

November 2025

Optimizing service lines: better business, less busy-ness

Many health systems assume their core service lines are their financial pillars. These programs are highly visible, central to their identity as high-quality providers and often among the most active areas in the system. But activity is not the same as performance. Health systems need to confront whether their service lines are truly profitable, or just busy.

There is urgency to the question. Margin pressure is permanent, and variation in cost, quality and outcomes is under the microscope. The potential for site-neutral payment looms. Given these pressures, old assumptions about service line performance are risky. Systems need a clearer understanding of whether their service lines contribute to sustainable margin. If they don't, they need to understand why.

Unfortunately, many systems have an accountability gap when it comes to their service lines. No one is truly responsible for their success or failure, and therefore no one truly understands whether the service line is a net contributor or a drain. But a cross-functional, margin-focused approach can optimize a health system's service lines to maintain profitability and even drive growth.

Visibility: The foundation for improvement

Many systems lack a clear view of service line financials. Performance is often measured at the hospital level alone, or based on siloed metrics that do not account for losses in the medical group or ambulatory sites. Even when financials are rolled up, they are often obscured by allocated overhead or exclude key components of the care pathway. Leaders may assume a service line is profitable based on volume, referral patterns or downstream revenue. But these assumptions often don't withstand scrutiny, especially in specialties in which variation in cost structure, practice patterns or care site use can significantly affect margin.

This lack of consolidated, system-level visibility leaves health systems operating in the dark.

This is a problem and about to become a bigger one. Site neutrality will shift reimbursement, eliminating a premium hospitals have long received. That will put pressure on



Matthew Bates
Managing Director,
Service Line Leader,



Rebecca Gray
Vice President

systems to understand which services are sustainable under flat payment models and which are not.

Visibility starts with pulling together data across all care settings including hospital, physician and ambulatory. From there, systems need to focus on **direct margin**—not contribution margin nor fully allocated net margin, but the portion of revenue that covers direct, controllable costs related to patient care. This is where improvement efforts can take root.

Systems should review both internal and external data. Internally, the primary question is: are our internal processes under control? Comparing the performance across sites throughout the system by looking at key metrics like reimbursement and cost per case can help identify high-performers and low-performers within the system (that is, internal benchmarking). Externally, look at leading systems and competitors to understand if processes need to change *even if they are currently working*.

Who owns performance?

Once performance issues are identified, someone must take responsibility. This is where many systems fall short. Service lines often lack clear P&L ownership, with clinical and administrative leaders managing only pieces of the continuum. Too often, performance is managed in isolation: one leader focuses on length of stay, another on OR efficiency, another on patient access and physician productivity.

This fragmentation leads to siloed decision-making, in which stakeholders optimize their own area without accountability for the whole. If no one is responsible for the full performance picture, no one has the authority to drive change. Some service lines operate at a loss for years because no structure exists to intervene.

Systems can address this by adopting an **accountability structure**. This does not need to be achieved through a single leader, although it can be; perhaps a **cross-functional team** with defined reporting relationships and aligned incentives might be the right model. A cross-functional, system-level view means assessing not just inputs, but outcomes. For instance: a higher-cost procedure may be justified if it reduces length of stay; or a shift to a lower-cost setting might lower admissions but improve margin.

These tradeoffs emerge with integrated data, a shared sense of responsibility and an accountability structure.

Volume is not the same as value

The assumption that high-volume service lines are profitable is persistent, but often wrong. Growth can

mask inefficiency, and volume in the wrong place or under the wrong payment model can deepen losses.

The essential question is whether each unit of service adds value. Is care delivered in the most cost-effective setting and manner? Are practice patterns aligned with top performers? Are returns consistent with investments? As payment models evolve, the focus must shift from downstream revenue to downstream margin. Growth is beneficial only when it is margin-positive and strategically aligned.

Start with a commitment to honesty. Run the numbers in a true service line portfolio review. If a typical high-margin service like orthopedics, for instance, is losing money, that's a red flag. Conduct a structured review of each service line's performance and be ready to face the hard truths.

Here are five actions every system can take:

1. **Consolidate financial data across settings:** Build a unified view that spans hospital, physician and ambulatory sites.
2. **Focus on direct margin:** Isolate what operational teams can control, and assess whether margins are sufficient to support shared system costs.
3. **Benchmark internally first:** Look at variation across sites and physicians to identify positive outliers and internal leading practices to adopt.
4. **Understand market share and growth opportunity:** Getting larger by stealing Medicaid market share from competitors is rarely financially sustainable.
5. **Assign ownership:** Designate accountability for performance and give leaders the tools and authority to drive improvement.

Most systems already have enough data for a basic "Goldilocks test." Is this service line too hot, too cold or about right? That simple test can expose where deeper analysis is needed.

The right time to evaluate profitability was yesterday. The second-best time is now. Systems that fail to rationalize their portfolios risk years of losses. The work ahead is to move from assumption to insight, from activity to accountability, and from volume to value.

What leading systems do differently

- **Metric 1: Holistic margin analysis and direct margin focus.** Combine hospital and provider performance across inpatient, outpatient and ambulatory settings; strip out allocated overhead and focus on controllable margin
- **Metric 2: Internal benchmarking.** Compare sites within the system to identify positive outliers with stronger margins (or throughput or care models) to replicate
- **Metric 3: External benchmarking.** Look at what leading systems and competitors are doing to understand if internal processes are becoming dated, even if they are currently working
- **Metric 4: Apply the 'Goldilocks' test.** Use "good enough" data; you don't need perfection to know when something's off

Questions? Contact Matthew Bates (matthew.bates@kaufmanhall.com)
or Rebecca Gray (rebecca.gray@kaufmanhall.com)