The First OIG Opinion on Hospital Pay for Call

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THE EMERGENCY MEDICAL TREATMENT and Active Labor Act (EMTALA) requires hospitals to provide emergency treatment to patients regardless of their ability to pay. However, EMTALA does not extend this obligation to physicians.

Consequently, many hospitals find themselves between a rock and a hard place because of shortages of physician specialists and the increasing unwillingness of physicians to provide emergency care without compensation.

Some hospitals have responded to this quandary by entering into transfer agreements with neighboring hospitals, while others have established minimum call coverage requirements for medical staff membership through hospital and medical staff policies.

Still others have resorted to paying physicians for emergency department call coverage and uninsured patient services. Such call coverage agreements are not inexpensive or simple. According to the California Hospital Association, hospitals in California pay over $600 million a year in on-call coverage payments. Further, agreements between hospitals and physicians are tightly regulated by federal and state laws and, therefore, must be carefully structured.

The Office of the Inspector General (OIG) recently issued its first opinion regarding application of the federal anti-kickback law to emergency department call coverage agreements, providing welcome guidance to hospitals and physicians that have, or are considering, such arrangements.

The anti-kickback law broadly prohibits the payment or receipt of compensation for referrals, and carves out numerous safe harbors for arrangements deemed to pose little risk of fraud and abuse. It is not necessary for an arrangement between a hospital and physician to fit within a safe harbor, but doing so may reduce exposure to possible civil monetary penalties, imprisonment and automatic exclusion from federal health care programs.

The arrangement at issue in OIG Advisory Opinion 07-10 is typical of many call coverage arrangements that fall just short of meeting the four corners of an anti-kickback safe harbor, making the OIG's reasoning and conclusion of particular interest.

Under the arrangement, physicians participate in a monthly call schedule, respond to calls within a prescribed time, provide 1.5 days per month of coverage gratis, provide follow-up care to patients admitted through the ED regardless of their ability to pay, and participate in the hospital's quality assurance programs. The hospital, in turn, pays physicians a per diem based on whether coverage occurred on a weekday or weekend and the extent of each specialty's responsibility for uncompensated care responsibilities. An independent consultant reviewed the per diem stipends and concluded that they were

consistent with fair market value.

At the outset of its opinion, the OIG recognized that hospitals face increasing pressure to compensate physicians for call coverage and that there were legitimate reasons to do so, as described above. It noted, however, that the proliferation of such arrangements creates the risk that physicians might unlawfully demand compensation for call coverage as a condition for doing business at the hospital, or that a hospital might illegally use such arrangements to entice physicians to join or remain on the hospital's medical staff or to refer business to the hospital.

Thus, the OIG emphasized that the facts and circumstances of each call coverage arrangement must be evaluated to assure that compensation is fair market value for actual and necessary items or services, and that compensation is not determined in a way that considers the volume or value of referrals or other business generated between the parties.

After considering the background and details of the arrangement in question, the OIG ultimately approved it, based on several key findings. First, the OIG found merit in the hospital's position that the per diem payments to physicians were fair market value for actual services needed and provided because physicians were required to do more than just be "on call" - they were obligated to provide "substantial, quantifiable services" that justified the per diem payments under the arrangement.

Second, the OIG determined that the hospital's understaffed ED and its consequent outsourcing of emergency care was indicative of a legitimate, unmet need for on-call coverage and uncompensated care services.

Third, several features of the call coverage arrangement minimized the risk of fraud and abuse, including that participation in the arrangement was offered uniformly to all physicians in the relevant specialties; call obligations were divided among participating physicians as equally as possible (so as not to reward high referrers); physicians were required to provide inpatient follow-up care to every patient admitted after being seen in the ED regardless of ability to pay (reducing the risk of "cherry-picking" patients); and physicians were required to document services in medical records (thereby promoting transparency and accountability).

Fourth, the OIG determined that the hospital's call coverage arrangement promoted the hospital's charitable mission by facilitating better emergency and uncompensated care to patients in the hospital's community.

Finally, as icing on the cake, the OIG commented that all costs associated with the arrangement were absorbed by the hospital and were not passed on to federal health care programs.

Some questions remain in the wake of OIG Opinion No. 07-10, such as determining at what point it becomes appropriate to compensate physicians for providing ED coverage and uncompensated care; the extent to which the fair market value must be documented and supported (i.e., whether an outside consultant opinion is always necessary); and the level of substantial, quantifiable services, in addition to "being on call," that should be a part of a call coverage arrangement.

Further, the OIG's opinion does not address the physician self-referral law (a.k.a. the Stark law), which is always a consideration when hospitals and physicians enter into arrangements.

Nevertheless, for hospitals considering call coverage arrangements as a mechanism for assuring sufficient emergency department coverage and uncompensated care services, the OIG's analysis and conclusions provide guidance as to how they might best be developed.

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