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THOUGHT LEADERSHIP

REDUCING EMPLOYED PHYSICIAN NETWORK LOSSES AND CREATING FINANCIAL SUSTAINABILITY

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SUMMARY

Many hospitals are increasingly challenged by the financial performance of their employed physician networks. As these networks grow, the concern about financial performance moves to the forefront, with the losses becoming an increasingly visible drag on the system's overall profitability. This, in turn, puts pressure on health system and physician network leadership to, at a minimum, figure out how to bend the cost curve, if not reduce net losses altogether.

From our vantage point, the overall key to building high-performing employed physician networks is financial sustainability. This is the point at which health system leadership is reasonably assured the performance of the employed physician network is not a detriment to the health system's overall financial performance, and that in the long term, the physician network has the infrastructure, management capabilities, and provider engagement to make maintaining the cost curve realistic.

When assessing the performance of employed provider networks, we find a litany of issues contributing to poor financial performance that must be identified, explored, and addressed through an implementation plan. While not all of these are present in every network, most networks are experiencing at least a handful of these issues:

Underperforming Revenue Cycle

This includes underperformance in hitting benchmarks in the billing office (in the hospital financial office or in a dedicated central billing office); properly credentialing providers with payers in a timely manner; maximizing revenue capture in the office setting; documentation and coding.

Misalignment of Compensation and Performance

This includes providers being overpaid relative to production; providers being given incentives inconsistent with network financial goals; or providers having incentives focused on individual (not group) performance.

Inconsistent and/or Inefficient Approaches To Operations, Staffing, and Space Usage

Most commonly, this relates to practices being left to operate much as they did before they were employed – which results in wild variation on a practice-by-practice basis when it comes to throughput, staffing, space, and other operational indicators.

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Insufficient Usage of Advanced Practitioners.
This applies to the mix of Physicians to Advanced Practitioners (AP's), as well as whether AP's are being used at top-of-license or as glorified clinical staff. This results in cost per provider being excessive relative to production.

Underinvestment In Management Infrastructure
Networks struggling with financial performance frequently under invest in their management team, resulting in a crippling lack of resources that create an inability for management to move beyond "fighting fires" on a daily basis.

Poorly Designed Organizational Structure That Creates A Lack of Accountability
Many employed physician networks are still managed by multiple hospital executives, or have executive directors/managers who are not held directly accountable for performance of the network. If there's not a place where the buck stops, the performance will not improve.

Strategic Issues Disguised As Performance Issues
In some cases, poor financial performance is a symptom of larger strategic issues at the network or health system level. As an example, if the employed network doesn't have the right primary care strategy and a sufficient primary care base, all the performance improvement initiatives in the world won't make employed specialty practices productive and profitable.

Employing "Who We Have" vs. "Who We Need"
Not every provider and practice who was brought into the network years ago is still a strategic fit for the network. Some providers are never going to have the mindset that will make them an effective employed provider. Some practices brought into the network long ago under a different strategic mindset may not be relevant now.

To identify these (or other) issues in networks looking to create financial sustainability, a phased assessment in three parts is recommended. The first phase includes opportunity identification, followed by opportunity exploration and then, finally, implementation.

PHASE ONE
Opportunity Identification

This Phase focuses on assessing and benchmarking the performance data of the network and collecting management opinions and observations on performance improvement. The output is an overall analysis defining how much financial improvement opportunity is available within the network, and a prioritization of issues to explore more deeply to understand the achievability of potential improvements.

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PHASE ONE SAMPLE ANALYSES

SAMPLE PRACTICE BENCHMARK DASHBOARD

Name of Practice/Rollup:	Sample Data				
Specialty:	Family Medicine				
Benchmark Percentile:	50				
Service Line:	Primary Care				
Metric	**FY 2016**	**FY 2017**	**Variance 2016 to 2017[1]**	**HSG Benchmark**	**Variance from Benchmark**
Operations:					
Physician FTEs	4.2	3.7	(0.6)		
APP FTEs	1.0	2.0	1.0		
Provider FTEs	5.2	5.7	0.4		
Net Income or (Loss) per Provider	($157,982)	($206,423)	($48,441)	($112,850)	($93,573)
Total Operating Cost as % of Net Patient Revenues	64.2%	73.2%	9.0%	69.3%	3.9%
Total Provider Cost as % of Net Patient Revenues	67.9%	74.5%	6.6%	60.6%	13.9%
Building and Occupancy Expense as % of Net Patient Revenues	7.6%	7.8%	0.2%	8.5%	-0.7%
Total Physician Cost per Provider	$271,685	$210,548	($61,137)	$193,000	$17,548
Total APP Cost per Provider	$29,877	$39,280	$9,403	$47,682	($8,402)
Total Provider Cost per Provider	$301,562	$249,828	($51,734)	$239,785	$10,043
Building and Occupancy Expense per Provider	$34,877	$35,202	$325	$35,961	($759)
Provider Productivity %ile less Compensation %ile	(5.0)	(17.8)	-12.8	0.0	-17.8
Average Comp %tile per Physician	73.0	78.0	5.0		
Average Comp %tile per APP	60.0	44.0	(16.0)		
Average Comp %tile per Provider	71.0	74.0	3.0		
Total Support Staff FTEs	11.0	13.2	2.2		
Total Support Staff FTE Cost	$502,317	$617,589	$115,272		
Total Support Staff FTEs per Provider	2.1	2.3	0.2	2.2	0.1
Total Support Staff FTEs per 10,000 wRVUs	4.8	5.5	0.7	3.9	1.6
Revenue Cycle:					
Total Net Patient Revenues	$1,905,665	$1,756,984	($148,681)	$2,758,946	($1,001,962)
Days in AR	45.4	43.2	(2.2)	36.1	7.1
Adjusted FFS Collection Rate	96.7%	95.4%	-1.3%	96.9%	-1.5%
% Commercial Charges	39.5%	40.5%	1.0%	54.9%	-14.4%
Total Collections per Provider	$364,372	$310,421	($53,951)	$494,875	($184,454)
Total Collections per wRVU	$84	$74	($10)	$79	($5)
Volume/Throughput:					
Average wRVU %tile per Physician	64.0	58.0	(6.0)	50.0	8.0
Average wRVU %tile per APP	75.0	44.8	(30.2)	50.0	(5.2)
Average wRVU %tile per Provider	66.0	56.2	(9.8)	50.0	6.2
wRVUs Total: Physician(s)	18,254	17,250	(1,004)	17,970	(720)
wRVUs Total: APP(s)	4,478	6,584	2,106	8,616	(2,032)
wRVUs Total: All Providers	22,732	23,834	1,102	26,586	(2,752)
% of Appointments Filled	51.2%	54.2%	3.0%	95.0%	-40.8%
No Show Rate (%)	4.7%	4.3%	-0.4%	6.0%	-1.7%

Priority for Management Review: High

Variance in Net Income from Benchmark:
($533,366)

Practice Overview:

- Provider complement grew from 2016-2017, however volume receded. This has caused a number of metrics to grow out-of-line with benchmarks. Viability of current number of FTEs should be evaluated.

Areas of Concern:

- Provider productivity
- Staffing levels at current productivity
- Mismatch of compensation to production
- Declining Collections per wRVUs
- Increasing overall loss per provider

Opportunities for Improvement*

Building & Occupancy Cost	$0
Provider Compensation	$120,622
Support Staff Cost per 10,000 wRVUs	$178,763
Net Patient Revenue per wRVU	$125,902
wRVU Production	$202,847

**Note: Opportunities for Improvement are potentially not cumulative, depending on metric.*

The **Practice Benchmark Dashboard** provides an overview of how a practice trends over time and benchmark performance. The Dashboard also quantifies potential financial improvements and defines priorities for management.

SAMPLE PRACTICE BENCHMARK SUMMARY

The **Practice Benchmark Summary** is a roll-up of opportunities across all the practices in the network that identifies the opportunity if practices reach benchmarked performance, and prioritizes which practices should be tackled first by management.

Practice	Net Loss In Excess of Benchmark	Provider FTEs	Priority for Management Intervention	Type of Opportunity
Client Internal Medicine 1	($878,822)	4.0	High	Building and Occupancy expense severely out of line Improve 3:1 Physician to APP ratio
Client Pediatrics 2	($347,242)	1.0	High	Low Volume not sustainable
Client Family Medicine 1	($433,045)	6.4	Moderate	Production per provider very high Practice understaffed
Client Internal Medicine 2	($335,165)	6.9	Moderate	Payer Mix a challenge Improve 6.9:0 Physician to APP ratio
Client Internal Medicine 3	($425,198)	4.8	Moderate	Improve 3.8:1 Physician to APP Ratio Building and Occupancy Cost high
Client Family Medicine 2	($423,346)	6.1	Moderate	Excess capacity in practice; needs to grow into recent provider additions
Client Internal Medicine 4	($324,534)	8.0	Low	Building/Occupancy Cost excessive Provider growth needed
Client Family Medicine 3	($237,888)	3.0	Low	Payer mix a challenge APP Ratio needs to improve

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SAMPLE NETWORK IMPROVEMENT OPPORTUNITY BY KEY METRIC

Metric vs. Benchmark or Target	Variance from Benchmark	Potential Causes	HSG Commentary
Net Income (or Loss)	($13,287,744)		
Building & Occupancy Cost per Provider	$548,789	• Inefficient space usage • Excessive lease rates	• Not a significant issue • Lease rates need to be reviewed • Consolidation should be explored as network grows
Provider Compensation per Provider	$2,215,459	• Mismatch between productivity and compensation • Provider Mix	• Some issues likely related to new physicians still ramping up • Mature practices should be evaluated for performance improvement
wRVU Production per Provider	$4,549,868	• Practice Volume • Operational Inefficiencies, i.e. Throughput • Staffing Levels • Inefficient APP usage	• Largely unproductive group • Should improve as group ages • A handful of productive practices are understaffed per benchmark – possible growth opportunity
Support Staff per Provider* *Salary only. Total benefit cost for providers and support staff was not available to HSG (benefit cost was not broken out)	$378,456-778,875	• Severely Low Productivity Below Minimum Threshold for Staffing Levels • Inefficient Staff Usage	• Practice staffing wildly variable • Some practices showing "under"staffing as well – need to look at operations to understand if this is a barrier to increased productivity
Net Patient Revenue per wRVU	$4,423,213	• Payer Mix • Payer Rates • Documentation & Coding • In-Office Revenue Cycle • Provider Credentialing	• AR Management an issue • In-office activities must be maximized to ensure revenue cycle is as robust as possible • Credentialing a clear historic issue

The **Network Improvement Summary** is a roll-up of opportunities across the entire network by key leverage point. This allows management to understand its largest opportunities and allocate efforts and resources accordingly.

PHASE TWO

Opportunity Exploration

This phase involves a deep dive into issues identified in the opportunity phase. Exploration usually includes on-site assessment of the practices and billing operations, as well as interactions with providers and practice staff to truly understand the root causes of negative variance in performance. This also provides an opportunity to engage on-the-ground stakeholders, such as practice leadership and providers, in order to create a sense of awareness and understanding of the network's opportunities for improved performance.

PHASE THREE

Implementation

Combining the insights from the opportunity and exploration phases, the final phase of implementation focuses on defining the network's path and initiatives that must be accomplished for the network to be successful. This results in a comprehensive implementation plan, which focuses on:

- Creating a clear path forward for all stakeholders
- Providing guidance to management, provider leadership, and the provider group at large of where and when to prioritize efforts and what success looks like
- Creating mutual accountability among providers, management, and network leadership
- Defining expected timelines, responsibilities, and resources needed
- Achieving the desired results

CONCLUSION

As concern grows about the financial impact of employed physician networks, healthcare executives must turn to experts for help. The long-term financial implication to the health of the organization and its sustainability are significant. Taking a thorough, phased approach to address the financial sustainability of the organization will increase the likelihood of reaching goals and improving overall performance.

To learn more about reducing employed physician network losses and creating financial sustainability, contact Travis Ansel:

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