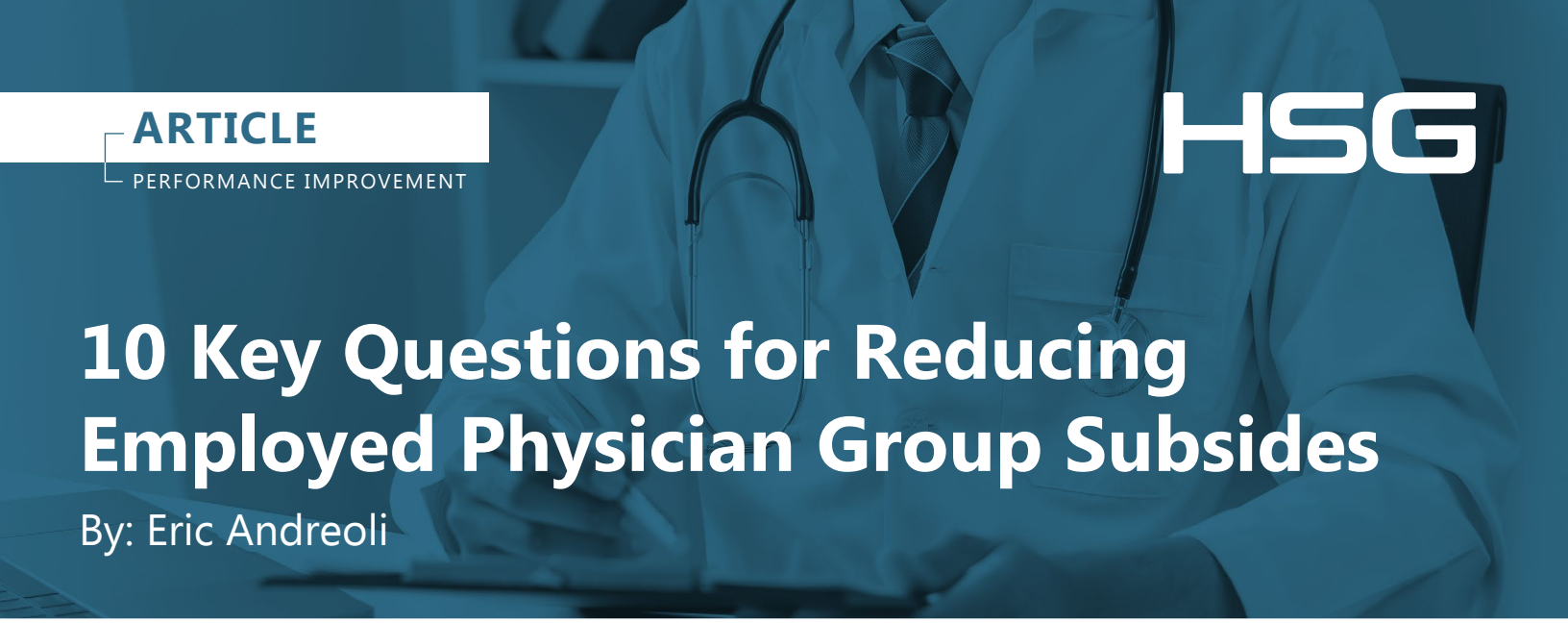


ARTICLE

PERFORMANCE IMPROVEMENT

10 Key Questions for Reducing Employed Physician Group Subsides

By: Eric Andreoli

Subsidies for health system-owned employed physician groups continue to grow in both totality and run-rate. While "breakeven" is not a realistic target, health systems looking to increase bottom-line financial performance should focus on optimizing the subsidies generated by the employed network. However, many health systems struggle with how to identify what level of subsidies are appropriate and how to take action on improving performance.

HSG's Network Assessment process focuses on 10 Core Questions that drive financial performance within an employed physician group with a focus on both revenue generation and expense reduction. The key to ultimate improvement is having a prioritized, actionable plan that comprehensively identifies opportunities and needed actions to execute on those opportunities.

1 **Patient Access:** Are we making it easy for patients and providers within our system to access our specialists and services?

Questions around patient capture and retention are extremely important but rarely receive proper diligence. Many leaders assume their employed primary care providers are referring patients to their employed specialists; though we frequently see this assumption proven false. In some cases, the primary care providers prefer to refer to non-employed specialists. More commonly, however, patients may be self-directing or selecting specialists based on other factors including marketing, reputation, and availability.

We suggest utilizing a claims-based approach such as **HSG Physician Network Integrity Analytics®** to understand exactly how patients in your market are accessing care. By analyzing patient flow, you can work with your primary care providers to understand why patients might be choosing other specialists and identify opportunities for improvement.

2 **Revenue Cycle:** Do we have optimal revenue cycle processes?

With tightening payer-rates and increasingly competitive market landscape, it is crucial to ensure your revenue cycle process maximizes collections. Organizations cannot afford to leave money on the table

with sub-optimal revenue cycle. Unfortunately, we commonly see health systems focus on hospital revenue cycle at the expense of practice collections. . then often scrutinize the employed group for increasing loss.

We recommend looking at multiple indicators to asses revenue cycle performance. Common metrics such as a collections per wRVU, days in A/R, and denial rate should be evaluated. Additionally, contextual indicators such as market demographics, payer mix, and payer rates should be considered as well. This information may explain deviation from benchmarks or help identify other barriers to performance improvement.

3 **Expense Reduction:** Is there opportunity to decrease our expenses without sacrificing quality or volume?

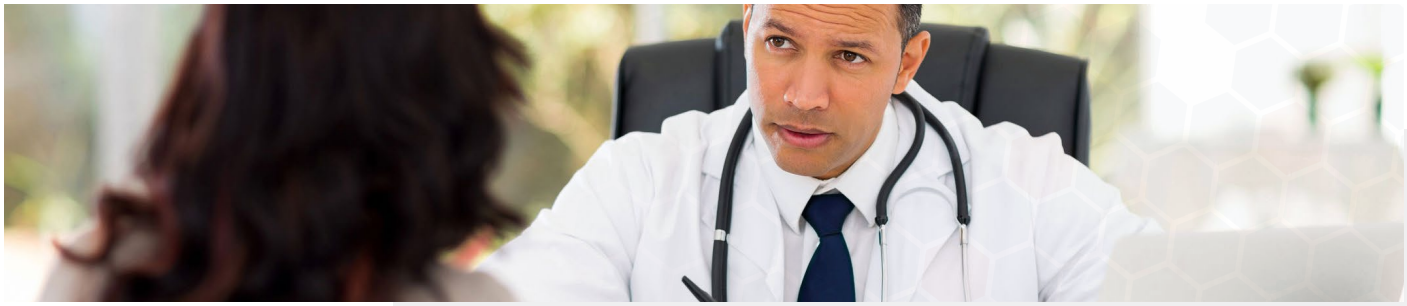
When scrutinizing the bottom line, it is easy to assume there is opportunity in expense reduction. However, we offer caution around this line of thinking. As is often said, it is very difficult to cut your way to profitability. Revenue growth is the preferred method for bottom-line improvement but that does not mean you should turn a blind eye to your expense structure.

We recommend routine analysis of major expense categories, particularly those related to provider cost, staffing cost, and overhead. Comparing to benchmarks using per provider and per wRVU ratios may identify potential opportunities. Care should be taken to ensure that cost reductions do not hurt long-term revenue.

4 **Provider Mix:** Does our mix of practices and specialties support the strategic needs of our organization?

At HSG, we spend a lot of time talking about **HSG's Physician Network Growth Phases**. This framework describes how employed provider organizations go through a series of phases on their way to high-performance. It is important to note that strategic needs of an employed group change throughout these phases, and therefore follows that the mix of providers needed to address these strategies will also change.

We recommend evaluating your current provider mix against your existing and future strategic needs. For example, by analyzing ratios of primary care to medical and specialty providers, you can identify if you have a sufficient primary care base to keep your specialists busy. This type of information can guide decisions around provider recruitment and practice acquisition.



5 **Market Presence:** Are our practices distributed across our market to allow for easy access to primary care and other services?

A health system's practice footprint must reflect its ambition for growth; markets cannot be penetrated without a provider presence. This often takes the form of primary care access points but may also include specialty clinics or other services. Too often, we see organizations with mostly on-campus practices struggling to gain market share across their service area.

We routinely help employed networks assess and improve their geographic footprint. One effective analysis is to identify the number of people who have convenient access to an employed primary care practice. If only a small proportion of an urban market's population lives within a 10-minute drive time to an employed primary care practice, for example, the organization is likely losing the primary care market share battle which in turn impacts specialty visit and hospital market share.

6 **Provider Compensation:** What is our provider compensation philosophy?

Provider compensation is the largest expense of an employed network. It follows that organization's should put significant effort into developing sustainable compensation plans. Such plans should align with current future organizational strategies and must also evolve with the organization over time. It is therefore no surprise that many organizations are in the process of updating their years old productivity-driven plans to alter existing and incorporate additional incentives.

We recommend routine examination of provider compensation on two levels. First, compensation must be evaluated through the lens of commercial reasonableness and fair market value. Every organization should have a process by which every provider's compensation is evaluated in relation to performance. High compensation levels create compliance risk which must be mitigated by FMV justification or compensation alteration. Second, the compensation structure must be assessed through the lens of operational and strategic need. If incentives are not driving desired behavior, the compensation plan should be altered. This is especially true as organizations increasingly employ APPs and must reevaluate **incentives for both APPs and their physician counterparts**.

7 **Staffing Levels:** Are practice staffing levels sufficient?

It takes more than physicians and APPs to make a practice run. Practice managers, back-office staff, front-office staff, and clinical support are all required to ensure the providers can efficiently see patients. Thus, it is important to review support staffing levels with the same rigor as revenue collection or provider productivity. There is a strong connection between appropriate staffing and strong practice performance; understaffed practices are less likely to have highly productive providers and more likely to accelerate provider burn-out.

When evaluating the performance of an employed network, it is therefore necessary to evaluate support staffing levels in relation to the number of physicians, providers, and wRVUs. Each of these ratios can be compared to benchmarks to understand staffing levels. A very busy practice's support level, for example, may appear higher than the per physician benchmark but lower than the per wRVU benchmark.

8 **Advanced Practice Providers:** Do we have a clear strategy for recruiting, integrating, and maximizing advance practice providers in our practices?

Advanced Practice Providers (APPs) are increasingly being utilized to improve access, address physician shortages, and support value-based care delivery. However, introducing APPs and utilizing APPs at their maximum capacity represent significant paradigm shifts for most organizations. For this reason, we see many organizations struggling with effective APP utilization. Issues with physician and market acceptance may lead to mis-utilization of APPs and failure to realize the intended benefits of incorporating APPs into the practice model.

We recommend comparison of your organizations APP policies to best practices in order to identify any potential barriers to APP utilization. HSG has published multiple articles on this topic, such as **Incorporating APPs into Patient Care Delivery** by Dr. Terry McWilliams. Additional, quantitative analysis can include APP productivity levels, compensation levels, and ratios of APPs to physicians.

9 **Management Infrastructure:** Do we have the right management infrastructure to support our practices?

As employed networks grow, so should the level of sophistication required to properly manage the provider enterprise. Unfortunately, many organizations we work with have not updated their management infrastructure to keep pace with their group's growth. As a result, many employed groups are severely under resourced. This creates operational issues as specialty growth increases variation in practice models and primary care growth often increases geographic dispersion. It also creates cultural and provider issues as communication becomes strained.

Creating the right management infrastructure requires understanding the status quo and identifying areas for improvement. The first step to this is often reviewing the current organization chart for bottlenecks and areas with potential span of control issues. We often recommend divisions for primary care, medical specialties, and surgical specialties but the right structure will depend on specialty mix and geographic footprint of practices. Additionally, practice management job descriptions should be reviewed to ensure consistency across the group and with overall strategic objectives.

10 | **Physician Leadership:** Do we have an effective structure for provider leadership?

Physician leadership is indispensable to delivering high-quality and cost-efficient care to engaged and satisfied patients. Incorporating an effective physician leadership structure into an employed provider group propels the group on its path towards high performance while increasing provider engagement, supporting recruitment, and mitigating burnout. For these reasons, organizations who focus on physician leadership often see significant return on investment.

When assessing improvement opportunities within your employed network, physician leadership should be evaluated. The type and role of the leadership structure should be considered, as well as how the leadership structure relates to the group's organizational structure. Additional considerations should be given to leadership council make-up, charter, expectations, and sub-committee roles. These elements should be compared to best practices, many of which have been defined by HSG in articles such as **Physician Leadership Within Employed Networks**.

ABOUT HSG

HSG is a national healthcare consulting firm that focuses on building high-performing employed physician networks and physician integration so health systems can address complex changes with confidence. We work as a part of your team to build an operationally efficient, strategically valuable provider network. If physician employment is not an option, we define the best model for integration of private groups, the model that best aligns strategy and incentives.

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