Executive Briefing
Emergency Department Call Coverage Payment Solutions

The U.S. Department of Health & Human Services’ (HHS’s) Office of Inspector General (OIG) recently issued Advisory Opinion 12-15, addressing an existing arrangement under which a hospital pays a per diem fee to physicians for on-call coverage at the hospital's emergency department (ED). This is the third advisory opinion that the OIG has provided related to ED call coverage arrangements. Together, Advisory Opinions 07-10, 09-05, and 12-15 provide guidance to hospitals developing and maintaining call coverage arrangements. This Executive Briefing summarizes our thoughts on the key takeaways from the advisory opinions and implications for payments under these arrangements.

What We’ve Learned

Advisory Opinion 07-10
Advisory Opinion 07-10 describes a per diem call coverage payment arrangement that the OIG considered to be appropriate. It states that per diem payments “lower the risk that the arrangement is a vehicle to disguise payments for referrals.” As a result, per diem fees now represent the most prevalent payment mechanism to pay for ED call coverage. In addition, the OIG opinion favors the hospital’s tiered per diem payments as a payment system that recognizes the burden of call on the individual specialties, as well as the difference in weekday and weekend call.

Advisory Opinion 09-05
Advisory Opinion 09-05 is unique in that the OIG reviewed a payment methodology reimbursing on-call physicians for uncompensated care. Under the arrangement reviewed in this opinion, physicians submit a claim request form to the hospital to receive payment for services rendered in the ED. The physicians are compensated only for time they spend providing services in the ED to uninsured patients. The physicians must waive all billing and collection rights and claims against any third-party payor and the patient. The OIG noted that these limitations eliminate the risk that a physician could be paid twice for the same service by collecting from the hospital under the agreement and also from an insurer or the patient.

Advisory Opinion 12-15
Similar to Advisory Opinion 07-10, Advisory Opinion 12-15 describes a per diem payment arrangement. In the arrangement reviewed in Advisory Opinion 12-15, the payment by specialty is determined by the burden of providing coverage considering factors specific to the organization. However, the arrangement did not recognize a differential between weekday and weekend call. The OIG identified several features that supported the independent verification of FMV, including the fact that the payment appears tailored to reflect the burden on a participating physician in a particular specialty. In addition to looking at available survey data, hospital administrators should quantify the burden of call on the participating physicians to ensure that payments are appropriate.

Key Takeaway

Given the uncertainty regarding fair market value (FMV) for call coverage payments, a more comprehensive analysis considering the unique factors contributing to the burden of call is required. Simply relying on reported benchmarks in surveys is often inadequate to capture the unique factors facing physicians.
So What? – Implications for Call Coverage Payment Models
In designing a call coverage payment system, administrators should consider incorporating the elements described below.

Preference for Per Diem Payments or Reimbursement for Uninsured
The OIG has looked favorably on per diem payment rates that account for the burden of providing coverage as well as reimbursement for uninsured patients. In contrast, activation fees that pay physicians who are adequately reimbursed by third parties could potentially be construed as payment for referrals. The OIG has not provided an advisory opinion for an arrangement that provides both per diem payments and additional payment for uninsured/indigent patients, although such models are common.

- **Per Diem Payments** – Based on commentary in the advisory opinions, we can infer that the per diem rates should take into account the expected frequency and duration of on-call physician activations, particularly for uninsured patients. Per diem rates should be consistent for all physicians within a particular specialty but may vary based on when the services are to be provided because of the greater personal burden that is imposed by call coverage responsibilities during more inconvenient times. The FMV assessment for the per diem payments should consider the expected un-reimbursed care, activation frequency, and relative burden of the call schedule.

- **Uninsured Versus Underinsured Patients** – While the OIG’s comments directly reference un-reimbursed care, they do not specifically address under-compensated care (e.g., Medicaid in most states). Although the OIG states that it views compensation structures that pay on-call physicians for professional services for which they receive reimbursement from insurers or patients as problematic and potential sources of kickback payments, it does not specifically state whether this view would also apply to underinsured patients.

Opportunity for All Physicians to Participate
All physicians on the medical staff should be able to participate in a hospital’s call coverage program. Participation in the program should be governed by the medical staff’s bylaws, be uniform within each specialty, and should not be used to selectively reward high referrers. Payments by specialty should be set annually, in advance, based on a uniform methodology.

Payments for Actual Services
Participating physicians should provide actual and necessary services for which they are not otherwise compensated – for example, a stipulation that participating physicians must respond to the hospital within 30 minutes or a requirement that they provide un-reimbursed follow-up care.

There remains a great deal of uncertainty about FMV for the variety of on-call pay structures that exist in the marketplace. For example, a call schedule that involves frequent activation with a high number of uninsured patients will generally have a higher value than a call schedule with infrequent activation and a high proportion of commercial insurance. As a result, hospitals should be aware that simply referencing the limited market benchmarks available for call coverage cannot adequately account for the myriad of relevant factors. A more comprehensive analysis is generally necessary to increase the likelihood that call payments are within FMV and appropriately account for the burden of call coverage.

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