The New World of Physician Networks

Building an Efficient Cost Structure

BY LISA OZAETA AND MICHAEL DUFFY

The Institute for Healthcare Improvement’s Triple Aim calls on healthcare organizations and providers to improve patient experience, advance population health, and reduce the cost of care. To satisfy this mandate, hospitals are strengthening ties with their physician networks to provide better patient experiences and clinical outcomes. By integrating the cost structure of the hospital and physician clinic, the expectation is that overall, costs of care will come down. Unfortunately, the experience of hospitals has been that this tight affiliation is expensive and drives up the cost of care.

Network Filters

Effective and efficient networks are not realized through ad hoc design but rather are the product of a well-defined approach. Applying the Three Filters of Physician Networking (Figure 1) allows you to achieve a robust strategy that provides the proper complement of physicians at a sustainable price.

The Right Physicians

The first filter of physician networking is defining the ideal physician and number of physicians for the network. Meeting with and signing up as many physicians as possible in your market will only produce a bloated, disjointed network that provides little strategic value for the hospital or its patients.

There are three main goals for increasing the size of the physician network: staffing service lines, improving care coordination, and/or building a primary care base for population health management. Before meeting with physicians or announcing a new recruitment vehicle, hone your strategic planning process to answer the following questions:

*Hospitals are strengthening ties with their physician networks to provide better patient experiences and clinical outcomes.*

What are the attributes of the physicians we want to recruit? Creating a list of match characteristics streamlines the recruiting process. Sample characteristics include practice size, panel size, geographic location, hospital affiliation, and reputation.

How many physicians do we need to achieve our goal? Forecasting demand and assessing competitors will help determine the number of physicians needed in each specialty.

The Right Level

The second filter is choosing the right level of network integration. A common mistake is to adopt one model and apply it across all physicians. This tends to create rigid structures throughout the physician network and can be too costly. Below is a brief description of affiliation options available.
Employment. Employment is the traditional model for affiliating with physicians. Hiring physicians onto the medical staff or into the medical foundation creates 100 percent clinical and financial alignment. However, this model is the most expensive and has the potential to dissatisfy physicians by diminishing the autonomy and control they once enjoyed in their practices. Hospitals are increasingly attempting to tie the financial performance of physicians’ practices to salaries in hopes of aligning the financial incentives of the hospital and physicians. Employment is best suited for practices that are necessary to the network but cannot survive on net collections, due to either lack of patient volume or payer mix. Although this is the most straightforward model, hospitals should not simply settle for it when others may be more appropriate for their circumstances.

Associate model. In an associate model, hospitals do not employ physicians or their staff. Rather, physicians continue to own and manage their practices. A hospital and physicians enter into an agreement to allow joint contracting, quality improvement, and cost containment. Under this model, a hospital agrees to bill and collect for physicians under the hospital’s contracts and passes on the net revenue. In exchange, physicians either participate in the clinical integration or financial integration program of the hospital. This model allows hospitals to build tight affiliations with physicians without undertaking the financial management of their practices.

Affiliate model. The affiliate model is a cost-effective way of broadening the physician network. As affiliates, the hospital and physicians agree to be part of a single network, but the physicians are not clinically or financially integrated with the hospital. The affiliation focuses on achieving jointly decided quality metrics and cost containment measures, and physicians participate in the clinical leadership council governing the overall physician network. The hospital generally provides desired services to affiliated physicians, such as an after-hours nurse advice line, urgent care clinics, electronic health record (EHR) subsidization, and patient-centered medical home assistance—although these services often vary by specialty. Hospitals need to work closely with their regulatory attorneys in crafting affiliation agreements to ensure compliance with Stark and anti-kickback laws.

The Right Price
Regardless of which model is used, choosing a proper price point—the third filter—is imperative. Using appropriate benchmarks, market studies, and service selection ensures that the offering is sustainably priced. Hospitals should strive for a mix of the three levels, with each costing half as much as the higher level. For example, if the hospital is losing $200,000 in the employment model, the associate model should cost roughly $100,000 per physician, and the affiliate model should cost no more than $50,000 per physician. Once the model is set in this tiered fashion, the next step is to reduce operating costs associated with the delivery of care in the network.

Network Delivery
Structuring an efficient and cost-effective medical group that supports employed, associate, and affiliated physicians requires thoughtful planning and a clear understanding of factors that can diminish group performance and contribute to elevating costs. The aggregate cost of employing a single physician is approximately $767,000 per year,1 highlighting the

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**TABLE 1**

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>Clinic Staff per Physician FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Operations</td>
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</tr>
<tr>
<td>Front-Office Staff</td>
<td>1.09</td>
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<tr>
<td>Clinical Support Staff</td>
<td>1.05</td>
</tr>
<tr>
<td>Combined</td>
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**FIGURE 1**

The Three Filters of Physician Networking

1. **RIGHT Physicians**
   - Number. hinge aligns the number of physician partners with the hospital’s strategic goals.
   - Attributes. streamlines the contracting process by defining shared characteristics.

2. **RIGHT Affiliation Level**
   - Employment. provides the greatest level of integration, but comes with high costs.
   - Association Model. promotes tighter alignment between hospitals and physicians, while preserving physician independence.
   - Affiliation. allows hospitals to initiate relationships with physicians who are not prepared for associates or employment models.

3. **RIGHT Price**
   - Benchmarks. helps in setting the right price for services by comparing to national and regional market data.
   - Market Factors. allows for benchmarks to be adjusted to local dynamics and norms.
Administrators and physician leaders can begin building high-performing groups by establishing consistent operating principles and standards across the network, which reduces inefficient and redundant work efforts.

So, what are the key drivers of aggregate group costs, and how can organizations structure efficient networks to reduce operating losses and optimize operating margins?

**Medical Group Benchmarks**

For medical groups to fully understand their cost structure relative to peers, costs need to be defined so as to make “apples-to-apples” comparisons across organizations. A recent survey indicates that costs can vary significantly across groups, ranging from $530,000 to $964,000 per physician (FTE)² (Figure 2). Large and mature organizations are within ± $20,000 of the $767,000 median.³

When factoring in productivity in terms of total relative value units (RVUs), group expense structures range between $53.00 and $74.00 per total RVU. At the median of $64.00 per total RVU, groups must have aggregate reimbursement of almost 190 percent of Medicare to break even, which is impractical to achieve.⁴ As such, groups must develop operating standards that support a highly productive ambulatory enterprise and minimize expenses.

The greatest opportunities to create efficiencies are typically in the number of support staff and physicians, as these two areas represent approximately 25 percent and 44 percent of aggregate group costs, respectively, as shown in Figure 3.

With an average annual physician cost of $339,000 per FTE (see Figure 3), organizations must be strategic about which physicians to employ. The addition of even a modest number of physicians can increase expenses by millions of dollars. Further, administrative and clinical support infrastructure and staff must be sufficient to support physicians. The cost associated with business operations and clinical support staff exceeds $141,000 per physician FTE, which can further diminish a group’s ability to be profitable. Instituting consistent operating principles across core medical group functions, centralizing selected services, and managing staffing levels enhances productivity and contains costs effectively.

**Operating Principles**

Physician groups tend to suffer from poor organizational design when core operating functions are inefficient and performance metrics are undefined. Standard operations applied by well-trained staff in a centralized department can translate to greater productivity that supports the incremental operating margin across the network. Best practices should be defined to streamline important group operations, including:

- Registration and scheduling
- Prior authorization and medical renewals
- Referral management and care coordination
- Pre-visit and post-visit follow-up

As an example, our experience reveals that groups that have either centralized patient scheduling or established protocols adhered to throughout the network can increase patient visit volumes between 15 percent and 20 percent by improving management and follow-up of canceled appointments and no-shows.

The lack of operating principles can also affect a group’s administrative oversight when there are minimal standards related to performance metrics, such as:

- Clinical operations support and costs
- Operating expenses and overhead
- Productivity, financial, and quality reporting
A recent assessment of a large medical group highlighted the degree of variability that occurs in staffing and associated staff expenses, as this group lacked a consistent approach to staffing clinics to support provider productivity. This resulted in a wide range of front-office and clinical support staff per physician FTE across clinics, as shown in Figure 4.

Because staffing expenses can represent 25 percent of a group’s aggregate costs,\(^1\) each clinic’s expense structure varied significantly, as did financial results. While adding staff can support a degree of efficiency, bloated staffing that is not structured appropriately inhibits group performance.

To improve group results and consistency across the ambulatory network, staffing ratios could be developed with administrative and physician leaders.

Ratios will vary between primary care and specialty clinics and also depend on the extent to which a team-based approach to care delivery is used. However, large multispecialty medical groups with multiple clinics have median clinic staff-per-physician of approximately 2.1 FTEs (Table 1).

Business operations staffing also presents opportunities to create efficiencies as it represents almost 10 percent of aggregate group costs and almost 37 percent of staffing-specific expenses. Typical groups have 0.90 FTEs across various business operations functions.

Parting Thoughts

High-performing medical groups design and implement several key strategies for cost-effective ambulatory networks, including:
Developing flexible approaches to building a physician network of both employed and affiliated providers to minimize operating expenses

Defining operating principles across core group functions to support productivity and introduce operational consistency across the network

Targeting functional areas that represent large components of aggregate group costs

Establishing centralized services for many “high-touch” and redundant patient activities to alleviate demands on clinic staff and improve patient access and experience

By taking a critical and strategic approach to network design and delivery, medical groups can create efficient ambulatory networks that ensure patient needs are met while building lean expense structures that minimize losses and maximize operating margins.

References
2. Ibid.
3. Ibid.
4. Centers for Medicare and Medicaid. 2012. 2012 Physician Fee Schedule. 190% is calculated as $64.61 cost per total RVU ÷ $34.04 conversion factor.

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