

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

September 24, 2009 · 1:00-2:30 pm Eastern

Speaker(s):

Ann M. Bittinger, Esq.

D. Louis Glaser, Esq.

Spencer K. Turnbull, Esq.

Albert D. “Chip” Hutzler (Moderator)

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
Industry Guidance Branch
Office of Counsel to the Inspector General

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
Katten Muchin Rosenman, LLP

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 valuers

#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?

Thank you for your attention!

Question and Answer Session

How To Reach Us:

Spencer K. Turnbull

Industry Guidance Branch
Office of Counsel to the Inspector General
(202) 619-0335
Spencer.Turnbull@oig.hhs.gov
www.oig.hhs.gov

D. Louis Glaser

Partner
Katten Muchin Rosenman LLP
(312) 902-5210
louis.glaser@kattenlaw.com
www.kattenlaw.com

Ann M. Bittinger

The Bittinger Law Firm
(904) 821-9000
ann@bittingerlaw.com
www.bittingerlaw.com

Albert D. “Chip” Hutzler

Principal
HealthCare Appraisers
(561) 330-3488
chutzler@hcfmv.com
www.healthcareappraisers.com

Best Practices in Structuring Call Coverage After the Recent OIG Advisory Opinion 09-05 © 2007 is published by the American Health Lawyers Association. All rights reserved. No part of this publication may be reproduced in any form except by prior written permission from the publisher. Printed in the United States of America.

Any views or advice offered in this publication are those of its authors and should not be construed as the position of the American Health Lawyers Association.

“This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is provided with the understanding that the publisher is not engaged in rendering legal or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought”—*from a declaration of the American Bar Association*