WHITE PAPER

The Keys to Maximizing an Aligned Physician Enterprise

And Achieving Appropriate Levels of Investment per Physician

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A recent item in Becker's Hospital CFO Report contained some sobering information for health system leaders. According to Kaufman Hall's Physician Flash Report, investment/subsidy per physician rose above $300,000 for the first time in 2024. Matthew Bates, managing director and Physician Enterprise service line leader with Kaufman Hall, saw this as a sign that current models of physician employment are not sustainable. According to him, "Revenue is increasing but physicians and providers are working more while generating less revenue. Health systems need to rethink operations to align the costs of provider employment with the current healthcare environment."[1]

To most health system leaders, this observation comes as no surprise. Financial challenges have steadily risen over the past decade. In this environment, it is more crucial than ever that health system leaders ensure they are capitalizing on the advantages of having an aligned physician enterprise. You must work diligently to enhance performance in order to drive investment per physician to appropriate levels. (Spoiler alert: This means far lower than the average investment per provider reported in most surveys.)

Keys to Peak Performance

There are many advantages of having an aligned physician enterprise irrespective of structure, but key elements are necessary to optimally support and operate this enterprise, and several tactics will move your physician enterprise toward peak performance.

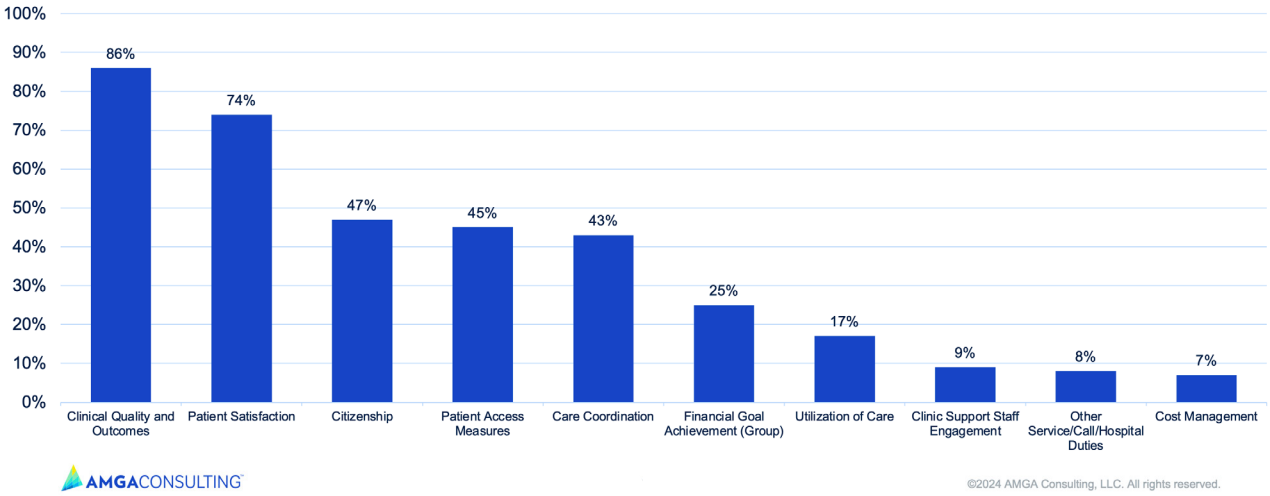
First, let's examine the significant advantages of system-physician enterprise alignment. By "alignment," we refer to collective vision, governance, and operating capabilities. It should be noted that if you have alignment, you can operate a wide range of models that, in our experience, can lead to optimal capabilities of hospital and physician enterprise collaboration. This can take the common form of an employed model (whether structured as a medical group subsidiary or aligned in a service-line structure), a professional services agreement (PSA), joint ventures with aligned incentives and collective vision, and value contracting that aligns the respective parties. When properly aligned, each of these models offers tangible benefits:

- Improved patient access to care
- Recruitment strategy that is inclusive of physicians and advanced practice clinicians (APCs)
- Ability to provide care management processes to reduce costs
- Increased volume and throughput (not to be confused with volume of referrals)
- Joint focus on drug and supply costs, driving standardization
- Improved payer mix management and diversification
- Improved performance on system-focused goals such as patient experience, growth, and quality (see diagram on following page for detail on top components included in provider compensation plans)
- Improved call coverage
- Standardized operations

[1] www.beckershospitalreview.com/finance/physician-employment-models-are-not-sustainable-as-labor-expenses-rise-5-notes.html

Prevalence of Incentive Compensation Metrics

Source: AMGA 2024 Medical Group Compensation and Productivity Survey Report



Note that each of the above comes with a complex set of processes and approaches, or "keys," that must be managed to achieve enhanced performance. Although the keys may be different in a physician enterprise (or clinic) setting than in an acute hospital setting, alignment is essential. Tighter alignment can lead to better acute care performance if managed properly.

Involving the physician enterprise in system-level initiatives is essential. Given that physicians operate in myriad settings, it is important that they have a key role in all improvement initiatives in all settings, including outpatient, inpatient, and ancillary care. Relegating the physician enterprise to involvement in "clinic only" direction is not only a limiting perspective, but it also robs the health system of any ability to capitalize on its partnership with the physician enterprise. If this happens, the profound opportunity to align with your physicians is lost and the time cost of your physician enterprise will actually increase—in most cases, dramatically.

Building Blocks

If these are the benefits, what are the building blocks to achieve enhanced performance?

In order to focus on essential aspects that require alignment, AMGA and AMGA Consulting created a model referred to as the High Performing Physician Enterprise (HPPE). This model seeks to explain what must be managed to achieve high performance, and the characteristics are included in seven (7) domains, with a collective of more than 130 indicators. The model utilized in the HPPE Program appears at right.

Below are some of the components of the HPPE model.

- Governance and decision making in order to align authority, responsibility, and accountability
- Physician leadership

- Annual professional review for providers
- Team-based leadership organized as dyads or triads
- Clear data, alignment, and reporting of your KPIs, including spread of information and common messaging
- Accurate and consistent treatment of ancillaries and allocations
- Payer/value strategy supported by an infrastructure necessary to participate in value
- Understanding of your cost position, with appropriate data that can be shared transparently
- Incentive and quality reporting
- Standardization of compensation plans, operating metrics and approaches, recruitment criteria, etc.
- Staffing plans that are based upon market data and adjusted for your unique setting and the volume of the respective practice
- A functioning compact among physicians, the physician enterprise, and the health system

Note all of these must focus on the goal of aligning authority, responsibility, and accountability. For example, there needs to be accountability related to those who have authority to make decisions. If there is no accountability at the physician enterprise to focus on standardization, such as scheduling expectations, the enterprise should not be able to make decisions around templating. If they are not focused on improvement or alignment, they lack accountability for the decisions they have authority over. This misalignment sets a dangerous precedent.

Another example would be a compensation plan that compensates all established physicians at the same percentile of total cash compensation, regardless of production or attainment of any goals. In such a situation, those with the lowest production or those accomplishing the fewest number of incentive goals are actually paid at a higher rate (compensation per wRVU or compensation per successful incentive goal) than those who are performing at a high level (production or incentive plan success). If incentive payouts are the same across the board, it creates perverse incentives and can be very costly to organizations (more on the latter point below).

Ideally, a physician enterprise and health system should be moving forward in an aligned manner, focused on goal achievement and reality-based improvement. The desired end state is a self-managed strategic business unit (SBU) aligned via physician enterprise leaders, professional performance reviews, and comparative analytics.

The Right Investment per Physician

Now on to the ever-elusive question: What is the right investment per physician?

We could write books exploring this question, but the most important lesson is that you should be able to maintain performance that is much closer to break even than the median numbers reported in surveys on this topic. Although there may not be a “right” investment per physician, there are concrete ways to lower it.

First, a word or two about accounting. We advocate isolating performance that is controllable and ensuring this includes standard components so that you can have an apples-to-apples comparison of true performance. Typical profit/loss items such as allocations and ancillary revenue (or lack thereof) are not entries that should be the real focus, as they are handled differently from system to system and their inclusion in an assessment only muddies the water. This is because an organization’s methodology, rather than true physician enterprise performance, can dramatically shift results when these components are included. Therefore, we see these items as artificial and able to be manipulated (not in a pejorative sense). True performance improvement happens at the operational, not record-keeping, level. This means attempting to isolate performance at the specialty or clinic level.

Rather than get caught up in allocation methodology or how ancillary revenue is or is not assigned, consider how to drive down investment on a direct revenue/cost basis at the clinic or specialty level.

We have identified six (6) methods to achieve optimal and aligned performance. While there are several more that could be included, these tend to drive results in the most efficient manner with a very high ROI.

1. Move production composite past median on average

Not doing so rewards low producers and uses up resources that could instead be shifted to those meeting or exceeding goals (such as higher level of compensation if exceeding target productivity).

As detailed in the following examples, the difference between having low producers vs. a reasonable level of production is significant.

Example 1: Clinic-Level

Investment per Provider with Lower Producers

Scenario 1 *(3 Physicians)*	
wRVUs (3,933 per 1.0)	**11,800 wRVUs** (16th Percentile per 1.0)
Pay at Median ($320k per 1.0 x 3)	$960,000
Support Staff ($50k per 1.0 x 9)	$450,000
Benefits (20% of Comp)	$282,000
Total Comp Expense	**$1,692,000**
Professional Collections (Commensurate with wRVUs)	**$1,040,000**
Income (Investment)	($652,000)
Investment per Provider	**($217,300)**

Scenario 2 *(2 Physicians)*	
wRVUs (5,900 per 1.0)	**11,800 wRVUs** (50th Percentile per 1.0)
Pay at Median ($320k per 1.0 x 2)	$640,000
Support Staff ($50k per 1.0 x 6)	$300,000
Benefits (20% of Comp)	$188,000
Total Comp Expense	**$1,128,000**
Professional Collections (Commensurate with wRVUs)	**$1,040,000**
Income (Investment)	($88,000)
Investment per Provider	**($44,300)**

Example 2: Medical Group

	Medical Group A	Medical Group B
# of FTE Physicians	500.00	420.00
Aggregate wRVUs	2,874,238	2,874,238
Avg wRVU Percentile	36	50
Avg TCC Percentile	50	50
Revenue	**$ 221,976,795**	**$ 221,976,795**
Expenses	**$ 358,467,999**	**$ 319,805,515**
Net Investment	**$ (136,491,205)**	**$ (97,828,721)**
Investment per Physician	**$ (272,982)**	**$ (232,926)**

2. Utilize variable staffing

Variable staffing ensures support for those doing the right things. A per physician staffing model, in which each full-time equivalent (FTE) physician receives a standard staffing complement, will lead to complacency. It simply doesn't make sense that someone producing at the 25th percentile receive the same staffing complement as someone who is at the 75th percentile. Instead, we recommend a variable staffing indexed to productivity level (xx/10,000 wRVUs), which in essence creates alignment and links accountability. By not adjusting staffing based upon volume, but rather providing a standard per physician, you, in essence, reward low producers with staffing not aligned or indexed to their production and at too high a ratio. This approach will also alienate high producers, who under such a system receive the same staffing complement as low producers. This is not to say that there may be certain minimum staffing requirements, for example in a solo provider practice location.

3. Ability to manage in a value-based environment

There are a lot of questions within health systems today regarding whether they should pursue a value-based strategy, given the current uneven playing field and general dissatisfaction with Medicare Advantage

and commercial plans. With the constant decrease in the Medicare conversion factor/rates and the erosion this causes to commercial rates, it is our opinion that if you feel you can decrease your cost structure and in return reap benefit by engagement in value, a value-strategy can be extremely important to your future.

In our opinion, decreased length of stay, cost per case, and decompression of EDs are all potential outcomes that you can achieve with an aligned group. Allow your aligned physician enterprise to drive change; however, give the providers an opportunity to impact more than just professional risk/fees. There is only so much that can be done to decrease professional fees, and at some point you will experience diminishing returns (a.k.a. a race to the bottom). Rather think of, and utilize, your physician enterprise as the infrastructure to manage care. This allows you to truly impact high-cost services, which are the larger piece of the cost pie. Physician services typically represent approximately 20% of overall spend in healthcare, which means that 80% of costs are outside of professional fees. It is our opinion and experience that this 80% can be impacted significantly by having an aligned physician enterprise involved in care redesign, with a focus on driving down costs in a value-based environment. This creates significant upside opportunity that can be achieved with proper focus and engagement of your physician enterprise.

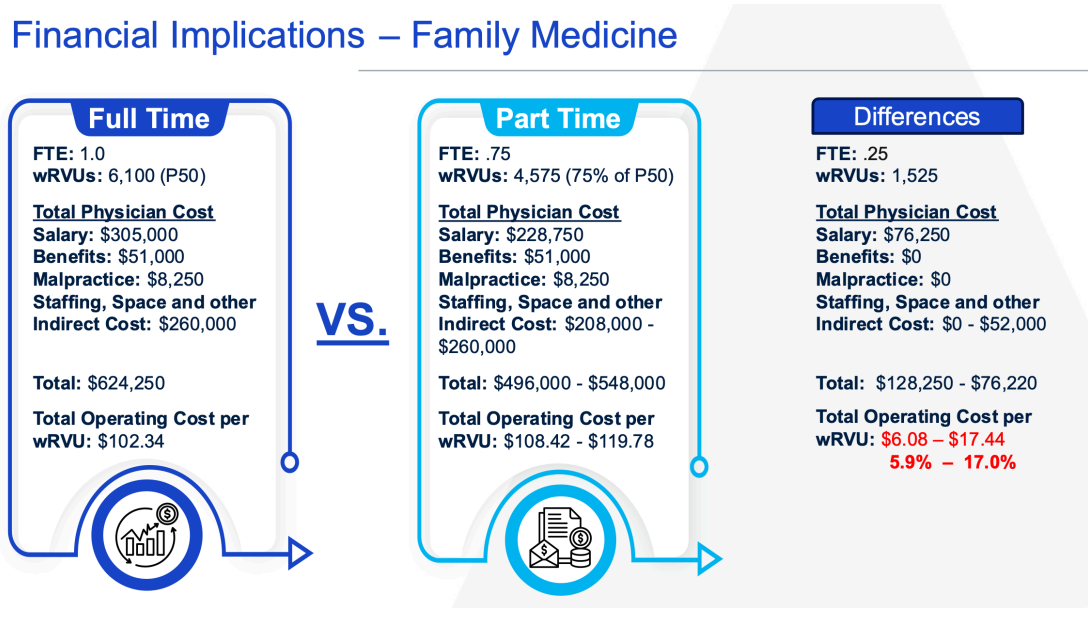
4. Proper staffing of "ist" models

While wRVUs are rarely included in compensation plans for hospitalists and shift-based physicians, using wRVUs for analytics related to staffing levels is extremely important. For instance, let's assume System A's hospitalist staffing results in average production at the 25th percentile, while System B's average is at median. System A's staffing costs are substantially greater than those of System B.

We recently worked with an organization with low volume but a lot of shifts to cover. This resulted in compensation that was roughly two times what it could have been with more reasonable production levels. The higher production results in better aligned staffing costs. In the particular case referenced, the low volume and higher staffing ratios were leading to a lack of sustainability. We decreased some of the shifts and established targets based on increased (but not above median) production. This also aligned revenue to expense, as optimal revenue is indexed to your staffing levels.

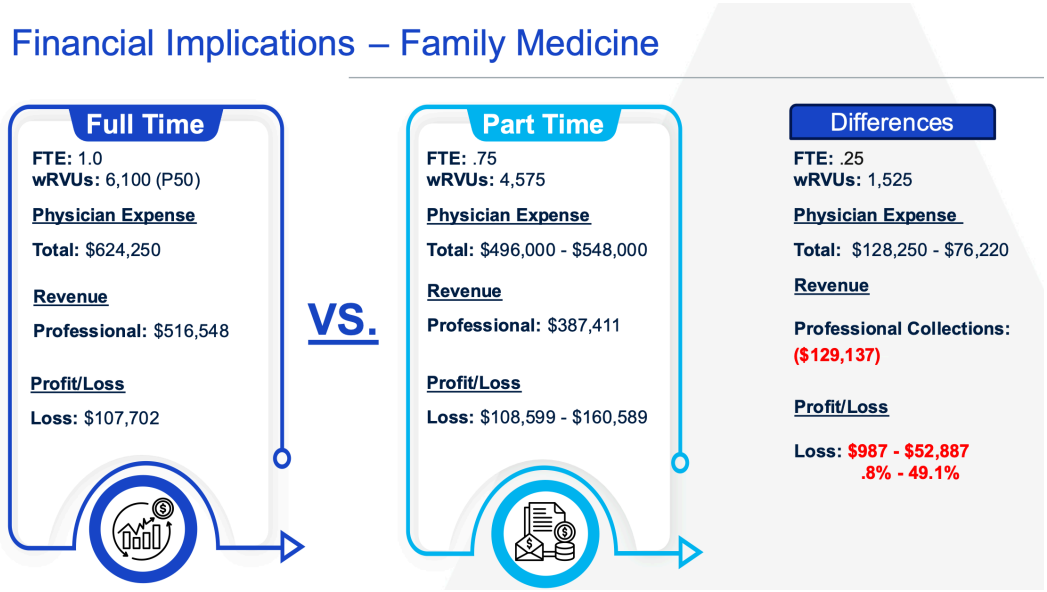
5. Use of part time has significant cost

As can be seen in the "Financial Implications – Family Medicine" figures, part-time physicians, even when producing at an FTE-adjusted equivalent level to a full-time, median level of production, are simply costlier for an organization.



Strategies to create a more aligned model include:

- Set a finite number of part-time options, rather than any discount in FTE that a provider may desire. In other words, maybe an organization establishes that FTE level must be one of four increments: 0.25, 0.5, 0.75, and 1.0. This allows for more standardization and circumvents having myriad more difficult-to-manage, ad hoc increments, such as someone seeking to be a 0.95. In our work, standardizing part-time options tends to align better to staffing models and overall expense outlay for the provider's practice.



- Establish a compensation formula that results in lower compensation per wRVU for part-time providers. This may be a difficult step for many organizations, but if you seek to align authority, accountability, and responsibility, it is appropriate to compensate at lower levels when providers make the personal decision to reduce their FTE status, as the economies of their practice are negatively impacted. If they continue to receive the same compensation per unit as full-time physicians, who contribute more to the practice in terms of production and the bottom line, you are once again breaking the rule of alignment and providing greater reward for those who made the decision to go part-time. This would then create an incentive for all providers to be part-time, which is a perverse incentive.

6. Pay APPs on productivity

As you work to align your overall provider complement to your productivity goals, it is helpful to pay at least a portion of APP compensation on the basis of productivity. This has several advantages.

As depicted below, organizations that tied at least 10% of APP compensation to productivity experienced, on average, a 12% higher production from their primary care APPs.

2024 National AMGA Compensation Data: 3115 - Nurse Practitioner - Primary Care wRVUs							
	N Size	25th Percentile	40th Percentile	Median	60th Percentile	75th Percentile	90th Percentile
All Respondents	6,145	3,485	4,195	4,613	5,014	5,779	7,281
10% or more tied to productivity (wRVUs)	544	4,019	4,790	5,096	5,644	6,411	7,926
Calculated Variance		534	596	483	630	632	645
% Variance		15%	14%	10%	13%	11%	9%

Productivity averaged 12% higher for this cohort of NPs

This productivity linkage is critical in compensation design from a fairness perspective. Compared to compensation plans that simply compensate on a straight salary basis, regardless of production, linking compensation to productivity enables you to reward those attaining your production goals, rather than those producing below expected levels.

Linking compensation to productivity begins to phase in APP compensation plan parameters consistent with those of physicians, which is extremely important as you develop your overall care models and staffing plans, rather than parameters that have divergent goals where only physicians are accountable for their production.

Conclusion

So, what is the "right" level of investment per physician investment? Although there will be much variation among different organizations, it is certainly much less than $300,000. The key to a better than average investment per provider is alignment of the health system and the physician enterprise. By creating that alignment and using the methods detailed above, you can lower your investment per physician and move your organization to peak performance.

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