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Hospitals Settle Cases Over Call Payments, Rent; Hybrid Calls May Affect Compensation

By Nina Youngstrom

Overly generous deals with physicians—for call coverage, office space, equipment and other perks—are variously alleged in three recent civil monetary penalty settlements with an Ascension hospital and two hospitals now part of Ascension. These kinds of allegations continue to pop up as hospitals and health systems strive to keep physicians happy without running afoul of the Anti-Kickback Statute (AKS) and Stark Law.

Hospitals often pay physicians for being on call to the emergency room, with compensation affected by a growth in hybrid calls, a physician shortage and an increase in freestanding emergency departments (EDs). "There's more call for a shrinking population of physicians," said Don Crawford, a partner in HMS Valuation Partners.

In the settlement about call coverage, Ascension St. John Medical Center in Oklahoma agreed to pay $556,717 to settle allegations that it paid remuneration to a group of referring physicians "in the form of above-fair market payments for on-call services for general surgery and trauma surgery," from Feb. 1, 2014, through June 30, 2020. According to the settlement, the HHS Office of Inspector General (OIG) alleged the hospital violated the civil money penalties authorities that prohibit remuneration to induce referrals and billing for designated health services while in a prohibited financial relationship. The settlement, which was obtained through the Freedom of Information Act (FOIA), stemmed from the hospital's self-disclosure to OIG. Ascension's compliance officer, who signed the settlement, didn't respond to *RMC*'s request for comment.

The compliance risk for call coverage may be intensifying with the shortage of physicians and their level of burnout. "There's a lot of pressure on health systems related to physician recruitment and retention," said Catherine Martin, chief compliance officer at Luminis Health in Maryland. "They're asking for higher dollars and as an organization you need to support what you're paying" and document accordingly. With the push for more call-coverage dollars, it's important to "look at the entire relationship with the physician" in terms of fair market value (FMV) and commercial reasonableness.

Documentation of compensation for call coverage should paint a picture of both the need for the specialists and the on-call burden placed on them (i.e., how many calls they take), Martin said. "You're paying for time they're not spending with their own patients," she explained. "If it's a heavy call burden, that provides support for paying them a higher dollar amount." The opposite is true with physicians who take call occasionally or never have to show up when they're on call.

A physician compensation committee at Luminis reviews physician arrangements in the higher percentile of national survey data for their specialty (i.e., 75th percentile or above). "The committee reviews the documentation to support community need and make sure everyone is comfortable with the total compensation package," Martin said. To supplement its reviews, the committee has added an FMV calculator developed by a vendor. "You plug in the information about the proposed arrangement, and the calculator provides an analysis of FMV and commercial reasonableness," she said. "It will flag anything that may need further review or further documentation to support the payment review. It's a great use of technology and a way to standardize what

you're doing in terms of physician compensation and documentation."

Hybrid Calls and Other Factors Affecting Value

Developments in recent years have affected the calculus of call compensation. "One trend we're seeing is call agreements, including a requirement for on-site coverage during a portion of the 24-hour shift—a hybrid shift," said Joe Aguilar, a partner in HMS Valuation Partners. Hybrid call arrangements are showing up in certain specialties like gastroenterology. He refers to them as hybrid because the call contract requirement is modeled on a traditional off-site unrestricted call shift but also has a direct or implied on-site restricted coverage requirement. "This is important because the value of off-site unrestricted coverage is less than on-site restricted coverage. By recognizing the value difference, hospitals have been able to bridge the gap between compliance and the increased call compensation demands from physicians," Aguilar explained. "What the hospital needs to think about in terms of compliance is whether or not the on-site requirement aligns with the burden" (e.g., volume of patients, complexity of care and/or overall physician efforts to care for the patient on-site). Hybrid call arrangements may help hospitals accurately reflect the facts and circumstances of the call service, Aguilar noted.

Another development is the use of advanced practice providers (APPs), such as physician assistants and nurse practitioners, to serve as first call and/or follow up with surgery patients after the physician completes the call, Crawford said. Sometimes hospitals supply their employed APPs to the physician, which is a risk under the AKS and Stark Law. "The surgeon is potentially getting free services provided by the hospital," he noted. "Setting aside any billing compliance concerns, that should be taken into account inside the valuation." However, many states require APP supervision by a physician, and a physician providing call may supervise an APP as part of the coverage but not receive extra payment for it, said Chip Hutzler, a partner at HMS Valuation Partners. "The question is whether people have done the math to include the value of supervision in the calculation."

Hospitals also should be alert to compensation for concurrent calls, Aguilar said. When physicians agree to be on call at two ERs at the same time, "you can't always have that value doubled." A significant component of the call value is associated with the availability of that particular provider and "a particular provider can't be available more than once during any given period," he explained.

Sometimes physicians take concurrent calls at hospitals owned by different health systems, Crawford noted. "It's potentially a risk of whether you will have the doctor if you need them. The hospital is paying for a service and the question is whether they're able to deliver it," he explained. Physicians also must cover freestanding emergency departments (EDs), "spreading doctors a little thin," Crawford said. It's on the physicians to ensure they have a back-up plan if they're needed at more than one ED at the same time "and the two facilities don't talk to each other," Hutzler added. But hospitals also have to worry about compliance with the Emergency Medical Treatment and Labor Act.

In rural areas in particular, doctors may be traveling longer distances to answer calls because of coverage shortages, Hutzler noted. "It's a nuance, but it impacts the cost of securing call coverage."

Real Estate Is Focus of Other Settlements

Other types of arrangements led to two civil monetary penalty settlements with Presence hospitals. According to Ascension's website, Presence is now part of Ascension.

In one of the settlements, Presence Chicago Hospitals Network agreed to pay $577,433 in connection with OIG's allegations that two of its hospitals paid remuneration to physicians and/or physician practices in the following ways:

- Presence Saints Mary and Elizabeth Medical Center provided free or below FMV space and medical record copying services to a physician between May 1, 2015, and Dec. 17, 2020. The hospital also provided free or below FMV space to a physician from Jan. 1, 2017, through July 7, 2023.
- Presence Saint Joseph Hospital-Chicago provided free or below FMV space, equipment, furniture, technology and staff to a physician between Dec. 1, 2015, and May 15, 2023.

In the other settlement, Presence Central and Suburban Hospitals Network in Illinois agreed to pay $174,421 over remuneration paid to physicians by two of its hospitals. According to the settlement, at Presence St. Joseph Hospital-Elgin, remuneration was paid to a physician "in the form of the free use of approximately 25 square feet of space" in which the physician performed radiology services unrelated to the hospital from May 1, 2016, through May 31, 2022. Also, at Presence Mercy Medical Center, remuneration was paid to a physician "in the form of the free use of approximately 27 square feet of space," in which radiology services unrelated to the hospital were performed, from May 1, 2016, to July 31, 2022.

None of the hospitals admitted liability in the settlements, which all stemmed from self-disclosures to OIG.

Even when real estate isn't driving settlements, it shows up in a fair number of them, said attorney Bob Wade, with Nelson Mullins in Nashville, Tennessee. He said if there were a reality show for compliance officers and the winner finds inappropriate financial relationships the fastest, "If the billing office is 10 feet away and the real estate office is 10 miles away, I'd be sprinting to the real estate office."

The peril grows when real estate managers at health care systems lack the training and expertise to help ensure compliance with the Stark Law, Wade said. "A bad scenario is when real estate is only one part of a person's job," he noted. Among other things, the real estate manager should ensure that referring physicians who rent hospital-owned space are paying rent on time and that ancillary items and services are factored into rent (e.g., cleaning services, common-area maintenance, furniture, equipment and renovations). Every month, someone should walk through all space tied to a lease agreement and ensure it's consistent with the terms, Wade said. That will help identify whether, for example, a physician in a time-share is encroaching on space they don't pay for.

There are three types of leases, Wade explained:

- **Gross rent:** All expenses, including utilities, taxes and maintenance, are included in the rent.
- **Triple net rent:** Rent per square foot is lower than tenants pay with gross rent, but they pay for common area maintenance in addition to rent.
- **Modified triple net:** The most common version is a certain amount charged per square foot with increases from the baseline for common area maintenance.

A problem he has seen with triple net rent is using it to justify the gross. The referral source may pay a small additional amount for common area maintenance, but the hospital supplies everything else.

He has also seen problems with tenant improvements. The negotiated payment for the space includes upgrades, but the physician has Brazilian hardwood in mind instead of linoleum. That's fine—the hospital can put in a gold toilet if that's what the physicians want—but if the cost isn't factored into the lease payment, "they will be underpaying," Wade said.

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