Cutting losses IN HOSPITAL-EMPLOYED PHYSICIAN NETWORKS

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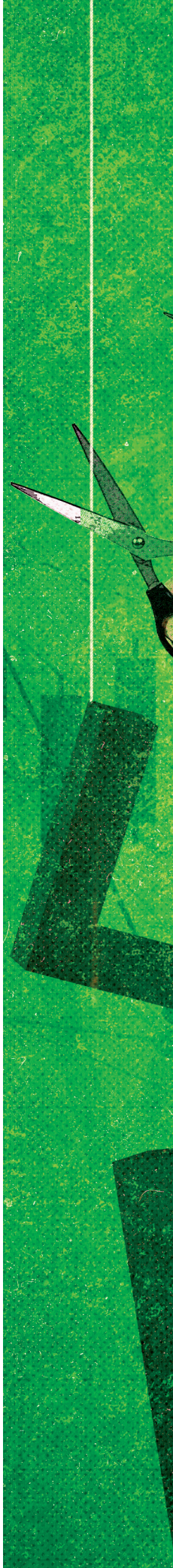

With the growth of physician employment by health systems, many challenges have emerged. Due to mismatches in supply and demand, inadequate management infrastructure and a hospital's willingness to invest capital in practices (such as for EHRs), losses on employed physician networks have steadily risen, to the point of beginning to threaten hospital bottom lines.

Hospitals have been willing to invest this money as they bought expanded patient access, emergency department (ED) coverage and ensured market viability. Health systems also realize that by building their employed network they are investing in capabilities to improve quality by better coordinating care and managing risk contracts over the long term.

While these factors have been much discussed within the industry, most health systems still do not have a sophisticated understanding of the root cause of the losses within their network. This understanding is the first step required for the organization to take action. Benchmarking will reveal a number of the factors that could be improved to produce results to mitigate those losses. To that end, MGMA's expansive survey data is an essential element in this process.

SETTING IMPROVEMENT TARGETS

A key first step in improving is setting a target. This cannot be done in a vacuum and should be based on baseline benchmarking consistent with the composition of a health system's employed physician network. Two approaches will be useful to provide context.

1. **Benchmarking losses by specialty**. Using MGMA data, you should compare your subsidy by specialty versus the norms, adjusted by number of full-time-equivalent (FTE) physicians. Generally, we recommend using the 50th percentile or median for this comparison. This approach gives you an idea of magnitude of the opportunity.
2. **Compare revenue and expense per work RVU (wRVU) and define the level of improvement required to achieve different productivity targets**. This approach has proved useful in testing if targets are realistic.

For example, a large health system defines its objective as decreasing losses by $11.7 million. Starting with collections of $65.71 per wRVU and expenses of $114.16 per wRVU, Table 1 (page 32) indicates a sensitivity analysis of collections and expenses required to achieve the objective. The analysis helps executives focus on what will be required to achieve the improved performance and becomes a prism through which tactics can be screened and prioritized.

This framing of the issue also focuses management on the importance of both revenue enhancement and cost reduction. And it begins to frame the tough decisions and pain points required to achieve the objective.

TABLE 1. SENSITIVITY ANALYSIS OF PER-wRVU COLLECTIONS AND EXPENSES BASED ON LAST FY* DATA

wRVUs	Collections per wRVU	Expenses per wRVU	Subsidy goal — 50% reduction
	$65.71	$89.98	($11.78MM)
	$67.71	$91.98	($11.78MM)
	$69.71	$93.98	($11.78MM)
	$71.71	$95.98	($11.78MM)
	$73.71	$97.98	($11.78MM)
	$75.71	$99.98	($11.78MM)
Group total wRVUs=485,124	$77.71	$101.98	($11.78MM)
	$79.71	$103.98	($11.78MM)
	$81.71	$105.98	($11.78MM)
	$83.71	$107.98	($11.78MM)
	$85.71	$109.98	($11.78MM)
	$87.71	$111.98	($11.78MM)
	$89.71	$113.98	($11.78MM)
	$91.71	$115.98	($11.78MM)

Group collections per wRVU = $65.71

We anticipated the group's actual performance should be in this range.

Group expenses per wRVU = $114.16

* fiscal year

DRIVERS OF REVENUE AND EXPENSE

In completing the benchmarking, MGMA data is used to address three buckets of opportunities.

1. **Increasing collections on the current volume of business**. Data on the revenue cycle, payer mix and fee schedules will help you gauge this opportunity. Managed care rate negotiations are also critical. Many health systems are more comfortable negotiating hospital rates and prioritize those in interactions with insurers. The lack of focus on capturing higher rates for the employed network is often a big contributing factor to the losses.
2. **The ability to reduce expenses on existing patient volume**. MGMA benchmark data is rich in this area, with data about provider compensation, staffing levels and practice overhead. Table 2 shows a complete list of items that require scrutiny to address this expense issue.
3. **Generating more revenue with the same base of providers and costs**. Issues such as scheduling, throughput, coding and retaining referrals are all important is this analysis. (Again, see Table 2.)

The physician complement is also relevant. Identifying physicians who cannot build a strong practice (who frequently correlate with big subsidies) will lead to decisions to divest some doctors. Just as important is to review the current strategic fit of the providers and practices within the network. Physicians who were employed 15 years ago based on one health system strategic plan may not be relevant to today's strategy. Acknowledging this dynamic can lead to divestiture decisions.

While the focus has been on benchmarking, direct observation is often required to fully understand what is going on in practices. This direct review of process failings is an integral part of the analysis.

CULTURE AND PHYSICIAN ENGAGEMENT

Having insights into the opportunities for improvement and having specific targets are essential steps in the improvement process. But all of this will be wasted effort if the physicians are not engaged and do not understand and support the changes required. This starts with transparency about the group and the health system's objectives. Likewise, having a shared vision of the group's future and how it should evolve is important.

Identify or develop a physician leadership council for the employed group that understands the imperative to improve and that can help guide the health system through the process. These changes will be resisted and their effectiveness diminished if pursued by management fiat. The importance of this point cannot be overemphasized.

DEFINING ACTIONS FOR IMPLEMENTATION

Turning the data into actionable information with defined priorities is the next step. Actions

TABLE 2. INFLUENCING FACTORS FOR NETWORK IMPROVEMENT OPPORTUNITIES

Network improvement opportunities	Influencing factors
Can we collect more revenue on our current volume?	• Managed care strategy and rates • Fee schedule • Payer mix • Revenue cycle effectiveness
Can we reduce expenses on our current volume?	• Provider total compensation • Provider mix (physicians vs. advanced practitioners) • Staffing levels and professional utilization • Staffing total compensation • Administrative overhead • Practice overhead • Practice consolidation
Can we produce more volume without increasing providers and staff?	• Retention of patients/improvement of network integrity • Coding and documentation • Provider schedules/scheduling templates • Remove barriers to patient access • Remove barriers to efficient practice operations • Care management • Top-of-license provider usage
Should we reduce our provider complement?	• Mismatch with current/future health system strategic needs • Opportunities to move practice to independence or aligned third party (FQHC, etc.) • Realization that practice/provider is not going to meet performance standards

can be defined at the network level (common cause variation) for opportunities that are systematic across the network. Examples include revenue cycle deficiencies or systematic issues with the compensation model.

Actions also might be defined at the individual practice level (special cause variation) if the opportunities relate to the operations of the specific practice. These challenges might relate to overstaffing in a practice, scheduling problems in a practice or the weakness of an individual physician.

Once the important steps are defined, building action plans is a key step in increasing accountability. Beyond identifying the action, the owner and time frame, the plan should also include the financial implications, the required resources and the projected impact on the cost per wRVU, as well as the impact on revenue and expense per wRVU. This level of detail will help management ensure the actions are comprehensive enough to reach the objective.

The resources available to management will be documented in these plans. It is useful to create some urgency around the financial objective — highlighting the management resources required to change the group's performance can be vital to the success of the work. This is no time to attempt to save FTEs.

CONCLUSION

In reducing losses, there are six core lessons to bake into your process:

1. Understand the benchmark data.
2. Use that data and organizational imperatives to set a dollar saving objective.
3. Analyze the data to identify the root causes of the problems.
4. Verify those insights with "boots on the ground" reviews.
5. Build action plans with an eye toward the objective and improvement needed to achieve it.
6. Ensure adequate management resources are dedicated to implement the plan.

With these basic tenants and good data, you are guaranteed to make progress in improving performance. ■

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