Recent Legal Developments in Hospital Compensation for On-Call Physicians

By Craig S. Smith

It has long been the custom for physicians providing emergency room call coverage to our nation's hospitals to do so without receiving any compensation from the hospitals. And, prior to twenty or thirty years ago, it likely would have been difficult to produce a legitimate economic rationale in support of hospitals paying physicians for such services. After all, whenever an on-call physician rendered treatment to a patient arriving at a hospital's emergency room, the physician would typically be paid for his services by the patient or, more recently, by the patient's insurer. This model has worked and continues to work for many hospitals and physicians. Nevertheless, the last few years have seen a growing nationwide trend in which hospitals are increasingly compensating physicians for providing call coverage to their emergency departments. This trend appears to be driven, at least in part, by a combination of federal and state legislation requiring hospital emergency departments to accept, stabilize and treat non-paying patients, and the seemingly ever-growing number of uninsured and underinsured patients visiting hospital emergency rooms. Thus, the ratio of cases for which hospitals and on-call physicians receive meager or no compensation is on the rise. Relative to hospitals, physicians are usually less able to bear the economic brunt of uncompensated care. Not surprisingly, many on-call compensation arrangements now in place between hospitals and physicians involve non-profit hospitals that serve a significant number of indigent patients, as well as hospitals located in geographic areas in which specialists are in short supply.

The "page-me, pay-me" trend of physician on-call payment arrangements has been slow-moving, however, due, in part, to the fact that such arrangements are subject to government scrutiny as potentially illegal pay-for-referral arrangements. The good news for physicians and hospitals desiring to enter into on-call compensation arrangements is that the government is increasingly recognizing the legitimacy of these arrangements in various circumstances. In two unrelated advisory opinions issued by the Office of Inspector General ("OIG") of the Department of Health & Human Services, in May this year and in September, 2007, the OIG in each opinion blessed a proposed on-call compensation arrangement between a hospital and physicians. In the OIG's 2009 opinion, the hospital proposed to pay on-call physicians for services rendered to indigent and uninsured patients pursuant to an agreed-upon fee schedule under which the fee would be based on the specific service provided. In the OIG's 2007 opinion, the hospital proposed to pay on-call physicians a flat *per diem* rate for each day a physician is on-call. Below, I briefly describe the federal law under which the OIG analyzed each of the proposed compensation arrangements and then discuss the aforementioned advisory opinions in greater detail.

<u>On-Call Compensation and the Anti-Kickback Statute</u>. While not the only potential law of concern, the federal anti-kickback statute often stands as a significant legal challenge for hospitals and physicians seeking to enter into on-call compensation arrangements. In the particular context at hand, the anti-kickback statute makes illegal any payments made

by a hospital to a physician for performing on-call services if the payments are made with the intent to induce or reward the physician's referral to the hospital of patients covered by Medicare or any other federal health care program. While the anti-kickback statute provides for certain "safe harbors," pursuant to which a given arrangement is deemed by the government to comply with the statute if (and only if) the arrangement satisfies all of the required elements of a safe harbor, most proposed on-call compensation arrangements do not fit cleanly within any of the anti-kickback statute's safe harbors. Those who violate the anti-kickback statute are subject to potentially severe civil and criminal penalties, including, but not limited to, administrative penalties enforceable by the OIG.

Enter OIG advisory opinion nos. 09-05 and 07-10, each of which addresses a proposed on-call compensation arrangement that does not fully satisfy any of the available anti-kickback statute safe harbors, but for which the OIG states that it will not impose penalties based on its conclusion that the proposed arrangement would pose a low risk of fraud and abuse to federal healthcare programs. Based on the issuance of these advisory opinions, physicians and hospitals seeking to enter into on-call compensation arrangements of the type described in these opinions may do so with a relatively greater degree of legal comfort.

<u>Advisory Opinion 09-05: Compensation for Serving Indigent Patients While On-Call</u>. On May 21, 2009, the OIG posted its advisory opinion no. 09-05 (the "2009 opinion") in response to a non-profit hospital's request to the OIG to review a proposed arrangement under which the hospital would pay physicians for on-call services performed in its emergency department on behalf of the hospital's indigent and uninsured patients. In its opinion, the government concluded that *". . . while the proposed arrangement could potentially generate prohibited remuneration under the anti-kickback statute, if the requisite intent to induce or reward referrals of Federal health care program business were present, the [OIG] would not impose administrative sanctions on [the hospital under the proposed arrangement] . . ."* Most lawyers consider the above-quoted language to constitute the OIG's "blessing," although the blessing comes with some strings attached. For one thing, the OIG's approval of the proposed arrangement is binding only on the U.S. Department of Health and Human Service if and only if all of the information provided to it by the requesting party is true and complete. In addition, only the particular party requesting the advisory opinion may rely upon it in defense of any action taken by the government against those who are parties to the proposed arrangement.

While the 2009 opinion is good news indeed for physicians and hospitals, I hasten to point out that it is limited in its applicability, and physicians and hospitals should view the opinion as being relevant (from a risk management standpoint) only as to those on-call arrangements that bear those features and characteristics the OIG cites as being germane to reaching its favorable conclusion. Those features and characteristics include the following:

- The hospital certified that the payment amounts would be within the range of fair market value for the services to be rendered by the physicians, without regard to

referrals between the parties, and physicians would only be paid for services rendered to *indigent and uninsured* patients.

- The hospital had a legitimate rationale for revising its emergency department on-call coverage policy, being that the hospital was struggling to keep needed specialists on-call.

- The hospital would offer the proposed arrangement to *all* physicians and would impose *responsibilities* on them, such as requiring physicians to respond to call within 30 minutes, to evaluate patients in person, and to provide clinically appropriate care.

- The government believed that the proposed arrangement was an "equitable mechanism for the hospital to compensate physicians who actually provide care that the hospital must furnish to be eligible for [state program] funding and so conferred a public benefit."

The OIG made note of the following additional facts and trends related to on-call coverage issues experienced by the hospital in question, which, I believe, may have also been relevant to the OIG's analysis and to its reaching a favorable conclusion:

- The hospital's existing bylaws provided that all members of its active medical staff provide on-call coverage for its emergency department, and the hospital paid no compensation to physicians for such coverage. However, the hospital reported that most physicians "dislike the duty of performing on-call coverage" and that one of its specialty practice groups had "reduced its weeks of Emergency Department coverage to the minimum required under the hospital's policy, citing no payment for on-call services."

- The hospital reported that ". . . whereas its physicians historically performed on-call coverage out of a sense of duty to their profession, that sentiment is no longer shared by all; rather, the physicians commonly view on-call coverage as an unwanted obligation, jeopardizing the hospital's ability to serve patients."

- The state in which the hospital is located participates in a federal matching-funds program that meets federal requirements to provide additional payments to hospitals that provide a disproportionate share of uncompensated services to the indigent and uninsured (as does Texas and under which hospitals located in and around Nueces County receive such additional payments). However, physicians do not have any similar mechanism for compensating them for services provided to the indigent and uninsured and, unlike the hospital, provide such services without compensation.

In general, the OIG recognized that the hospital had legitimate reasons for entering into the proposed compensation arrangement with on-call physicians and that the payment

method the hospital had developed in connection with the proposed arrangement had been structured so as to minimize the potential for violating the anti-kickback statute.

Advisory Opinion 07-10: *Per Diem* Compensation for Being On-Call. On September 27, 2007, the OIG posted advisory opinion no. 07-10 (the "2007 opinion"), which, like its 2009 opinion, involved a request made by a non-profit hospital to the OIG to review a proposed arrangement to compensate on-call physicians serving its emergency department. Many of the factual elements described in the 2007 opinion are the same as or similar to those at issue in the 2009 opinion. For example, nearly one in four patients visiting the emergency room of the hospital had no insurance coverage and, of these uninsured patients, one in ten would be admitted to the hospital for inpatient care. The growing number of indigent patients arriving at the hospital's emergency department had "depleted the local supply of various types of physicians providing [emergency department] on-call coverage and uncompensated follow-up care . . ." As a result, the hospital ". . . consequently had to transfer [emergency department] patients to other medical facilities . . ." In response to these circumstances, the hospital formed an *ad hoc* committee of hospital board members that developed a plan under which members of the hospital's medical staff in certain specialties would provide emergency department on-call coverage and provide inpatient care for uninsured patients. In return, the hospital would pay the participating physicians a *per diem* rate for each day spent on-call. The *per diem* rate would vary among specialists based on a variety of factors and would be consistent with fair market value.

Based on an analysis similar to the one set forth in its 2009 opinion, the OIG concluded that it would not impose administrative sanctions on the hospital requesting the advisory opinion under the federal anti-kickback statute.

Despite the similarities involved in the two advisory opinions, the 2007 opinion differs from the 2009 opinion as to how on-call physicians are to be paid. The 2009 opinion involves a proposed arrangement in which on-call physicians are to be compensated only for those services provided to indigent and uninsured patients according to a fee schedule, whereas the proposed arrangement involved in the 2007 opinion proposes to pay on-call physicians a *per diem* rate for each day spent on call regardless of the number of services provided to indigent and uninsured patients. The fact that the OIG reaches a favorable conclusion for the parties in each of the two advisory opinions, which deal with fairly similar circumstances, even though the proposed compensation methods differ, is encouraging, as it indicates that the OIG may allow requesting parties some flexibility in developing solutions that work best for their particular situation. As to the core standard by which the OIG analyzed the propriety of the proposed arrangement involved in its 2007 opinion, the OIG stated that:

> *". . . with respect to compensation for on-call coverage, the key inquiry is whether the compensation is: (i) fair market value in an arm's-length transaction for actual and necessary items or services; and (ii) not determined in any manner that takes into account the volume or value of referrals or other business generated between the parties. We believe it should be possible for parties to*

> *structure on-call payment arrangements that are consistent with this standard and therefore pose minimal risk under the [anti-kickback] statute."*

Again, as in its 2009 opinion, the OIG recognized that the hospital had legitimate grounds for entering into the proposed compensation arrangement and that the plan the hospital had developed in connection with the proposed arrangement had been structured so as to minimize the potential for violating the anti-kickback statute.

Relevance of Advisory Opinions to Our Healthcare Community: In summary, as the number of uninsured and underinsured patients continues to rise in Nueces County and surrounding counties, as in the rest of the nation, both hospitals and physicians will continue to struggle to serve the needs of such patients. To some extent, the 2009 opinion and 2007 opinion may be used to help alleviate this problem, as they offer hospitals and physicians a regulatory road-map for structuring emergency department on-call compensation arrangements so as to satisfy legal requirements. By so doing, these advisory opinions offer a means by which hospitals can address on-call physician shortages, physicians can provide on-call services in an economically viable manner, and, perhaps best of all, our community can better serve the healthcare needs of those among us who are indigent and uninsured.

Craig S. Smith is a partner at the Welder Leshin LLP law firm in Corpus Christi, Texas, where he and his wife, Tracey Smith, practice health law. Mr. Smith is Board Certified in Health Law by the Texas Board of Legal Specialization and is a graduate of The University of Texas at Austin (1986) and the University of Texas School of Law (1989). Tracey Smith, who assisted in the preparation of this article, is a former Assistant General Counsel to M.D. Anderson Services Corporation in Houston, Texas, where she routinely handled legal issues specific to physicians and health care facilities. Ms. Smith is a graduate of Princeton University (1989) and The University of Texas School of Law (1995).