Cutting Physician Network Losses

HSG Philosophy and Frameworks

Learning Objectives

- Break down the factors contributing to subsidies for employed provider networks

- Prepare an appropriate subsidy target based on benchmark data

- Outline a prioritized performance improvement plan

Today's **Presenters**

TRAVIS ANSEL
MBA

MANAGING PARTNER

Email: TAnsel@HSGadvisors.com
Office: (502) 814-1182
Cell: (502) 994-0073

10+ Years in Management Consulting for Health Systems and Employed Physician Networks

Expertise in:
- Employed Physician Network Growth
- Physician Network Strategy
- Market Development Strategy
- Operational and Financial Performance
- Management Infrastructure

ERIC ANDREOLI
MBA

DIRECTOR

Email: EAndreoli@HSGadvisors.com
Office: (502) 814-1193
Cell: (502) 322-2087

10+ Years in Health System Strategy Consulting

Expertise in:
- Strategic Planning for Employed Networks
- Market Development and Growth Strategy
- Network Integrity and Patient Capture

HSGs Observations on Employed Physician Network "Losses"

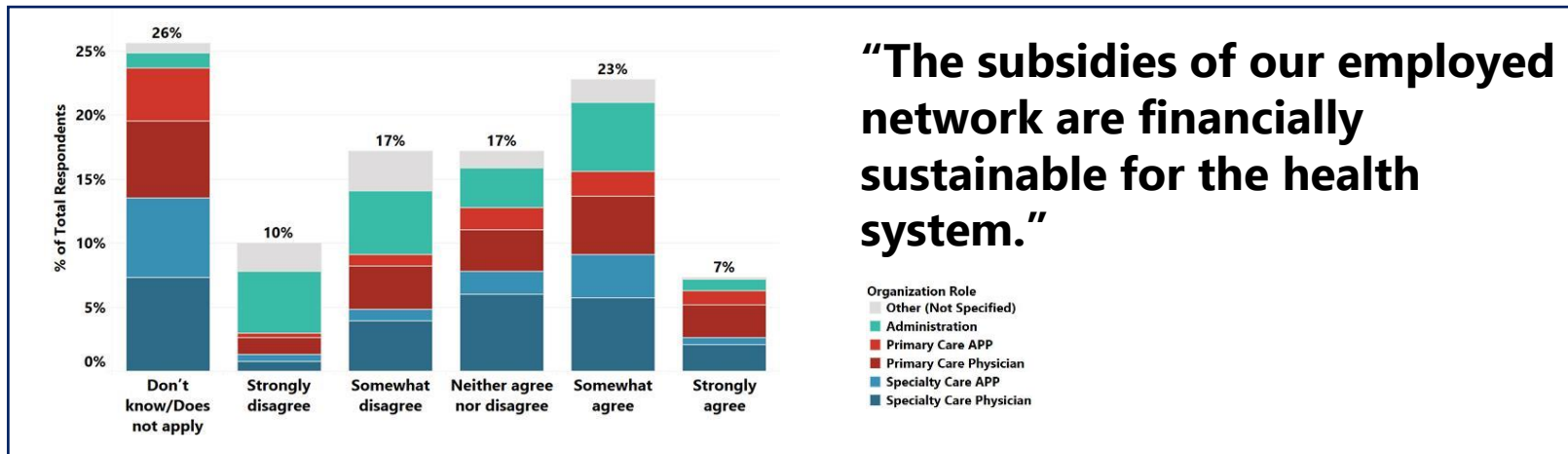# Employed Physician Network Losses
Definitions

Definition: "Losses" / "Subsidies" / "Investment"; net financial performance of operations of employed physician practices on direct expenses plus allocated health system overhead

- Important to use a standard definition when benchmarking

- Many organizations struggle with allocations of overhead, distorting performance against benchmark

Employed Physician Network Losses
Views from Health Systems in Today's Environment

- Historical pressure point for health systems

"**The subsidies of our employed network are financially sustainable for the health system.**"

- Many organizations struggle with both totality and growth in run rate of losses
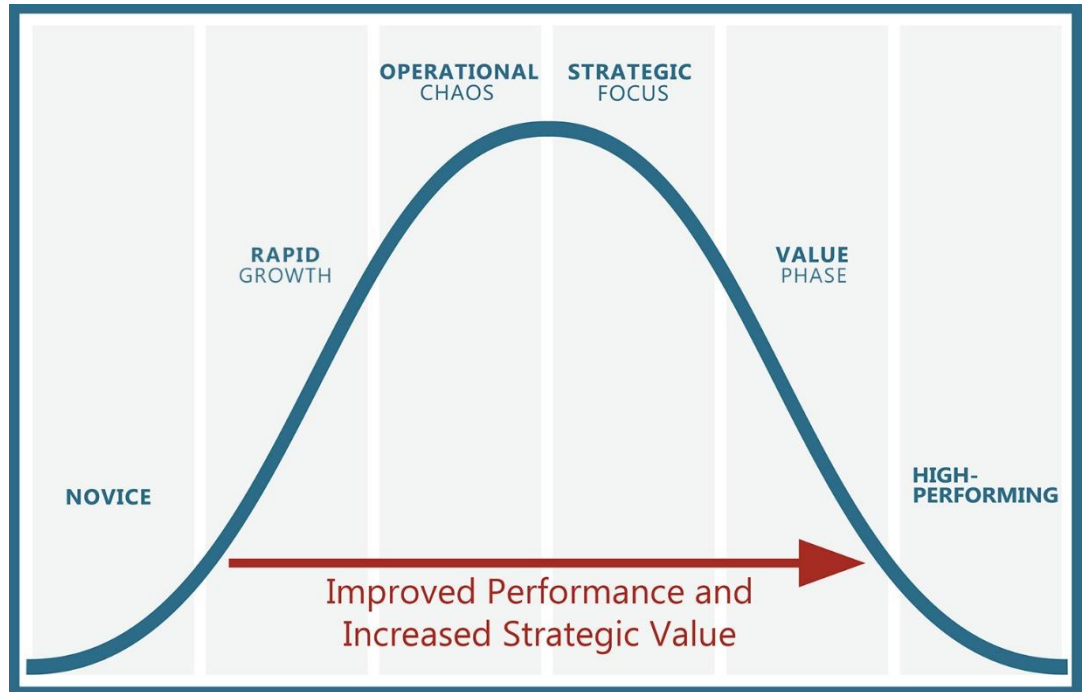
Employed Physician Network Losses
HSG Philosophy

- Economics of employment inevitably drive subsidies

- Views of getting to "breakeven" are unrealistic in today's (and future) environment

- Optimization of "losses" should be the focus

- Optimization of subsidies requires a robust view of both halves of the P&L

- Goals of performance improvement initiatives must be done within the context of the network's evolution

HSG Physician Network Growth Phases
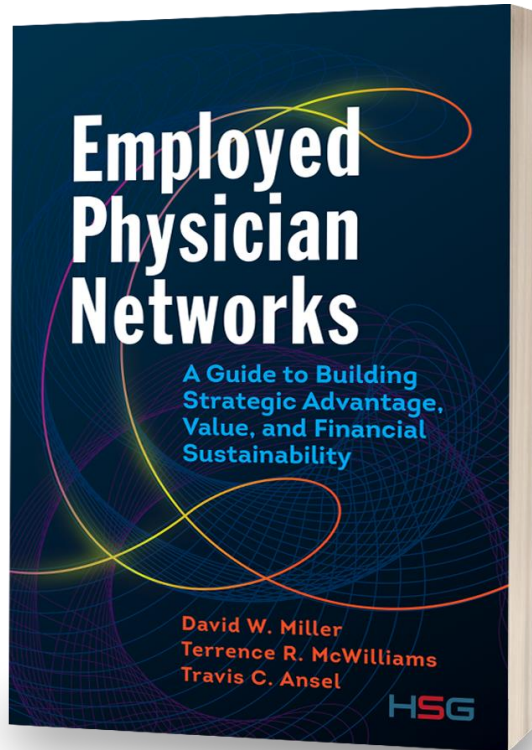
HSG Physician Network Growth Phases™

Our Philosophy on Employed Network Growth: As an Employed Physician Network evolves towards maturity in terms of its growth and size, **the network must have a systematic plan** that is focused on evolving its management team's capabilities, infrastructure, governance, provider engagement and leadership to address the network's current and future needs as well as execute on the health system's strategic goals.

Employed Physician Network Losses

HSG Physician Network Growth Phases™
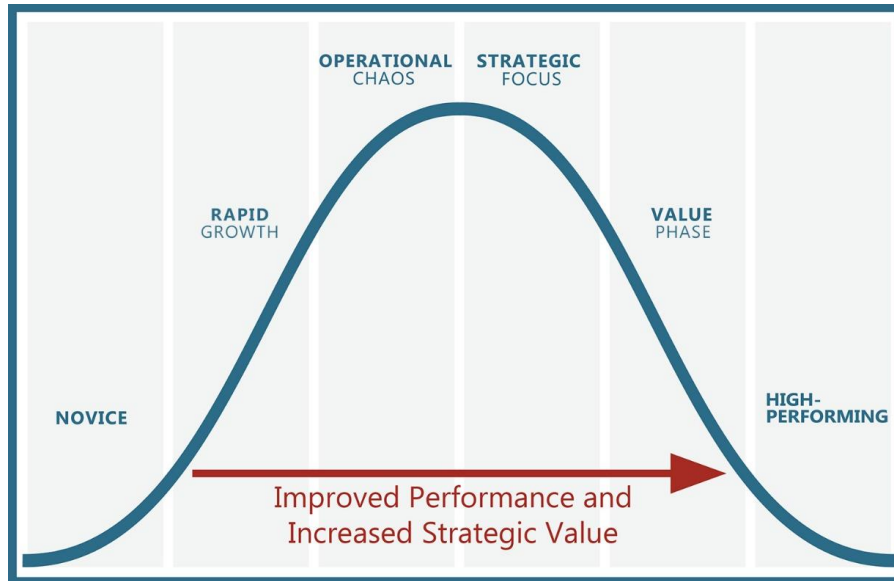
- Concern over losses most prevalent in "Operational Chaos"
- "Rapid Growth" excitement has worn off – subsidies a reality
- Board/Executive hesitancy to increase losses impedes investment in infrastructure
- Physician/provider frustration with hearing about "losses" impedes strategy and culture development
- Network Leadership and practice managers continually pressured by "fire-fighting" of day-to-day

Putting Your Network's Subsidies in Context and Defining Realistic Targets
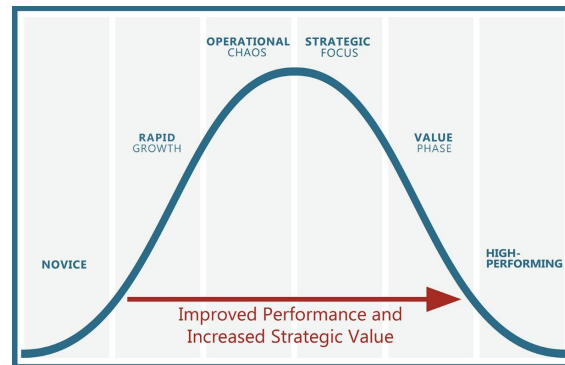
Putting Network Subsidies in Context
Contextualizing Employed Group Losses

Employed group and hospital/system leaders struggle to put losses into context.

Three reasons:

1. Variable progression along network growth curve

HSG Physician Network Growth Phases™

2. Differing views on role of physician enterprise

"If private practices can operate independently, our employed practices should too"

"Employed network losses do not matter because the hospital is so profitable"

Continuum of Delusion

3. Sub-optimal interpretation of benchmark data

Putting Network Subsidies in Context
Shouldn't This Be Easy?

| If I know the benchmark… | And have my P&L… | Shouldn't this be easy? |

Charges & Revenue per FTE Physician for Multispecialty for Hospital/IDS Owned

Expand Table   Choose measures ▼

	Benchmark	All Practice Types Median
Total gross charges		$1,230,717
Total medical revenue		$669,656
Total medical revenue after operating cost		$214,901
Total medical revenue after operating and nonphysician provider cost		$162,888
Net FFS revenue		$588,596
Net capitation revenue		$52,508
Net other medical revenue		$48,556
Net nonmedical income/loss		$55,963
Net income/loss, excluding financial support (all practices)		-$186,126

Source: 2020 MGMA DataDive
Cost and Revenue

115 Physician Employed Group

	Actual
Gross charges	$300M
Net Revenue	$100M
Total Expenses	$120M
Net Income (Loss)	($20M)

Loss Per Physician Compared to Benchmark

Actual loss	$174k
Benchmark loss	$186k
Conclusion	**Doing great!**

Putting Network Subsidies in Context
Benchmarking Consideration

Five considerations for optimal benchmarking:

1. Pick the right comparison groups

2. Use the most relevant ratios

3. Make adjustments

4. Apply thought and acknowledge nuance

5. Have frameworks to assess status quo and identify opportunities

Putting Network Subsidies in Context
Benchmarking Consideration

#1: Pick the right comparison groups

2019 MGMA Hospital-Owned Multispecialty loss per physician: $158,343
But consider an employed group with considerable make-up of specialty providers.

Example Group Practice	MGMA Specialty/Group Type	Physician FTEs	MGMA Median	Expected Value at MGMA Median
INTERNAL MEDICINE	Primary Care Single Specialties	5.98	($175,610)	($1,050,148)
ORTHOPEDIC SURGERY	Orthopedic Surgery	5.00	($460,231)	($2,301,155)
NEUROSURGERY	Surgery: Neurological	3.41	($577,486)	($1,969,227)
GENERAL SURGERY	Surgery: General	2.99	($309,612)	($925,740)
PODIATRY	Nonsurgical Single Specialties	2.24	($309,077)	($692,332)
CARDIOLOGY	Cardiology	2.11	($464,703)	($980,523)
BARIATRIC SURGERY	Surgical Single Specialties	1.54	($406,260)	($625,640)
GASTROENTEROLOGY	Gastroenterology	1.08	($269,312)	($290,857)
SPORTS MEDICINE	Primary Care Single Specialties	0.75	($175,610)	($131,708)
ONCOLOGY	Hematology/Oncology	0.75	($558,714)	($419,036)
NEUROLOGY	Neurology	0.75	($383,364)	($287,523)
NEPHROLOGY	Nonsurgical Single Specialties	0.75	($309,077)	($231,808)
GERIATRICS/INTERNAL MEDICINE	Primary Care Single Specialties	0.75	($175,610)	($131,708)
FAMILY MEDICINE	Primary Care Single Specialties	0.75	($175,610)	($131,708)
CARDIOTHORACIC SURGERY	Surgery: Cardiovascular	0.75	($684,139)	($513,104)
VASCULARY SURGERY	Surgical Single Specialties	0.50	($406,260)	($203,130)
ENDOCRINOLOGY	Endocrinology/Metabolism	0.47	($241,755)	($113,625)
Weighted Average Based on Physician FTEs & MGMA Median		30.57	**($359,796)**	($10,998,971)

Source: Source: 2019 MGMA DataDive Cost and Revenue (includes groups with less than 3 providers)
MGMA Median = Net income/loss, excluding financial support (all practices)

Putting Network Subsidies in Context
Benchmarking Consideration

#2: Use the most relevant ratios

Benchmarks available as ratio of Physician FTEs, Provider FTEs, and wRVUs.
Consider a very busy employed network with a high number of APPs.

Example Group Number of Providers in Each MGMA wRVU Percentile

	<25th	25th – 50th	50th – 75th	>75th
Provider Count	39	31	45	101
Provider %	18%	14%	21%	47%

Physician : APP Ratio

Group Actual	1.0
MGMA Median	0.37

Key Metrics Compared to Benchmark by Ratio Type

	Per Physician		Per Provider		Per wRVU	
	Group Actual	MGMA Median	Group Actual	MGMA Median	Group Actual	MGMA Median
Total gross charges	$2,218,703	$1,154,456	$1,108,532	$749,453	$191	$157
Net Patient Service Revenue	$598,649	$510,278	$299,103	$350,458	$52	$69
Total physician compensation	$466,508	$385,805	$233,081	$227,708	$40	$50
Total cost	$970,296	$820,049	$484,789	$541,360	$84	$110
Net Income / (Loss)	($371,647)	($126,126)	($185,686)	($165,585)	($32)	($27)

Source: Source: 2020 MGMA DataDive Cost and Revenue (Hospital/IDS Owned)
Weighted averages based on practice specialties and number physicians, providers, and wRVUs for each practice.

Putting Network Subsidies in Context
Benchmarking Consideration

#3: Make adjustments

Adjustments may be required to ensure apples to apples comparison to benchmarks.
Consider a network that allocates certain hospital revenue back to practices for financial reporting.

Metric	Example Group Unadjusted Actual	Example Group Adjusted Actual	Projected Range assuming MGMA Median Performance
Gross charges	$300M	$225M	$160M - $180M
Net Revenue	$100M	$75M	$60M - $85M
Total Expenses	$120M	$120M	$80M - $115M
Net Income (Loss)	($20M)	($45M)	($20M-$35M)

Source: 2019 MGMA DataDive Cost and Revenue (Hospital/IDS Owned)
Projected range calculated by taking each practice's number of providers multiple by MGMA median for the practice's specialty.
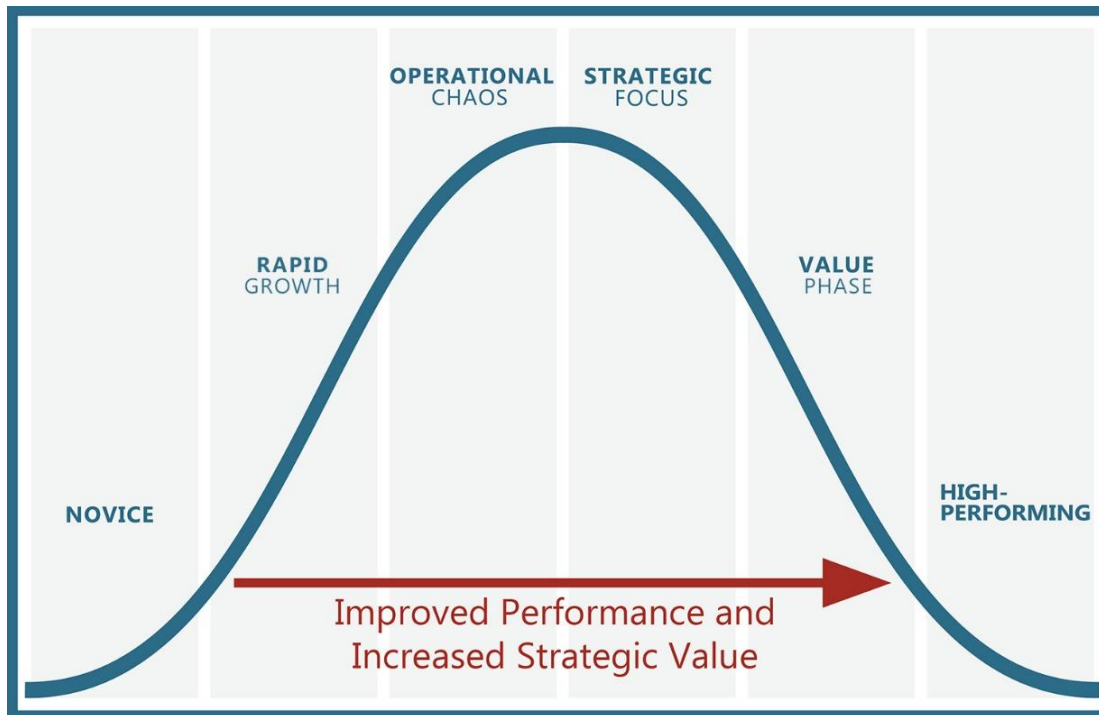Total represents sum of all practices.

Also applicable to:
- Overhead expense allocations including HR, billing, IT, etc
- Staffing allocations, where some practices may be supported by a hospital cost department.

Putting Network Subsidies in Context
Benchmarking Consideration

#4: Apply thought and acknowledge nuance
Deviation from benchmarks is sometimes explained and/or expected.
Consider a network that is very progressive in providing value-based care.

OPERATIONAL CHAOS   STRATEGIC FOCUS

RAPID GROWTH

VALUE PHASE

NOVICE

HIGH-PERFORMING

Improved Performance and Increased Strategic Value

Network with heavy value emphasis might employ care coordinators, clinical practice leads, or other supporting staff.

This may result in some metrics being higher than the benchmarks:
- Staffing ratios
- Staffing cost

Putting Network Subsidies in Context
Benchmarking Consideration

#5: Have frameworks to assess status quo and identify opportunities
One data-point does not tell the study; a framework is required to bring together multiple analyses.

Network Improvement Opportunities	Influencing Factors
Can we increase collections on existing volume?	• Fee schedule • Payer mix and market demographics • Revenue cycle effectiveness • Coding and documentation
Can we decrease expenses on existing volume?	• Provider mix • Staffing levels and utilization • Staffing compensation • Administrative overhead • Practice overhead • Practice consolidation
Can we generate more volumes with existing providers and staff?	• Patient retention • Provider schedules and scheduling templates • Patient access • Efficient practice operations • Care management • Service and procedure mix • Top-of-license provider utilization
Should we divest or add any providers or practices?	• Mismatch with current/future health system strategic needs • Opportunities to move practice to independence or aligned 3rd Party

Cost Per wRVU

Fiscal Year wRVUs = 310,000 / Revenue Per wRVU	$97.00	$95.00	$93.00	$91.00	$89.00
$51.00	($57.2M)	($54.7M)	($52.2M)	($49.8M)	($47.3M)
$54.00	($53.5M)	($51.M)	($48.5M)	($46.M)	($43.5M)
$57.00	($49.8M)	($47.3M)	($44.8M)	($42.3M)	($39.8M)
$60.00	($46.M)	($43.5M)	($41.M)	($38.6M)	($36.1M)
$63.00	($42.3M)	($39.8M)	($37.3M)	($34.8M)	($32.3M)
$66.00	($38.6M)	($36.1M)	($33.6M)	($31.1M)	($28.6M)
$69.00	($34.8M)	($32.3M)	($29.9M)	($27.4M)	($24.9M)
$72.00	($31.1M)	($28.6M)	($26.1M)	($23.6M)	($21.1M)
$75.00	($27.4M)	($24.9M)	($22.4M)	($19.9M)	($17.4M)
$78.00	($23.6M)	($21.1M)	($18.7M)	($16.2M)	($13.7M)

MGMA Hospital Owned Multispecialty Practices

Net Revenue per wRVU	25th percentile: $72 50th percentile: $89 75th percentile: $117
Cost per wRVU	50th percentile: $138 25th percentile: $117

Legend
Most Recent FY
Realistic Target Range
Stretch Target Range
Unrealistic Target Range

HSG Framework for Evaluating Employed Physician Network Subsidies and Defining Areas of Opportunity

Subsidy Reduction Framework

Network Improvement Opportunities	Influencing Factors
Can we increase collections on existing volume?	• Commercial payer contract rates • Fee schedule • Payer mix and market demographics • Revenue cycle effectiveness • Coding and documentation
Can we decrease expenses on existing volume?	• Provider mix (Physicians vs Advanced Practitioners) • Staffing levels and utilization • Staffing compensation • Administrative overhead • Practice overhead • Practice consolidation
Can we generate more volumes with existing providers and staff?	• Patient retention • Provider schedules and scheduling templates • Patient access • Efficient practice operations • Care management • Service and procedure mix • Top-of-license provider utilization
Should we divest or add any providers or practices?	• Mismatch with current/future health system strategic needs • Opportunities to move practice to independence or aligned 3rd Party

Increasing Collections on Current Volume

Network Improvement Opportunities	Influencing Factors
Can we increase collections on existing volume?	• Commercial payer contract rates • Fee schedule • Payer mix and market demographics • Revenue cycle effectiveness • Coding and documentation

Fiscal Year wRVUs = 1,000,000		Cost Per wRVU						
		$125	$123	$121	$119	$117	$115	$113
Revenue Per wRVU	$75	(50.0)	(48.0)	(46.0)	(44.0)	(42.0)	(40.0)	(38.0)
	$77	(48.0)	(46.0)	(44.0)	(42.0)	(40.0)	(38.0)	(36.0)
	$79	(46.0)	(44.0)	(42.0)	(40.0)	(38.0)	(36.0)	(34.0)
	$81	(44.0)	(42.0)	(40.0)	(38.0)	(36.0)	(34.0)	(32.0)
	$83	(42.0)	(40.0)	(38.0)	(36.0)	(34.0)		
	$85	(40.0)	(38.0)	(36.0)	(34.0)	(32.0)		
	$87	(38.0)	(36.0)	(34.0)	(32.0)	(30.0)		

Color	Description
(light blue)	**Most Recent Fiscal Year** Organizations Current Performance
(green)	**Realistic Target Range –** Based on National Benchmarks
(yellow)	**Stretch Target Range –** Each variable requires significant change from current state
(red)	**Unrealistic Target Range –** Collections Per wRVU and Cost Per wRVU both required to moved too drastically

Decreasing Expenses on Current Volume

Network Improvement Opportunities	Influencing Factors
Can we decrease expenses on existing volume?	• Provider mix (Physicians vs Advanced Practice Providers) • Staffing levels and utilization • Staffing compensation • Administrative overhead • Practice overhead • Practice consolidation

Fiscal Year wRVUs = 1,000,000	Cost Per wRVU						
	$125	**$123**	**$121**	**$119**	**$117**	**$115**	**$113**
$75	(50.0)	(48.0)	(46.0)	(44.0)	(42.0)	(40.0)	(38.0)
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$79	(46.0)	(44.0)	(42.0)	(40.0)	(38.0)	(36.0)	(34.0)
$81	(44.0)	(42.0)	(40.0)	(38.0)	(36.0)	(34.0)	(32.0)
$83	(42.0)	(40.0)	(38.0)	(36.0)	(34.0)		
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Revenue Per wRVU (row axis label)

Color — Description

Most Recent Fiscal Year – Organizations Current Performance

Realistic Target Range – Based on National Benchmarks

Stretch Target Range – Each variable requires significant change from current state

Unrealistic Target Range – Collections Per wRVU and Cost Per wRVU both required to moved too drastically

Generating More Volume Within Existing Cost Structure

Network Improvement Opportunities	Influencing Factors
Can we generate more volumes with existing providers and staff?	• Patient retention • Provider schedules and scheduling templates • Patient access • Efficient practice operations • Care management • Service and procedure mix • Top-of-license provider utilization

Fiscal Year wRVUs = 1,000,000	Cost Per wRVU						
	$125	**$123**	**$121**	**$119**	**$117**	**$115**	**$113**
$75	(50.0)	(48.0)	(46.0)	(44.0)	(42.0)	(40.0)	(38.0)
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$81	(44.0)	(42.0)	(40.0)	(38.0)	(36.0)	(34.0)	(32.0)
$83	(42.0)	(40.0)	(38.0)	(36.0)	(34.0)		
$85	(40.0)	(38.0)	(36.0)	(34.0)	(32.0)		
$87	(38.0)	(36.0)	(34.0)	(32.0)	(30.0)		

Revenue Per wRVU

Color	Description
(light blue)	**Most Recent Fiscal Year** — Organizations Current Performance
(green)	**Realistic Target Range** — Based on National Benchmarks
(orange)	**Stretch Target Range** — Each variable requires significant change from current state
(red)	**Unrealistic Target Range** — Collections Per wRVU and Cost Per wRVU both required to moved too drastically

Divestiture Considerations

Network Improvement Opportunities	Influencing Factors
Should we divest providers or practices?	• Mismatch with current/future health system strategic needs • Opportunities to move practice to independence or aligned 3rd Party

Fiscal Year wRVUs = 1,000,000 — Cost Per wRVU vs Revenue Per wRVU matrix

Fiscal Year wRVUs = 1,000,000	Cost Per wRVU						
Revenue Per wRVU	$125	$123	$121	$119	$117	$115	$113
$75	(50.0)	(48.0)	(46.0)	(44.0)	(42.0)	(40.0)	(38.0)
$77	(48.0)	(46.0)	(44.0)	(42.0)	(40.0)	(38.0)	(36.0)
$79	(46.0)	(44.0)	(42.0)	(40.0)	(38.0)	(36.0)	(34.0)
$81	(44.0)	(42.0)	(40.0)	(38.0)	(36.0)	(34.0)	(32.0)
$83	(42.0)	(40.0)	(38.0)	(36.0)	(34.0)		
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Color — **Description**

Most Recent Fiscal Year Organizations Current Performance

Realistic Target Range – Based on National Benchmarks

Stretch Target Range – Each variable requires significant change from current state

Unrealistic Target Range – Collections Per wRVU and Cost Per wRVU both required to moved too drastically

Divestiture Considerations

- Why consider divesting practices?
  - Employed Physician Networks often grew in a serendipitous fashion, rather than strategic fashion
  - Serendipitous = whoever approached for employment
  - Strategic = who do we need to employ to achieve our vision and strategic objectives, i.e., core to mission

- Serendipitous growth can result in the presence of individuals or specialties that are not ideally suited for the network

- Metrics exist to determine/review individual and practice performance and fit within the Network

- The long-term health of the employed network might disproportionately be adversely impacted by providers and practices that do not exhibit a good fit with vision and desired culture

Organizational Capabilities Needed to Achieve Performance Improvement

(Not an Exhaustive List)

Shared Vision

Shared Vision Description

- Lengthy, descriptive narrative that clearly articulates how the group will ideally look and act in 5-10 years

- Defines an idealistic future state in enough detail so all stakeholders within the network can understand and work toward it

- Becomes cornerstone for "Group" Culture

- Becomes the basis for strategic planning and management action

- Physician leadership and subcommittees therein should actively be tasked with achievement of the Shared Vision

HSG | **Physician Network**
Building a Shared Vision

YOUR ROADMAP
TO SUCCESS

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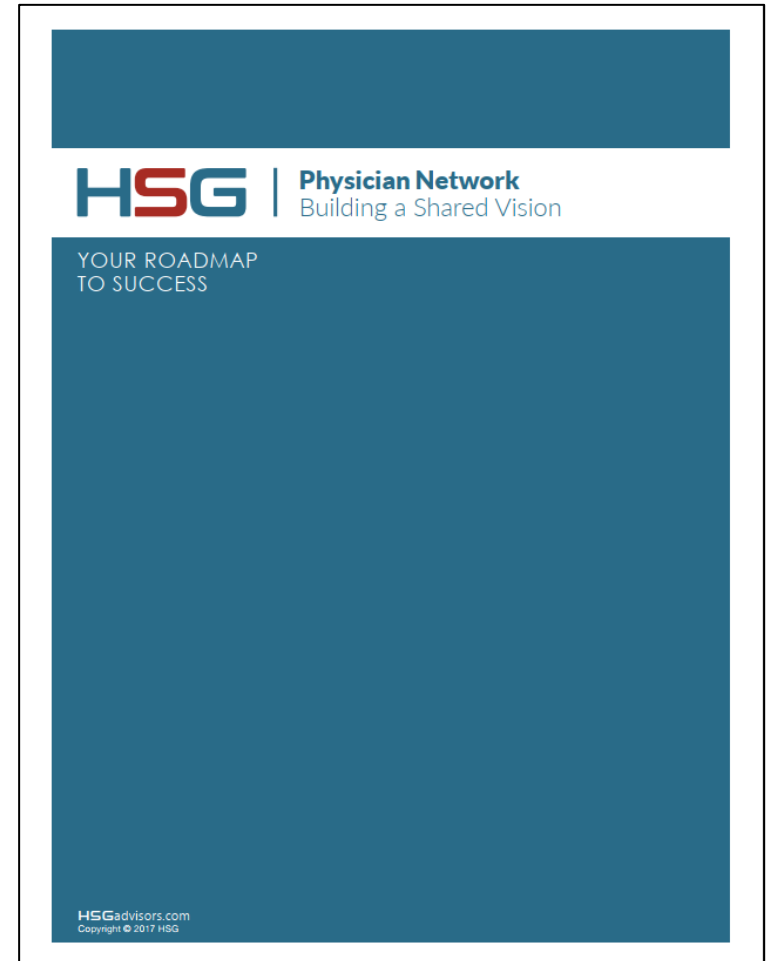
Addressing Management Infrastructure

Common Characteristics of Inadequate Management Infrastructure

Lack of Dedicated Resources

Operational Chaos networks tend to have multiple shared resources with the health system, leading to a lack of support for the network overall. Employed networks in Operational Chaos should seek to have full-time leadership, as well as clearly dedicated personnel and resources, even for functions shared with the health system (i.e. revenue cycle and billing).

Excessive Span of Control

Operational Chaos networks tend to have a lack of investment in leadership, resulting in wildly out-of-line management span of control. Networks should aim for having an organizational structure that promotes a span of control of 5-7 capable direct reports. Any more than this, and the accountability and mentorship of the reporting roles suffers.

Disconnect Between Administrative and Physician Leadership

Operational Chaos networks frequently do not have well-developed physician leadership or advisory functions, and when these do exist, they operate in a vacuum outside of the administrative chain-of-command.

Gaps in Capabilities of Practice-Level Leadership

Underinvestment in management resources, combined with excessive span of control usually results in a lack of mentorship and training for practice-level management. This results in the network feeling paralyzed, unable to implement initiatives that would help it move out of Operational Chaos.

Lack of Standardization of Process Leading to Daily "Fire-Fighting"

Operational Chaos networks tend to be characterized by the practices within the network operating similarly to how they existed when they were acquired and brought into the network. This results in each practice operating with a diverse set of policies and procedures, which makes implementation of initiatives to drive organizational change nearly impossible.

Book Chapter 7

Aligning Compensation Models

Figure: Relationship Between Provider Compensation and Productivity Determines Strategic Action
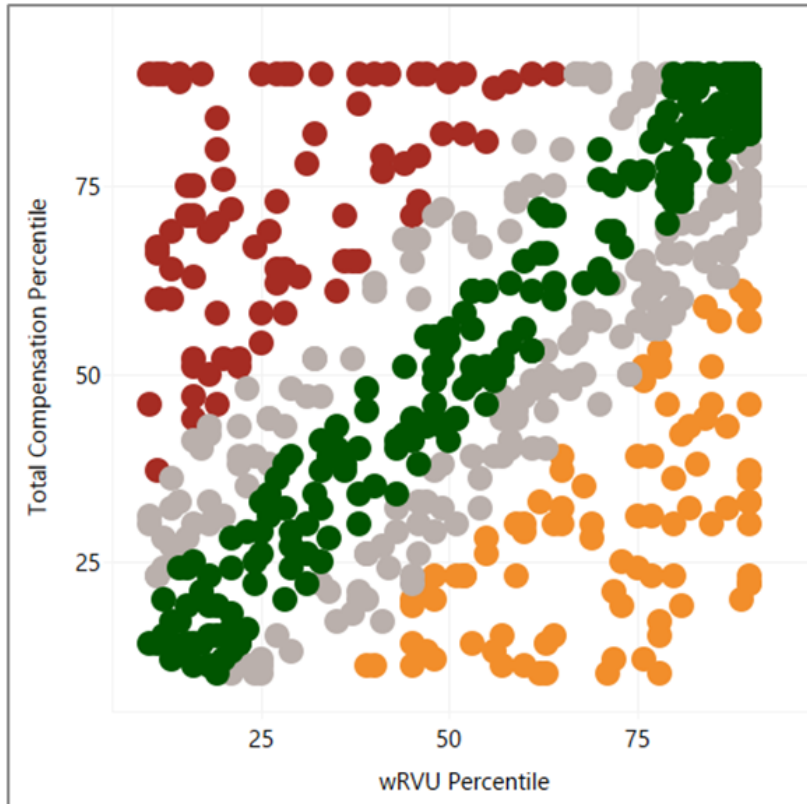
Upper Quadrant: Potential Compliance Risk

(42% of sampled providers)

Center: Aligned Compensation & Productivity

Lower Quadrant: Potential Retention Risk

Source: Blinded HSG client data (total compensation and total wRVUs for most recent 12 months by client) Compared to MGMA Provider Compensation and Productivity Survey: 2019 (National)

Each dot represents one physician. Position along x axis corresponds to productivity percentile. Position along y axis corresponds to compensation percentile.

Book Chapter 8

Supplemental Resources to Today's Presentation

- For additional information, please see our January article in MGMA Connections

- https://www.mgma.com/resources/revenue-cycle/cutting-losses-in-hospital-employed-physician-netw

Supplemental Resources to Today's Presentation

CLICK HERE to learn more about the HSG Network Opportunity Analysis

Company **Overview**

HSG builds high-performing physician networks so health systems can address complex changes with confidence.

Headquarters: Louisville, KY

Formed: 1999

Focus: Health Systems and Physician Network Strategy and Execution

Physician Strategy
Driving a common strategic focus with engaged physicians.

Physician Leadership
Identifying and engaging strong physician leaders is integral to the network's development and success.

Performance Improvement
Improving the performance of employed physician networks.

Network Integrity
Leveraging Physician Network Integrity Analytics™ to create and monitor strategies for patient acquisition and retention.

Physician Compensation
Aligning physician compensation with health system and employed network goals.

HSG | Questions

HSG | Thank You