They include:

> Reluctance to go without pay for uninsured patients
> Fear of malpractice lawsuits
> Disruption of personal lives
> A declining physician supply, with fewer physicians working for hospitals

In addition, the physician workforce is aging, and many medical staff bylaws allow older physicians to opt out of on-call duty.

The industry has also been undergoing a fundamental change in recent years. Historically, physicians provided on-call coverage in exchange for privileges at a hospital, which helped them to build their practices. Today, many physicians are shifting away from hospital settings to freestanding ambulatory surgery centers or specialty hospitals that don’t have EDs. And the growth in physician-owned surgery, imaging, diagnostic, and other facilities is expected to continue, thereby giving physicians more alternatives to on-call duty as the means to build their practices.

Meanwhile, hospitals have felt compelled to implement payment programs for call coverage in large part because of physician threats to cease on-call coverage and the desire to create equity among all physicians. As a result, many hospitals face the challenge of structuring on-call coverage arrangements. For healthcare organizations contemplating on-call payments for the first time, a basic understanding of the regulations and payment models for on-call coverage is essential.

AT A GLANCE

> Hospitals are finding they must pay for call coverage because of physician’s growing unwillingness to provide such coverage without compensation.
> In light of a July 2007 Office of Inspector General advisory opinion and federal regulations surrounding payments to physicians, it is critically important that call coverage arrangements be structured appropriately and at a fair market value (FMV) rate.
> Failure to set compensation at FMV could result in criminal and/or civil penalties based on healthcare fraud and abuse laws.
Structuring On-Call Arrangements

When considering implementing an on-call arrangement, hospitals should start by understanding the first and only Office of Inspector General (OIG) opinion related to on-call coverage—OIG Advisory Opinion No. 07-10, issued on Sept. 20, 2007. This OIG opinion stipulated several guidelines for healthcare organizations considering compensation for physicians who provided on-call coverage.

Specifically, the OIG found a certain arrangement to be at low risk for fraud and abuse, based on several factors:

> An independent third-party analysis concluded that the compensation reflected FMV for the services furnished.
> The per diem rate was designed to compensate each physician for the burden of being on call and to account for the likelihood that the physician would be required to provide subsequent inpatient services.
> On-call physicians were obligated to provide continuing care to ED patients, regardless of their ability to pay.
> Physicians in each specialty received the same per diem payment without regard to the individual physician’s referrals to, or business generated for, the hospital.
> The medical center had a legitimate, unmet need for on-call coverage and indigent care services as demonstrated by the fact that it was previously forced to outsource emergency care and related treatments to other facilities.

The OIG’s advisory opinion also warned of a substantial risk that improperly structured payments for on-call coverage could be considered unlawful remuneration if the payments exceed fair market value (FMV).

FMV is a common regulatory requirement related to many compensation arrangements between physicians and healthcare organizations. The federal government has presented guidelines for determining the FMV of physician compensation. Most notably, the Stark regulations state specific methods for determining FMV. Although the Stark regulations may not be directly applicable to an on-call arrangement, they provide insight into what federal authorities consider appropriate methods in determining FMV within the healthcare arena:

We will continue to scrutinize the Fair Market Value of arrangements as Fair Market Value is an essential element of many exceptions. Reference to multiple, objective, independently published salary surveys remains a prudent practice for evaluating Fair Market Value.

(Stark II, Phase III, FR Vol. 72, No. 171)

The methodology must exclude valuations where the parties to the transactions are at arm’s length but in a position to refer to one another.

(Stark II, Phase II, FR Vol. 69, No. 59)

Based on the above regulatory language, the guidelines for determining the FMV for on-call payments should reasonably include referring to multiple, objective, independently published salary surveys and limiting reliance on information produced from referral relationships.

Therefore, before determining on-call compensation, one should understand the available on-call market data.

On-Call Payment Data

Unfortunately, the market does not offer multiple surveys for on-call compensation. To date, there are only two substantial surveys: a survey by Sullivan, Cotter and Associates, Inc., 2008 Physician On-Call Pay Survey Report, published in July 2008 (see the sidebar on page 86); and a survey by the Medical Group Management Association (MGMA).

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a. OIG Advisory Opinion No. 07-10 may be accessed at www.oig.hhs.gov/fraud/advisoryopinions.asp.
Medical Directorship/On-Call Compensation Survey Report, published in April 2009. In addition, the data in these two surveys are based on referral relationships. It is therefore prudent to look to other methods when determining the FMV for on-call compensation. The following discussion addresses the pros and cons of the market surveys, as well as alternative methodologies for determining on-call compensation.

It is important to note that although there are various types of on-call payment models, both surveys report data as a daily or hourly pay rate. The Sullivan Cotter survey, in particular, states that 90 percent of organizations use this compensation methodology for employed physicians and 97 percent use this methodology for nonemployed physicians.

The Sullivan Cotter survey. Although relying on the Sullivan Cotter survey alone has its drawbacks, it does provide the most relevant data available. In addition, the survey’s median per diem payment data for certain specialties, such as orthopedic surgery, are in line with professional FMV analyses for on-call coverage that the author has either participated in or had the opportunity to review. Specifically, a review of the Sullivan Cotter survey data for orthopedic surgery on-call coverage compensation shows the median per diem payments for 2006, 2007, and 2008 were $975, $968, and $1,000, respectively, and the author has observed similar amounts in the findings of analyses focused on valuing on-call arrangements in the orthopedic surgery specialty.

Reliability is an issue of concern associated with using the Sullivan Cotter survey. Specifically, of the 36 reported specialties, two-thirds of those specialties have fewer than 20 respondents for on-call compensation. In addition, some specialties show questionable year-over-year growth. For example, per diem median payments for anesthesiology jumped 50 percent, from $500 to $750, in 2008; and per diem median payments for gastroenterology rose 42 percent, from $300 to $425, in 2008. Other red flags with certain data in the survey include the decrease of median per diem payments for specialties such as neurosurgery, which dropped 15 percent to $1,000, and psychiatry, which dropped 50 percent to $200 in 2008.

The MGMA survey. Reliability appears to be an issue with MGMA’s survey as well. Specifically, of the 17 reported specialties, seven of those specialties have fewer than 20 respondents for on-call compensation. In addition, variability within the specialties is extremely wide. For example, general surgery shows per diem rates ranging from $388 to $2,000 per day, while neurology ranges from $500 to $3,105.


A Look at the Trends

Eighty-six percent of respondents to a July 2008 survey—presenting data from 132 healthcare organizations nationwide—said they currently provide compensation to nonemployed physicians for call coverage (2008 Physician On-Call Pay Survey Report, Sullivan, Cotter and Associates, Inc.). The survey’s findings also indicate that lack of coverage has become a real challenge, as 85 percent of survey respondents have experienced difficulty finding physicians to provide on-call coverage, and 16 percent of respondents reported the discontinuation of service lines due to lack of on-call coverage.

Survey respondents also said that the costs associated with retaining call coverage is on the rise:

> From 2006 to 2008, the median expenditures reported by trauma centers for physician on-call pay increased by 88 percent, and the median expenditures in nontrauma centers increased by 91 percent.
> Nearly two-thirds of respondents saw their on-call pay expenditures increase over the most recent 12-month period.
> For 15 percent of respondents, on-call pay expenditures increased more than 50 percent over the same period.
> About 28 percent of the respondents said they were planning to begin paying physicians for call coverage within the next six months.

The survey results may be accessed at www.sullivancotter.com/resources/news20080728.php.
MGMA also segments its data in several ways, but its conclusions do not necessarily support FMV guidelines. For instance, the MGMA report states that invasive-interventional cardiology respondents reported an 80 percent difference in on-call compensation between single-specialty ($4,65 per day) and multispecialty groups ($2,298 per day). From an FMV perspective, the type of group a physician participates in should not change the value of its per diem on-call rate.

Perhaps one of the biggest issues with both surveys is that some survey respondents bill and collect, but most do not. Therefore, some of the higher per diem rates may be a function of the physician not billing and collecting.

**Alternatives to the surveys.** Based on the survey findings and appropriate FMV methodologies, survey data alone are not enough to fully support FMV payments for on-call coverage. It is important that an FMV analysis also consider additional valuation methodologies, the OIG opinion, and other factors, such as the burden of on-call duty. For example, if an arrangement's circumstances included an exceptionally poor payer mix or very low volume, market indications could warrant an adjustment up or down.

Other alternatives for determining the FMV for on-call payments include adjusted locum tenens rates and beeper rates. The *locum tenens* approach provides a proxy for the cost of on-call coverage by adjusting a market locum tenens quote by an industry margin and patient contact time. The beeper rate methodology is based on what a provider would earn, as a percentage of base pay, for being on call. If conducted appropriately, this method can reference multiple surveys for the specialty and provide an on-call rate based on nonreferring provider data. These methodologies are based on a daily or hourly pay rate, but there are other alternatives for obtaining call coverage.

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Call Coverage Models
Although the most common means of retaining physicians to provide on-call coverage is to provide a daily or hourly rate as discussed previously, other approaches are used in the industry. In fact, just recently, the FY09 final rule for hospital inpatient prospective payment system finalized provisions relating to the Emergency Medical Treatment and Labor Act (EMTALA) that outline community call plan requirements. The community call plan allows hospitals to develop a plan that best leverages local resources and relieves specialty physicians call obligations by permitting two or more hospitals to implement a plan to coordinate on-call coverage in a specific geographic area.

Other approaches to obtain call coverage that have been used in the market include:
> Payments for “excess” on-call duty (typically more than three to five shifts per month)
> Fee-for-service payments
> Payment of professional fees for uninsured patients (typically based on Medicare rates)
> Payment of the physician’s malpractice insurance premium
> Unique compensation plans, including 457Fs, which are deferred compensation plans that allow eligible employers to contribute money to investments on a pretax basis, and company-owned life insurance plans
> Dedication of physicians to on-call coverage and unassigned patients—e.g., physicians with laborists (obstetricians) and surgicalists (general surgeons and orthopedists)
> Contracting with an entire physician group to provide on-call coverage
> Use of residents and physician “extenders”
> Use of locum tenens agencies
> Technology-driven on-call, whereby the physicians call in remotely and, through live video/audio feed, can review imaging scans and on-site reports to direct the on-site physician

Regardless of the call coverage model implemented, understanding what federal authorities consider to be a compliant payment arrangement is essential.

Steps to On-Call Compliance
If healthcare organizations are not careful in structuring call coverage arrangements, they risk being noncompliant with healthcare regulations. To best document the hospital’s due diligence, with a thorough consideration of regulatory guidance, in determining the on-call payment and structure, healthcare organizations should:
> Understand the various market costs and FMV guidelines for determining call coverage payments
> Understand the recent OIG opinion when drafting on-call agreements
> Document factors to show the burden of call was considered in determining the payments, such as logging call volume by specialty

If an on-call agreement between a physician and hospital were to be audited by federal or state healthcare authorities, the analytical process the hospital used to justify that the payment is at FMV, and supporting documentation, would be essential in defending the compensation level.

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