HSG | FROM OPERATIONAL CHAOS TO **HIGH-PERFORMING**

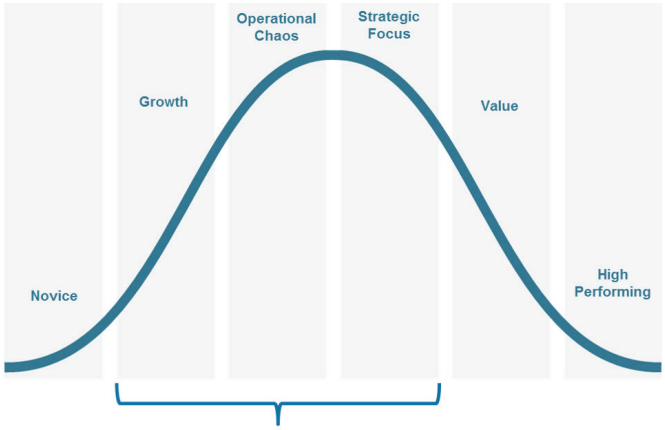
THE RIGHT PATH FOR YOUR PHYSICIAN NETWORK

HSGadvisors.com

INTRODUCTION

Between 2012 and 2015, the number of physicians employed by hospitals and health systems in the United States grew by 46,000 (48%), up from 95,000 (26% of practicing physicians) to 141,000 (38% of practicing physicians).[1] Clearly, over this short, three-year period, many hospital and health system physician networks have been in an accelerated growth mode—some in an all-out buying spree.

As a consulting firm specializing in physician/hospital alignment and employed physician networks, HSG has in-depth knowledge of and firsthand experience addressing the challenges and difficulties faced by networks. We have found that hospital-employed physician networks progress and evolve across a predictable evolutionary curve -- Physician Network Growth Phases.



Networks across the country span the bell curve, but the vast majority are in one of these three stages.

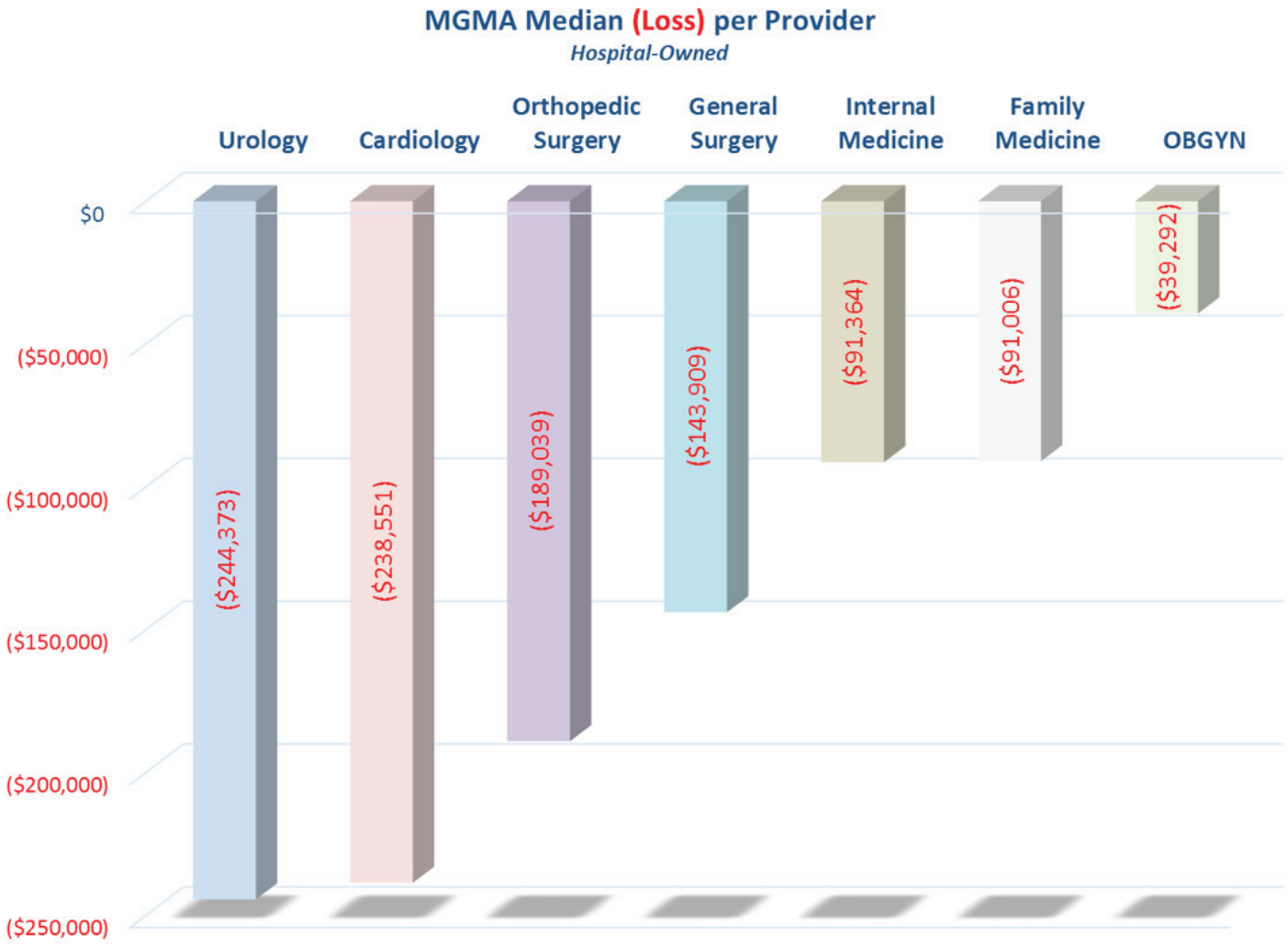
A few progressive health systems, those that committed to physician employment in the 1990s and early 2000s, have already experienced the growing pains and challenges of the Novice, Growth, and Operational Chaos phases and are now reaping rewards of Strategic Focus and Value. At the same time, however, they are experiencing new challenges inherent with those phases. No phase is without its unique set of challenges and opportunities. You never truly arrive. **The minute you start to rest on your laurels, that's the minute you fall behind.**

1. Avalere analysis of SK&A hospital/health system ownership of physician practice locations data with Medicare 5% Standard Analytic Files.

OPERATIONAL CHAOS

For most of our clients, the Novice and Growth phases are in the rearview mirror, but the aggressive pace at which they progressed through those phases now has them squarely in Operational Chaos. The chaos worsens when you compound that with the liberal nature by which they evaluated the quality, work ethic, and strategic and cultural fit of the physicians they acquired and employed. Some never saw a physician they didn't want.

For networks in Operational Chaos, their growth in size and scope has typically outstripped the capabilities of those managing the network. Increasing practice losses (see graph below of MGMA median losses per provider by selected specialties) cry out for immediate performance improvement and the continual need for a formal, professional management infrastructure.



Source: MGMA 2016 Cost and Revenue Survey Report based on 2015 data

Additionally, hospital leadership senses the need to control the group's growth and limit employment offers—or at least make wiser, more discriminant decisions. The most common issues we find in networks and practices struggling in Operational Chaos are:

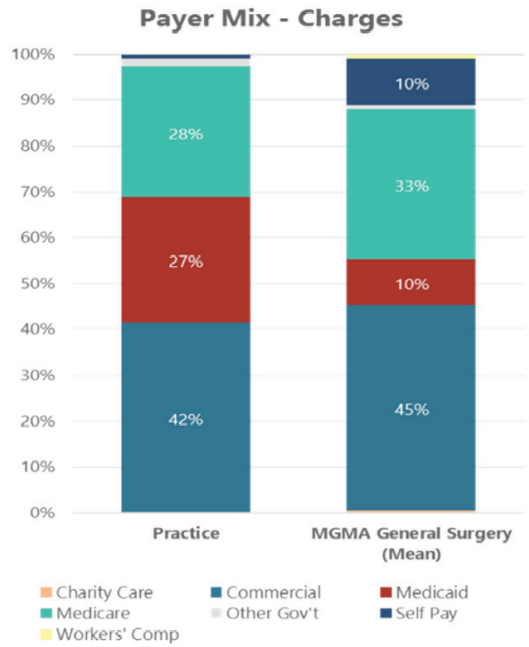
- Inefficient revenue cycle function, resulting in poor collection rates, high denial rates and a high, but also aging, AR balance;
- Insufficient oversight of daily practice operations and limited investment in appropriate management talent;
- Push to cut costs through staff reductions having an adverse effect on daily office-based throughput;
- Disconnect between office and revenue cycle staff, affecting point-of-service collections, registration errors, denial rates, and overall revenue cycle performance;
- Inefficiencies and lack of control over patient scheduling negatively impacting patient volume;
- Misaligned physician compensation lacking appropriate incentives;
- Hospital-based IT infrastructure and reporting capabilities handicapping management's ability to manage effectively;
- Inconsistencies in physician contracting and contract structure; and
- Low physician engagement in operations and culture development, making management and implementation of change difficult.

DIAGNOSIS: PHASE ONE

As a result of these challenges, HSG has engaged with many organizations to root out problems and chart a course of improvement through a comprehensive network assessment/performance improvement initiative. While the challenges are different, the purpose of these engagements is always the same—discover and document the problems stalling the evolution of a network and chart a path for improvement. To accomplish this purpose, HSG employs a comprehensive two-phased process. The first phase focuses on extensive data review and benchmarking, using industry surveys and sources such as the Medical Group Management Association (MGMA), Sullivan & Cotter Associates (SC), and American Medical Group Association (AMGA). The second phase uses the results of data analysis to target our survey. **We complete a qualitative analysis involving onsite observations, interviews, and impromptu questioning of key stakeholders.**

Specifically, Phase One evaluates defined benchmarks and data points for a network in order to begin the diagnosis process. Provided below are twenty (20) specific benchmarks and data points that are the focus of a comprehensive assessment process. **These 20 items are categorized into three (3) main areas—Volume/Throughput, Operations, and Revenue Cycle.**

1. **Volume/Throughput**
   a) Work Relative Value Units ("wRVUs") per provider;
   b) Average time to next available appointment (in days);
   c) Percentage of appointment slots filled per day; and
   d) No show/same day cancellation rate.
2. **Operations**
   a) Net income or (loss) per provider;
   b) Overhead rate (total operating expenses) as a percentage of revenue;
   c) Total provider cost as a percentage of revenue;
   d) Total support staff cost as a percentage of revenue;
   e) Total support staff FTEs per provider;
   f) Total support staff FTEs per 10,000 wRVUs;
   g) General administrative staff per FTE provider; and
   h) Provider compensation relative to productivity (i.e., compensation levels versus wRVU levels via a scatter plot diagram).
3. **Revenue Cycle**
   a) Days in accounts receivable;
   b) Gross and adjusted collection rate;
   c) Percentage of accounts receivable over 90 days;
   d) Registration error rate;
   e) Claim denial rate;
   f) Late (or delinquent) charges rate;
   g) Point-of-service collections rate; and
   h) Professional collections per wRVU.



In addition to the revenue cycle metrics highlighted above, we also evaluate practice-to-practice, and network level payer mix versus available industry data. This analysis adds context and background to the results of revenue cycle metrics, such as gross collection rate and professional collections per wRVU. Understanding the impact of the local payer mix helps us evaluate what each practice and the network, as a whole, should be collecting against its charges.

Assessing the network's fee schedule (or charge master) is also a vitally important step. We've seen networks "leave money on the table" by charging below a payer's allowable. And we've witnessed other organizations set their charge masters at unreasonable levels—which can skew certain revenue cycle metrics and be off-putting to patients/customers. We recommend a uniform, structured approach and template for the charge of each CPT code, based on a defined percentage of Medicare. Each CPT code is categorized and set based on a selected percentage assigned to each category. **An exception being if a relevant payer's allowable is higher than the calculated fee. See example template below:**

Type	Recommended %
Surgical	250%
Evaluation and Management/Medicine	160%
X-Ray	160%

CPT	Description	Type	Current Fee Amount	Current Medicare Part B PFS	Current % Medicare	Highest Payer	Highest Payer Rate	Highest Payer % of MCR	Recommended Fee	Recommended Fee % of MCR	Recommended Fee % of Highest
10021	Fna W/o Image	Surgical	$ 213	$ 118	181%	BCBS	$ 280	238%	$ 294	250%	105%
10040	Acne Surgery	Surgical	$ 121	$ 85	143%	BCBS	$ 200	236%	$ 212	250%	106%
10060	Drainage Of Skin Abscess	Surgical	$ 167	$ 91	184%	Aetna	$ 200	220%	$ 227	250%	114%
51701	Insert Bladder Catheter	Surgical	$ 68	$ 57	119%	Humana	$ 135	237%	$ 142	250%	105%
51702	Insert Temp Bladder Cath	Surgical	$ 163	$ 73	224%	Humana	$ 173	237%	$ 182	250%	105%
58300	Insert Intrauterine Device	Surgical	$ 185	$ 69	268%	Humana	$ 164	237%	$ 173	250%	105%
64405	N Block Inj, Occipital	Surgical	$ 190	$ 89	213%	Humana	$ 212	238%	$ 223	250%	105%
64430	N Block Inj, Pudendal	Surgical	$ 150	$ 134	112%	Humana	$ 317	237%	$ 334	250%	105%
64435	N Block Inj, Paracervical	Surgical	$ 150	$ 124	121%	Humana	$ 294	237%	$ 310	250%	105%
65205	Remove Foreign Body From Eye	Surgical	$ 113	$ 45	249%	Humana	$ 108	238%	$ 113	250%	105%
69200	Clear Outer Ear Canal	Surgical	$ 130	$ 100	130%	Humana	$ 238	237%	$ 251	250%	105%
69210	Remove Impacted Ear Wax	Surgical	$ 86	$ 42	204%	Humana	$ 100	238%	$ 105	250%	105%
71010	Chest X-Ray	X-Ray	$ 28	$ 22	129%	Humana	$ 33	152%	$ 35	160%	105%
71020	Chest X-Ray	X-Ray	$ 30	$ 29	105%	Humana	$ 44	153%	$ 46	160%	104%
71030	Chest X-Ray	X-Ray	$ 50	$ 42	119%	Humana	$ 64	153%	$ 67	160%	105%
99203	Office/outpatient Visit, New	E&M/Medicine	$ 141	$ 86	163%	BCBS	$ 131	152%	$ 138	160%	105%
99204	Office/outpatient Visit, New	E&M/Medicine	$ 202	$ 134	150%	BCBS	$ 204	152%	$ 215	160%	105%
99205	Office/outpatient Visit, New	E&M/Medicine	$ 288	$ 170	170%	BCBS	$ 258	152%	$ 272	160%	105%
99213	Office/outpatient Visit, Est	E&M/Medicine	$ 80	$ 58	138%	BCBS	$ 88	151%	$ 93	160%	106%
99214	Office/outpatient Visit, Est	E&M/Medicine	$ 116	$ 88	132%	BCBS	$ 133	152%	$ 140	160%	105%
99215	Office/outpatient Visit, Est	E&M/Medicine	$ 186	$ 119	157%	BCBS	$ 180	152%	$ 190	160%	105%
99291	Critical Care, First Hour	E&M/Medicine	$ 290	$ 242	120%	BCBS	$ 368	152%	$ 387	160%	105%
99292	Critical Care, Add'l 30 Min	E&M/Medicine	$ 141	$ 110	129%	BCBS	$ 167	152%	$ 176	160%	105%
99304	Nursing Facility Care, Init	E&M/Medicine	$ 75	$ 77	97%	BCBS	$ 117	152%	$		
99305	Nursing Facility Care, Init	E&M/Medicine	$ 132	$ 108	122%	Aetna	$ 164				
99306	Nursing Facility Care, Init	E&M/Medicine	$ 145	$ 139	105%	BCBS	$				
99309	Nursing Fac Care, Subseq	E&M/Medicine	$ 90	$ 77	117%						
99310	Nursing Fac Care, Subseq	E&M/Medicine	$ 113	$ 114							
	Nursing Fac Discharge Day	E&M/Medicine	$ 70	$							
	Day	E&M/Medicine	$								

Note, if data is available, we include a fourth category of Quality/Patient Experience. This category utilizes CG-CAHPS and/or HCAHPS measures, as well as MIPS and MACRA metrics, to monitor the quality and patient experience associated with the care delivered by the group's providers.

For most of the data points presented above (not including Quality/Patient Experience), industry surveys (i.e., MGMA, AMGA, and Sullivan Cotter) provide specialty-specific benchmarks that serve as a gauge of current status and provide a goal and standard for future performance. In these cases, we most often utilize the median as a benchmark, as the median is not influenced by extreme values. Additionally, we utilize specialty-specific benchmarks for each specialty/practice we are benchmarking. We very rarely utilize "multispecialty" benchmarks.

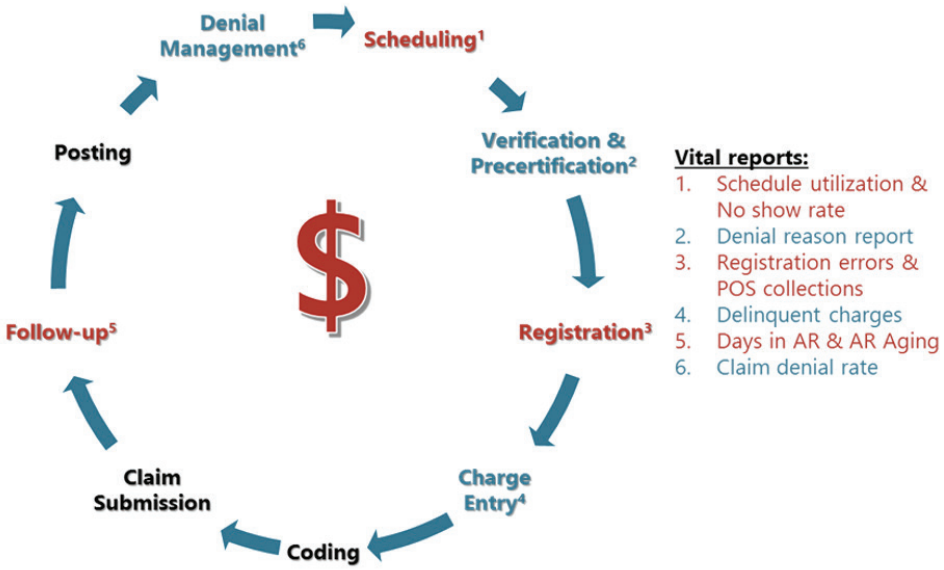
We also tend to use the national and all-practices data versus regional and hospital-owned only data. The national and all-practices data have larger numbers of respondents and tend to not be influenced by extremes, as does the data with fewer respondents (i.e., the regional and/or hospital-owned only data). Also, the all-practices data includes independent practices, which tend to be more efficient than hospital-owned … because they must be. This is particularly important when assessing the performance and efficiency of a practice's operating expenses and overhead.

The table below presents an example of a benchmarking exercise by which the operating expenses and overhead of a practice are assessed. This particular exercise calculates each operating expense category amount as a percentage of the practice revenue generated and compares to like percentages from MGMA's Cost Survey.

Dr. Doe 2016 Income Statement				
MGMA Category	**$**	**% of Net Medical Revenue**	**Variance w/ MGMA Median**	**2015 MGMA Cardiology Median**
Total Medical Revenue	$1,101,829			
Other Revenue	$0			
Total Net Revenue	**$1,101,829**			
Expenses - Key Operational Indicators				
Total Staff and Benefits	$412,342	37.4%	4.3%	33.1%
Medical and Surgical Supply	$138,122	12.5%	11.9%	0.6%
Building and Occupancy	$98,589	8.9%	3.4%	5.6%
Furniture and Equipment Depreciation	$2,482	0.2%	-0.5%	0.8%
Administrative Supplies and Services	$18,724	1.7%	0.9%	0.8%
Miscellaneous Operating Cost	$68,231	6.2%	2.9%	3.3%
Total Operating Cost	**$738,489**	**67.0%**	**-0.4%**	**67.4%**
Net Contribution Before Provider Cost	**$363,340**			
Provider Cost				
Total Physician Compensation	$300,000	27.2%	-55.5%	82.8%
Total Physician Benefit Cost	$10,502	1.0%	-5.3%	6.3%
Total Provider Cost	**$310,502**	**28.2%**	**-67.2%**	**95.4%**
Total Cost	**$1,048,991**	**95.2%**	**-70.2%**	**165.4%**
Net Income (Loss) Including Provider Salary	**$52,838**	**4.8%**	**77.8%**	**-73.0%**

For some metrics, such as registration error rate, claim denial rate, late (or delinquent) charges rate, and point-of-service collections rate, benchmarks are difficult to find or are simply not available. For these data points, past performance and your best judgement on reasonability are sufficient for establishing goals for improvement and standards for current performance. For example, a 2-to-5% registration error rate is reasonable for most practices. That said, if your practices have been exhibiting a 15% registration error rate, perhaps an intermediate goal of 10% is a reasonable place to start.

To the right is our view of the revenue cycle process, with the types of reports and information that are required at each touchpoint to monitor performance and root out problems in each stage of the revenue cycle function.



Because physician compensation and its alignment (or misalignment) with production is often the number one driver of losses in a physician network, it receives a great deal of attention from our consultants in any performance improvement initiative. An extremely helpful illustration of physician compensation alignment (or misalignment) is a scatter diagram -- compensation percentiles are plotted on the "y" axis and wRVU production percentiles are plotted on the "x" axis. Each physician is represented as a point on the diagram. **The following questions often surface, depending on the physician's placement on the diagram:**

Upper Left Quadrant (High Compensation and Low Production):

1. Is it likely that the compensation is not financially sustainable?
2. Do we have a compliance (fair market value and commercial reasonableness) risk?
3. Is this a new physician who is ramping up production in a new practice?
4. Is the physician providing other services, not captured by traditional production metrics such as wRVUs (i.e., medical direction and call coverage)?

Lower Left Quadrant (Low Compensation and Low Production):

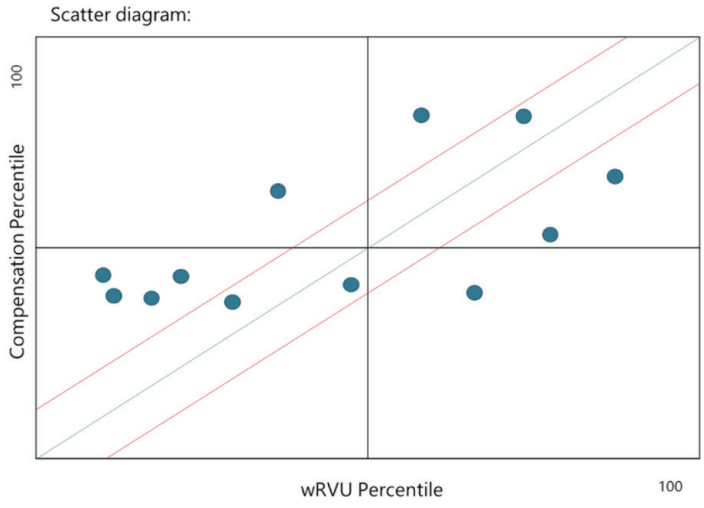
1. Is this a part-time physician?
2. Is there a role for this physician in one of our practices at this reduced/partial level?
3. Is the physician able to cover his or her direct cost and overhead?

Lower Right Quadrant (Low Compensation and High Production):

1. Is something wrong with the production calculations? Is production overestimated?
2. Is something wrong with the compensation model or compensation calculations?
3. Are we at risk of losing a high producing physician because we are not competitive on compensation, given his or her level of work and effort?

Upper Right Quadrant (High Compensation and High Production):

1. Is this ideal alignment?
2. If production is extremely high, should we be concerned about quality?
3. Is the physician overworked and a risk for burnout?



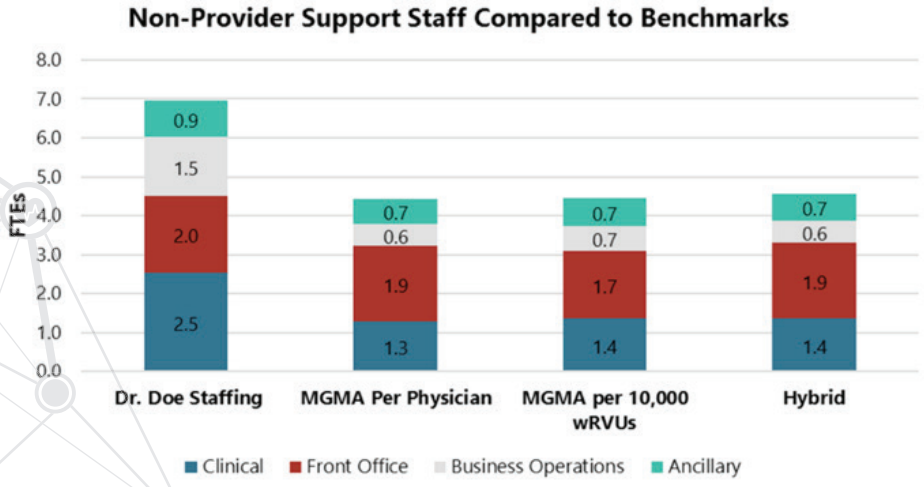
Here is an example of physician compensation and production plotted on a scatter diagram:

A collection of answers to the types of questions discussed above, centered around these data points, will help executives and managers of employed physician networks begin to answer the primary question many are asking—Why are we losing so much more than our peers on a per provider basis?

DIAGNOSIS: PHASE TWO

Armed with data and benchmarking, Phase Two can proceed with conversation, inquiry, and observation. **The key to Phase Two is to ask the right questions and observe the processes and behaviors that illuminate the answers to questions, such as:**

- Why are our days in AR at 55 days?
- Why is our adjusted collection rate at 82% instead of 98%?
- Why are our adjustments so high? Is the revenue cycle staff too aggressive with write-offs?
- Why are collections per wRVU in this practice 25% less than the MGMA median for the specialty? Is it payer mix or a problem with the revenue cycle function?
- Why does the practice have a 20% no-show rate and only a 60% slot fill rate?
- Why is the physician compensation in the practice consistently at the 60th percentile, but physician wRVU production is at the 45th percentile?
- Why are we not maximizing point-of-service collections opportunities at the front desk?
- Are we staffed appropriately given our complement of providers? Given our wRVU (patient) volume? **See table below.**



A CALL TO ACTION

After identifying what is occurring in the network and why, the next step is to develop action plans to address problems and move the network in a positive direction. This requires communication with network physicians. One purpose for this communication is to utilize the physicians as resources for ideas and solutions to the problems facing the network and its individual practices. The second reason is to communicate the details of the action plan in order to facilitate ownership and buy-in, which will contribute to the ultimate success of the initiative.

The detailed action plans should include the action, expected start and completion dates, responsible individuals or parties, and space for notes and status updates. A sample is provided below.

#	Category	Action step	Responsibility	Timetable	Start Date	End Date	Resources Needed
1	Revenue Cycle	Update Fee Schedule	PBFS (CBO)	2 weeks	4/15/2017	4/29/2017	CFO approval
2	Revenue Cycle	Coding Review & Education All Providers	PBFS (CBO) Director	12 months	4/1/2017	3/31/2018	Third-party Coding Auditor
3	Revenue Cycle	Implement POS Collection Incentives for Staff	Executive Director	5 months	5/1/2017	9/28/2017	POS Report & HR approval
4	Volume/Throughput	Implement Pt. Scheduling Incentives for Staff	Executive Director	3 months	5/1/2017	7/30/2017	HR approval
5	Volume/Throughput	Add 3 NPs/PAs to GS to Improve Throughtput	Gen Surg Practice Mgr	3 months	5/1/2017	7/30/2017	HR, MD/Practice Mgr time
6	Operations	Redesign Physician Compensation Model	Executive Director & PAC	6 months	5/15/2017	11/11/2017	Board approval
7	Operations	Recommend New EMR/PM System	IT Committee of PAC	6 months	6/1/2017	11/28/2017	IT Dept. Involvement

The action plans are an invaluable tool for building accountability and bringing about positive change in the network, and should be reviewed periodically to ensure continuing relevance and appropriate focus.

MONITORING THROUGH DASHBOARDS

To ensure that executives and front-line management continuously monitor the progress of their network and its collection of individual practices, the team needs an effective dashboard report. We believe a successful dashboard must be simple and poignant, highlighting the most critical metrics for a network or practice. We also believe there should be a dashboard for the C-suite of the organization (an Executive Dashboard) and a dashboard for the management team of the network (an Operations Dashboard). The Executive Dashboard should provide the hospital or health system's C-suite executive team (CEO, CFO, COO, CMO, etc.) with higher level metrics that provide a feel for the overall health and performance of the network. The Operations Dashboard looks at additional metrics, in the same areas as the Executive Dashboard but that allow the management team a deeper dive into the operational specific as they continuously monitor and head off problems. **Please see the next page for examples of the Executive and Operations Dashboards.**

Employed Network Executive Dashboard

Metric	YTD Current Year	YTD Prior Year	Annualized Current Yr	Annual Prior Year	Variance	Benchmark (Goal)	Variance2
Quality/Patient Experience:							
CG-CAHPS (Overall Provider Rating Composite)*	70%	80%	70%	80%	-10%	90%	-20%
MACRA Score	49	40	49	40	9	60	-11
Operations:							
Physician FTEs	50	35	50	35	15	N/A	N/A
APP FTEs	30	20	30	20	10	N/A	N/A
Net Income or (Loss)	($20,000,000)	($13,750,000)	($20,000,000)	($13,750,000)	($6,250,000)	N/A	N/A
Net Income or (Loss) per Provider	($250,000)	($275,000)	($250,000)	($275,000)	($25,000)	($127,799)	$122,201
Overhead Rate**	50%	60%	50%	60%	-10%	45%	5%
Total Provider Cost as % of Revenue	60%	70%	60%	70%	-10%	60%	0%
Provider Comp vs. Productivity (% outside corridor***)	25%	30%	25%	30%	-5%	10%	15%
Revenue Cycle:							
Days in AR	45.0	60.0	45.0	60.0	-15	35	10
Adjusted Collection Rate	90%	85%	90%	85%	5%	99%	-9%
Total Professional Collections	$35,000,000	$25,000,000	$35,000,000	$25,000,000	$10,000,000	N/A	N/A
Professional Collections per wRVU	$100	$100	$100	$100	$0	$120	($20)
Volume/Throughput:							
wRVUs Total (Personally Performed Only)	350,000	250,000	350,000	250,000	100,000	N/A	N/A
wRVUs per Provider (Personally Performed Only)	4,375	4,545	4,375	4,545	(170)	4,982	(607)
Specialty Capture Rate^	80%	60%	80%	60%	20%	90%	-10%

** Reported annually*

*** Total Operating Expense as % of Revenue*

**** Corridor is defined as compensation benchmarks greater than +/- 10%tiles of productivity benchmarks*

^Referrals to Employed Specialists from Employed Providers / All Applicable Referrals from Employed Providers

Employed Network Operations Dashboard

Metric	YTD Current Year	YTD Prior Year	Annualized Current Yr	Annual Prior Year	Variance	Benchmark (Goal)	Variance2
Quality/Patient Experience:							
CG-CAHPS (Access to Care Top-Box Score)	60%	50%	60%	50%	10%	90%	-30%
CG-CAHPS (Provider Communication Top-Box Score)	80%	70%	80%	70%	10%	90%	-10%
CG-CAHPS (Test Results Top-Box Score)	85%	75%	85%	75%	10%	90%	-5%
CG-CAHPS (Office Staff Top-Box Score)	65%	50%	85%	50%	35%	90%	-5%
MIPS (Quality Measure) *Select a Measure*	75%	70%	75%	70%	5%	80%	-5%
MIPS (Improvement Activity) *Select a Measure*	80%	75%	80%	75%	5%	80%	0%
MIPS (Advancing Care Information) *Select a Measure*	65%	70%	65%	70%	-5%	80%	-15%
Operations:							
Total Support Staff FTEs	360	350	360	350	10	N/A	N/A
Total Support Staff FTEs per Provider	4.50	6.36	4.50	6.36	-1.86	3.30	1.20
Total Support Staff FTEs per 10,000 wRVUs	10.29	14.00	10.29	14.00	-3.71	6.53	3.76
Total Support Staff Cost as a % of Revenue	35.00%	40.00%	35.00%	40.00%	-5.00%	28.62%	6.38%
General Admin. Staff per FTE Provider	0.10	0.20	0.10	0.20	-0.10	0.22	-0.12
Revenue Cycle:							
% of AR Over 90 Days	35%	55%	35%	55%	-20%	25%	10%
Registration Error Rate	15%	20%	15%	20%	-5%	7%	8%
Claim Denial Rate	11%	15%	11%	15%	-4%	7%	4%
Late (Delinquent) Charges Rate	6%	10%	6%	10%	-4%	5%	1%
Point-Of-Service Collection Rate	73%	60%	73%	60%	13%	90%	-17%
Volume/Throughput:							
Avg. Time to Next Available Appointment (in Days)	12.00	14.00	12.00	14.00	-2.00	7.00	5.00
% of Appointment Slots Filled per Day	74%	65%	74%	65%	9%	95%	-21%
No Show/Same Day Cancellation Rate	15%	25%	15%	25%	-10%	8%	7%

CONCLUSION

Physician networks are extremely complex entities. Managing them effectively requires investment in talent and appropriate resources. Even well-prepared organizations can find that their aggressive growth has facilitated the emergence of Operational Chaos. A comprehensive and well-defined performance improvement initiative can be invaluable to an organization as it plans the next phase of its maturation. If you embark on such an initiative, make sure the following are components of your process:

1. **Physician engagement and communication;**
2. **Action plans; and**
3. **Poignant dashboards.**

GETTING STARTED

HSG works with health systems across the country to build high-performing networks. We want to help your network evolve through the Physician Network Growth Phases and develop the competencies it needs.

Please feel free to reach out to us to schedule a discussion about a performance improvement initiative for your network.

Neal D. Barker
Partner

(502) 814-1189
nbarker@HSGadvisors.com

WHO WE ARE

HSG builds high-performing physician networks so health systems can address complex changes with confidence. From boosting market power and financial strength to preparing for value-based care, we can help you define your strategy, implement that strategy, and manage your physician network, short or long-term. We guarantee results and deliver the greatest value as a trusted member of your team.

Physician Strategy

- Physician Alignment Strategy
- Strategic Plans with Physician Focus
- Employed Physician Network Strategy
- Creating Shared Vision
- Service Line Strategy & Co-Management
- Provider Manpower Planning
- Referral Capture/ Network Integrity

Physician Network Optimization

- Network Leadership Acquisition
  - Interim Management
  - Executive Search
- Network Performance Improvement
- Network Revenue Cycle
- Aligned Physician Compensation
- Practice Acquisitions
- Fair Market Value Opinions

Value-Based Care

- MACRA Assessments, Planning and Implementation
- Practice Transformation
  - Care Coordination
  - Population Health
- Direct Contracting
- Bundled Payments
- ACO Development and Optimization
- Hospital Efficiency Improvement Program (HEIP)

HSG

HSGadvisors.com
502.814.1180
info@HSGadvisors.com