

Five strategies for revenue and expense improvement



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Medical groups have seen their margins become tighter and tighter over the past several years. The COVID-19 pandemic has only exacerbated the situation, and organizational resiliency has become a primary concern for medical groups and health systems. In order to survive in an increasingly volatile environment, they need to be highly focused on financial and operational performance in the areas that are within their control. Here, we present five areas where leaders can optimize operational efficiency and enhance financial accountability to sustain resilient, healthy organizations.

The Tipping Point

One of the reasons for the shrinking margins is that provider compensation continues to increase, despite the fact that productivity and net collections have not seen equally appreciable increases and have actually experienced declines. The

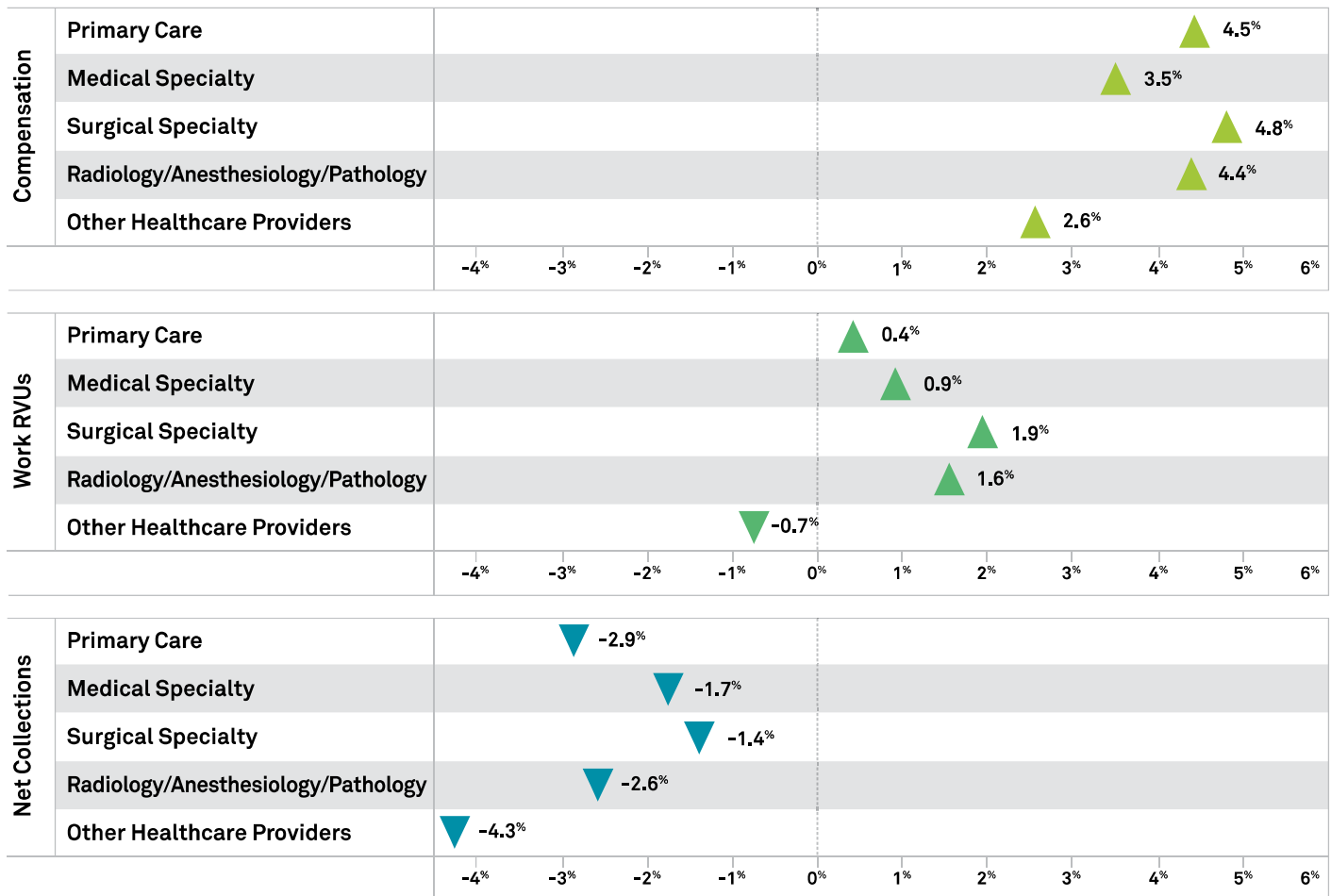
AMGA 2020 Medical Group Compensation and Productivity Survey shows that for all specialty types there has been a minimal increase in provider work relative value units (wRVUs) and a greater increase in provider compensation. Figure 1 demonstrates this gap between changes in median values of compensation, wRVUs, and net collections by specialty type from 2019 to 2020.

These trends were also found in the AMGA 2020 Medical Group Finance and Operations Survey, which demonstrated that provider salaries and benefits as a percent of total operating expenses climbed from 56% in 2019 to 61% in 2020. When you add the COVID-19 pandemic, changes in Medicare reimbursement, and the new evaluation and management (E/M) coding changes to the equation, many medical groups are experiencing a financial tailspin.

This situation is not sustainable, and medical groups need to respond with a highly focused effort to align improvement

Figure 1

Median Change in Compensation, wRVUs, and Net Collections from 2019 to 2020



in financial and operational performance. Through this alignment, medical groups can optimize operational efficiency and maintain financial accountability. They can also ensure their resiliency in order to survive in turbulent times.

This alignment requires integrating risk for financial performance into provider compensation plans, rather than simply increasing compensation rates per wRVU regardless of financial results. It requires linking provider compensation to both upside and downside performance, thus providing the opportunity to engage physicians in the financial results of the enterprise. It should be noted that private practices have managed this way for years, and this technique can be applied to all groups, whether integrated or independent.

Many integrated organizations tend to focus on the “bottom line,” or the loss (investment) per provider. We find that focusing on this single number is fraught with many issues. First, in order to benchmark against other medical groups, all organizations

would have to utilize the exact same allocation practices, provide the same centralized services, and assign ancillary revenue in the same manner. We know that is simply not the case. We also have found that by focusing on a single outcome metric, it is easier to miss all the opportunities for improvement, as they get “masked” by the one metric in focus. It is frequently the case that regardless of investment per provider, there are certain areas that can still be improved upon. Not focusing on input metrics is a significant deficiency in this bottom line approach.

The Big Five

AMGA Consulting has found it beneficial and actionable to focus on five areas that make up the majority of the revenue and expense structure of a medical group. By examining just five areas and digging deeper when performance is below the benchmark, medical groups can better focus efforts and create tangible action plans for improvement. Below, we explore

Table 1

Medical Group Care Model Analysis (APC to Physician FTE Ratio)

Department	Clinic APC to Physician FTE Ratio	AMGA Median Benchmark	Variance From Benchmark
Family Medicine	1.56:1	0.61:1	17.23
FM/IM Blend	1.31:1	0.48:1	7.61
Cardiothoracic Surgery	2.38:1	0.50:1	5.64
Internal Medicine	2.73:1	0.38:1	4.98
Pediatrics	1.38:1	0.24:1	2.43
Multispecialty	0.91:1	0.50:1	2.19
Vascular Surgery	1.20:1	0.50:1	2.09
Surgical Oncology	0.95:1	0.50:1	1.36
Behavioral Health	1.90:1	0.67:1	1.23
Bariatric Surgery	0.90:1	0.50:1	1.22
Orthopedic Surgery	0.99:1	0.75:1	1.16
Anesthesia Pain Clinic	1.00:1	0.50:1	1.00
OB/GYN – General	0.58:1	0.32:1	0.75
Neurosurgery	1.11:1	1.00:1	0.55
Palliative Care	0.80:1	0.50:1	0.30
Breast Surgery	0.70:1	0.50:1	0.24
Pulmonology	0.44:1	0.59:1	-0.36
Otolaryngology	0.00:1	0.39:1	-0.39
Urology	0.41:1	0.49:1	-0.45
PMR (IP Rehab)	0.33:1	0.50:1	-0.53
Ophthalmology	0.00:1	0.50:1	-0.59
Trauma Surgery	0.37:1	0.50:1	-0.98
Maternal and Fetal Medicine	0.00:1	0.50:1	-1.22
General Surgery	0.08:1	0.45:1	-2.99
Cardiology	0.58:1	0.91:1	-4.84
Greater than Market Median Number of APCs:			50.00

the five areas with illustrative case studies that highlight each of the analysis areas. These findings and opportunities were identified through operational and financial assessments conducted by AMGA Consulting.

1 APC to Physician Complement

Many organizations have made the decision to hire advanced practice clinicians (APCs) for a variety of reasons. They are a less expensive resource compared to physicians; they are easier to recruit than physicians in some specialties; and more and more states have reduced physician supervision rules and are allowing APCs to practice independently.

Some medical groups have failed to clearly define and develop their care model up front. They have also failed to align incentives between physicians and APCs and have, therefore, created an environment where the two compete with one another. We also have found organizations tend to make hiring decisions for either APCs or physicians in a vacuum, rather than ensuring the care team is in balance with the demand for services. When these mistakes are made, the resulting financial impact can be negative, as each provider carries significant cost, while not having productivity levels to offset this investment (see Table 1).

Groups should also be mindful of their APC to physician complement and compare it to the norm for each specialty.

2 Clinic Staffing

Although many medical groups believe that they have a standardized clinic staffing model, our analysis reveals that, typically, there is significant variation even for same-specialty sites across an organization's physician enterprise (see Table 2). We also find that many times organizations utilize a "per provider" staffing regimen when significant production variation exists, thus leading to an inadequate matching of clinic staff support levels for practices with high or low productivity.

A variety of factors should be taken into consideration when evaluating clinic staffing. Benchmarking staffing on a per-physician or per-provider basis is always a good first step, since a minimal level of staffing must exist, especially with small practices. However,

an organization shouldn't stop there, as some flaws exist in solely using that methodology or benchmark. Staffing on a per provider basis assumes that every provider is at median productivity, and that is not always the case.

We recommend adjusting staffing by specialty and on a volume-adjusted basis since (a) different staffing levels are needed with various specialties, and (b) it provides a more appropriate matching of support to output, whether using wRVUs, visits, or panel size.

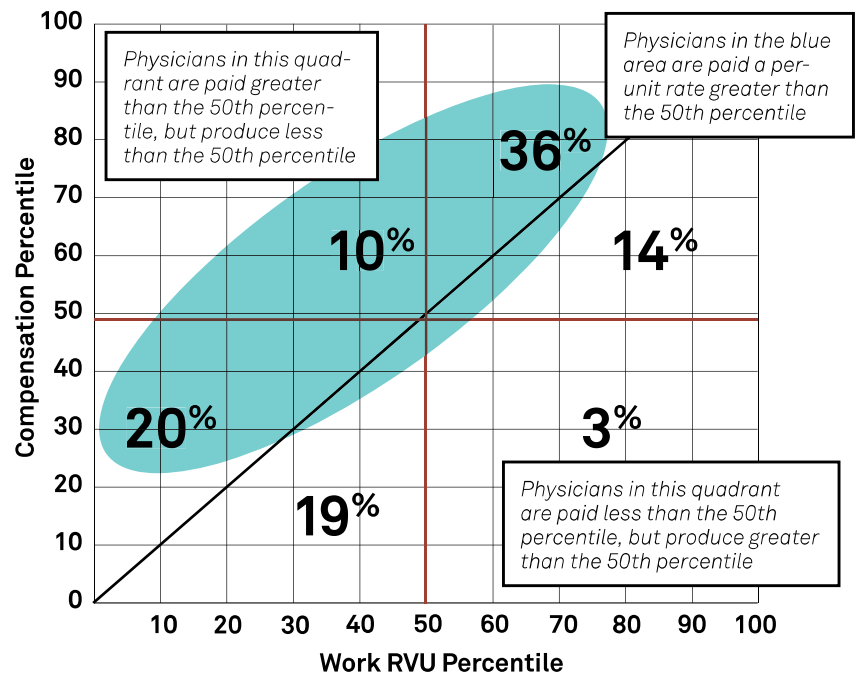
3 Provider Productivity and Compensation Alignment

As referenced earlier, provider compensation is one of the largest expenses within the medical group cost structure. It is very important to have alignment between provider productivity and compensation.

Plotting both compensation and productivity in a scatter diagram is a way to easily view a very comprehensive picture of alignment (see Figure 2). Areas to identify are (1) provider productivity less than required standards for established physicians, which will highlight the potential for improved volume; (2) provider compensation that is much higher than productivity levels, which could indicate equity and/or fair market value concerns; and (3) high productivity with low compensation, which could signal a looming problem with provider retention.

Figure 2

Provider Productivity and Compensation Benchmarking



CASE STUDY A

APC to Physician Complement

Establishing a specialty-specific care model, criteria, and guidelines and comparing the APC to physician complement to market metrics will identify areas of opportunity where the care model could be optimized.

Overall Findings (64 Clinics)

Revenue Opportunity:
\$6,993,154

Total Opportunity:
\$29,847,007

Expense Opportunity:
\$23,206,865

Opportunity per Provider:
\$187,717

Medical Group Demographics

Integrated Medical Group in the East with 280 providers in 60+ locations. The physician enterprise includes owned and leased practices, as well as rural health clinics. The medical group is part of a larger integrated health system, which includes six hospitals and provides care to more than 500,000 people.

Organizational Challenges

The medical group experienced exponential growth during the previous four years, increasing from approximately 27 to 64 practice sites, with an additional 20 satellite locations. During this growth phase, the group saw a 50% increase in patient base and a 226% increase in net patient revenue. Due to the rapid growth, they were seeking an unbiased opinion on the performance of the medical group.

Assessment Findings

- Low overall physician and provider productivity
- APC providers producing at higher levels than physicians
- Staffed with 50 APC FTEs greater than market median across 25 departments
- Overall misaligned compensation and productivity across the physician enterprise
- 62% of physicians producing below the median
- 54% of APCs producing below the median
- Non-sustainable care model, characterized as competitive between APCs and physicians

Recommendations

Lack of care model guidelines and goals resulting in a high number of APCs and low overall provider productivity

- Establish care model with goals, parameters, and target production
- Establish recruitment guidelines to maintain an in-balance provider complement

APCs with low productivity consuming the same amount of resources as higher producing providers

- Right size APC to physician complement by specialty compared to market benchmarks
- Implement minimum productivity targets for existing providers before hiring additional providers

Table 2

Family Medicine Department Staffing Analysis

Benchmarking Specialty:	Family Medicine	
	FTEs	wRVUs
Physicians:	25.14	88,698
APCs:	9.53	26,517
Total:	34.67	115,215

Staffing Category	Department FTEs	"Per Provider Variance"	Volume Adjusted (Per 10,000 wRVUs) Variance
Registered Nurses	7.64	-1.32	1.07
Licensed Practical Nurses	7.78	-0.01	2.46
Medical Assistants/ Nurses Aides	50.96	22.59	34.49
Back Office Support Staff Total Variance:		21.26	38.01
Laboratory Staff	NA	-	-
Radiology/Imaging Staff	NA	-	-
Ancillary Support Staff Total Variance:		-	-
Medical Receptionist	28.48	3.16	11.85
Front Office Support Staff Total Variance:		3.16	11.85
	94.86		

4 Department Productivity and Compensation Quartile Analysis

Conducting a quartile analysis of provider productivity by specialty also offers good insight into how productive each specialty in the organization is as a whole (see Table 3). The analysis places each provider within the same specialty in a quartile ranking for productivity and compensation. It is also a useful tool to utilize when contemplating hiring additional providers within a specific specialty. Lastly, this tool will uncover equity issues and imbalances between compensation and productivity levels.

CASE STUDY B

Clinic Staffing

Implementing a staffing model that is volume adjusted by specialty allows the clinic providers to perform at optimal levels of production by having the right amount and complement of clinic staffing based upon the individual clinic volume.

Overall Findings (18 Clinics)

Revenue Opportunity:
\$2,404,033

Total Opportunity:
\$33,268,674

Expense Opportunity:
\$30,864,641

Opportunity per Provider:
\$209,131

Medical Group Demographics

East Coast medical group with 1,100+ providers. The physician enterprise includes employed and aligned practices. The medical group is part of the larger integrated health system, including an extensive network of outpatient services, home health care, urgent care centers, three hospitals, and a freestanding emergency department.

Organizational Challenges

The medical group functioned within a hospital-centric service line structure, which hindered the group's ability to assess operational and financial performance as a whole. In addition, the medical group lacked standardized processes, structured benchmarking and performance management tools, consistent overhead expense allocation, and formal physician leadership governance and structure.

Assessment Findings

- ▶ 83% of clinics were staffed at levels greater than median benchmarks for clinical support staff positions (RN, LPN, and MA) after adjusting for clinic volume
- ▶ 61% of clinics were staffed at levels greater than median benchmarks for front-office positions after adjusting for clinic volume
- ▶ Variation within like specialties and across specialties indicating a lack of a standardized, volume-adjusted staffing model
- ▶ 85% of physicians analyzed were producing less than the 50th percentile wRVU productivity
- ▶ 70% of APCs analyzed were producing less than the 50th percentile wRVU productivity

Recommendations

Lack of a uniform clinic staffing model and staffing benchmarks resulting in significant over-staffing in multiple clinics

- ▶ Adopt and implement a volume-adjusted clinic staffing model that aligns staffing with clinic volume
- ▶ Establish minimum provider productivity targets at median (or above) to bring staffing into better alignment
- ▶ Ensure staffing complement is appropriate and that staff are working to the top of their licensure
- ▶ Where appropriate, apply refined staffing metrics on a volume-adjusted basis

CASE STUDY C

Provider Productivity and Compensation Alignment

Plotting individually mapped provider compensation and productivity on a scatter diagram provides a visual overview of compensation and productivity alignment and easily identifies outliers.

Overall Findings (173 Clinics)

Revenue Opportunity:

\$32,023,840

Total Opportunity:

\$93,929,055

Expense Opportunity:

\$61,905,215

Opportunity per Provider:

\$116,743

Medical Group Demographics

Midwest system-affiliated medical group with 1,400+ providers in 200+ locations. The medical group is an integral part of the larger health network's continuum of care. The full continuum of care integrates hundreds of physician practice sites, specialty and acute care hospitals, surgery centers, home care services, urgent care, behavioral health, and employer health services.

Organizational Challenges

The medical group experienced significant acquisition-based growth over the prior 10 years, but did not focus on post-acquisition standardization. The organization was not adequately monitoring or tracking financial and operational performance and lacked actionable data. The medical group sought assistance to address the lack of standardization and inadequate benchmarking in an effort to measure and improve performance.

Assessment Findings

- ▶ Misaligned provider compensation and productivity
- ▶ Average provider compensation at the 58th percentile
- ▶ Average provider productivity at the 48th percentile
- ▶ Average compensation per wRVU at the 69th percentile
- ▶ No established productivity criteria or standards
- ▶ Identified provider (physician and APC) compensation opportunity of nearly \$58 million (across 1,200 providers)

Recommendations

Misaligned compensation and productivity with a high compensation per wRVU rate for the majority of physicians resulting in a significant opportunity for alignment

- ▶ Decrease percentage of physician's bonus opportunity to better align compensation and productivity
- ▶ Evaluate implementing a tiered compensation model to drive productivity
- ▶ Align physician bonus structure to include organizational financial performance

Lack of productivity criteria/standards within the medical group with an opportunity to align compensation and productivity

- ▶ Utilize productivity criteria based on years of service and patient contact hours expectations by specialty
- ▶ Consistently measure and report productivity measures to all providers

After seeing initial projections, the organization made a decision to reduce bonus compensation by a cumulative \$25 million. As part of the response to the findings, the organization began evaluating compensation redesign that would create a tighter alignment between productivity and compensation levels by utilizing a "tiered" model.

Table 3

Department Productivity Quartile Analysis

Physicians		
Physicians wRVU Production – Primary Care		
Productivity Range	Count	% of Physicians
<25th	20	29.0%
25th–49th	20	29.0%
50th–74th	18	26.1%
75th–100th	11	15.9%
	69	100.0%

Physicians Compensation – Primary Care		
TCC Range	Count	% of Physicians
<25th	8	11.6%
25th–49th	6	8.7%
50th–74th	30	43.5%
75th–100th	25	36.2%
	69	100.0%

Advanced Practice Clinicians (APCs)		
APCs wRVU Production – Primary Care		
Productivity Range	Count	% of APCs
<25th	9	15.0%
25th–49th	23	38.3%
50th–74th	17	28.3%
75th–100th	11	18.3%
	60	100.0%

APCs Compensation – Primary Care		
TCC Range	Count	% of APCs
<25th	0	0.0%
25th–49th	4	6.7%
50th–74th	17	28.3%
75th–100th	39	65.0%
	60	100.0%

Table 4

Net Revenue per Work RVU by Specialty Chart

Clinic Net Collections Per wRVU Analysis		
Clinic	Difference Per wRVU	Total Opportunity
Family Medicine Clinic A	\$2.61	
Family Medicine Clinic B	\$9.61	
Internal Medicine Clinic A	-\$8.23	-\$238,276
Internal Medicine Clinic B	-\$6.94	-\$154,949
Urogynecology Clinic A	-\$5.59	-\$138,175
Urogynecology Clinic B	-\$11.17	-\$74,620
OB/GYN Clinic A	-\$41.05	-\$1,051,371
OB/GYN Clinic B	\$2.62	
Orthopedic Surgery Clinic A	-\$30.32	-\$1,214,380
Sports Medicine Clinic A	-\$8.05	-\$369,233
Sports Medicine Clinic B	\$5.69	
Hematology/Oncology Clinic A	-\$18.56	-\$991,246
Hematology/Oncology Clinic B	-\$22.86	-\$285,446
Otolaryngology Clinic A	-\$18.09	-\$383,786
Urology Clinic A	-\$9.51	-\$160,067
Bariatrics Clinic A	\$5.47	
Bariatrics Clinic B	-\$28.58	-\$173,059
Pulmonology Clinic A	\$10.57	
Endocrinology Clinic A	\$6.52	
Pain Management Clinic A	-\$8.39	-\$7,962
Neurosciences Clinic A	-\$15.06	-\$232,708
Neurosciences Clinic B	\$27.87	
Total Identified Opportunity:		-\$5,475,277

CASE STUDY D

Department Productivity Quartile Analysis

Utilizing a specialty or departmental level quartile analysis provides a more granular view of compensation and productivity alignment. It also provides a side-by-side comparison of APC and physician productivity and compensation.

Overall Findings (62 Clinics)

Revenue Opportunity: \$8,118,993 Total Opportunity: \$38,523,034

Expense Opportunity: \$30,404,041 Opportunity per Provider: \$116,442

Medical Group Demographics

System-affiliated medical group providing the full range of primary care, medical, and surgical specialties to communities throughout its upper Midwest regional locality. The medical group employs 400+ providers, providing care at 95+ locations and supporting five regional hospitals. The medical group serves as an integral component of the health system's overall care delivery strategy, which focuses on bringing providers, technology, and patients together to improve health care in the communities they serve.

Organizational Challenges

The medical group was facing escalating medical group costs, while operating in a hospital-centric environment that was predominately bottom-line focused. The organization lacked hierarchical accountability for financial decisions, which negatively affected the medical group's bottom-line performance, including an organizational goal to implement a care model featuring a 2:1 APC to physician ratio.

Assessment Findings

- ▶ Misaligned provider productivity and compensation
- ▶ Lack of distinct criteria of when to add additional providers
- ▶ Average primary care physician productivity at the 43rd percentile
- ▶ Average primary care APC productivity at the 50th percentile
- ▶ Identified provider (physician and APC) compensation and productivity alignment opportunity of \$11,530,207

Recommendations

Lack of formal criteria of when to add additional providers resulting in opportunities to align provider complement, right-size staffing, and improve productivity

- ▶ Develop specialty-specific productivity criteria to be met before a clinic or department adds providers
- ▶ Consistently measure and report productivity measures to all providers

Misaligned primary care APC compensation and productivity resulting in a significant opportunity for alignment

- ▶ Implement market-based APC compensation plan with defined production expectations or thresholds

CASE STUDY E

Net Revenue per wRVU by Specialty

Analyzing net collections per wRVU by specialty allows identification of opportunities with revenue cycle performance and/or managed care contracting.

Overall Findings (22 Clinics)

Revenue Opportunity: \$5,475,277
Total Opportunity: \$27,229,994

Expense Opportunity: \$21,754,716
Opportunity per Provider: \$236,536

Medical Group Demographics

System-affiliated medical group located in a major metropolitan area in the Northwest. The medical group comprises 700+ providers across 40 specialties, providing care at 120+ locations. The medical group has steadily increased in size through acquisitions of community providers and targeted growth.

Organizational Challenges

The hospital-centric organization perceived one of their medical groups as having high performance yet lacked the ability to truly benchmark performance since the financials were integrated into hospital service lines. The organization also operated another medical group on a more standalone basis, especially in regards to how the financials were tracked.

Assessment Findings

- ▶ Across the 22 clinics analyzed, a \$5,475,000 opportunity was identified in net collections, amounting to a \$9.39 per wRVU opportunity
- ▶ 63% of the clinics analyzed had net collections opportunities, with an average opportunity of \$391,091 per clinic
- ▶ Substantial net revenue variation within and across specialties, indicating a lack of standardized payer contracting strategy
- ▶ Lack of actionable revenue cycle data and KPI reporting

Recommendations

Lack of standardized ambulatory payer contracting strategy and hospital-centric revenue cycle operations, resulting in a significant financial opportunity

- ▶ Ensure actual net professional revenue is tracking appropriately with expected collections to ensure optimal revenue cycle performance
- ▶ Develop revenue cycle governance committee to review current managed care payer rates and revenue cycle strategies and performance
- ▶ Evaluate all revenue cycle functions to ensure optimal performance
- ▶ Implement monthly revenue cycle KPI reporting

5 Net Revenue per wRVU by Specialty

With tightening margins, it is extremely important to ensure that revenue is collected for the work performed. Benchmarking net revenue per wRVU by specialty provides insight into how the organization is performing compared to the market (see Table 4). This “per unit” analysis provides a more focused review, rather than looking at overall revenue. If revenue is lower, per unit, than benchmarks, a deeper examination into revenue cycle performance or payer contracting may need to be conducted to better understand the cause for the deficiency.

Creating Resilient Organizations

As you can see, the findings are significant and the financial opportunities for improvement are large. We believe that by focusing on these five areas, leaders can optimize operational

efficiency and enhance financial accountability to sustain resilient, healthy organizations.

Given the degree of opportunity, we suggest a multi-year plan to adequately achieve the desired results. This typically means that an organization will attempt 25% to 30% improvement per year. In rare situations, organizations may be able to achieve more improvement in a single year or two. We find that there are contractual barriers that limit achieving full success in this short of a timeframe. Additionally, operational changes of the level required cannot always be quickly embedded into the environment. Lastly, physician engagement is critical for the improvement to be realized, and that takes time in most organizations. **GRJ**

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