The Ins and Outs of Hospital Coverage Agreements

Hospitals play a crucial role in healthcare, providing advanced medical services to patients requiring the most acute levels of care from specialized physicians. To ensure adequate physician coverage of various specialty service lines and timely high-quality patient care, hospitals often enter into coverage agreements with independent provider groups. Through these agreements, provider groups provide on-site clinical coverage, unrestricted on-call coverage, and administrative management services to hospitals, often in exchange for the right to bill and collect from patients/payors and compensation payable by the hospital.

In structuring these types of hospital coverage arrangements, due diligence is necessary to ensure the compensation terms are consistent with fair market value (FMV) and maintain compliance with the Stark Law and Anti-Kickback Statute. In this article, we'll discuss the key fair market value and operational considerations for the most common hospital coverage agreement compensation structures.

Compensation Structures

The first step in structuring a service arrangement with an independent provider group is often determining which party will bill and collect for the professional services the group will provide. In many cases, the hospital, especially if affiliated with a larger health system, might enjoy better-contracted rates with major commercial payors due to market bargaining power. Hospitals may also benefit from economies of scale enabling more efficient revenue cycle management. In other cases, a provider group, especially if affiliated with a large national or regional entity, may already have the infrastructure, commercial contracts, and billing and coding expertise within their medical specialty to efficiently bill and collect for its professional services.

This article focuses on considerations in structuring hospital coverage arrangements in which the independent provider group bills and collects for its professional services rendered. Service arrangements in which the hospital bills and collects for professional services are not covered in this article.

Common Compensation Structures When Group Bills and Collects for Professional Services

Provider groups incur significant costs to staff a hospital coverage arrangement including provider salaries, benefits, malpractice insurance premiums, billing and collection, back-office support, and overhead costs.

In some hospital coverage arrangements, the professional collections generated by the group directly from patients/payors are sufficient to cover these expenses. However, in scenarios in which the professional collections generated by the group are not sufficient to cover its costs of providing the coverage, hospitals often pay additional compensation to the group to offset the shortfall of professional collections to costs incurred.

This shortfall may be due to relatively low case volume and collections relative to the on-site and on-call coverage required by the hospital. Additionally, some hospitals serve a high percentage of Medicaid, self-pay, and charity care patients resulting in relatively low professional collections generated by the provider group.

In these types of scenarios, there are two common structures to compensate the provider group: (1) a fixed subsidy or stipend, or (2) a collections guarantee. VMG Health has observed other compensation structures in hospital coverage agreements, but these two remain the most common.

Fixed Subsidy/Stipend Structure

This compensation structure compensates the provider group based on a pre-determined fixed amount to subsidize the group's shortfall in professional collections relative to costs incurred to staff the service line.

Benefits of a Fixed Subsidy/Stipend from a Hospital's Perspective

Easy to Administer: Because of the fixed nature of the compensation structure, this is a relatively simple compensation model to administer for the hospital once the coverage agreement is executed. Once the subsidy is established as FMV at the outset of the arrangement, the hospital pays the group the negotiated amount, typically without the need for data collection or reconciliation. The hospital may refresh the FMV analysis of the fixed subsidy periodically, often every one to two years to ensure the fixed subsidy does not exceed FMV based on changing patient volumes, coverage requirements, or professional collections.

Incentivizes Provider Group to Maintain Efficient Billing and Collection Processes: Because the provider group is receiving a fixed subsidy from the hospital, any collections the provider group receives above the projected professional collections would effectively result in incremental compensation to the group. This might incentivize the provider group to develop and maintain efficient billing and collection procedures.

Drawbacks of a Fixed Subsidy/Stipend from a Hospital's Perspective

Compliance Risk: Conversely, because the subsidy amount payable to the provider group is determined at the outset of the arrangement, there is a risk that the compensation paid by the hospital to the provider group could exceed fair market value if the professional collections generated by the provider group exceed expectations.

Collections Guarantee Structure

A collections guarantee structure compensates the provider group based on the difference between a pre-determined collections guarantee and the actual professional collections generated by the provider group under the coverage arrangement for a given period. The negotiated collections guarantee is typically set at a level meant to cover the projected costs of the provider group to staff the service line.

Benefits of a Collections Guarantee from a Hospital's Perspective

Self-Adjustment Mechanism: Because this compensation structure reconciles the difference between the negotiated collections guarantee and the actual collections generated by the provider group, the compensation payable by the hospital to the provider group self-adjusts for the precise shortfall of the provider group's collections to its expenses incurred to provide the clinical coverage. Therefore, theoretically, the hospital would never overpay or underpay the provider group for periods in which the provider group has higher or lower professional collections than initially projected.

Less Compliance Risk: Because of the self-adjustment reconciliation process of a collections guarantee, if the provider group's collections improve due to more a favorable payor mix, more efficient collections processes, higher patient volumes, etc., then the compensation paid by the hospital would self-adjust for these changes. Therefore, the hospital would have less risk of paying the provider group compensation that exceeds FMV and running afoul of the Stark Law and Anti-Kickback Statute.

Drawbacks of a Collections Guarantee from a Hospital's Perspective

Greater Administrative Burden: Because the compensation structure requires a reconciliation of the negotiated collections guarantee and the actual collections for a given payment period, it may create a greater and more frequent administrative burden to the hospital relative to a subsidy compensation model. The hospital would need to collect accurate revenue data from the group periodically to compensate the provider group for the clinical coverage.

Less Incentive for the Provider Group to Maintain Efficient Billing and Collection Processes: Because the provider group would be compensated for the difference between a negotiated collections guarantee and actual professional collections, its total compensation from staffing the arrangement remains static regardless of professional collections generated. Therefore, there is theoretically less incentive for the provider group to invest resources to bill and collect efficiently for its professional services as the hospital would subsidize any shortfall. This could result in the hospital paying a higher compensation amount if the provider group does not bill and collect efficiently.

Conclusion

Hospital coverage agreements between independent provider groups and hospitals can help improve patient outcomes, reduce healthcare costs, and increase efficiency. Hospital administrators must balance compliance considerations, administrative burden, and operational alignment between the hospital and the provider group. When structuring these arrangements, it's important to understand the risks and benefits of each model and to ensure the compensation structure and amounts result in compensation consistent with FMV.

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