Helping Hospitals Navigate Financial Assistance Arrangements to Secure Specialty Coverage in an Evolving Healthcare Landscape

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A financial assistance arrangement (i.e., a subsidy) is typically a contractual agreement between hospitals or health systems (singularly, Hospital and collectively, Hospitals) and private practice physician groups (singularly, Group and collectively, Groups) for a Group to provide services at a Hospital. In a financial assistance agreement, typically the Group bills and collects for professional services rendered, while the Hospital bills and collects for technical services. At times, a subsidy is needed as the professional collections generated by the Group do not cover the costs of operating the practice, including fair market value compensation for its providers (inclusive of physicians and advanced practice providers (APPs)). Subsidies are common in hospital-based specialties, such as anesthesiology, critical care, emergency medicine, hospitalist, neonatology, pathology, radiology, and others.

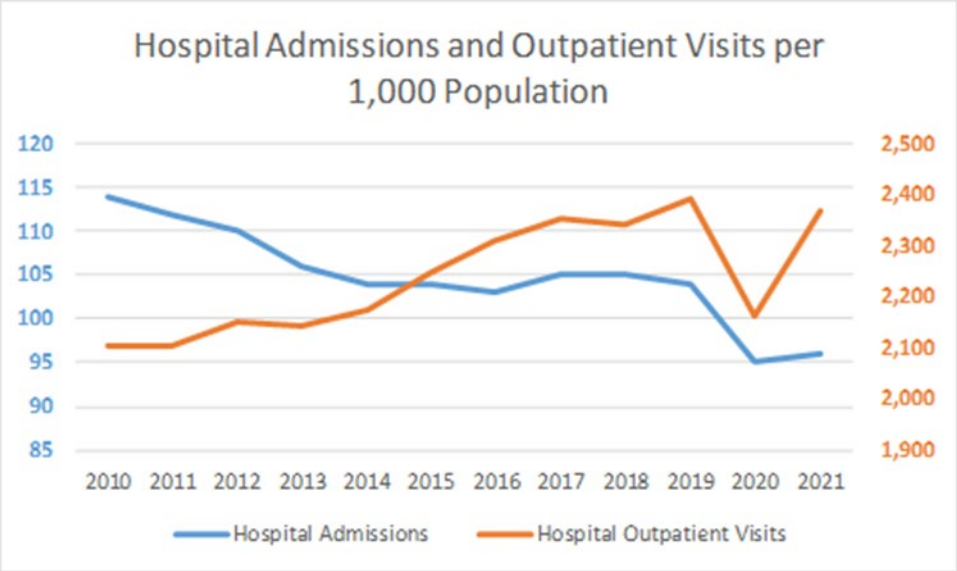
There are a variety of reasons why the professional collections generated by a Group may not cover the Group's costs, including coverage requirements, payer mix, declining reimbursement, and increasing costs. Per PYA experience and recent benchmark data, some Groups are operating at larger losses year over year. While subsidies are not new in the industry, recent industry trends have left many Groups either requesting subsidies for the first time or requesting increases in subsidies already established.

With the substantial increases in subsidy amounts in recent years, it is important to understand current trends affecting financial assistance arrangements, common pitfalls to avoid, and best practices for subsidy arrangements. The facts and circumstances governing each arrangement and the need for such an arrangement vary, and Hospitals should consult with experienced healthcare legal counsel to ensure the structure and associated compensation meets the regulatory requirements of the Stark Law, the Anti-Kickback Statute, and the Internal Revenue Service.

Current Trends

Shift from Inpatient to Outpatient Care

For many hospital-based specialties, Hospitals require coverage 24 hours per day, seven days per week. This coverage requirement continues to be the case even as healthcare delivery shifts towards outpatient versus inpatient care. As shown in the following graphic, hospital admissions per 1,000 population have continued to decline year over year while outpatient visits have continued to increase, excluding 2020 as an outlier for the COVID-19 pandemic.[1],[2] This trend is expected to continue. Per an article published by Guidehouse Center for Health Insights, based on a survey of 182 hospital and health system chief executive officers, chief financial officers, chief operating officers, and other executives, 17% of executives expect a decrease of 10% or more in inpatient volumes in 2023. Further, 95% of executives expect higher outpatient volumes in 2023 with 40% of those expecting increases of 10% or more.[3]



Hospital-based specialties are greatly impacted by this shift in site of care delivery as they must continue to staff the Hospital 24 hours per day despite a reduced number of inpatients. Said another way, Group expenses are held constant, while they are no longer able to bill and collect as much given the reduced number of inpatients. With this shift to outpatient care, more financial assistance may be required if coverage requirements remain the same.

Private Equity Enters Market

The introduction of private equity investors into the healthcare industry is another factor influencing financial assistance arrangements. From 2013 through 2016, private equity investors acquired 355 physician practices. From 2017 through 2020, private equity investors acquired 578 physician practices, a 63% increase in acquisitions.[4] In a hospital-based setting, if investors cannot reduce expenses or effectively negotiate higher managed care contracted rates to obtain required internal rates of returns, they often approach Hospitals seeking more financial assistance.

Decreasing Revenues and Increasing Expenses

Another trend in the industry resulting in new or increased financial subsidies is a decline in revenue coupled with an increase in expenses.

Changes in the Medicare Physician Fee Schedule (MPFS) over the last few years left many specialties, such as anesthesiology, with cuts to reimbursement rates. Even those specialties where reimbursement was not negatively affected, the established rates do not cover or keep pace with the increase in costs associated with operating a practice. Decreases in reimbursement rates affect the collections generated by Groups, particularly Groups with a heavy Medicare population, which results in an increase in the financial assistance needed. Further, even Groups without a heavy Medicare population may be impacted as other payers often use Medicare as a basis for their own reimbursement rates.

Another regulation affecting Groups' ability to generate enough professional collections to cover their expenses is the No Surprises Act (NSA). Effective January 1, 2022, the NSA applies to services furnished by an out-of-network provider at an in-network facility and most affected anesthesiology, emergency medicine, hospitalist, intensivist, neonatology, pathology, and radiology Groups. Groups are not necessarily in-network with all the same payers or payer plans as the Hospital where the services were provided, meaning they could historically bill patients at a higher out-of-network rate. Where NSA is applicable, a Group cannot charge patients more than the in-network cost sharing amount and is required to furnish good faith estimates of charges to patients. Groups who may have had an

out-of-network strategy for managing payer relationships can no longer take advantage of that strategy. Over time, this change may be something Groups can remedy if they work to go in-network and negotiate better contractual rates. However, in the interim, Groups may be unable to collect consistent with the past results, leading to a decline in revenues and compelling them to seek higher subsidies to offset this financial setback.

In reviewing national survey data from multiple sources, the average total compensation at the median for anesthesiology and hospital medicine was approximately $475,000 and $320,000 in 2023, respectively. For these same specialties in 2022, the average total compensation at the median was approximately $445,000 and $305,000, respectively. Additionally, professional collections per FTE physician were approximately $435,000 and $230,000 in 2023 and $425,000 and $235,000 in 2022 for anesthesiology and hospital medicine, respectively. While compensation increased approximately 7% and 6% in one year for anesthesiology and hospital medicine, respectively, professional collections only increased approximately 2% for anesthesiology and decreased approximately 2% for hospitalist medicine further widening the gap between a Group's expenses and professional revenue. This trend is seen for many hospital-based specialties; anesthesiology and hospital medicine were chosen here for illustrative purposes only.

Provider compensation is not the only expense to increase in recent years, particularly since the onset of the COVID-19 pandemic. As of September 2023, 2022, and 2021, the United States inflation rate was 3.7%, 8.2%, and 5.4%, respectively.[5] Groups must continue to operate in an inflationary environment with costs, such as benefits (including health insurance), recruitment costs, malpractice insurance, billing and collection expenses, practice management, cybersecurity insurance, and other items continuing to increase.

Shift from Private Practice to Hospital Employment

The above trends indicate that while Groups were once able to effectively manage their practices with little to no financial assistance, it may not be possible anymore. Groups continue to request higher financial assistance when they can, and when they cannot, many physicians are leaving private, independent practices for employment by a Hospital (where allowed by state law) foregoing the financial risk and operational management side of the business.

Pitfalls to Avoid and Best Practices to Help

Billing and Collection Performance and Lack of Annual Reconciliation

The first pitfall to avoid is financially supporting a Group's poor billing and collection performance. Both the Group and the Hospital must monitor the billing and collection performance of the Group, ensuring alignment between the two parties. Specifically, Groups should be held accountable to meet some level of industry-standard billing performance to ensure financial health. For example, when reviewing a Group's professional collections, the Hospital should ensure the Group's adjusted collection ratio[6] (i.e., gross charges less contractual adjustments divided by professional collections) is consistent with the industry. Per PYA research and experience, adjusted collections ratios typically approximate 95% for anesthesiology and other hospital-based specialties.

It is important to include annual reconciliation provisions for revenue, at a minimum, in a financial assistance agreement. Such provisions ensure the Group continues to maintain its historical collections and collection patterns; groups must remain motivated to optimize their professional collections rather than solely relying on the subsidy. While reconciliations may be time consuming and create an administrative burden, if forgone, then key assumptions used to calculate the financial assistance may not hold true. Further, recall that one of the main reasons to enter into a subsidy arrangement is to ensure the Group's providers earn fair market value compensation. If a subsidy is calculated and agreed upon based on certain revenue assumptions but greater revenue is achieved, the Hospital could inadvertently support the Group in paying more than fair market value to its providers. Accordingly, if a Group collects more than is expected, the required financial assistance should decrease.

While having a reconciliation provision in the agreement is best practice, such a provision does not have to necessarily require that the subsidy amount will change concurrently. For instance, revenue could be reconciled quarterly, but the agreement could be written such that the corresponding subsidy amount does not change unless professional collections increase or decrease for three consecutive quarters by a certain amount (e.g., 10%).[7] Alternatively, if a Group collects more than originally anticipated, the parties to the arrangement could agree upon (and document via the agreement) a certain threshold or period of time for which the Group is able to retain excess collections before remitting anything to the Hospital or even that such excess collections will be incorporated into future reconciliations. Therefore, while having a reconciliation provision in the agreement is key, the agreement itself should also outline in detail what happens as a result of the reconciliation (i.e., if the subsidy will change, when the subsidy will change, and how the subsidy will change).

Inappropriate Staffing Ratios

Subsidizing inappropriate staffing ratios is another common pitfall to avoid. As a best practice, the Hospital and Group should agree on the staffing and coverage model, including the physician to APP staffing complement. For anesthesia, for instance, adhering to a ratio of one physician to three or four certified registered nurse anesthetists (CRNAs) is considered best practice.[8] Having an appropriate staffing ratio not only can help reduce expenses but also maximize professional collections. For example, in anesthesia, the medical direction of up to four CRNAs typically results in the highest reimbursement for the Group.

Conducting regular staffing assessments is another best practice in financial subsidy arrangements. If a Group proposes additional full time equivalents (FTEs) to provide the services at a Hospital, the Hospital should only agree to the higher number of FTEs after considering patient volume, coverage hours, and/or additional locations. The opposite is also true. Hospitals should regularly evaluate their coverage requirements and ensure they are optimizing resources to the best of their abilities. For instance, a Hospital may determine it would be more efficient (i.e., less expensive) to close an operating room for a portion of a day. The agreement between the Group and Hospital should allow for changes in coverage and staffing requirements thereby increasing or decreasing the associated subsidy.

Unusual Group Profit Margins

The next common pitfall to avoid is to ensure the arrangement does not subsidize a Group's profit margins greater than what the Hospital could realize, which is particularly relevant in Group's backed by private equity investors. Though Hospitals may currently be losing money on Hospital operations, prior to the last few years Hospitals often generated profit margins on hospital-based services ranging from 2% to 3%. From a commercial reasonableness perspective, the Hospital may want to avoid subsidizing profit margins greater than what they would realize.

Neglecting Administrative Documentation

Another pitfall often seen in financial assistance arrangements is a Hospital agreeing to pay for time spent by the Group providing administrative services yet not having agreement provisions establishing a maximum number of hours and monitoring and documentation requirements. Accordingly, agreements should include consideration of the amount of time involved with administrative services, as well as a way to monitor and track the time whether via timesheets, attendance at meetings, or milestones set for administrative achievement.

Not Allowing for Renegotiations

Not accounting for changes in regulatory frameworks, such as the MPFS, can also create problems in financial assistance arrangements. For instance, if changes in the MPFS result in material changes to the Group's professional collections, the agreement should include provisions that allow the parties to renegotiate the financial assistance.

Natural disasters and global pandemics also affect financial assistance arrangements. With the onset of the COVID-19 global pandemic, for instance, many Hospitals found themselves with clinical coverage requirements that were vastly different than those outlined in their financial assistance agreements, and often times, the agreements did not include provisions that allowed for renegotiation. Accordingly, more Hospitals are incorporating language in agreements that allows for renegotiation for events outside of human control, like natural disasters or global pandemics (i.e., Force Majeure clauses).

Other Best Practices

When structuring a financial assistance agreement, the Hospital should consider ways to align the Group with the Hospital's strategy and operations. One way to support alignment would be to appoint a medical director to work with the Hospital's leadership team. Another way would be to incorporate financial incentives for quality and performance to align the Group's goals with that of the Hospital.

Further, as there are provider shortages with many of these hospital-based specialties, agreements should incorporate what happens if the Group must recruit providers to fulfill the agreed upon coverage requirements or utilize locum tenens. This may include consideration of whether recruiting expenses or locum tenens costs will be passed through to the Hospital, shared with the Group, or if the Group will solely incur the costs, etc.

From a Group's perspective, an agreement should also incorporate protections for the Group such that they will not be penalized for factors outside of their control but within the Hospital's control. For instance, antiquated software and technology used by a Hospital can create an unnecessary administrative burden on a Group who then has less time to see patients and bill and collect for services.

Lastly, the agreement should include governors to ensure the agreement stays financially and operationally consistent with what was negotiated. Agreement governors can also be used to track performance metrics (both financially and operationally) and serve as guardrails to prevent service or collection issues.

Conclusion

Subsidies serve as a lifeline for many Hospitals and Groups, ensuring the needs of the community are met while also ensuring a Group can cover operational expenses including fair market value compensation for its providers. In doing so, Hospitals and Groups more easily retain providers and attract new ones to the market. While essential in many instances, financial assistance arrangements should be carefully negotiated and align the goals of the Hospital with that of the Group.

[1] "Hospital Admissions per 1,000 Population by Ownership Type," <https://www.kff.org/other/state-indicator/admissions-by-ownership/?activeTab=graph&currentTimeframe=0&startTimeframe=11&selected Distributions=total&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>, accessed October 26, 2023.

[2] "Hospital Outpatient Visits per 1,000 Population by Ownership Type," <https://www.kff.org/other/state-indicator/outpatient-visits-by-ownership/?activeTab=graph&currentTimeframe=0&startTimeframe=11&selected Distributions=total&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>, accessed October 26, 2023.

[3] "Hospital C-Suite Leaders Project 2023 Outpatient Volumes to Increase by 10% or More," <https://guidehouse.com/news/healthcare/2023/gh-hfma-exec-survey>;, accessed October 26, 2023.

[4] "Private Equity and the Monopolization of Medical Care," <https://www.forbes.com/sites/robertpearl/2023/ 02/20/private-equity-and-the-monopolization-of-medical-care/?sh=12d79c632bad>, accessed October 25, 2023.

[5] "US Inflation Rate," <https://ycharts.com/indicators/us_inflation_rate#:~:text=Basic%20Info-,US%20Inflation% 20Rate%20is%20at%203.70%25%2C%20compared%20to%203.67%25,in%20price%20over%20a%20year.>, accessed October 26, 2023.

[6]The adjusted collection ratio measures the Group's efficiency in collecting the funds it should have collected after considering contractual adjustments.

[7] This is an example for illustrative purposes only. Agreements should be monitored and analyzed regularly to ensure they remain consistent with fair market value at all times.

[8] This ratio may not be achievable in all situations due to the availability of CRNAs, complexity of the patient(s), and/or location of anesthetizing sites.