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White Paper

Modernize Your Medical Group's Financial and Operational Metrics

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The lens through which medical groups assess operational and financial performance has changed. As medical groups continue their COVID-19 recovery, new barriers and challenges have arisen. Evaluation and management (E/M) coding changes, 2022 Medicare Physician Fee Schedule reductions, and the continued pressure to add value while decreasing overall costs will have a significant impact on medical group costs and revenue. Such uncertainty and instability leaves us to the question: How can medical groups improve their financial and operational performance?

One important component to improving financial and operational performance is to measure the most impactful metrics and, when possible, use these metrics as a guide for improvement.

Medical groups have often struggled to identify the most actionable operational and financial metrics upon which to base their improvement efforts. Groups frequently apply metrics that may have unintended consequences and hamper their financial and operational improvement efforts by focusing resources in a misguided manner. The following article will present how your medical group can utilize contemporary, validated metrics in a structured approach to drive financial and operational improvement.

Patient Volume

In a fee-for-service environment, patient volume has been considered the heartbeat of any medical group's operational or financial indicators. Many medical groups use **daily clinic visit volume per provider** as the key indicator of patient volume in the ambulatory setting. This metric does not quantify the acuity or intensity of the patient volume, thus providing an inaccurate depiction of volume within the practice. Furthermore, this metric can be easily "gamed" by a practice projecting an image of "busy" on paper and having lower acuity visits or a greater percentage of established patient visits, which would decrease new patient access and translate to less financial success.

The highest performing medical groups manage their provider resources to an agreed-upon expectation, often centered on work RVU (wRVU) production

Clinic Visit Volume Disadvantages

- Fails to account for patient acuity or overall work effort of the provider
- Lack of standardized benchmarking adopted within the industry
- Measuring clinic visit volume does not provide indication of individual performance

and benchmarked to a national survey source. Translated into a metric, this is often viewed in the form of **monthly wRVU production per provider**. This measure, when coupled with patient access metrics, can provide a roadmap to understanding and maximizing patient volume. As organizations move from volume-based to value-based payment, additional metrics should be factored in, including panel size and clinical and quality outcomes. Even in a value-based environment, some connection to wRVU production still needs to exist.

wRVU Production Advantages

- Granular metric that provides a more specific indicator of work effort
- Validated metric with consistent, reliable industry data
- Singular metric can identify opportunities in scheduling, coding, access, and operations

Revenue Cycle/Reimbursement

If patient volume is considered the heartbeat of a medical group's operational and financial indicators, revenue cycle should be viewed as the vascular system. Similar to our body's vascular system, a small blockage or issue with the revenue cycle can have catastrophic consequences to your medical group's financial performance. As the U.S. healthcare landscape has continued to change, medical groups still rely on a limited number of financial indicators to measure their financial "success." One such indicator, **days in accounts receivable (A/R)**, is often perceived and/or misinterpreted as a holistic indication of revenue cycle or financial performance.

Days in A/R Disadvantages

- Lagging indicator, alerting to issues occurring in the significant past
- Outcome indicator that does not provide direction for improvement
- Measures your ability to collect, often outside the control of the medical group

Over the course of the last 10 years, individual patient financial burden has increased, and the vigor with which payers deny claims has increased.[1] The most prudent medical groups have utilized **net collection ratio** to more closely monitor all collections and as an indicator of overall financial and revenue cycle performance. This measurement can provide a medical group with the granular details by payer needed to improve their financial positioning. Other financial indicators to monitor include co-pay collections, denial rates (front end and back end), and lag days to coding and claims submission.

Net Collection Ratio Advantages

- Measure the appropriateness of the payments for the work being rendered
- Allows for greater granularity in measurement, with isolation of data by payer, provider, or clinic
- Singular measure to assess controllable financial performance

1. M. Gavidia. 2021. Medical Claim Denial Rates Rising, Highest in Initial COVID-19 Hotspots. *AJMC*. ajmc.com/view/medical-claim-denial-rates-rising-highest-in-initial-covid-19-hotspots

Clinic Staffing

On average, clinic staff salaries and benefits account for more than 22% of clinic expenses, second only to provider salaries and benefits.[2] Establishing staffing criteria and managing staffing based on overall productivity is a practice often limited to the hospital staffing. Traditionally, medical groups have relied on general **staffing per physician** measures to establish clinic staffing or review their current clinic staffing complement. This narrow view measure does not account for the clinic volume or the prevalence of employed non-physician providers or advanced practice clinicians (APCs) in the clinic setting. In addition, this overall measure fails to provide insight into overall skill mix in clinical staffing.

Staffing per Physician Disadvantages

- Does not account for variation in patient volume/ provider productivity
- Fails to account for the increased utilization and production of non-physician providers (APCs)
- Does not account for the variation in utilization of clinical staff across specialties

In an effort to account for the shortfalls of a generalized staffing per physician approach, medical groups should utilize specialty-specific **volume-adjusted staffing** (per 10,000 wRVUs) metrics to ensure each clinic and/or department is appropriately staffed in terms of skill mix and total full-time equivalent employees (FTEs). These metrics are designed to ensure that highly productive providers and practices have sufficient support, while ensuring fiscal prudency by aligning staffing levels to the overall productivity of the provider or practice. Other staffing benchmark metrics could include visit volume per provider and panel size for primary care in value-based environments.

Volume-Adjusted Staffing Advantages

- Accounts for variation in practice pattern and productivity across specialties
- Provides a volume-adjusted manner in which to control your second largest clinic expense
- Ensures clinic staffing levels align with overall productivity in terms of FTEs and skill mix

Bottom-Line Performance

One of the most significant mistakes medical groups make is the use of a singular bottom-line measure to assess the overall operational and/or financial performance of the group or a singular clinic. **Investment per physician** is the most commonly utilized metric to measure the financial performance at the group level or the individual clinic level. The reliance on a singular indicator of financial performance often provides a medical group with false perception of performance. This singular focus often masks negative performance in one area with positive performance in others, and most significantly, this methodology can be affected by a multitude of measures that are outside the control of medical group leaders. In addition, groups utilize different allocation methodologies, which does not lead to an apples-to-apples comparison.

Investment per Physician Disadvantages

- Fails to indicate specific areas for improvement, requires additional resources to decode the measure
- Does not account for difference in overhead and revenue allocation practices
- Inconsistent measurement and masks underperformance in specific revenue and expense metrics

2. AMGA 2020 Medical Group Operations and Finance Survey Data

To develop a true gauge of overall operational and financial performance, AMGA advocates for the utilization of a **multi-faceted review** of metrics to measure performance. This approach reviews five key areas of operational and financial performance including:

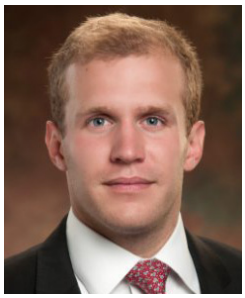
1. Provider compensation and productivity alignment
2. Department level productivity positioning
3. Care model configuration
4. Clinic staffing
5. Net collections

Multi-faceted Review Advantages

- Accounts for 90% of controllable variation in financial performance
- Measures financial performance based on factors within the control of the medical group
- Provides direction for improvement

This holistic approach analyzes more than 90% of the operational expenses and all of the net revenue at the individual clinic or department level. This proven approach allows for an individualized assessment of each department's or individual clinic's true performance in the key high-leverage areas and can provide a roadmap for improvement.

As medical groups continue to face the pressures of increasing provider and staffing costs, coupled with decreased revenues, financial and operational improvement is crucial to your long-term success. In today's challenging medical group environment, using contemporary, validated metrics in a structured approach as your guide is key to achieving financial and operational improvement.



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