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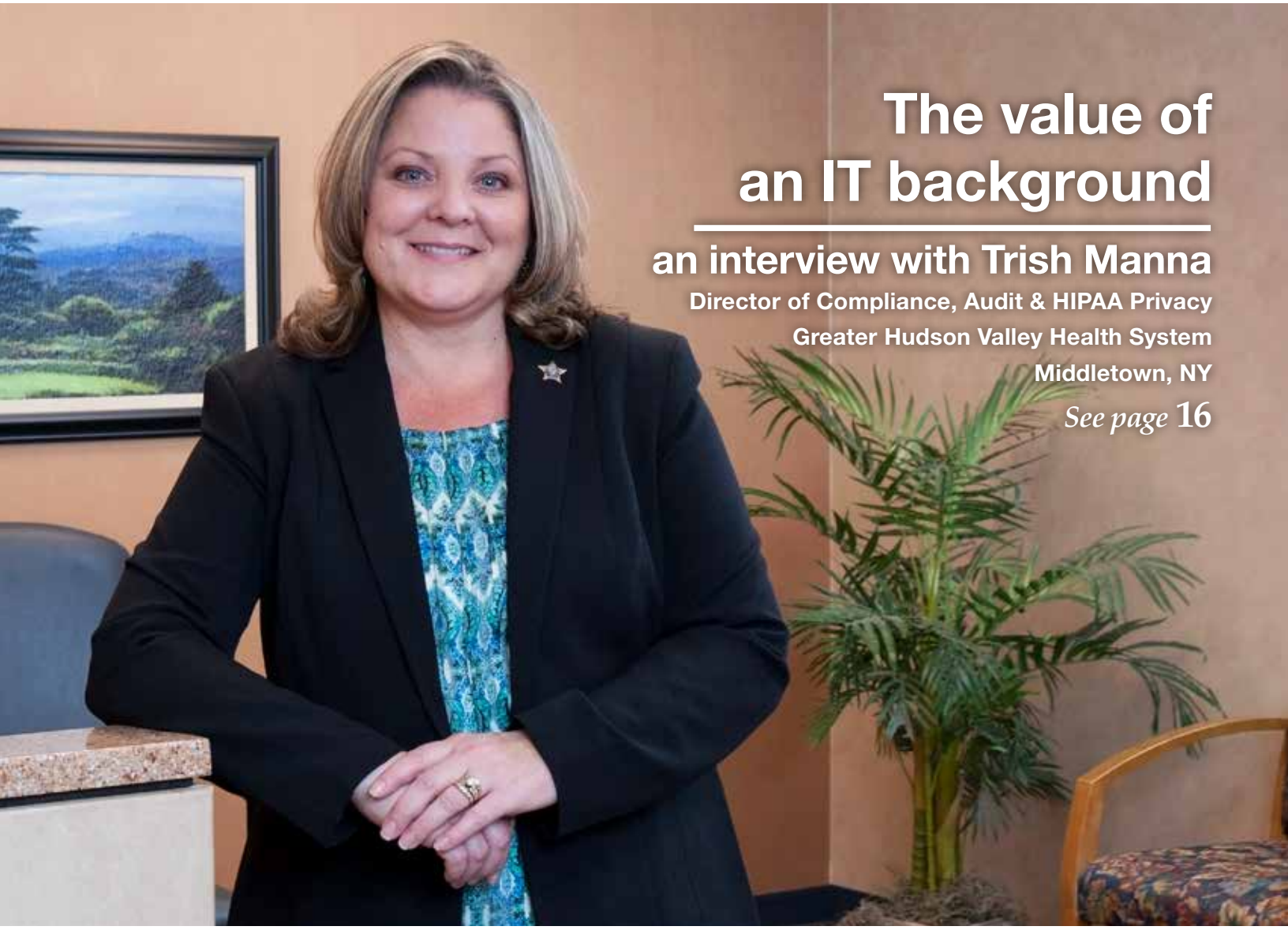

The value of an IT background

an interview with Trish Manna

Director of Compliance, Audit & HIPAA Privacy
Greater Hudson Valley Health System
Middletown, NY

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> Helping employees understand how to avoid violations, mitigate risk, and create an optimal working environment is a task my team and I take to heart.

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by Bartt B. Warner, CVA

Should on-call independent contractors be compensated more than employed physicians?

» Physician on-call coverage arrangements are subject to various laws and regulations.
» Understanding the underlying value drivers of unrestricted call coverage is crucial.
» The fair market value (FMV) rate for independent contractors is normally not the same as the FMV rate for employed physicians.
» Understand the Stark Law and Anti-Kickback Statute and review with internal legal counsel for compliance.
» Seek an independent valuation firm to complete an FMV opinion if there is any concern related to the on-call coverage payments.

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The Emergency Medical Treatment and Labor Act of 1986 (EMTALA) created a need for hospitals that participate in Medicare to have physicians available to provide emergent medical services to patients in the hospital's Emergency Department (ED). Thus, hospitals are required to ensure their EDs are either staffed or have physicians available to respond to emergent cases within a predetermined timeframe. As a result, there has been a proliferation of hospitals entering into agreements with physicians to provide both restricted (i.e., remain on-site) and unrestricted call coverage services. This trend continues today and has created the need for hospitals to understand both the financial and regulatory impact when determining the appropriate call coverage rates. In addition, one of the most commonly misunderstood concepts relates to the compensation that can be paid to physicians who are employed by a hospital/health system versus physicians who serve as independent contractors.


Warner

Unrestricted call coverage is often defined as "off-site," "availability," or "beeper" coverage where an on-call physician must be available to report to the hospital in person within a set timeframe (typically 30-45 minutes, but this may vary by state) for emergent cases. Hospital administrators are faced with a dilemma when preparing unrestricted call coverage agreements—determining the appropriate rate to pay both employed and independent contractors. One may intuitively think that the rate should be the same, since the exact same service is being provided regardless of the employment status of the physician. However, this may not be the case, because the value drivers of each rate are considerably different. In fact, paying the same rate could potentially lead to a rate that may not be consistent with fair market value (FMV). FMV is

defined as, "The price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arms-length in an open and unrestricted market, when neither is under compulsion to buy or sell and when both have reasonable knowledge of the relevant facts."[1]

To fully understand the difference between each rate, one must first understand how each rate is normally derived. With regards to physicians who are employed by a hospital/health system, the physician's benefits, continuing medical education (CME), and malpractice insurance are typically already included in his/her corresponding employment agreement. Thus, when determining the per shift rate, one should not include the aforementioned expenses in order to ensure the proposed rate does not exceed FMV. In addition, a certain amount of call coverage compensation is typically already included in the physician's base salary. Consequently, the rate to be paid to the physician is, in essence, "*excess* call coverage" and paying the physician from Day One may not necessarily be consistent with FMV.

Another difference for employed physicians is related to how they are compensated for their provision of professional clinical services. According to *Merritt Hawkins' 2016 Review of Physician and Advanced Practitioner Recruiting Incentives*,[2] volume-based production incentives are the most frequently utilized physician productivity metric. Therefore, it is important to understand all forms of compensation the physician will receive while providing the call coverage services.

In addition, the corresponding unrestricted call coverage rate may need to be lower than the rate for the independent contractors, because the employed physician could be receiving two forms of guaranteed payments while providing the call coverage services.

With regards to physicians who are considered independent contractors to a hospital/health system, the independent physicians are typically responsible for covering their own benefits, CME, and malpractice insurance. Accordingly, when determining the per shift rate, it is an acceptable practice to factor the aforementioned expenses into the unrestricted call coverage rate, because these expenses are considered a cost of doing business. In addition, independent contractors are typically "at risk" for collections for their professional services. Thus, a higher rate is usually warranted due to the risk of not being able to collect from the patients, which is partially driven by the hospital's payer mix.

Key questions and value drivers

Understanding the underlying value drivers of unrestricted call coverage is crucial for administrators and legal counsel who are involved in the call coverage agreement process. One should carefully evaluate and ask each of the following questions when determining the appropriate unrestricted call coverage rate:

1. **What is the required specialty of the physician and the type of coverage being provided?** Surgical specialties are generally compensated at higher levels than non-surgical specialties.
2. **What is the burden (i.e., frequency of phone calls and in-person emergent responses) of the unrestricted call coverage?** Higher volume typically warrants a higher rate.
3. **What is the timeframe required to respond in-person for emergent cases/consults?** This is normally 30-45 minutes, and instances involving a longer in-person response time may justify a lower rate.
4. **What is the patient acuity/difficulty of the case mix?** The compensation rate normally increases with the difficulty of the cases/consults.

5. **What is the approximate time to complete each in-person case/consult?** Longer cases usually result in higher rates.
6. **What is the trauma designation of the hospital?** Hospitals with a trauma designation normally have higher volume and potentially higher acuity emergent cases, resulting in higher rates.
7. **Does the physician receive guaranteed or productivity-based compensation?** This is usually in the form of production bonuses or guaranteed payments for indigent patients.
8. **Who is at-risk for the professional collections?**
9. **What is the payer mix (i.e. uninsured, Medicaid, Medicare)?** A poor payer mix may justify higher reimbursement if the physician is at-risk for professional collections.
10. **How many physicians will be providing the call coverage?** A low supply of physicians available to provide the coverage may warrant a higher rate.
11. **What is the market (local, regional, national) paying for call coverage services in the same specialty?**
12. **What are the alternatives?** Locum tenens coverage is normally used as a last resort and is typically the most expensive option.

Hospital/health system administrators face the difficult task of determining the compensation to pay physicians who provide unrestricted call coverage services. Part of the difficulty arises, because the rate must be competitive, but also be consistent with FMV due to various regulations, including the Stark Law and Anti-Kickback Statute. The Stark Law prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies.[3] The Anti-Kickback Statute prohibits offering, paying, soliciting, or receiving anything of value to induce or reward referrals or to generate business when the claim is paid by a federal health care program.[4]

To further compound the issue, administrators must ensure the determined rate is financially viable for the hospital. As previously shown, the rate that may be paid to the employed physicians may not necessarily be the same as the rate paid to physicians serving as independent contractors. Normally, a higher rate is warranted for independent contractors due to the independent physicians being responsible for their own benefits, CME, and malpractice insurance and typically being at-risk for collections for professional services rendered. However, it is not uncommon for the same rate to be paid as long as both rates are consistent with FMV.

Key takeaways and nuances

Physician on-call coverage arrangements are subject to various laws and regulations, which mandate/require the compensation paid to physicians be consistent with FMV. If there is a concern regarding a particular engagement, hospital/health system administrators should ensure physician compensation arrangements are consistent with FMV by seeking an independent valuation firm to complete an FMV analysis and reviewing the arrangement with legal counsel. In addition, remember the following prior to executing and/or reviewing a call overage agreement:

1. Understand what type of coverage is needed (restricted vs. unrestricted).
2. Understand who will be providing the coverage (employed vs. independent contractors).
3. Understand who will be responsible for covering the physician's benefits, CME, and malpractice insurance (hospital/health system vs. physician).
4. Understand each of the value drivers.

5. The FMV rate for independent contractors is normally not the same as the FMV rate for employed physicians; however, the same rate may be paid to both as long as both rates are consistent with FMV.
6. The FMV rate may vary for the same specialty between different hospitals, due to each rate being based on specific facts and circumstances.
7. Always benchmark the determined call coverage rate to what is currently being paid in the corresponding market. Locum tenens quotes are usually higher than the FMV rates due to the overhead and profit margin being "baked" into the quote.
8. Understand the Stark Law and Anti-Kickback Statute and have all on-call coverage agreements reviewed for compliance by internal legal counsel.
9. Seek an independent valuation firm to complete an FMV opinion if there is any concern related to the on-call coverage payments.

Conclusion

As the number of physicians receiving compensation for the provision of unrestricted call coverage services continues to increase, the importance of structuring on-call compensation arrangements that are consistent with FMV is increasingly important. In addition, administrators should be cautious about structuring agreements identically for employed and independent contractor physicians, as the FMV rates are typically not the same. With the assistance of an independent valuation expert and a better understanding of the value drivers associated with unrestricted call coverage compensation, structuring an on-call agreement that is competitive and consistent with FMV should be an easier undertaking.

1. AICPA: International Glossary of Business Valuation Terms is available at http://bit.ly/2oZDfQR
2. Merritt Hawkins: 2016 Review of Physician and Advanced Practitioner Recruiting Incentives. Available at http://bit.ly/2o7TSdP
3. 42 USC § 1395nn
4. 42 USC § 1320a-7b(b)