How to Assess Medical Group Performance

Organizations are revisiting medical group strategy and physician alignment in the face of private equity investment, growing medical group losses, and a decline in overall performance. Approaches on how to address medical group performance vary but can broadly be categorized as performance optimization (i.e., enhancing the current alignment vehicle) or pursuing a structure change to an existing model that improves sustainability. In lieu of performance-focused optimization, organizations are increasingly considering whether there are alignment models that are more sustainable and functional than traditional employment given the price transparency and site neutrality trends. The following article explores the evaluation of current medical group performance.

More health systems are taking a multi-faceted approach to maximize medical group performance. The exponential growth in physician and advanced practice provider employment and the growth in reimbursement tied to cost, quality, and access have heightened the importance of medical group strategy. However, many organizations continue to experience underperformance across several domains (cost, growth, access, etc.), and attempts to improve performance have stalled or been met with significant resistance. In most cases, the definition of performance is too narrow to identify the actionable strategies necessary for improvement.

Measurement of medical group performance and provider efficiency has historically been based on investment or operating loss per physician. In VMG Health's experience, questions pertaining to a medical group optimization are complicated and require consideration of several indicators. Commonly used measures like investment per physician and provider FTE are helpful but can be misconstrued without proper context due to a myriad of factors. Some of these factors include but are not limited to medical group provider composition (e.g., primary care, hospital-based, pediatric subspecialties, etc.), medical group structure, care model, payor contracting strategy, overhead allocation, and payor mix.

To truly understand medical group performance, performance should be evaluated across a series of clinical, financial, operating, and community domains to ensure the group's value is fully realized and understood. Focusing on only one or two aspects of medical group activity can result in an overly narrow and often inaccurate assessment of medical group value. The approach to assessing the economic sustainability/affordability of a medical group should be based on a complete picture of the medical group's impact on health system financial performance and should not be limited to a simple financial review of practice operations.

It is critically important to consider how the medical group functions, performs, and contributes to the health system in several areas including: 1) growth trajectory and overall affordability, 2) engagement of the provider group, 3) data availability and reporting, 4) provider care model and compensation, and 5) provider governance. Strong performance across one or two domains is not indicative of sustainability and category weighting is required to acknowledge the relative importance of each.

Each of the domains can be evaluated and indexed across several factors to essentially score the medical group's overall health and determine whether financial, strategic, and clinical alignment requires modification for sustainability.

Performance Domains

Affordability

The affordability domain evaluates the extent to which the magnitude of the hospital or health system's investment in the medical group is appropriate given the size, operating performance, structure, and breadth. The domain also considers whether the investment is financially sustainable for the organization when tested against the parent organization's size, operating performance, and market conditions.

VMG uses a wide array of metrics to measure affordability, including but not limited to metrics that measure the enterprise-wide impact of employing physicians. Depending on organizational compliance and internal firewalls related to information sharing, our preference is to develop management models that combine enterprise-wide economic contribution to the underlying net investment in the professional practice.

Without a common understating of enterprise-wide performance, medical groups are all too often in the position of defending their status in a health system. Further, our experience suggests there is increased dissatisfaction among providers and operators.

Engagement

The degree to which medical group infrastructure and policies support physician-to-physician and physician to group accountability. The engagement domain evaluates whether policies support the individual or the collective, and to what extent the governance structures create peer accountability and a set of medical group values that align with health system goals and objectives.

Data Reporting

The ability of the health system and the medical group to track, report (internally and externally), and act on data is essential. Supportive data systems, with actionable dashboards and reports for providers, are deployed to maximize the utility of the group practice. Medical groups lacking effective data tracking, reporting, and management capabilities are extremely limited.

Care Model

Exponential growth exists in patient care delivery in non-traditional settings and by care teams versus individual providers. What policies, procedures, and models have been developed and implemented that support care innovation, efficiency, and patient access? How well developed are virtual protocols and how mature is the medical group's thinking about advanced practice provider utilization and deployment? Does this translate into aligned remunerations systems for providers?

Governance

The governance domain assesses how decisions pertaining to medical group management and operations are made as well as who is making the decision. There is not a one size fits all approach to organizational structure and decision making. What structures and policies support provider-led management and decision-making? To what degree are service line management and medical group operations integrated to assure efficient and effective operations.

Completing an internal assessment across these domains will benefit the medical group and the broader health system clinical enterprise. Completing this type of assessment generally assumes arrangements are fair market value and commercially reasonable, however, there is some inherent connectedness between affordability and internal compliance standards. Since the inception of the Stark Law in the late 1980s, there have been concerns about the commercial reasonableness of physician practices that lose money. While most operators could rationalize why practice in a health system model may lose money, there have been decades of discomfort with the strict interpretation of the Stark Law. In the most recent changes to Stark, there has been a clarification noting that the determination of an arrangement's commercial reasonableness does not turn on whether the arrangement is profitable. Under the statute, there are several examples of community need, EMTALA, charity care, and quality that may support underlying commercial reasonableness despite practice losses. Nevertheless, assuring internal compliance policies and oversight are contemporary with the current law is paramount.

In VMG Health's experience, questioning medical group sustainability is both essential and complicated. Many organizations struggle with assessing current performance in a way that provides a comprehensive view and provides actionable strategies for improvement. It is critical this work effort is organized in the right way since a simple benchmark exercise is largely ineffective in driving change.

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