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Trends and FMV Considerations in Structuring On-Call Coverage Payments

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Payments to physicians for providing on-call coverage have become increasingly popular in the marketplace. As such, on-call compensation arrangements have been thrust into the regulatory spotlight, and the importance of ensuring a fair market value (FMV) compensation structure has never been greater. Understanding the trends, payment methodologies and FMV considerations are vital in structuring a compliant on-call coverage arrangement.

On-Call Coverage Trends

Historically, it has been standard practice for physicians to provide call coverage. They provided uncompensated emergent coverage to gain admitting privileges at hospitals and as a means of building patient volume for their practice. Hospitals generally required physicians to participate in call rotations as a contractual expectation to maintain emergent coverage at their facilities. Today, the trend and market for physician on-call coverage has completely transformed.

Physicians have become increasingly averse to providing uncompensated emergent coverage. Key factors influencing this trend include the rise in the uninsured population, fear of malpractice lawsuits, and the disruption of their personal lives and private practices. Additionally, there is a shortage of physicians in the United States that is only expected to worsen. According to the Association of American Medical Colleges, there could be a shortage of up to 90,000 physicians in the United States within the next eight years. Recent trends have also indicated that it has become more common for tenured physicians to negotiate on-call opt-out clauses.

The trend toward compensated call coverage arrangements has been particularly influenced by the growth in the population of uninsured individuals. According to the Kaiser Commission on Medicaid and the Uninsured, the number of nonelderly, uninsured people has increased 16 percent from 43.4 million in 2007 to 49.1 million in 2010.The increase in the uninsured population has led to physicians providing more care to patients from whom they are unable to collect.

For these reasons, many organizations are considering paying physicians for call coverage and are struggling with how to structure the arrangements and determine the payments.

Compensated Call Coverage

The Sullivan, Cotter and Associates (SCA) 2011 Physician On-Call Pay Survey Report states that 92 percent of the survey respondents currently provide some method of compensation to nonemployed physicians for providing on-call coverage. In addition, approximately 49 percent of those surveyed reported their on-call expenditures have increased in the past 12 months. Supporting this trend, SCA statistics show overall expenditures for call payments have been increasing exponentially since 2008. From 2008-2011, average on-call expenditures have increased by 57 percent for trauma facilities.

There are a variety of on-call payment models in the marketplace. Some common compensated call coverage models include:

- Compensating a physician for the "burden of the beeper;" typically through a 24-hour or per-shift rate
- Commonly known as providing unrestricted call coverage, these arrangements typically require a 30-minute response time.
- Providing payments for "excess call" (typically over four to six shifts per month)
- Paying per "activation" or response into the facility
- Paying professional fees for providing care to uninsured patients (typically a flat fee or based on Medicare rates)
- Paying the physician's malpractice insurance
- Paying a physician to be physically on-site at the facility should an emergent need occur
- Utilizing residents and physician extenders to fill gaps in coverage
- Contracting with locum tenens agencies

All of the above on-call payment models could be viable options for obtaining emergent coverage. Health systems utilize one or many different on-call models based on their employed physician mix, average emergent patient volumes and budgetary considerations.

Regulatory Guidelines

An understanding of the regulatory environment surrounding on-call

coverage payments is essential. The federal government has presented guidelines to apply in structuring a physician compensation arrangement. Most notably, key Stark Law regulation prohibits the determination of FMV compensation from considering the volume or value of referrals. The Stark regulations also include insight as to what the federal government considers appropriate methodologies in determining FMV compensation. These regulations indicate that reference to multiple, objective, independently published salary surveys and limited reliance on information produced from referral relationships should be guidelines in determining FMV compensation.

The Office of Inspector General (OIG) has issued advisory opinions related to on-call payments and has warned of a substantial risk that improperly structured payments could be considered unlawful remuneration if they exceed FMV. The OIG has noted several on-call payment structures that are at higher risk for fraud and abuse. These structures include:

- Payments when no discernible services are provided
- Aggregate payments that are larger than a physician's clinical income
- Direct payments for services rendered when the physician receives additional reimbursement from third-party payors.

With these in mind, healthcare executives should start by understanding what factors to consider in structuring an on-call agreement. A key question to ask is whether that particular specialty has a legitimate need for emergent coverage. Paying physicians to provide daily coverage in circumstances where there is not an emergent need could be viewed as a high-risk model.

Fair Market Value Considerations

In determining the reasonability of the compensation included in an on-call agreement, one should account for the burden of call. The burden of call can be influenced by the physician's ability to collect or receive any guaranteed compensation, the physician's payor mix risk, volume of expected emergent responses, typical patient contact time, procedure acuity, and available physician supply and demand. For example, the more unfavorable the payor mix, the less likely a physician will be able to collect professional fees when called into the facility. Therefore, this would increase the burden of providing these services on the physician. As such, compensation within specialties in the market varies with the physician's burden of providing call coverage. In situations where the physician is receiving guaranteed professional fees when called in, the hospital is incurring the risk of the uninsured payor mix and, thus, the payment to the physician should be less.

In gauging the range of on-call compensation for a particular specialty, there are two on-call market surveys available: MGMA Medical Directorship and On-Call Compensation Survey (2012 report based on 2011 data) and Sullivan, Cotter & Associates' 2012 Physician On-Call Pay Survey. These surveys report compensation ranges payable to physicians for providing unrestricted call coverage in the form of an hourly and daily rate. The surveys include payment rates summarized by specialty as well as the number of respondents supporting each compensation range.

There are significant drawbacks and factors to consider prior to solely utilizing market surveys. One of the biggest issues with the market survey data is that the terms of the arrangements are unknown. Specifically, some of the respondents in the surveys bill and collect for professional services rendered, and some do not. Additionally, the volume of emergent responses, payor mix, case acuity, and physician supply and demand are not detailed in the surveys. From an FMV perspective, it could be argued that on-call survey data is tainted in that it reflects solely hospital-to-physician relationships. As the compensation rates include data from parties in a position to refer patient volume, many question whether the surveys can even be considered in a valuation. Given these factors, relying solely on market on-call survey data is highly risky.

Many health systems have opted to streamline the contracting process by utilizing third-party internal compensation calculators. On-call calculators are generally quick and cost-effective options that employ consistent methodologies for establishing physician payments. Some calculators support conservative levels of compensation, while others incorporate more robust approaches. Additionally, the added benefit of utilizing a third-party calculator is that it ensures an unbiased and consistent method for deriving on-call payments across specialities and arrangements.

Analyzing and documenting the burden of call in an arrangement by utilizing consistent measurements is vital in ensuring a consistent and defendable level of compensation. Key steps to follow in structuring these arrangements should include:

1. Understand the regulatory guidelines and OIG opinions related to on-call payments
2. Question whether the proposed compensation model is logical given the expected emergent response volume
3. Document the "burden of call" on the physician and consider the key indicators, including payor mix risk, response volume, and the supply and demand of available physicians
4. Consider utilizing a third-party compensation calculator to establish a consistent and reasonable level of compensation across all specialties

Ensuring compensation is set at FMV is a vital component of a compliant agreement. With careful planning, key regulatory considerations and a consistent methodology, many of the headaches associated with paying for call coverage can be avoided. ✚

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