OIG Issues Advisory Opinion 07-10 on Payments to Physicians for On-Call and Uncompensated Care Services

On September 27, 2007, the Office of Inspector General (OIG) of the United States Department of Health and Human Services posted an Advisory Opinion (OIG Advisory Opinion No. 07-10) regarding payment of physicians for emergency call coverage and uncompensated care services. The Advisory Opinion analyzes the risk of civil monetary penalties arising from one hospital’s plan to pay *per diem* compensation to physicians for emergency department call coverage and subsequent inpatient follow-up care to uncompensated patients admitted from the emergency department. Significantly, the Advisory Opinion makes clear that the practice of paying physicians to provide on-call coverage implicates the federal Anti-Kickback Statute because physicians may demand on-call compensation as a condition of practicing at and referring patients to the hospital, and, in this one hospital’s case, because the proposed plan to compensate physicians on a *per diem* basis would not squarely fit within the safe harbor for personal services and management contracts at 42 CFR § 1001.952(d). Nevertheless, the OIG concluded that this hospital’s plan to compensate physicians would not result in the imposition of administrative sanctions under the Anti-Kickback Statute because there is a legitimate, unmet need for physician on-call coverage and uncompensated care services, and because the contemplated arrangement was carefully structured to contain numerous safeguards against fraud and abuse, including assurances that all compensation to the physicians is fair market value for actual and necessary services rendered.

The Advisory Opinion is significant given the numerous areas of the country where rising malpractice insurance costs, the perceived risk of lawsuits, and a general reluctance to treat uninsured emergency patients have led to a shortage of physicians who are willing to provide on-call coverage without compensation, while the obligation to comply with the Emergency Medical Treatment and Labor Act (EMTALA) has increased hospitals’ willingness to pay for on-call coverage for emergency rooms. Accordingly, this Alert summarizes the OIG’s analysis of hospital compensation to physicians for on-call coverage and care to uncompensated patients so that hospitals and physicians can be aware of areas of risk and understand what may be permissible in these arrangements.

**Background and Outline of the Hospital’s On-Call Coverage Plan**

The hospital requesting the Advisory Opinion (referred to as “Medical Center”) is a tax-exempt, not-for-profit institution with a charitable mission “to help the poor and less fortunate.” Reportedly, nearly one in four patients visiting Medical Center’s emergency department has no form of health insurance, and nearly one in ten uninsured patients presenting in the emergency department is subsequently admitted to Medical Center for inpatient care. The burdens of uncompensated patient care and malpractice insurance costs, combined with other factors, reduced the local supply of various types of specialty physicians who were willing to provide emergency department call coverage without compensation, forcing the Medical Center to transfer emergency patients to other medical facilities for emergency treatment and subsequent inpatient care, even when such care “might have been handled more efficiently and conveniently at the Medical Center.”
Medical Center proposed an arrangement whereby physicians on Medical Center’s staff would be compensated for covering emergency patients, as follows:

• Staff physicians would be offered a contract for a two-year term.

• Under the contract, physicians would have the following obligations: (1) participate in a monthly emergency department call rotation to be established by the appropriate department or division chief on a monthly basis; (2) provide inpatient care to any patient seen in the emergency department while on-call, if the patient is admitted, and regardless of the patient’s ability to pay for the care (the duty to provide inpatient care continued until the patient is properly discharged from the Medical Center); (3) respond to all emergency department calls within a reasonable amount of time; (4) cooperate with and participate in risk management and quality assurance initiatives of the Medical Center; and (5) complete medical records for all emergency department patients in accordance with specific time and other requirements.

• Physicians who fail to adhere to any contractual obligations, specifically including the requirement to cooperate and participate in risk management and quality improvement initiatives, will have their payments suspended until they demonstrate compliance. Continuing non-compliance with contract obligations will result in termination of the contract.

• Physicians are paid *per diem* compensation based on two factors: (1) the physician’s specialty; (2) whether call coverage is on a weekend or weekday. The difference in *per diem* rates is based on:

  (i) the severity of illness typically encountered by a physician of the specialty treating a patient presenting in the emergency department;

  (ii) the likelihood of having to respond when on-call for the emergency department;

  (iii) the likelihood of having to respond to a request for inpatient consultative services for an uninsured patient while on-call;

  (iv) the degree of inpatient care typically required of the physician’s specialty for patients that initially present at the emergency department.

• The Medical Center certified that the physicians’ *per diem* rates are and will be fair market value for the services, as determined by an independent third party experienced in valuing the types of services to be provided under the contract. The third party analysis focused on the reasonableness of the *per diem* rates, and incorporated both publicly available and proprietary data concerning practices and pay rates at dozens of health care facilities. The details of the fair market value analysis were set out in an opinion letter which was provided to the OIG for purposes of review.

**OIG Analysis of On-Call Compensation Plan**

The Anti-Kickback Statute prohibits knowingly and willfully offering, paying, soliciting or receiving any remuneration, directly or indirectly and in any form, to induce or reward referrals of items or services that are reimbursable by a federal health care program (e.g., Medicare, Medicaid, Tricare). The Anti-Kickback Statute has been interpreted to proscribe any arrangement where even one purpose of the arrangement is to induce referrals. Violations of the Anti-Kickback Statute are punishable as a felony against parties on both sides of the transaction — i.e., against both the payor and the recipient of the illegal remuneration. To define permissible conduct within this statutory framework, the government has promulgated certain “safe harbors.” When all criteria of a safe harbor are met, the parties are protected from prosecution under the Anti-Kickback Statute.
The Advisory Opinion addresses the safe harbor for personal services and management contracts. This safe harbor requires that:

- the arrangement is in writing and signed by the parties;
- the written agreement sets forth the specific services to be provided;
- if the services to be performed under the arrangement are periodic, sporadic or part-time, the agreement sets forth the specific schedule, length and charge for each interval of service;
- the agreement is for at least one year;
- the aggregate amount of compensation is set in advance, is consistent with fair market value in arm’s-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties;
- the services performed under the agreement do not involve the promotion of a business arrangement or other activity that violates any state or federal law; and
- the aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services.

The Advisory Opinion suggests that a proposal to compensate physicians for on-call and uncompensated care services could be structured to squarely fit within the safe harbor for personal services and management contracts. However, in Medical Center’s case, the OIG determined that the proposed arrangement does not fit within this safe harbor because Medical Center’s payments to physicians could vary from month to month. As such, the aggregate compensation is not “set in advance.” Nonetheless, the Advisory Opinion makes clear that the “key inquiry” from the perspective of the OIG is whether the compensation to be paid to the physicians is fair market value for actual and necessary items or services, determined in a manner that does not take into account the volume or value of referrals or other business generated between the parties. Importantly, the Advisory Opinion states that the OIG will view as suspect any on-call payments that are based on: (1) “lost opportunity” or any payments that do not reflect bona fide lost income; (2) payment structures that compensate physicians when no identifiable services are provided; (3) aggregate on-call payments that are disproportionately high compared to the physician’s regular medical practice income; (4) payment structures that compensate the on-call physician for professional services for which he or she receives separate reimbursement from insurers or patients, resulting in the physician being paid twice for the same service.

Taking into account “totality of the facts and circumstances,” the OIG concluded that Medical Center’s on-call and uncompensated care plan does not warrant sanctions under the Anti-Kickback Statute based on the following:

- In Medical Center’s plan, the per diem rate to be paid to physicians reflects the actual burden on the physician (e.g., what the physician has to do to make himself or herself available in a short response time on a weekend versus a weekday) as well as the actual likelihood that the physician will have to provide uncompensated treatment, and the likely extent of that treatment. In short, the payments to physicians are “tailored to cover substantial, quantifiable services…[and] contrast sharply with payments that are less plainly tied to tangible physician responsibilities,” which the OIG views as suspect because they “may represent little more than illicit payments for referrals.”

- Medical Center had a documented, legitimate and unmet need for on-call and uncompensated care services. In the OIG’s analysis, this documented need “lower[s] the risk that the arrangement was instituted as a way to funnel remuneration to physicians for referrals.”
• The arrangement includes strong safeguards against fraud and abuse. For example: (1) The arrangement is offered uniformly to all physicians in the relevant specialties and not only to select physicians as a means of attracting or keeping them as a referral source. (2) Monthly call obligations are required to be divided as equally as possible, so as to discourage use of call scheduling to selectively reward the highest referrers. (3) All on-call physicians must provide follow-up care to any patient who is admitted, regardless of the patient’s ability to pay, thereby lessening the risk that physicians could “cherry pick” those emergency patients that are likely to be most lucrative. (4) The requirement that on-call physicians document their services promotes accountability and creates a mechanism to monitor actual services provided.

• The arrangement promotes an obvious and beneficial public health purpose by facilitating better emergency care and follow-up services at Medical Center and in Medical Center’s service area.

Conclusion
The Advisory Opinion instructs that compensation for on-call arrangements may be designed to meet the safe harbor for personal services contracts. It also advises that when on-call payments may vary from month to month, the requirements of the safe harbor are not met and there is a risk of prosecution under the Anti-Kickback Statute because of the potential that on-call payments may be misused or abused to generate referrals or other business between a hospital and on-call physicians. The risk of prosecution may be mitigated when an arrangement is a response to a documented unmet need, all compensation to physicians is fair market value, and the arrangement is structured to contain strong safeguards against fraud and abuse. Accordingly, a hospital that is considering an arrangement in which compensation does not satisfy the requirement to be “set in advance” should: (1) consider whether there is a documented, legitimate need for the type of compensation arrangement proposed; (2) assure that the compensation to physicians reflects fair market value based on the services likely to be delivered in each specialty; and (3) structure the arrangement to include safeguards that will prevent fraud and abuse. In all cases, the proposed plan should be reviewed by appropriate legal counsel.