

Budgeting and Forecasting

Chapter FastFACTS

- 1. It is essential for physicians to review monthly the practice's operations or income statement, balance sheet, and statement of cash flow.**
- 2. Forecasting helps determine how many patients each physician needs to see each month to break even.**
- 3. Benchmarking categories include median total revenue per full-time physician.**
- 4. Successful practices don't have to achieve every industry benchmark or best practice.**
- 5. MGMA data confirm that practices that pay close attention to basics, such as billing and collections, tend to fare better financially.**

In late 2010, when pediatrician Anne B. Francis, MD, looked at her practice's preliminary budget for 2011, she saw potential trouble ahead. Revenue from office visits was likely to decline in January and February, when patients with high-deductible insurance plans typically forego discretionary visits to avoid paying out-of-pocket. At the same time, the practice would face a 15% hike in health insurance costs for its own staff.

Armed with these facts, Dr. Francis, one of eight pediatricians at Elmwood Pediatric Group in Rochester, N.Y., which employs about 50 people at two offices, instructed her staff to contact parents of new college students and kindergartners in order to schedule routine checkups during the anticipated slow months.

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As a result, the practice avoided a potentially significant drop-off in revenue during the first few months of the year. “You need to do some modeling and projecting in order to be prepared to deal with the consequences,” says Dr. Francis, who is immedi-



“Many practices are still in the shoebox mentality. Particularly in smaller, rural practices, much of their revenue is just what’s left over at the end of the month.”

Terry McGeeney, MD, MBA
 President and CEO
 TransforMED
 Leawood, Kan.

ate past chair of the AAP’s section on administration and practice management. “If you don’t measure it, you can’t fix it.”

That’s widely accepted advice for most small businesses, which routinely engage in budgeting and forecasting. However, doing so is less common among primary care practices. With little time to focus on financial matters, physicians often don’t know the details of their cash flow and have no plan in place to control expenses or increase revenue. “Many practices are still in the shoebox mentality,” says Dr. McGeeney at TransforMED. “Particularly in smaller, rural practices, much of their revenue is just what’s left over at the end of the month.”

Understanding Cash Flow

Projecting annual revenue for a small practice is fairly straightforward because most revenue comes from visits, says Robert Eidus, MD, a family practitioner at Cranford Family Practice in Cranford, N.J. Based on past yearly trends, he has been able to predict revenue for the coming year within \$10,000. “I look for whether there will be changes in reimbursement and look at my capacity in terms of how many additional patients I can take on,” he says. “Patient volume is highly predictable—I know that we will grow by between 700 and 1,100 visits a year.” To predict expenses, Dr. Eidus keeps track of monthly fees, infrastructure costs, and staffing as well as determining whether

he will need to invest in new equipment or initiatives.

Dr. Eidus has been able to stay profitable by keeping close tabs on his revenue and expenses, but he may be the exception among small practices. Unfortunately, says Mr. Arend of TransforMED, many doctors in small practices know very little about the details of their cash flow. He recalls asking one physician about his payroll and having the physician answer, “I don’t know. My bookkeeper does all that.”

While it’s fine to hire outside parties to help with accounting, says Mr. Arend, it’s essential for the physician to monitor financial statements in order to spot potential problems, track progress, and plan for growth. He advises physicians to review the following reports on a regular basis:

- **Monthly financial statements:** Review the operations or income statement, balance sheet, and statement of cash flow. Compare numbers with the previous month and your monthly budget in order to spot potential problems. “The statement of cash flow may be the most important report to review,” writes Mr. Arend on TransforMED’s Website. “It shows the sources and uses of cash and details the changes in the cash position.”
- **Accounts receivable:** This report shows the amount of all current and past-due balances summarized by aging categories (current or 30, 60, or 90-plus days past due). Review balances by customer in order to focus on problem accounts.
- **Metrics reporting:** TransforMED recommends that practices measure productivity and report certain metrics monthly for each provider in the practice. Metrics may include hours scheduled for patient visits, number of visits, or revenue generated per provider. Compare these metrics on an hourly or per-patient basis to determine overall revenue generation. Non-provider metrics might include no-show rates, claims processed, referral completion rates, etc.

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- **Coding review:** Each month, review CPT code distributions by provider monthly. “Large variations among providers with similar patient morbidities could be a red flag,” Mr. Arend notes. Also consider periodic self-audits, which involve peer-reviewing a sample set of charts from each provider for proper coding and documentation.

MGMA consultant Mr. Milburn advises his small-practice clients to put together a month-by-month cash flow estimate. To do so, first calculate your total available cash each month by adding cash on hand at the beginning of the month to the amount you expect to collect, he explains. Then estimate your expenses and how much you will have to take out as salary to determine your cash at month’s end. “It’s a simple spreadsheet forecast that the physician ought to be doing,” Mr. Milburn says. “It tells you what you need in terms of initial cash investment and when you will need it.” For more tips, see “Keeping Track of Cash Flow: 15 Tips” and “Three Budget Process Essentials.”

Forecasting

If you know your expenses, it’s fairly simple to project annual revenue, Mr. Milburn says. Using a simple 12-month spreadsheet, you can compare your monthly expenses with your expected revenue in order to estimate how much revenue you will need to bring in to produce a profit.

Start by estimating how many patients you will see per day, per week, and per month; then multiply by the average charge and collections for an office visit. Next, build a lag report; this is an estimation of how long it will take you to collect the month’s charges, Mr. Milburn says. For example, it might take several months to collect on billings made in the first month. “Figure out what portion of that first month’s cash is going to come in the first, second, third, and fourth months and what portion you are never going to collect,” he explains (calculate using historical data on the average time between filing a claim and receiving payment from Medicare or private insurers). “Then build in a 10%-to-15% loss ratio for bills that go to collections. When you add up what you think you will collect every month, that’s the cash you will have on hand.”

Forecasting helps determine how many patients the physician

Keeping Track of Cash Flow: 15 Tips

Healthcare consultant Mr. La Penna recommends that practices go through the following checklist annually:

1. Spot-audit receivables posting, especially adjustments.
2. Check fee schedule and determine if it is still reasonable.
3. If using multiple fee schedules on the billing system, determine if they are current and complete. When were they last updated? (They should have been updated at year's end or at the beginning of the year.)
4. Spot-audit the accuracy of cash-handling policies at the front desk, along with mail payments, and for purchasing for accuracy.
5. Spot-audit payment and adjustment posting.
6. Assure that billing department staff attended at least one Medicare carrier in-service training and at least one other billing seminar of reputable quality as appropriate for your practice.
7. Assure that your manager is regularly attending classes (e.g., at a local college) or seminars geared to enhance his or her professional education and growth.
8. Verify that your billing staff have access to a network of other physician offices that use the same billing software. Are they meeting with these people on a regular basis (e.g., at least quarterly)?
9. Review your insurance needs and their costs. It's important to comparison-shop annually.
10. Review your accounting and legal needs and the service you have received at least every three years. Comparison-shop.
11. Verify that physicians are meeting regularly as a governance body, documenting those meetings with minutes and following up with "accountable" agendas.
12. Verify that physicians are meeting regularly (at least monthly) with management staff to keep staff apprised of changes in policy and procedure, planned changes, etc.
13. Assure that patient satisfaction surveys are being conducted and reviewed and that changes are being made within the practice in response to concerns expressed.
14. Assure that employees' performance reviews have been conducted and documented annually.
15. Verify that medical records are being archived appropriately and in the most cost-effective and reasonably safe manner possible.

Three Budget-process Essentials

A practice's budget should be its internal control tool, according to Fred Simmons, CEO of Clearwater Cardiovascular and Interventional Consultants, and Lee Ann Webster, practice administrator for Pathology Associates of Alabama, on MGMA's blog. Knowing your actual and projected expenses can enable you spot errors and to protect your practice from fraud or embezzlement.

Mr. Simmons and Ms. Webster recommend the following three budget-process essentials:

■ **Be disciplined and thoughtful.** Think about how changes in reimbursement, new services, and perhaps even new locations will affect your budget. Set a date when the budget will be complete and stick to it.

■ **Be realistic.** "Sometimes we have a tendency to pad our budgets to make ourselves look good," Ms. Webster says. "In some organizations, there's a tendency on the part of the owners to come up with a budget that's unrealistic, in that it tries to squeeze every nickel out." Budgets are important tools for planning, and it's difficult to plan when the budget doesn't tell you your current reality or reflect your expectations for the future, she says.

■ **Involve department managers and physician leaders.** Having everyone contribute to the budget will help keep them accountable, realistic, and aligned with the practice's financial steps toward profitability. In addition, physicians will understand the rationale behind the amount of staff needed to get the work done, which may avoid knee-jerk, short-term layoffs that turn into long-term disasters.

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needs to see per month to break even and when he or she might have to draw from other financial resource pools. It also allows new practices to estimate how much they will need in personal investments or loans as they build up their patient panel, Mr. Milburn notes.

Without a budget and revenue forecast, physicians often do not have a clear picture of what they could do to increase revenue, Dr. McGeeney says. "From a revenue perspective, we try to get doctors to understand that a lot of their costs are fixed,"

he says. Therefore, seeing one extra patient per day may be pure revenue, he explains. “The first 20 to 25 patients may just pay the overhead, but the last two or three patients are where the revenue lies.”

With that knowledge, physicians can focus on improving areas that affect volume, he says. For example, providing advanced access (same-day appointments) and reducing no-shows can potentially increase the number of patients seen without extending the workday.

Benchmarking

Experts recommend using nationally recognized standards and benchmarks to help decide which expenses to track and how to estimate your costs. The two main sources for primary care cost data are the MGMA’s *Cost Survey: Physician Compensation and Productivity Survey* (group practices) and the *Statistics Report on Medical and Dental Income and Expense Averages* (solo and small practices), both produced annually with statistics on expenses such as staffing and accounts receivable as a percentage of revenue (see “For More Information” for links).

Benchmarking allows practices to gauge how they are doing compared with national standards and best practices, with the goal of improving over time. Categories might include median total revenue per full-time physician and total gross charges per full-time physician (\$492,635 and \$816,295, respectively, for all primary care single specialties, based on MGMA’s 2010 report), among many others.

Practices should customize industry benchmarks to their own situation, writes consultant Keith C. Borglum, owner of Santa Rosa, Calif.-based Professional Management and Marketing, in “Three steps to an effective practice budget,” published in the January 2004 *Family Practice Management*. For example, costs vary based on staffing needs. Additionally, practices may want

Investment Strategies in Times of Low Yields



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to create new categories in order to track specific expenses, such as malpractice insurance or special one-time events, such as relocation.

Mr. Borglum includes a sample chart of accounts (on paper and CD-ROM) that practices can revise to suit their own needs in the third edition of his book, *Medical Practice Forms: Every*



“ [Physicians] have the loyalty of a lot of patients and they’re an integral part of the healthcare delivery system; but they need a plan and they need to know about their own operations.”

Michael La Penna
Principal
The La Penna Group
Grand Rapids, Mich.

Form You Need to Succeed, co-authored with Diane Cate (available at www.practicemgmt.com). Other forms in the book focus on, for example, dividing expenses in a group practice, monitoring business performance, and keeping tabs on finances.

When starting to benchmark, set baselines for the areas you have chosen to track in your practice, according to “Benchmarking Basics,” one of the free online tools in MGMA’s *Lessons for Financial Success* series. A baseline reflects where you are today, which could be calculated using your own historical data or from national statistics from similar practices. To track your progress, subtract the baseline value from the corresponding industry standard or benchmark you are trying to achieve, which might be taken from MGMA statistics on “better performers”—a term MGMA uses to identify above-average performing practices using their criteria.

“Benchmarking Basics” recommends the following 10-step process to help you get started:

1. Determine what is critical to your organization’s success and understand current processes and information;
2. Identify metrics that measure the critical factors;

3. Identify a source for internal and external benchmarking data;
4. Measure your practice's performance;
5. Compare your practice's performance with the benchmark;
6. Determine if action is necessary based on the comparison;
7. If action is needed, identify the best practice and process used to implement it;
8. Adapt the process used by others in the context of your particular practice;
9. Implement a new process, reassess objectives, evaluate benchmarking standards, and recalibrate measures; and
10. Do it again—benchmarking is an ongoing process, and tracking over time allows for continuous improvement.

Focus on the Basics

Dublin Primary Care, a 10-physician family practice in Colorado Springs, Colo., doesn't offer group visits or ancillary services that might bring in extra revenue. Yet the group has stayed profitable year after year since 1999 despite making sizable investments in information technology and dealing with stagnant reimbursement rates. Its secret? Never take your eye off the books. "In today's environment, there's not a lot of slack; so you need to run your business well, understand your operations, and pay attention to your operations; then the rest is a fallout of that," says Deborah Milburn, practice administrator who oversees budgeting. "You need strong financial practices and skills, and you need to know how to apply those in a medical practice."

Because she is so familiar with the formal budget, Ms. Milburn is quick to spot any irregularities or inconsistencies and to initiate immediate solutions. "If a practice doesn't budget and forecast, it would take them longer to realize that they're in trouble in a certain area," she says. "You have to know the root cause of why you're not meeting targets. If you don't, you might identify the wrong solution."

Successful practices like Dublin Primary Care don't necessarily aim to achieve every industry benchmark or best practice, preferring to zero in on the basics. In a small practice, meticulous attention to basic billing and collecting—and investing in electronic systems to streamline those processes—can result in

consistent profits.

Indeed, national benchmarking reports include a dizzying array of statistics by which to assess your practice's financial health. (For more on benchmarking, see "Sample MGMA Benchmarks for Primary Care.") But small practices need only focus on a few key indicators to keep track of cash flow and to spot emerging trends or problems, writes Mr. Borglum in "Vital signs for assessing your practice's financial health," published in the Nov.-Dec. 2009 *Family Practice Management*. Mr. Borglum includes a checklist of measures to track in *Medical Practice Forms*. Categories include number of days worked, charges, collections, accounts receivable, total new patients, total visits, average visits per day, and hospital charges.

MGMA benchmarking data confirm that practices that pay close attention to basics such as billing and collections, expenses, and staffing tend to fare better financially. For example, the percentage of total accounts receivable overdue 120 days or more was 10.3% at better-performing practices (primary care single specialties) compared with 24.5% at other practices, according to the 2010 report. Better performers also had lower total operating costs as a percentage of revenue (almost 60% vs 72% for other practices) and spent more on support staff per full-time physician (\$211,297 vs \$153,600 at other practices).

Monthly monitoring of these areas can help physicians spot potential problems, says Mr. Borglum in the article. For example, you can identify the cause of decreasing charges by tracking days and hours worked (a physician was on vacation, for instance) or knowing that you need to investigate further if the numbers cannot explain a sudden decrease in billings. Keeping close tabs on your budget also helps physicians deal with unexpected expenses, says Dr. Eidus. Last year, for example, he had to pay \$4,000 to repair the office's mercury thermometer. He was able to absorb the extra expense because he had a contingency fund built into his budget forecast.

Dr. Eidus monitors his budget forecast monthly, noting any changes to ongoing fees, such as accounting or billing, and making necessary adjustments. Higher-than-expected patient loads might call for increasing the staffing budget, for example. Keep-

Sample MGMA Benchmarks for Primary Care

	Better Performers	Others	All
Total gross charges per FTE physician	\$1,079,377	\$734,224	\$816,295
Total medical revenue per FTE physician	\$613,696	\$446,351	\$492,635
Total operating cost as a percentage of medical revenue	59%	72%	69%
Total FTE support staff cost per FTE physician	\$211,297	\$153,600	\$162,356
Total medical revenue per FTE physician	\$738,989	\$456,150	\$492,635
Percentage of total accounts receivable 120+ days	10%	24%	19%

Source: Performance and Practices of Successful Medical Groups: 2010 Report based on 2009 data, ©2010 Medical Group Management Association.

ing abreast of his financial status is essential, he says, when deciding whether to embark on new initiatives or where to set staff performance bonuses.

Often small practices that run into financial trouble blame falling reimbursement rates or the economy; but these problems are surmountable with close attention to budgeting, forecasting, and benchmarking, notes Mr. La Penna. “If [physicians] looked at it, they’d realize that their practice is a pretty strong financial engine on its own,” he says. “They have the loyalty of a lot of patients, and they’re an integral part of the healthcare delivery system; but they need a plan, and they need to know about their own operations.”