WHAT TO CONSIDER WHEN STRUCTURING A HOSPITAL-BASED COVERAGE AGREEMENT

by Joe Aguilar

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With the goal of increasing quality of care while containing costs, hospitals and healthcare systems are focused on reducing lengths of stay, decreasing complication rates, and cutting readmission rates. One way to effectively accomplish these objectives is purchasing hospital-based service line coverage from physicians and/or clinical management groups. These arrangements involve a wide range of specialties, including, but not limited to, hospital, intensive care, emergency medicine, obstetrics and gynecology, trauma surgery, radiology, and neonatology services.

With shrinking reimbursements and increasing provider salaries, healthcare systems are perpetually contending with increased compensation demands by contractors.[1] For example, proposed changes to the rules associated with balance billing raise concerns over their impact on contractor revenues.[2] As a result, hospitals are feeling pressure from contractors to increase the compensation terms within their professional services agreements (PSAs). These market and regulatory factors will continue to challenge both the system and compliance professionals.

As hospital-based programs increase in number throughout the country to meet these challenges, compliance professionals within hospitals and health systems will encounter a wide variety of PSAs. It is important to consider the structure of these agreements and their impact on compliance. Three key items to consider are: (a) the difference between a collection guarantee and subsidy arrangement, (b) terms that can mitigate financial and/or compliance risk, and (c) the use of advanced practice providers (APP).

Understanding the difference: Collections guarantee versus interval subsidy payments

As you consider a PSA, it is critical to understand the method of compensation. While there are many nuances to these types of agreements, the compensation structure is typically either a collections guarantee or an interval subsidy. There are many similarities between the two structures. The following operational and financial indicators are key drivers to both forms of compensation:

- Resources required of the contractor in fulfillment of the PSA;
- Level of restricted on-site coverage;
- Staffing differences (physician vs APP);
- Provider compensation, benefits, and malpractice costs; and
- Expected collections and operating expenses for the services required.

While each indicator above has an impact on the fair market value (FMV) compensation, the structure of the compensation term can vary dramatically.

Collections guarantee

Collections guarantee means the payment amount to the contractor is variable. The subject agreement stipulates a maximum annual collections figure that the purchaser shall guarantee. However, the amount actually paid to the contractor is a function of the contractor's collections. An example of typical language used in such subject agreement is: "Purchaser shall compensate contractor an amount by which the contractor's collections are less than the maximum collections guarantee." See Table 1 for the calculations for three months.

Table 1: Collections guarantee quarterly reconciliation

		Month 1	Month 2	Month 3	Quarter reconciliation
Professional collections	A	$110,000	$250,000	$90,000	$450,000
Collections guarantee	B	$200,000	$200,000	$200,000	$600,000
Purchaser payment	B-A	$90,000	($50,000)	$110,000	$150,000

There is typically a reconciliation of payments done at certain intervals (i.e., quarterly and/or annually). Table 1 illustrates quarterly reconciliation, where the purchaser would not typically be obligated to pay or receive anything in the second month. At the end of the quarter, the parties will reconcile total payments against the total guarantee. As such, the contractor will always have $200,000 per month in funds to use for the services. However, the greater the amount the contractor collects for the professional services provided, the less the purchaser will pay and vice versa.

Interval subsidy

The interval subsidy is a predetermined rate paid based on a specific interval of coverage (per 24-hour shift, monthly, etc.) stipulated in the subject agreement. Regardless of the contractor's collections, the interval subsidy does not change. It is a fixed amount regardless of collections performance or production volume. As such, there is no reconciliation of payments. Table 2 illustrates the calculation for three months.

As can be seen in Table 2, the contractor's funds to cover the cost of the service change whether the collection performance is high or low in a particular month. The greater the contractor's collections, the greater the overall revenues they will receive for the service.

Now that we understand the methods of compensation, let's see their impact on the purchaser's payments in Table 3.

As you can see, at face value, there can be a significant difference between the two methods of compensation. In the example in Table 3 associated with a hospitalist program, the annual subsidy is $865,000, while the annual collections guarantee is $1,365,000. Using $1,365,000 as the FMV limit when the agreement terms are structured as a subsidy could lead to an overpayment to the contractor of $500,000 ($1,365,000 minus $865,000). As can be seen through this

Table 2: Total subsidy quarterly payments

		Month 1	Month 2	Month 3	Quarter payments
Professional collections	A	$110,000	$250,000	$90,000	$450,000
Subsidy	B	$50,000	$50,000	$50,000	$150,000
Purchaser payment	A+B	$160,000	$300,000	$140,000	$600,000

Table 3: Collections guarantee versus subsidy for a hospitalist service

		Base year: FMV analysis	Annual subsidy	
Professional collections	A	$500,000	$500,000	1. The FMV under an annual collections guarantee is typically derived from multiple methods; however, for the purposes of understanding Table 3, it is based on the sum of all the operating expenses for the program (B+C+D+E+F). 2. The FMV under an annual subsidy is also typically derived from multiple methods; however, for the purpose of understanding Table 3, it is based on the net loss for the service (A-B-C-D-E-F). 3. The purchaser's payment represents the hospital payment to the contractor. The numbers in Table 3 are for an annual subsidy of $865,000. As a result, the purchaser's payment to the contractor is $865,000. 4. The funds available to the contractor represents the sum of the purchaser's payment (annual subsidy) plus professional collections the contractor generates while covering the service.
Physician compensation	B	($1,000,000)	($1,000,000)	
APP compensation	C	($150,000)	($150,000)	
Physician malpractice	D	($60,000)	($60,000)	
APP malpractice	E	($5,000)	($5,000)	
Operating expense	F	($150,000)	($150,000)	
Net income/loss	G	($865,000)	($865,000)	
FMV annual collections guarantee	B+C+D+E+F[1]	$1,365,000	N/A	
FMV annual subsidy	G[2]	N/A	$865,000	
Purchaser payment	G[3]	$865,000	$865,000	
Total funds available to contractor	B+C+D+E+F[4]	$1,365,000	$1,365,000	

Table 4: Growing hospitalist service

		Base year: FMV analysis	Year 1: Growth in collections	Year 2: Growth in collections	
Professional collections	A	$500,000	$750,000	$1,000,000	1. The FMV under an annual collections guarantee is typically derived from multiple methods; however, for the purposes of understanding Table 4, it is based on the sum of all the operating expenses for the program (B+C+D+E+F). 2. The FMV under an annual subsidy is also typically derived from multiple methods; however, for the purpose of understanding Table 4, it is based on the net loss for the service (A-B-C-D-E-F). 3. The funds available to the contractor under a collections guarantee remain the same no matter what the amount of professional collections collected is. The purchaser's payment to the contractor is what changes as professional collections change. As professional revenues increase, the purchaser's obligation decreases. 4. The funds available to the contractor under a subsidy increase with the amount of professional collections collected. Under this arrangement, the contractor will receive the FMV rate of $865,000 per year regardless of professional collections.
Physician compensation	B	($1,000,000)	($1,000,000)	($1,000,000)	
APP compensation	C	($150,000)	($150,000)	($150,000)	
Physician malpractice	D	($60,000)	($60,000)	($60,000)	
APP malpractice	E	($5,000)	($5,000)	($5,000)	
Operating expense	F	($150,000)	($150,000)	($150,000)	
Net income/loss	G	($865,000)	($615,000)	($365,000)	
FMV annual collections guarantee	Pre-determined amount based on B+C+D+E+F[1]	$1,365,000	$1,365,000	$1,365,000	
FMV annual subsidy	Pre-determined amount based on G[2]	$865,000	$865,000	$865,000	
Total funds available to contractor under collections guarantee	See #3	$1,365,000	$1,365,000	$1,365,000	
Total funds available to contractor under subsidy	A + FMV annual subsidy[4]	$1,365,000	$1,615,000	$1,865,000	

example, your system could face a recordable event associated with overpayment if attention is not paid to aligning the FMV result with the actual term of the subject agreement. This is critical from the start of negotiation to the point of signing, as we have seen material terms change at the final stages of negotiations (i.e., converting the terms from a collection guarantee to annual subsidy).

Mitigating financial and compliance risks

From a compliance perspective, these options are not created equal. In fact, each option has the potential opportunity to mitigate both financial and compliance risk. The following are just two possible examples.

Growing hospitalist program

Under a subsidy, the contractor is compensated a fixed amount regardless of collections performance for a specific set of requirements (e.g., physician staffing). With a growing hospitalist service and increasing collections, the contractor could potentially increase their profit margin with a fixed subsidy arrangement. This poses a compliance risk should that profit margin exceed FMV. This can be seen in Table 4.

This arrangement is based on the assumption that physician/APP resources and operatting costs remain constant. In this case, the contractor has an incentive to improve collection performance. Under a collections guarantee, the contractor will have a total of $1,365,000 available to cover the service regardless of the growth in collections. However, under the subsidy arrangement, the contractor keeps all of the additional growth in collections ($500,000) and will have a total of $1,865,000 available by the second year.

Under a collections guarantee, the compensation paid to the contractor will vary based on their collections. The greater the collections, the lower the compensation under the subject agreement, and the lower the collections, the greater the compensation. As such, it is imperative that the purchaser pay close attention to the contractor's collection performance under this arrangement. While there is an FMV compliance risk, this scenario carries a financial risk to the

Table 5: Hospitalist service with good versus poor collection performance

		Base Year: FMV analysis	Poor collection performance	Good collection performance
Professional collections	A	$500,000	$250,000	$750,000
Physician compensation	B	($1,000,000)	($1,000,000)	($1,000,000)
APP compensation	C	($150,000)	($150,000)	($150,000)
Physician malpractice	D	($60,000)	($60,000)	($60,000)
APP malpractice	E	($5,000)	($5,000)	($5,000)
Operating expense	F	($150,000)	($150,000)	($150,000)
Net income/loss	G	($865,000)	($1,115,000)	($615,000)
FMV annual collections guarantee	B+C+D+E+F[1]	$1,365,000	$1,365,000	$1,365,000
FMV annual subsidy	A-G[2]	$865,000	$865,000	$865,000
Total funds available to contractor under collections guarantee	See #3	$1,365,000	$1,365,000	$1,365,000
Total funds available to contractor under subsidy	See #4	$1,365,000	$1,115,000	$1,615,000

1. The FMV under an annual collections guarantee is typically derived from multiple methods; however, for the purposes of understanding Table 5, it is based on the sum of all the operating expenses for the program (B+C+D+E+F).
2. The FMV under an annual subsidy is also typically derived from multiple methods; however, for the purpose of understanding Table 5, it is based on the net loss for the service (A-B-C-D-E-F).
3. The funds available to the contractor under a collections guarantee remain the same no matter what the amount of professional collections collected is. The purchaser payment to the contractor is what changes as professional collections change. As professional revenues increase, the purchaser's obligation decreases.
4. The funds available to the contractor under a subsidy increase with the amount of professional collections collected. Under this arrangement, the contractor will receive the FMV rate of $865,000 per year regardless of professional collections.

purchaser as well. Table 5 illustrates the payment under the subject agreement based on two levels of collection.

It is important to note that the collections for the service across the two examples in Table 5 assume the same payer mix and potential collectability but differentiates the contractor's collection performance. Under a collections guarantee arrangement, it does not incentivize the contractor to increase collection performance. As the table illustrates, the contractor receives a combination of funds from professional collections and the collections guarantee, but never receives more than the total of $1,365,000 per year. However, under a subsidy arrangement in the table above, the total funds varied from $1,115,000 to $1,615,000, depending on collection performance.

Other strategies to mitigate compliance risk include: (a) establishing a maximum subsidy in the context of a collections guarantee structure, (b) assigning a cap to the contractor's professional collections in the context of a subsidy structure, (c) specifying the hours of restricted and unrestricted coverage in the agreement, and (d) setting quality and performance metrics tied to contractor compensation.

Collections guarantee with a maximum subsidy

The benefit of the collections guarantee is that both parties can share in the financial risk. However, the primary risk to the purchaser associated with such a structure is when the contractor lacks the incentive to collect on their professional services. This risk can be mitigated by contractually setting a maximum subsidy to be paid under the subject agreement. In this case, if the contractor's collections less the guarantee is greater than the maximum subsidy under the agreement, the contractor will only receive the maximum subsidy stipulated in the contract.

Interval subsidy with a cap on contractor's professional collections

The benefit of the subsidy arrangement is that the compensation is fixed, which allows both parties to establish a fixed budget for the service. However, as stated above, the contractor has the potential to increase their collection performance while the purchaser remains contractually obligated to continue compensating them at the same subsidy. Collection performance can improve through increased collectability on the same volume of services or through an increase in volume. Either scenario has a potential material impact on the FMV subsidy. Should the subsidy payment exceed the FMV, the arrangement is subject to a compliance risk. Establishing a trigger to review the compensation terms based on an annual cap on the contractor's professional collections can help guard against overpayment. It also can ensure that the subsidy payment aligns with any potential volume increases.

Increase specificity regarding contractor's coverage requirement

Hospital-based coverage agreements are written with varying degrees of specificity regarding the contractor's coverage requirements. At a minimum, it may only specify that the contractor is to provide 24/7 coverage without reference to the type of provider and/or level of coverage. Under these contract requirements, the contractor could satisfy the requirement by providing off-site call coverage with an APP. To ensure that the contractor is providing the necessary coverage consistent with the FMV support, it is recommended the coverage requirements be detailed and, at a minimum, include the type of provider, hours of restricted coverage, and minimum response time. The FMV support should mirror these requirements in order to establish the appropriate compensation.

Quality and performance metrics

Whether the agreement compensation terms take the form of a collections guarantee or an interval subsidy arrangement, the purchaser has a desire to ensure that the patient care within the service line being covered maintains a high level of quality. To achieve this, the purchaser can incorporate specific quality and performance metrics tied to the contractor's overall compensation. For instance, if a service line contractor fails to achieve the target door-to-balloon time metric stipulated in the agreement for a patient with ST-segment elevation myocardial infarction heart attack, they will receive a lower compensation amount. The addition of this type of term will help align the incentives of both parties to increase patient care quality. It is important to note that the overall compensation inclusive of any quality/performance compensation needs to be within the FMV.

Use of advanced practice provider

APPs are increasing in numbers across the US healthcare system and are becoming more commonly used within hospital-based specialties. The term APP typically includes nurse practitioners, physician assistants, certified nurse midwives, and nurse anesthetists. According to the American Academy of

Nurse Practitioners 2019 Database, there are more than 270,000 nurse practitioners in the United States.[3] In 2018, there were more than 115,000 practicing physician assistants.[4] While the professions have their origins in primary care and surgical specialties respectively, their numbers are increasing within hospital-based specialties as well. More than 40% of full-time practicing nurse practitioners have hospital privileges,[5] and around 25% of the employed physician assistants practice in a hospital setting.[6]

Considering this, how could their presence potentially affect compliance risks?

Adding or subtracting APPs from the service line

As discussed above, one of the key drivers of value in a hospital-based coverage agreement are the provider resources required of the contractor. As such, the subject agreement should stipulate the required physician and APP resources to be provided by the contractor. In reality, APPs get added and removed from these hospital-based services frequently without consideration for the subject agreement compensation terms. Adding and/or removing APPs can affect the value, since the APP resource costs will increase or decrease based on their use. If they remove an APP full-time equivalent (FTE), the resource cost will decrease, and the associated compensation terms should be reduced accordingly. See Table 6 for examples.

Under a 4 physician FTE/4 APP FTE model, the annual collections guarantee and annual subsidy amounts are greater than if there were only 4 physician FTEs and 2 APP FTEs in the model. Not stipulating the coverage requirement can lead to the contractor providing less than anticipated coverage or possibly a compensation arrangement that is outside of FMV.

Table 6: Varying advanced practice provider FTEs

		4 MD FTEs/4 APP FTEs	4 MD FTEs/2 APP FTEs
Professional collections	A	$1,000,000	$1,000,000
Physician compensation	B	($1,000,000)	($1,000,000)
APP compensation	C	($480,000)	($240,000)
Physician malpractice	D	($60,000)	($60,000)
APP malpractice	E	($12,000)	($6,000)
Operating expense	F	($150,000)	($150,000)
Net income/loss	A-B-C-D-E-F	($702,000)	($456,000)
FMV annual collections guarantee	B+C+D+E+F	$1,702,000	$1,456,000
FMV annual subsidy	A-B-C-D-E-F	$702,000	$456,000

Who employs the APPs for the service line?

It is essential to the value of the subject agreement whether the APPs are employed by the purchaser or by the contractor. This is a distinction that is often overlooked. If APPs are being used but are not employed by the contractor, the costs associated with them should not be a factor in either the subsidy or the collections guarantee. As Table 6 illustrates, there is a significant difference to the subject agreement compensation depending on the APP costs (two versus four APP FTEs) factored into the model. The scenario below looks at it from another perspective.

A hospital employs two nurse practitioners that are being used by a contractor who provides surgicalist services to the facility. These nurse practitioners are primarily used for pre-operative and post-operative services. The surgicalist group bills the global fee associated with the surgeries performed.

In this case, the hospital is allowing its APP employees to provide services that are otherwise captured within the global payment for the surgical service. The surgicalist group is billing, collecting, and keeping the global payment, which includes those services performed by the APPs. As a result, the hospital is providing non-monetary compensation to the contractor in the form of APP services in excess of the limits allowed under the Stark Law and Anti-Kickback Statute.

Thus, having the hospital purchaser employ the APPs being used by a contractor without remuneration exposes the hospital to a compliance risk. If the hospital wishes to employ the APPs, there should be some financial arrangement within legal and regulatory guidelines whereby the contractor pays for use of the APPs at FMV. However, it is preferable for the contractor to employ their own APPs and negotiate for an adjusted collections guarantee or subsidy based on the increased provider coverage.

Potential impact on physician compensation with APP use

Adding APPs to a service to assist with procedures and/or patient visits has an effect on the physician

compensation value even after taking into account the supervisory responsibility. Assuming the same level of production in terms of patient visits and collections, the physician compensation value is typically higher for a physician who performs all those services on their own versus one that uses an APP. The impact of the APP on physician compensation value is multifactorial, but it does need to be considered. The following scenario illustrates this point.

A trauma surgery coverage program is being staffed by four physician FTEs, consistent with the requirement under the agreement with the purchaser. The compensation under the subject agreement was originally based solely on four physician FTEs. As the hospital trauma services increase in volume, the contractor begins complaining about their workload and corresponding subsidy. They wish to either increase the subsidy or request that the hospital provide APPs to assist with the services. The hospital administration decides to hire two APP FTEs to assist. The contractor is satisfied, and the hospital continues paying at the same subsidy rate.

With the additional APP support from the purchaser, the existing compensation terms should be reassessed to ensure that they remain within FMV. In this case, the additional APP support provided by the purchaser will reduce physician workload and have downward pressure on the compensation rate. However, given the increased volume experienced by the contractor, there appears to be a potential need for increased provider coverage, thereby providing upward pressure on the compensation due to the increased coverage burden. Without performing the appropriate due diligence and FMV analysis, the provision of APP support increases the hospital's compliance risk.

Summary

Understanding the compensation terms within the context of the key financial and operational drivers of the hospital-based coverage service is critical to structuring an agreement. Compliance professionals have the unique opportunity to influence this process with some of the considerations noted above. They can incorporate contractual terms that align with the healthcare system's goals while concurrently mitigating the financial and compliance risks. CT

Endnotes

1. Scott Becker and Ayla Ellison, "Hospital revenue cycle trends to watch in 2019 – 8 thoughts," *Becker's Hospital Review*, March 21, 2019, http://bit.ly/2HF4TLi.
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5. "NP Fact Sheet," American Association of Nurse Practitioners, 2019.
6. "Employment Projections," U.S. Department of Labor Bureau of Labor Statistics, accessed February 19, 2020, http://bit.ly/2SHhqnz.

Takeaways

- There are key differences to understand between a collections guarantee and an interval subsidy arrangement when setting the compensation term.
- Detailing contractor coverage requirements, establishing a maximum subsidy payment, and/or setting a professional collections caps in the agreement can mitigate a hospital's financial and compliance risks.
- Quality metrics tied to the contractor's compensation align their incentive with the healthcare system's goal of providing high-quality patient care.
- A contractor's use of advanced practice providers to cover the service will have a material impact on the fair market value compensation range.
- Hospitals should avoid employing advanced practice providers for the purpose of working with contractor physicians to cover a service line without considering remuneration for their services.

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