Top 10 Steps Toward Physician Practice Optimization
The situation:

Hospitals and health systems continue to invest significantly in their employed provider networks. Across the country, employed physicians lose up to $200,000 or more per employed provider per year. How is this possible given the fact that in many cases these very same providers were once practicing in sustainable (if not profitable) private practices within the community? Some of the causes of the losses that employed provider networks experience are strategic in nature. That is, due to strategic decisions made by the health system for which they now work, it is no longer possible for these employed providers to enjoy the revenues streams that may have been available to them as private practitioners.

Here are some examples of strategic causes of financial loss to employed providers:

- Ancillary and technical services – Often, private practicing physicians also owned and operated such ancillary services as laboratory and imaging. These ancillary services generated revenue and significant profits in private practice settings. Once employed by the health system, these types of services are generally redirected to hospital-owned settings, thereby redirecting the revenue streams to the organization and away from the employed provider.

- Non-clinical provider time – Many health systems require their providers to spend a portion of their time on non-productive, non-clinical activities such as directorships, committees, teaching, etc. All of these activities are not without cost to the organization. However, each can contribute significantly toward reducing providers’ clinical productivity.

- Payer mix – Private practicing physicians may choose to limit their participation with certain payers and/or payer classes. These decisions tend to improve their payer mix as compared with mission-driven healthcare organizations that accept virtually all payers including self-pay (read this as no pay).

Other causes contributing to provider losses are operational in nature. Although these causes can and do contribute significantly to bottom line losses, such contributing factors can be far more manageable by both providers and/or the physician enterprise leadership. Here are some examples of operational causes of financial loss to employed providers:

- Clinical productivity and compensation alignment – Low clinical productivity coupled with high compensation levels serves to create physician practice economics that are simply not sustainable by the organization over the long run. In many cases where payer mix is poor and reimbursements rates low, viable alignment of productivity and compensation may require as much as a 25 percentile spread between the two. More on this will be discussed later in this document.

- Payer contracts – Often decisions are made to accept lower than market reimbursement on the physician side of the organization in consideration for better rates on the hospital side. Additionally, years may pass before the physician enterprise negotiates or renegotiates existing evergreen payer contracts. In many cases these contracted reimbursement rates have never been updated to reflect current market conditions.

- Collections process – Revenue cycle, professional billing, coding, documentation, POS collections, etc., can all contribute significantly to bottom-line losses.

- Practice expenses – In private practice settings, physicians often ran lean practices with a minimum of staffing, lower payroll and benefits costs, etc. Once employed by a hospital or health system organization, additional costs in the form of clinical and clerical support staffing, practice managers and often an allocation of hospital management costs, etc., all serve to negatively impact the profitability of these employed providers.

To further complicate the task of developing and operating employed physician practices at optimal levels of performance, leaders must also factor in the importance of adapting to changes from volume-based payment incentives to value-based payment models. The Medicare Access and CHIP Reauthorization Act (MACRA) represents a major step in reforming the way Medicare pays for physician services.
The following Top 10 Steps will provide your network with the key areas of focus to help you identify opportunities for improvement to the bottom-line performance of your employed physician practices. To be clear, this is not a roadmap to breaking even. Sure, it may be possible for a particular specialty to break even from time to time. However, on the contrary and due to the strategic nature of some of those key factors contributing to the bottom-line losses, it is the author’s belief that overall breakeven performance of an employed multispecialty physician network is rarely achievable and sustainable over the long run. However, these 10 steps will serve as a guide for optimizing the performance of employed physician practices and identifying opportunities for minimizing the almost certain bottom-line losses these practices generate.

Much of the data and observations used in developing this 10-step approach was derived from Premier’s InflowHealth practice management tool. This tool measures and benchmarks data-driven metrics for virtually every possible metric associated with physician practice management. The database includes data from nearly 9,000 employed physician from across the country representing virtually every specialty. Among other things, the tool calculates the precise causes of your physician losses, down to the last dollar. In the table below, the InflowHealth tool demonstrates the causes of over $1.4 billion in recent practice losses in practices throughout the country. You’ll note that the losses are caused primarily by the issues already discussed above:

By following the recommendations below and focusing on operational areas that health systems can control, it is our experience that health systems can reduce employed physician losses by 20 or 30 percent. For a network that employs several hundred providers, this equates to many millions of dollars in savings.
The guiding philosophy underlying the Top 10 Steps are:
- Addressing both short-term and long-term areas of opportunity.
- Covering multiple, interrelated areas.
- Fostering physician engagement and partnership in the management of their practices.
- Identifying opportunities to reduce (not eliminate) bottom-line financial losses.

**Step #10 – Referral Retention**

Are all appropriate referrals retained within your provider network? Referral leakage to a competitor can be devastating to the financial viability of the organization. In some instances, making a referral to a provider outside the network may be warranted. Such an appropriate outside referral may be required due to the lack of a given specialty within the network or the need for referral to a higher level of care. However, in many cases leakage of referrals can be due to other more manageable and correctable reasons. Does your organization track the source of all incoming and outgoing referrals? Do you know the extent (as well as the reason behind) all referrals made “out of network”? All out-of-network referrals should be reviewed with the referring physician on a timely basis to determine appropriateness. Discussing referrals made six months ago will be less impactful compared to addressing a referral made yesterday. Actively reviewing referral patterns with your doctors can, in and of itself, prompt better overall referral retention. Do you know from whom your providers receive their incoming referrals? Understanding this will help identify opportunities to increase their individual productivity and your overall market share. Identify and manage both internal and external referral sources. Do these referring physicians know who your specialists are (by name and by face)? What services they perform? Developing referral relationships (let alone changing existing referral patterns) requires face-to-face, physician-to-physician engagement and marketing. Help your providers build their own personal practices.

How does your ratio measure up to national, regional and internal benchmarks? Do you have the ability to track the financial impact of adding or deleting support staff on a per-provider basis? Understanding how such decisions impact productivity and financial performance is critical to the operation of the practice. Too many FTEs costs money. Too few hurts productivity and throughput.

**Step #8 – Manage Payer Contracts**

When was the last time your physician enterprise negotiated its payer contract rates? Often payer contracts are evergreen and years can quickly pass without any changes to contracted rates. How do your current payer rates measure up to that of Medicare? Local, regional and national benchmarks? Payer rates set below that of Medicare create a very challenging economic environment for the employed physician. While payer rates may be, in some cases, difficult to renegotiate, it is critical to understand how your organization’s rates are impacting its financial performance. Further, downward pressure on rates makes it equally important to understand what other payer incentives (quality and outcomes based) may be available for participation. Don’t leave dollars on the table.

**Step #7 – Manage Revenue Cycle**

Cash is king. Every step must be taken to collect whatever payment your providers have earned in as short a time frame as possible. The organization must get paid for the care that your providers render. Maximizing this process is critical. Is your office staff trained to collect co-pays and deductibles at the time of service? Collecting payment at the time of service forgoes the need to bill for these payments on the back end. This reduces cost and speeds cash flow. In addition, does your staff know what outstanding patient balances may also be due? Are they taking steps to collect these old balances at the next patient encounter? Very often, patients leave the office without making a payment simply because no one asked!

How long does it take your providers to complete their documentation before a claim can be submitted? Charge lag beyond 24 hours is impacting your cash flow.
flow. Additionally, how long does it take your billing staff to submit a claim once your providers have completed their documentation? Once a claim is submitted, why are some claims not paid? Was the service not covered? Was there some other reason for non-payment? Providers who “work for free” are not working in a viable practice. Finally, how does your overall A/R look? What steps can you take to reduce the time it takes to collect cash?

**Step #6 – Coding and Documentation**

For providers to earn revenue for the organization and earn wRVU-based compensation for themselves, they must completely and accurately document the work they have performed in the form of rendered care. How do HCC risk scores affect your practice? Are your providers coding to the highest level of specificity for the services that they render? Does your providers’ documentation support the current level of coding? If they are coding too high (without documentation), this equals audit risk. Coding too low (with supporting documentation) equals money lost. Both scenarios are a problem for the organization. Further, providers can often earn their personal compensation based on wRVU productivity. The number of wRVUs earned for a given encounter is directly dependent upon the level of coding of that encounter. Because of this, coding and documentation audit and education are extremely important. What is your organization doing to ensure that your providers have maximized the reimbursement that they and the organization are entitled to receive? Payers are always happy to reimburse you less!

**Step #5 – Ensure Patient/Provider Access**

Each of your providers work based on an employment contract. This document spells out the terms of your professional relationship with the provider. Are your providers actually working according to their contract? Are your full-time clinical providers actually working full-time? Are provider appointment templates designed to maximize the use of the providers’ clinical time? Can patients get an appointment to see their PCP today? Are appointments scheduled at the convenience of the patient or at the convenience of the provider? Remember: Your patients are not lucky to see the provider. Your providers are lucky to see the patients. Can your primary care patients access specialty care today? There are likely other specialists in the phone book. Referring physicians (and self-referring patients) can easily dial another number if they can’t access your care in a timely fashion. How long will a new patient have to wait to establish with a PCP? How long will an established patient need to wait for acute care or a follow-up visit? Are your providers maximizing their efficiency? Do you know where and when there is capacity to fill? Vacant appointment slots are foregone opportunities for a patient to receive care and the organization to earn income. What is your “no show” rate? What is your cancellation rate? You should understand these rates as they apply to each individual provider. What steps are you taking to minimize these foregone opportunities? Do you have the correct number of providers in the correct geographic locations? What is your professional recruitment strategy? Are you employing midlevel providers to assist and extend your physician base?

Finally, and perhaps most importantly, are your staff answering the phones? How many calls go unanswered? How many calls go to voicemail? How long do I have to wait to speak with the correct person to assist with my particular need? See more about patient access in Step #2.

**Step #4 – Align Production and Compensation**

Fair market compensation should use respected national and regional benchmarks to establish compensation levels. However, the organization should establish guiding principles to help align compensation and production as well as quality and service delivery standards. While quality and service measures continue to grow in importance as components of compensation strategies, there is no getting away from the fact that providers must be highly productive to be financially viable and meet the demands for care from their patients. Using internal and external benchmarks in conjunction with understanding your specific payer mix and contracted reimbursement rates will help guide the alignment of compensation and production. Depending on actual payer rates and payer mix, compensation may need to be set as much as 25 percentile points lower than the production percentile targets to be financially viable for the long run. See more on the alignment of revenue generation and compensation in Step #2.

**Step #3 – Formal and Informal Physician Leadership**

Establish both formal and informal means of obtaining physician input into leadership and direction of the provider network. Identify and develop both formal and informal physician leaders among the providers in your network. Don’t be afraid to seek input from referral sources outside your network as well. Often
there are key elder statesmen in the network who have much wisdom to offer to the organization. Seek their counsel. Additionally, do not discount the talent represented by the new/younger providers in your network. They are the future leadership and should be fostered, engaged and retained. Be inclusive (not exclusive) when seeking physicians’ advice on pending changes or initiatives that may affect the providers in your network. It will be much easier to gain the support of your provider staff (even for difficult decisions that may be of a negative impact) if the physicians feel engaged with a meaningful means of sharing their input. Formal operating committees at the practice level as well as network-wide are critical to establish. These forums should meet on a monthly basis with a regular, formal agenda (including discussion of enterprise and practice-level financials). Informal encounters with physicians should be happening as often as possible. By the way, network executive leadership should come to meet the physician. Pulling a physician out of his or her office for a non-productive meeting with leadership is counter to the message of maximizing provider productivity.

**Step #2 – Understand and Prepare for Evolving Payment Methodologies (MACRA, MSSP, Bundled Payments and Other Value-based Purchasing)**

One thing is for certain: the healthcare industry is changing increasingly fast. With continued challenges to the economics of operating physician practices, more providers and practices are seeking to be employed or acquired by healthcare systems as opposed to the more traditional private practice model. These employed physician organizations must be nimble and well-informed to react and adapt to new and evolving means of revenue generation. With Medicare and other payers continuing to develop reimbursement methodologies that place increasing emphasis on pay for quality vs. pay for volume, physicians and practice leaders must take immediate steps to become well-educated on how physicians and health systems will generate revenue in the future. How will value-based payment models vs. alternative payment models affect your practice (as opposed to traditional fee-for-service methodologies)? What incentives are available to promote value-based payment systems? As part of MACRA and other value-based arrangements, physicians can be compensated or penalized based on adequate patient assessment as a clinical practice improvement activity. How will such new payment models serve to improve the delivery of care? How will enhanced information sharing affect my network?

Do I have the infrastructure and management tools necessary to successfully understand and operate in these changing conditions? None will be successful without the creating a well-developed and well-executed physician partnership strategy.

**Step #1 – Engage your Providers by Developing Strong Professional Relationships and Sharing Transparent Data**

Develop and articulate a clear vision for the network. Improving operational, financial and quality performance should be the mantra for you, your providers and your staff. Dedicate your leadership time and energy to building meaningful, professional relationships between you (the network leadership) and your providers. Development of strong professional relationships **now** results in a higher degree of engagement, buy-in and cooperation in the **future**. Tough conversations become easier when based on a history of strong professional relationships.

It is impossible for a provider to understand (let alone manage and improve) the performance of their individual practice without access to regular, accurate and transparent data at an organization, practice and individual level. Each provider should understand how they factor into the profit or loss generated by them as an individual as well as how their efforts impact the overall financial health of their practice and the organization. Do your providers know how they measure up to their provider colleagues? Often the simple act of widely sharing transparent financial and productivity data will prompt short-term improvements to provider productivity and bottom-line financial performance. No one wants to be last! Long-term improvement opportunities can only be identified and managed through detailed reporting down to the individual provider level. Reports of individual performance should be shared with each and every provider and reviewed (face to face) with the provider on a monthly basis. You will know when you have fully engaged the provider with their understanding of their practice when they begin to ask you tough questions and dig deeper into the reports that you are now sharing with them! If your system struggles to provide clean, reconciled and meaningful data to your providers on a regular basis, please contact the author for a demonstration of our InflowHealth platform.
Conclusion:

Employed physician losses can be enormous. But remember, there are very good reasons that prompted your organization to develop its employed provider network. These reasons include: defensive moves to retain market share, development of primary care referral bases, development of new service offerings, providing a lifeline to community-based providers and many more. Whatever the reasoning behind each particular employment agreement or acquisition, the underlying need to maximize the performance of these practices is key. True, physicians provide a means of generating downstream revenue to the hospital organization. Inpatient admissions, coverage of the Emergency Department, Surgery, Ancillary Testing, etc., all serve to generate revenue to the organization. However, without dedicated focus on the performance of the employed physician network, these downstream revenue streams can quickly be offset by the investments in the losses that are generated in the clinic side of the equation.

Remember, the goals of the Top Ten Steps as set forth at the beginning of this paper:

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- Covering multiple, interrelated areas.
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About the author:

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