

Healthcare Finance 101

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MGPO
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Framework for discussion

- Financial Statements
 - Accrual statements
 - Modified cash as an alternative
- Revenue and payment systems
- Expenses
 - Compensation
- Monitoring financial performance



Why am I here?



Dr. Leonard H. McCoy, MD
Chief Medical Officer, USS Enterprise, 2266 - 2364

“Damn it, Jim! I’m a
Doctor, not an

Good Financial
Management



Efficient Practice
Operations



Enhanced Patient Care
& Satisfaction

This is why we ALL are
here



3



Financial Statements

- Balance Sheet
 - A quantitative summary of a company's financial condition at a specific point in time. The first part (assets) shows what a company owns, and the second part (liabilities) what it owes. The remainder (Net Assets) is the difference between the two and represents the organization's "retained earnings".
 - $\text{Assets} = \text{Liabilities} + \text{Net Assets}$
- Statement of Operations (Profit & Loss - P&L)
 - An accounting of revenues, expenses, and net profit for a given period.
- Statement of Cash Flows
 - Summarizes the entity's cash receipts and payments for a given period – shows Operating, Investing, and Financing activities
- Statement of Changes in Net Assets identifies the reasons for the changes in the entity's value



Where do I look on an income statement?

Key subtotals and totals

- Revenue
 - Net Patient Service Revenue (NPSR) – Expected collections from patient care activity
 - Other Operating Revenue –non-patient activity such as research revenue, academic revenue, operating investment income, other
- Expenses
 - Salaries and Benefits
 - Supplies and Outside Services
 - All Other Expenses
- Operating Gain (Loss) - The amount of income we made, after expenses, from continuing hospital operations, “The bottom line”
- Excess (Deficit) of Revenues over Expenses (Net Gain (Loss))- The amount of money earned from all our lines of business, including non-operating gains, gifts, non-operating investment income, etc.. “The bottom, bottom line”



Statements of Operations by Category
for the period ending
(In \$ Thousands)

	2012	2011
Patient service revenue		
Inpatient	539,000	555,000
Outpatient	901,000	816,000
Capitation revenue	41,000	4,000
	<u>1,481,000</u>	<u>1,375,000</u>
Deductions from revenue		
Third party allowances	807,000	765,000
Charity care	22,000	22,000
Provision for bad debts	20,000	14,000
Prior year adjustments	(9,000)	(2,000)
	<u>840,000</u>	<u>799,000</u>
Net patient service revenue	<u>641,000</u>	<u>576,000</u>
	<u>175,000</u>	<u>168,000</u>
Total operating revenue	<u>816,000</u>	<u>744,000</u>
Operating expenses		
Salaries & wages	368,000	334,000
Employee benefits	110,000	100,000
Supplies	199,000	181,000
Space Related Cost	35,000	34,000
Purchased Prof Services	15,000	14,000
Malpractice and General Liability	18,000	17,000
Other	36,000	30,000
Depreciation and amortization	10,000	9,000
Interest	5,000	5,000
Total operating expenses	<u>796,000</u>	<u>724,000</u>
Income (Loss) From Operations	<u>20,000</u>	<u>20,000</u>
Nonoperating gains (expenses)		
Income from investments	26,000	4,000
Gifts and other	2,000	1,000
Total nonoperating gains	<u>28,000</u>	<u>5,000</u>
Excess (deficit) of revenues over expenses	<u>48,000</u>	<u>25,000</u>

Where do I look on a balance sheet?

Named because Total Assets will equal the sum of Total Liabilities and Net Assets

- Current Assets (C/A) represent resources that are available to the organization within a year
 - Cash, Investments, Receivables – generally for patient care services, other assets
- Current Liabilities (C/L) represent what the entity has to pay within a year
 - Debt payments, accounts payable, compensation & benefits, settlements with 3rd party payers
- The ratio of C/A to C/L is an important indicator to the organization's ability to meet near term responsibilities - Less than 2:1 can be a sign of financial stress. The ratio is generally referred to as the Current Ratio
- Other assets to look for plant & equipment and the depreciation of these assets – the Net PP&E relative to PP&E may indicate an aging plant
- Long term debt is the borrowing generally to build the facility and buy equipment
- Net assets is the difference between total assets and total liabilities it is one measure of the financial value of the organization



Balance Sheet for the period ending September 30, 2012 (In \$ Thousands)					
	FY12	FY11		FY12	FY11
ASSETS			LIABILITIES AND NET ASSETS		
Current assets:			Current liabilities:		
Cash and equivalents	33,000	51,000	Current portion of long-term obligations:	2,000	1,000
Investments	320,000	259,000			
Current portion of investments limited as to use:	51,000	29,000	Accounts payable and accrued expenses	5,000	6,000
Patient accounts receivable	87,000	76,000	Accrued compensation and benefits	49,000	43,000
less allowance for bad debts	(29,000)	(23,000)	Current portion of settlements w/ 3rd-party payers	7,000	15,000
net patient accounts receivable	58,000	53,000	Due to affiliates		
Due from Affiliates			Total current liabilities	61,000	64,000
Other current assets:	22,000	21,000			
Total current assets	484,000	443,000	Other liabilities:		
Investments limited as to use:			Accrual for settlements with third-party payers	5,000	3,000
Board designated funds:			Accrued professional liability	83,000	15,000
Sundry funds			Accrued employee benefits	12,000	9,000
Board designated endowments			Deferred compensation	41,000	39,000
Deferred compensation	41,000	39,000	Accrued other	1,000	1,000
Bond Funds	15,000	16,000	Total other liabilities	142,000	67,000
Total investments limited as to use:	56,000	55,000	Long-term obligations, less current portion:		
Pledges receivable and contributions receivable	1,000	1,000	Revenue bonds	107,000	109,000
Property and equipment	134,000	130,000	Capital leases and other		
less accumulated depreciation	(57,000)	(47,000)	Total long-term obligations, less current portion	107,000	109,000
Net property plant and equipment	77,000	83,000			
Other assets:	66,000	1,000	Net assets:		
			Unrestricted net assets	37,000	29,000
			Total liabilities and net assets	684,000	583,000

Accrual Accounting

Not cruel accounting!!!

- Accrual Accounting (GAAP)
 - Required approach for most corporate entities for financial and tax reporting
 - Recognition (recorded in books) of revenue occurs when the revenue is earned, not necessarily when it is collected.
 - Expenses are recognized when assets are used up or liabilities are incurred in the delivery of services, not necessarily when cash is paid.
- Matching Principle of accrual accounting
 - Expenses should be matched to the revenue that they helped create (e.g. wage, salary and supply costs usually can be easily associated with revenues of a given period).
 - If the association between revenue and expenses is impossible to discover, the use of a systematic, rational method of allocating costs to a period (e.g. depreciation, amortization) is allowable



Why use accrual accounting?

- Advantages
 - Rigorous standards on the application of principles
 - Corporate entities subject to audit, independent review
 - Meets requirements of lenders, tax filing and investors
- Disadvantages
 - Complicated accounting rules require resources to manage
 - Don't always seem to match the business
 - Difficult conversations with operating managers and physician leaders



Modified Cash Accounting

- Cash Accounting differs from accrual accounting in that the matching principle is replaced by recognizing transactions when cash is exchanged
 - It is used in physician practices in limited cases when allowed and often to show the performance of practices that are subunits of larger groups
 - Advantages
 - Simple to understand since it looks like a checkbook
 - Focuses attention of short term performance
 - Recognition of expenses and revenue is direct and doesn't involve calculations of reserves and allocation of expenses based on complicated assumptions
 - Disadvantages
 - Does not recognize liabilities the hospital owes to creditors (payables)
 - Does not recognize revenues that are earned but not yet received (receivables)
 - Does not recognize expenses as resources are used, but only when the money is paid out (expenditures)



Uses of accounting methods

- Health systems, hospitals, physician organizations use accrual accounting for corporate reporting purposes
- Many physician organizations use modified cash for internal reporting
 - These organizations use accrual accounting at the corporate level
 - Physician groups that are part of hospitals may use accrual accounting
- Hospitals generally use non-standard statements for departmental reporting
 - Charges are used in place of net revenue and often only direct expenses are reported
 - Hospitals most often use sophisticated cost accounting systems to allocate expenses and revenues to service lines and potentially individual services



Revenue Discussion

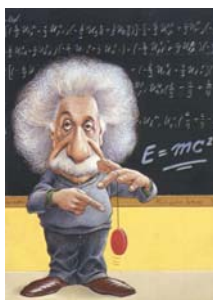
Categories of Revenue

- Patient Service Revenue
 - Gross Patient Service Revenue (GPSR) vs. Net Patient Service Revenue (NPSR)
 - Calculation of NPSR
 - Payment Methodologies
 - Membership revenue, capitation
- Other Revenue
- Research Revenue
 - Direct and Indirect
- Academic Revenue

Patient Service Revenue

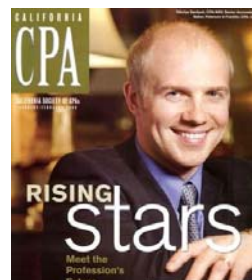
- Gross Patient Service Revenue (GPSR)
 - The total amount of charges that result from the provision of health care services to patients
 - “Sticker Price”
- Net Patient Service Revenue (NPSR)
 - The amount of patient revenue that remains after reducing charges to contractual rates and estimating the charges for services rendered for charity care, bad debts and insurer denials

Basics: Price and Quantity are Your Friend



Physicists
love $E=mc^2$

Accountants
love $P * Q$



One of the best ways to analyze a variance between 2 numbers:

- Isolates the drivers of the variance
- May pinpoint areas you can *Control*

Basics: $P * Q$ Example

You manage the flu shot clinic. While reviewing financial results, you notice that actual patient revenue is \$337,500, versus a budget of \$350,000. That's \$12,500 less than you planned. That's not too good....

You investigate a bit further, and you discover that your volume was 7,500 shots, versus a budgeted 7,000 shots. Hmmmm. If I did 500 more shots, how did I make less money?

Let's find out....

	Budget	Actual	Variance
Revenue	\$350,000	\$337,500	(\$12,500)
Volume (Shots)	7,000	7,500	500
Price per shot	\$50	\$45	(\$5)

Price Variance:
 (Actual P - Budget P) * Actual Q
 (\$45 - \$50) * 7,500 shots = (\$37,500)

Volume Variance:
 (Actual Q - Budget Q) * Budget P
 (7,500 - 7,000) * \$50 = \$25,000

$P * Q$
 * Not really controllable
 Somewhat controllable

Price	(\$37,500)
Quantity	\$25,000
Total	(\$12,500)

Basic: Patient Revenue

- Separate and more detailed patient revenue module
- Essentially: $P * Q$
- Need to understand volume at the macro and micro-levels
 - What will happen to overall volume? Increase? Decrease? Why?
 - CPT mix, including potential shifts in services or coding patterns
 - Provider capacity, including effect of ramp ups and shifts in provider schedules
 - Provider productivity expectations
- Payment rates
 - Who is paying you, and what will they pay you going forward?

Changes to Gross Patient Service Revenue

- Contractual Allowances & Denials
 - Contractual Allowance is the difference between the rates billed to a third-party payer and the amount that actually will be paid.
 - Denial Reserve for contested amounts adjusted by payers based on denials, bundling of services, and other contract interpretation issues
- Charity Care & Bad Debt
 - Charity Care is provided to patients who meet State and/or Federal criteria at no charge or at reduced rates
 - Bad Debt is the reduction in revenue for the estimate of services that are not paid by those not qualifying under charity care guidelines
 - The hospital or physician does not pursue collection of amounts qualifying as charity care
 - Providers generally pursue collections of bad debt before writing it off as not collectable
- Risk Contract Forfeitures & Incentives
 - Growth of Value-based contracts introduces reserves for forfeitures (withhold losses) or incentive or management fee payments.



Inpatient Payment Methodologies

- Case Rates (DRGs-Diagnostic Related Groups)
- Per Diems
- Percent of Charges
- Global Rates



Case Rates (DRGs-Diagnostic Related Groups)

- Under Medicare's Prospective Payment System (PPS), Medicare makes comprehensive, all-inclusive payments to the hospital. Other payers have now adopted this form of payment system.
- Diagnostic Related Group (DRG) is the basis of payment through which each diagnosis is assigned a specific pre-determined case rate value.
 - Reimbursement for DRGs is based on a fixed payment amount. Each DRG has a payment weight assigned to it, based on the average resources used to treat patients in that DRG relative to the average resources used to treat cases in all DRGs.
 - Example: a patient is admitted to The Hospital to have a stent inserted. Insurance Company A pays \$10,000 for a stent procedure whether the patient stays 2 days or 4 days, regardless of types of medication, or how complicated the recovery was.
- Incentives built into payment methodology encourage the hospital to:
 - Control costs
 - Reduce Length of Stay (LOS)
 - Improve efficiency

Per Diems & Percent of Charges

- Per Diems: Hospital receives a fixed payment per patient day
 - Hospitals paid by the per diem method receive payments based on the number of days a patient spends in the hospital. Some variation by type of care: med/surgical, ICU
 - Example: a patient is admitted to The Hospital to have a stent inserted. Insurance Company B pays \$2,500/day. If the patient stays 2 days, the company pays \$5,000. If patient stays 4 days, the company pays \$10,000.
 - Incentives built into payment methodology encourage hospital to:
 - Control cost
 - Improve efficiency
- Percent of Charges: The Hospital is paid on the basis of total charges, most often some negotiated percentage of total charges, e.g. 80%.
 - Example: a patient is admitted to The Hospital. Insurance Company C pays 80% of gross charges. All charges for this patient will be totaled, including room and board rate for however many nights the patient was in the hospital, charge of the stent, any medications, anesthesia, etc., and the company will pay 80% of that total
 - Incentive built into payment methodology encourages hospital to:
 - Utilize medically necessary services
 - Example: Many National Payers pay a Percent of Charges (PAF)

Global Fees

- Hospital may negotiate global fees covering hospital and professional fees for certain payers
- Individual case rates are developed for certain complex cases such as transplant, international cases or oncology
- Global rate contracts exist for inpatient psychiatric services where a case rate or per diem rate includes hospital and professional services.
- Episode payments that cover hospital and professional fees for an acute treatment such as joint and spine procedures. Prometheus system developed by Rand is one approach to global payments.



Outpatient Revenue

- Majority of the revenue the hospital receives from outpatient activity is for outpatient ancillary utilization (radiology, labs, etc..)
- Outpatient activity represents almost half of total patient revenue.
 - The bulk of the revenue from each encounter comes from the Outpatient Ancillaries, not the visits. (Note: Outpatient ancillaries relate to both hospital-based visits, as well as physician organization (PO) physician visits.)
- Over the past decade w/ the increase of ambulatory procedures most hospitals derive more than half their patient service revenue from outpatient



Outpatient Prospective Payment System (OPPS)

- Outpatient services for Medicare patients are paid on a prospective payment system, in which the rates are set prior to the service for all components of the service
- OPPS consists of groups of services known as Ambulatory Payment Classification (APC) groups, which are similar to DRGs for inpatients. Services within an APC are similar, both clinically and in resource utilization.
- Depending on the services provided, hospitals may be paid for more than one APC for an encounter
 - APCs are the current incentive to control costs.



Outpatient Fee Schedule

- Fee Schedule
 - A fee schedule is a list of services (usually at the CPT- 4* code level) with corresponding reimbursement amounts that a provider will receive from a payer for providing those services.
 - All fee schedules are payer-specific, and services include laboratory, radiology, ER, clinic, and ambulatory categories.
 - Fee schedules include both a technical and professional component.
 - Technical fee schedule is used for hospital services.
 - A professional fee schedule is used for physicians providing a service in an office setting or hospital staff physicians providing the same service in a hospital outpatient setting.
 - Items not listed on the fee schedule typically default to percent-of- charges payment method.



Pay for Performance

- With some new contracts, a percentage of expected revenue is held back (called a withhold) and put at risk.
- The entity will get this money only if/when it demonstrates measurable progress in
 - Efficiency and Utilization (i.e. patient days/1,000)
 - Quality and Safety (i.e. Electronic Medical Records)
 - Outcome Performance



Global Budget Approaches

- Both commercial payers (e.g. Blue Cross Blue Shield Alternative Quality Contract) and government payers (Medicare Pioneer ACOs) are moving towards a system of global payments and risk contracting.
- This typically involves providers being reimbursed on a fee for service basis and then truing up total expenses per member per month to a target or market benchmark at year end.
- This payment methodology creates an inherent incentive to manage the total cost of care for a patient population (i.e. reduce unnecessary utilization, shift care to lower intensity and/or cost settings, etc..)
- In the 90's high levels of financial risk were pushed down to the primary care level via capitation, leading to unclear roles for specialists and patient push back on "managed care".
- In the current iteration, providers and networks address these concerns by leveraging improved data and delivery models to effectively manage the trend in health care expenditures (e.g. medical homes, high cost beneficiary interventions, bundled payments to specialists, etc..)



Physician Payment Systems

- Percent of charges
- Resource Based Relative Value System
- Capitation
- Global Fee
- Case Rate



Other Revenue

- Represents revenue generated from normal day-to-day operations not directly related to patient care.
- Includes cafeteria sales, royalty income, parking, etc..



Research Revenue

- Direct research (such as lab-tech salaries and the cost of reagents) expenses are directly related to the cost of research being performed.
 - They should always equal direct research revenue
- Indirect expenses are overhead expenses (such as rent and utilities) that are not explicitly expensed to research projects but rather incurred by the sponsoring institution
 - Overhead expenses cannot be readily identified from the various expense categories so allocation methodologies are used to approximate overhead use by research
- Indirect Revenue - overhead rates paid by sponsors to reimburse the institution for indirect costs spent on research
 - Typically expressed as a percentage of payment for every dollar of direct expense
 - For example, the NIH negotiated indirect cost rate for a hospital may reimburse 65% for every direct dollar

Academic Fund Revenue

- Direct Academic Revenue
 - Charitable donations for hospital academic and research programs
 - Endowment spending distributions
 - Portions of royalties designated for lab and departments' program needs
- Hospital sets up these donations in individual sundry accounts and allows designated fund managers to oversee their use
 - Spending is under the discretion of the designated manager/MD
- Similar to research, Direct Academic Revenue equals Academic Expenses on the P&L Statement
- Indirect Academic Revenue
 - All academic funds are charged an overhead rate of when money is spent, which covers the administrative expense of managing the funds.

Expense Discussion

Expenses: Salary

Salary consists of the amounts paid directly to hourly and exempt employees

- May be paid weekly, biweekly, monthly
- Includes overtime, shift differentials & special pay
- Temporary and agency help

Bonus and incentive payments are included in salary

- Productivity incentives are common for physicians
- Quality based incentives beginning to appear for physicians and other staff

Other expenses accrued for future pay to employees such as earned, sick, vacation time

Expenses: Benefits

Benefit costs fall into 3 major categories:

- Health and welfare type benefits include health, dental, disability and other types of employer provided insurance
- Retirement benefits include retirement pension and other individual savings programs
- Employer portion of taxes: income, social security, Medicare, workers compensation, etc..

Benefit costs generally range from 20 to 35% of direct payroll

- Costs vary by the types of programs included in the benefit package



Expenses: Non-Salary

Operations and patient care generate other expenses

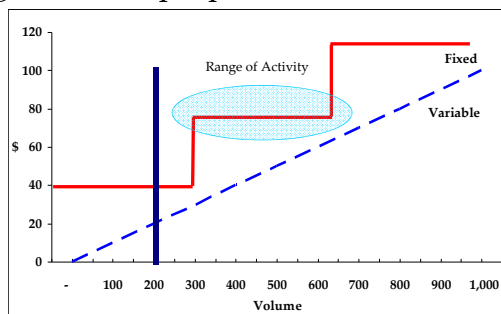
- Supplies include med/surgical supplies, pharmaceuticals, implants and other materials
- Utilities - Electricity, Steam, Gas, Oil, Telephone
- Other - services purchased from outside vendors outside, including rentals and leases, travel, consulting, etc..
- Corporate Allocations - costs related to centralized services can include finance, HR, legal, etc.
- Amortization & Depreciation - values the diminishing value of assets and capital over time as they are used
- Interest - for long-term debt



Basics: Expense Types

- Fixed Costs: Remain constant within a *range of activity*, but varies per unit
- Variable Costs: Change in direct proportion to volume, but varies in total

- Fixed Examples:
 - Rent
 - Malpractice
 - Salaried Administrative staff
- Variable Examples:
 - Clinical salaries
 - Utilities
 - Supplies



- What happens to costs when volume increases from 200 to 400?
- From 400 to 600? Introduces the concept of semi-variable

Improving Financial Performance

To improve the operating results, one can either increase revenues, decrease expenses, or both

- One can increase revenue either by growing volume or increasing revenue per unit (payment rate)
 - Many of the factors that affect volume are outside of the control of the hospital. Consequently, it is difficult to grow volume in the short run
 - Because many prices are fixed by external payer contracts that run for a term of several years or by the government, which dictates the prices that it will pay, it is also difficult to increase revenue per unit in the short run
 - Consequently, in the near term, the hospital can have little effect on revenue
- The hospital has control over many variables that affect the costs, including the number of FTEs that it hires
 - Consequently, the primary way to enhance profitability is through cost reduction, because many expenses are at least somewhat controllable in the short run

Large Physician Organization

Finance Definitions

Cash Flow:

- “the difference between cash receipts and cash disbursements for a given period of time”
- Target: collect enough revenues to surpass your expenses

Working Capital:

- “Not for profit organizations will use cash surpluses to fund future working capital needs”
- Target: have enough working capital accumulated to meet your future and pending needs.

Risk Capital:

- If you participate in capitated contracts, ACO, AQC, budgeted risk, agreements you need to be able to accumulate the capital to pay the costs

A Healthy Cash Balance

Days Cash on Hand

- Operating Funds
- Restricted funds



Operating Revenue = Cash Inflows

	<i>Large PO</i>	<i>Hospital</i>
Patient Revenue	Actual Cash Collected - from Patients and 3 rd Party Payers	NPSR Estimates
Other Revenue	Professional Service Agreements	Cafeteria, royalties, parking etc.

How are physician resources spent?



MASSACHUSETTS
GENERAL HOSPITAL

MASSACHUSETTS GENERAL
PHYSICIANS ORGANIZATION

Operating Expenses = Cash Outflows

Salary & Fringe	Large PO	Hospital
Non MD Compensation & Benefits	Weekly-paid employees direct charges	Same as PO
MD Compensation (monthly-paid)	MD Compensation Plans (Productivity-based)	
MD Fringe Benefits	Medical = cost per contract FICA = Actual \$ per MD Pension = Actual \$ per MD	Fixed % rate of compensation
Payroll Accrual	Same as hospital	

MASSACHUSETTS
GENERAL HOSPITAL

MASSACHUSETTS GENERAL
PHYSICIANS ORGANIZATION

Operating Expenses = Cash Outflows

<i>Non Salary Expenses</i>	<i>PO Practice Level</i>	<i>Hospital</i>
Supplies, Utilities & Other	same	same
Depreciation Bad Debt	n/a*	yes
Space costs	Direct charges	Institutional overhead
Research	none	yes

* non-cash item; recorded at the corporate level only



Margin Analysis: PO vs. Hospital

Category	Large PO	Hospital
Collections/Net Revenue & Indirect Allocations	<ul style="list-style-type: none"> Cash collections attributable directly to each practice (and physician) so margin is available directly Indirect expenses are allocated directly to each physician practice along with direct expenses 	<ul style="list-style-type: none"> Not allocated at the department level so margin is not available directly due to payment methodologies Reasonable estimates of service line performance obtained through cost accounting system
Cash/Margin Targets	<ul style="list-style-type: none"> PO targets set for both margin and cash/escrow funds. Have flexibility to spend cash surpluses 	<ul style="list-style-type: none"> Departments not asked to manage to a bottom line but to volume and expense targets
Cash/Margin Surplus or Deficits	<ul style="list-style-type: none"> Carries over and accumulates year-over-year 	<ul style="list-style-type: none"> Positive cash variances do not carry over year-to-year at the department level but are used to fund institutional capital budgets



Large PO: Case Study



Case Review: Recap

Cash Analysis for Neurology Associates

	FY10 Actual	FY11 Actual	FY12 Budget	\$ Change FY11- FY12	% Change FY11 - FY12	
Patient Cash	\$13,445,650	\$13,096,355	\$11,729,517	(\$1,366,838)	-10.4%	←
Other Revenue	1,489,131	2,015,435	2,400,000	384,565	19.1%	
Operational Support			500,000	(98,746)	-16.5%	
Part A Services		698,000	700,000	1,640	0.2%	
Cash Receipts	\$15,408,781	\$15,408,781	\$14,517,517	(\$1,079,380)	-6.6%	
MD Salaries	\$6,164,838	\$6,574,406	\$7,406,000	\$1,404,732	20.9%	←
MD Additional Compensation	500,000	1,949,918	2,150,000	2,070,000	191.7%	←
MD Fringe	1,600,000	1,949,918	2,818,601	868,683	44.5%	
Non MD Salaries	2,810,000	2,794,338	2,101,963	(692,375)	-24.8%	
Non MD Fringe	786,910	810,358	630,589	(179,769)	-22.2%	
Malpractice	389,783	416,265	452,821	36,556	8.8%	
Supplies	147,300	146,000	134,550	(6,631)	-4.7%	
Space Related Costs	212,800	212,800	220,000	5,000	2.3%	
Utilities	104,874	107,731	111,705	3,974	3.7%	
Outside Services & Other Exp	1,344,565	1,309,636	1,172,952	(136,684)	-10.4%	
Overhead & Allocated Expenses	632,969	699,485	851,291	151,807	21.7%	
Cash Expenditures	\$14,698,936	\$16,243,586	\$19,768,879	\$3,525,293	21.7%	
Operating Surplus/(Deficit)	\$1,021,027	\$165,311	(\$4,439,362)	(\$4,604,673)	-2785.5%	←
<i>Operating Margin</i>	6.5%	1.0%	-29.0%			

Case Review: Question 1

➤ What are the major items affecting a physician practice financial plan?

- ✓ Patient Volumes
- ✓ Service Mix
- ✓ Reimbursement rates
- ✓ Physician comp plans
- ✓ Staffing levels
- ✓ Capital

Case Review: Question 2

➤ What items should concern Mark? What would you want to know?

- ✓ Why is there a negative operating margin?
- ✓ Are there barriers to generating a positive margin?
- ✓ What is driving the drop in patient cash?
- ✓ Why is Operational Support decreasing?
- ✓ Are there other opportunities in Other Revenue?
- ✓ Is my staffing ratio adequate?
- ✓ Why are MD Salaries and additional comp increasing so rapidly
- ✓ Is there benchmark data we can review and compare against?

Case Review: Question 3

- How might you explain the change in Patient Cash? How much is volume affecting this?

- Decrease in patient cash is caused by a combination of a lower payment per unit and lower volume. Of the (\$1.3M) total decrease, (\$0.3M) is related to rate, and (\$1.0M) is related to volume.

	FY11 Actual	FY12 Budget	Variance
Revenue (000's)	\$13,096,355	\$11,729,517	(\$1,366,838)
Volume	87,000	80,000	(7,000)
Price per Unit	\$150.53	\$146.62	(\$3.91)

Price Variance:

$$(\text{Actual } P - \text{Budget } P) * \text{Actual } Q$$

$$(\$150.53 - \$146.62) * 80,000 = (\$313,108)$$

Price	(\$313,108)
Quantity	(\$1,053,730)
Total	(\$1,366,838)

Volume Variance:

$$(\text{Actual } Q - \text{Budget } Q) * \text{Budget } P$$

$$(87,000 - 80,000) * 150.53 = (\$1,053,730)$$

Amounts are rounded

Case Review: Question 4

- What might you do about the “promised” bonus?

- ✓ Determine if “promised” means “guaranteed”
- ✓ Options to tie it more closely to performance?
- ✓ Remove it from the budget
- ✓ Review parameters of comp plans
- ✓ Other ideas?

Case Review: Question 5

➤ What opportunities do you see to improve the planned margin?

- ✓ Increase clinical hours
- ✓ Increase volumes via efficiency measures
- ✓ Options to generate non-patient revenue
- ✓ Change in service mix
- ✓ Revert to the 4% benchmark MD salary increases
- ✓ Remove “promised” bonus
- ✓ What else?

Case Review: Question 6

➤ What is within your control?

- ✓ Productivity and efficiency
- ✓ Salaries and payroll
- ✓ Clinical hours
- ✓ Scheduling
- ✓ Others?

Case Review: Question 7

➤ Can Mark and Andy get to a positive margin?

- ✓ Possibly. Definitive estimates of specific items were accounted for, but have not been vetted fully. Even with what is presented, there is still a small margin deficit.
- ✓ The idea is to put all the options on the table, measure them, and be deliberate in the approach towards implementation.
- ✓ If they are NOT on the table, then they most likely will never occur.
- ✓ The budget is a perfect place to outline the various scenarios.

Improving Performance @ PO

Focus on:

- Managing to a margin
- Importance of healthy cash balance
- Key performance indicators (KPI)

Consider:

- Productivity measures (RVU, Service Mix)
- Patient Access (outpatient setting)
- Productivity-based compensation plans
- Support staff ratios
- Industry Benchmarks and Internal Targets



Productivity: wRVU

For each physician, calculate the total Work Relative Value Units (wRVUs) as follows:

- For each CPT code billed, multiple the volume billed by the applicable wRVU value.
- Sum the products calculated above.

Compare results to benchmarks and productivity requirements.

- Faculty Practice Solution Center at the University Hospital Consortium



Select Hospital Practice Expense Benchmarks

Measure	75 th Percentile	Mean
wRVU per FTE MD	7,102	6,313
Support Staff per FTE Provider	4.65	3.87
Sq Ft per FTE Provider	2,554	2,324

Source: MGMA Cost Survey 2012 Report based on 2011 Data Multi-specialty Practices, Hospital/IDS Owned



Select Primary Care Expense Benchmarks

Measure	75 th Percentile	Mean
Operating cost as a % of medical revenue	55.1%	58.2%
Support Staff Cost per FTE Provider	\$195,695	\$158,744
Operating Cost per FTE Provider	\$336,120	\$302,861

Source: MGMA Cost Survey 2012 Report based on 2011 Primary Care Physician Owned



Any questions? comments? observations?

Thank you!

