CHAPTER ONE

BUDGETING FOR PHYSICIAN PRACTICES

Marci S. Thomas

Objectives

This chapter will help the reader to

- Understand the purposes and advantages of budgeting.
- Describe the process of budgeting.
- Prepare a budget for a physician practice.

Each year physician practices go through the all-important exercise of planning for the coming year's activity. As more fully discussed in Chapter Sixteen, this should be a joint activity between practice management and the physician-owners. The budget is the tool that group practice managers use to translate the practice's goals and objectives for the year into dollars. The budget also serves as a vehicle to communicate financial targets to physician-owners and other stakeholders in the practice.

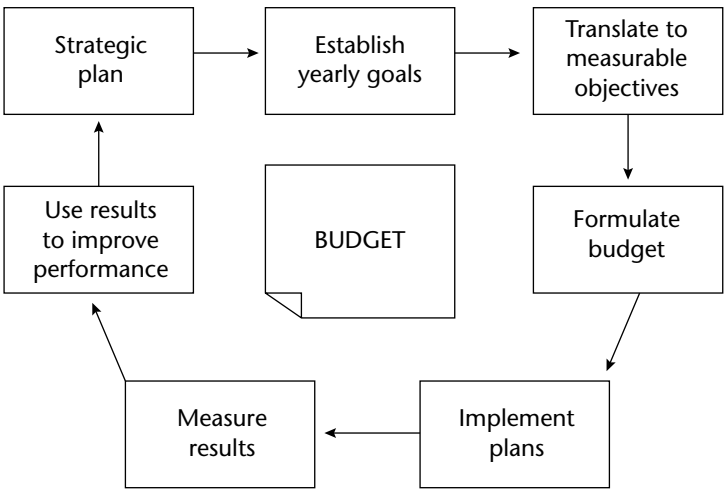
To the wise practice manager the budget is not just a financial plan. It is also a mechanism for monitoring and managing the activity of the practice on a periodic basis. Some practices compare actual results to the budget on a monthly basis. Others do it more or less frequently. The comparison of actual results to budgeted amounts enables practice management to

- Focus on where the practice is going and what it will take to get there.
- Determine where resources should be allocated.
- Assess the productivity of the practice.
- Foster accountability in department managers.
- Analyze the areas in which variances in volume have occurred.

- Identify rates paid by third-party payers that are either more or less than originally predicted.
- Identify costs of various inputs to the practice, such as labor and supplies, that are either more or less than originally predicted.
- Make the necessary changes on a timely basis to keep the practice healthy.
- Note opportunities for future expansion.

Practice managers can use this information to make timely changes to practice operations. Corrective action is particularly important in times like the present when reimbursement is low in comparison to the resources it takes to adequately deliver services and manage a practice. Thus the budget as a control mechanism takes on additional importance. Figure 1.1 illustrates the relationship between the budget and the planning and control cycle.

FIGURE 1.1. THE BUDGET IN RELATION TO THE PLANNING AND CONTROL CYCLE.



The budget is the focal point of the planning and control cycle.

Variety in Budgeting Methods

There is a great deal of variety in how physician practices budget. Some take budgeting very seriously and use it as a planning tool, whereas others don't prepare budgets at all. The wise group practice manager will develop a budget in sufficient detail to provide himself, the physician-owners, and other practice stakeholders with information that will be useful in guiding the practice and monitoring results. At the same time, the budget should not be so detailed that it takes an inordinate amount of time to accumulate and analyze the information. The size and complexity of the practice as well as the level of its administrative resources will play a role in determining the appropriate level at which to budget. However, it is better to budget with less detail than not to budget at all. Practice budgets vary in

- Level of stakeholder participation
- Level of detail
- Budgeting method used—incremental or zero-based

Level of Participation

Participation in the budgeting process varies from practice to practice. In some practices budgeting is left to the practice administrator, with little input from the physicians other than how much they intend to work in the coming year. This is unwise. Input from physicians, department heads, and other clinical staff can provide the practice manager with fresh ideas. In addition to making the budget more reliable, such input increases buy-in to the financial plan as well as awareness of what it costs to run a practice. At the same time, where participation is advisable and will most likely produce the best result, the practice manager must also consider the following:

- The budgeting process will take longer and consume resources that the practice might otherwise devote to patient care.
- Estimates of patient volume and of costs of the inputs to deliver patient care may be unrealistic.
- People who take time to provide their input to the budgeting process may be disappointed if their input is overridden by the practice manager.

Level of Detail

As more fully discussed later in this chapter, revenue budgets are constructed using estimates of patient volume at varying levels of reimbursement. Expense budgets are constructed using estimates of labor, supplies, and overhead. How far the practice manager disaggregates those estimates depends on the precision desired. For example, a more precise budget can be created by budgeting patient visits by intensity as well as by payer and contract type.

Physicians provide services in several settings. Office visits, surgical procedures, and other types of diagnostic and therapeutic services can be provided in physicians' offices, hospitals, skilled nursing facilities, hospices, outpatient dialysis facilities, clinical laboratories, and ambulatory surgical centers. Physician practices frequently use relative value units (RVUs) to express intensity of service. The resource-based relative value scale (RBRVS) was enacted into law as part of the Omnibus Budget Reconciliation Act of 1989. The fee schedule, phased in over a four-year period (1992 to 1996), reimburses physicians for their services based on three distinct components:

- Work (physician effort and skill)
- Practice expenses (rent, supplies, staff effort)
- Malpractice expenses

The objective of the RBRVS is to compensate physicians based on both the work involved and the resources used in patient care. There are codes for 7,000 distinct services, ranging from basic services such as injections to complex bundles of procedures associated with particular surgeries. These more complex bundles include the surgery and preoperative and postoperative visits. Each HCPCS (Healthcare Common Procedure Coding System) procedure code has a relative value (the basic value is 1). These values are adjusted for geographic factors to produce the reimbursement level. Although this payment system was created for services to Medicare patients, the methodology can be used to predict the level of effort involved in serving other patients as well.

In 2001, the American Medical Association performed a survey to determine whether non-Medicare payers used the RBRVS relative rankings in their payment systems. Respondents to the survey included Blue Cross Blue Shield organizations, health maintenance organizations, point-of-service plans, preferred provider organizations,

Medicaid agencies, and workers' compensation plans. Of the 226 entities surveyed, 74 percent used the RBRVS in at least one of their product lines.[1] The American Academy of Pediatrics has adapted the RBRVS relative rankings for services to pediatric populations.[2]

If a practice manager is budgeting using a high level of detail, she might compile a list of the Current Procedural Terminology (CPT) codes most frequently used by the practice and estimate the number of times each would occur during the year. Table 1.1 presents an example of such a list, in which estimated RVUs for each of the three reimbursement components are multiplied by the geographic adjustment to estimate the total RVUs. However, if that level of detail is not desired, the practice manager can determine the procedures most commonly performed and categorize them according to the average time it takes to perform each one, as illustrated in Table 1.2, using the following scale:

Work Level RVUs		*Time*
0–2	=	15 minutes
2.01–3.5	=	30 minutes
>3.5	=	45 minutes

Level of detail also comes into play when estimating the reimbursement to be received for a particular service. Depending on size and geographic location, a practice may have dozens of reimbursement levels for the same service. If a high level of precision is desired, the group practice manager will estimate by payer and by contract. Depending on the number of payers and of contracts per payer, this level of detail may be overwhelming. Practice managers may wish to use only a few payment levels, aggregating contracts with similar payment features and amounts.

The most basic level of detail that a practice can use is number of patient visits. If patient visits are generally homogeneous (that is, they require the same level of effort) and reimbursement levels do not vary significantly by payer, this level of detail may be all that is required. Figure 1.2 illustrates various levels of effort in relation to the precision achieved.

Physician practices may experience daily, weekly, or monthly variations in volume. This level of detail will be important to consider, especially when it comes to budgeting for revenue, labor usage, and cash flow.

TABLE 1.1. RBRVS ILLUSTRATION.

CPT Code Modifier	Work RVUs	Times Geo. Adj.[a]	Practice RVUs	Times Geo. Adj.[a]	Malpractice RVUs	Times Geo. Adj.[a]	Total RVUs	Estimated Procedures for Year	Estimated RVUs for Year
Adult Codes[b]									
99201	0.45	0.97	0.47	0.931	0.02	0.595	0.886	1,325	1,174
99211	0.17	0.97	0.38	0.931	0.06	0.595	0.5544	752	417
99241	0.64	0.97	0.62	0.931	0.62	0.595	1.5669	754	1,181
99213	3.43	0.97	0.67	0.931	0.24	0.595	4.0937	1,305	5,342
99395	1.36	0.97	0.54	0.931	0.04	0.595	1.8457	856	1,580
99396	1.53	0.97	0.61	0.931	0.05	0.595	2.0818	742	1,545
99397	1.71	0.97	0.68	0.931	0.05	0.595	2.3215	903	2,096
Pediatric Codes[c]									
99392	1.19	0.97	1.1	0.931	0.04	0.595	2.2022	3,325	7,322
99393	1.36	0.97	1.07	0.931	0.04	0.595	2.3392	1,224	2,863
99394	1.36	0.97	1.15	0.931	0.04	0.595	2.4137	785	1,895

[a] Geographic adjustment for North Carolina.

[b] American Medical Association.

[c] American Academy of Pediatrics.

TABLE 1.2. CPT CODES CATEGORIZED BY LEVEL OF EFFORT.

CPT Code	Work Level RVU (1,2,3)	Minutes
99201	1	15
99211	1	15
99241	1	15
99213	3	45
99395	1	15
99396	2	30
99397	2	30
99392	2	30
99393	2	30
99394	2	30

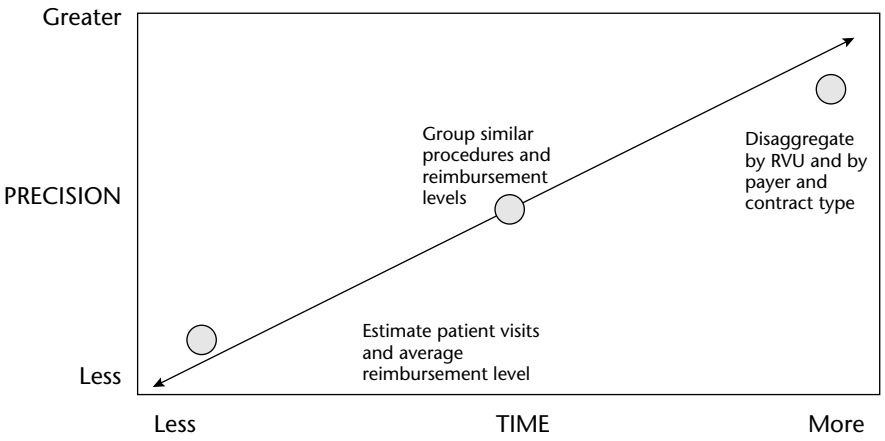
Incremental Versus Zero-Based Budgeting

Incremental budgeting begins with the results of the prior year's activity and adjusts for expectations of

- Increased or decreased patient volume for current payer contracts
- Additional patient volume from anticipated contracts
- Additional patient volume due to increased marketing activities
- Additional patient volume due to referrals from networking with other providers
- Changes in reimbursement for current contracts
- Changes in personnel, including increases or decreases in pay rates
- Changes in overhead costs due to increased space, additional machinery and equipment, changes in supply costs, or overall inflation

This form of budgeting takes the least amount of time to perform. However, the necessary research must still be performed to ensure that variables such as reimbursement levels and changes in market share and patient mix are accurate. Otherwise the practice might find that revenue is not sufficient to pay operating expenses. Because physician practices operate mainly with costs that are fixed, accurate volume and reimbursement projections are critical. In addition the importance of obtaining accurate predictions for expenses that are proportionately high and nondiscretionary, such as for malpractice insurance, cannot be overemphasized.

FIGURE 1.2. RELATIONSHIP BETWEEN LEVEL OF EFFORT AND PRECISION.



The greater the level of detail, the more precise the budget. However, more precision results in a more time consuming process.

An alternative method of budgeting for established practices is *zero-based budgeting.* Zero-based budgeting is a concept that has reemerged a number of times since the term was first used by Peter Phyrr in 1970. The technique, as its name implies, involves starting from ground zero and building a budget by identifying and prioritizing discrete business activities and then developing alternative methods for completing these activities. The alternatives include both different ways the activity can be completed and different levels of effort that can be used, so that the budgeting process attempts to align resource allocation with strategic business priorities.[3]

This method of budgeting requires the practice manager to

- Understand the possible volume, costs, and reimbursement of the activity.
- Determine the profitability of the activity.
- Review and evaluate the profitability of third-party reimbursement contracts.
- Look at how well the activity fits into the practice as a whole.
- Evaluate alternative ways to conduct the activity that may be more cost effective.

Zero-based budgeting can be used as a continuous quality improvement (CQI) tool because it challenges leaders to routinely question and justify their activities and resource allocation. However, its implementation presents challenges such as these:

The process requires a significant investment of time and effort. One KPMG study suggested that inefficient budgeting can consume up to 20 to 30 percent of senior leadership's time.[4]

The budgeting time horizon is often in conflict with business demands. Budgeting takes more time in dynamic, rapidly moving business sectors that need to respond quickly and less time in more stable settings where immediate decision making may not be required.[5]

Early proponents of the technique touted zero-based budgeting as a way to increase decision making by providing more timely feedback to managers. However, implementation of the process tends to be most successful in settings with centralized decision-making authority[6] or in practices that are more procedure or project oriented,[7] good news for small to moderate size physician practices. In a group practice setting, zero-based budgeting may be a useful technique if stakeholders are given a clear explanation of why the change to this method is taking place and if there is commitment to the time and effort necessary to implement the process.[8]

Notwithstanding its useful characteristics, zero-based budgeting has not caught on with many medical groups. In fact, newer techniques such as activity based costing (ABC) (discussed in Chapter Three) may be preferable in light of increased software options designed to facilitate their implementation.[9]

Cash Versus Accrual Accounting Method

A physician practice may maintain its accounting records on either a cash basis or an accrual basis. In the cash basis method of accounting, revenues are recorded when cash is received, and expenses are recorded when cash is spent. Generally, larger expenditures, such as those for building and equipment, will not follow the rule for operating expenses because they must be depreciated for tax purposes.

The accrual method of accounting is the method prescribed by generally accepted accounting principles (GAAP). In the accrual method, revenues are recorded when they are earned, and expenses are recorded when they are incurred. The accrual method provides for a better matching of revenues with the inputs or expenses it takes to produce them.

Although the cash method of accounting takes a little less effort, it does not provide the practice manager with information that helps him understand and monitor the profitability of the practice because revenues are not recorded as the service is delivered although the majority of expenses are recorded at that time. Given the prevalence of third-party payers in medicine, collection of receivables generally takes from thirty to ninety days, whereas expenses are generally paid by the end of the month.

Overview of the Budget Process

In order to get the desired level of precision for the budget, the practice manager should prepare several types of budgets. As illustrated in Figure 1.3, each of the individual budget types plays an important role in the overall budget process. The individual budgets are then integrated to create pro forma financial statements. The pro forma financial statements provide the practice manager with a view of the financial position and results of operations as they will be if budget forecasts are achieved as planned.

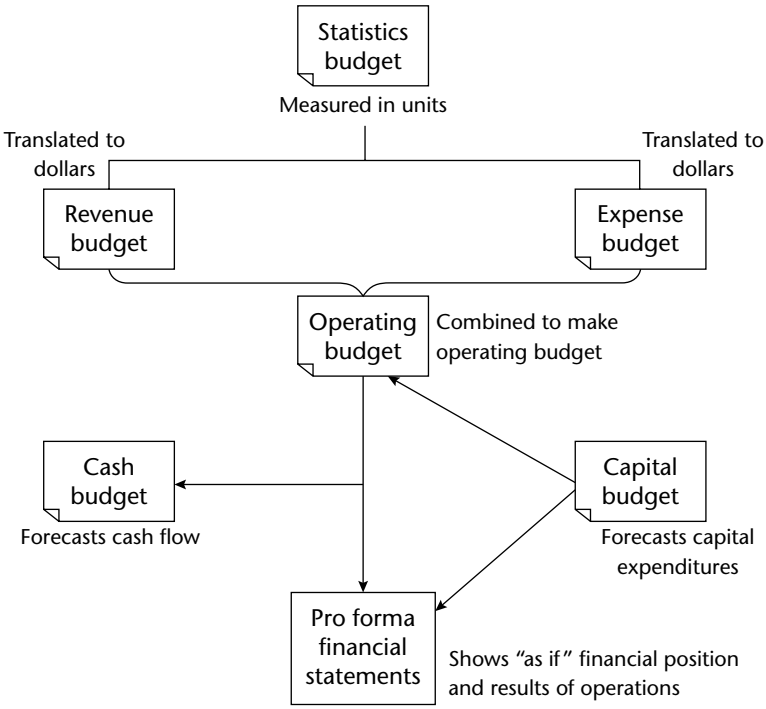
The *statistics budget* is the first budget that should be prepared. It forecasts the volume of activity anticipated for the practice and will be the basis from which the revenue budget and portions of the expense budget are prepared. Statistics generally take the form of units of service that are used to forecast revenue. For purposes of forecasting revenue, units of service may be patient visits, procedures, lab tests, X-rays, or any unit that can be converted to revenue. Statistics budgets may also be prepared for labor hours or units of supplies required. These labor and supply budgets can then be converted to dollars for the expense budget.

The *operating budget* translates the statistics budget into dollars and has two components, revenues and expenses. The *revenue budget* is prepared using the volume forecast in the statistics budget for varying levels of reimbursement. The *expense budget* forecasts labor and nonlabor expenses.

The *capital budget* is a forecast of the practice's long-term investment needs related to facilities and equipment. Capital budgeting, which is more fully discussed in Chapter Five, considers purchases of capital assets such as buildings and equipment and activities such as acquisitions of businesses by the practice and replacement and disposal of assets. The resulting interest on borrowings to finance the expenditures, depreciation on buildings and equipment, and rental costs for leased assets can represent significant expenses in the practice's operating budget.

When a practice operates on the accrual basis of accounting, one other budget must be considered. The *cash budget* is very important because it forecasts the cash

FIGURE 1.3. BUDGETING PROCESS.



Information from each of the various budgets is important to planning and controlling practice activities.

flowing into and out of the practice. The cash budget gives the practice manager a clear picture of whether cash inflows from operations will be sufficient to meet cash outflows, whether they are for operating expenses or capital expenditures.

We can examine the process of preparing a budget by following the steps taken by the practice manager at Highgrove Family Practice, a physician practice with three specialties, located in rural North Carolina. Highgrove's practice manager is beginning the budgeting process for 2004.

Creating the Statistics Budget

Step 1. The first step in creating a statistics budget is to forecast the demand for services for the year. The practice manager can perform this activity by

- Using the prior year's activity as a base and adjusting for changes in the numbers of physicians who will be working and any workload changes they have requested as well as for anticipated growth in the number of patients.
- Assessing the demand for the practice's services, given the present demographics of the area and projections of growth as well as the market share the practice would like to achieve. Physicians can then be hired to meet any excess demand.

Highgrove's practice manager decides to use last year's activity as a base for this year's budget, as illustrated in Table 1.3.

She performs a demographic survey of the area to estimate the percentage growth in patients for 2004, as illustrated in Tables 1.4 and 1.5. She expects that the practice will retain its overall market share of approximately 11 percent for patient visits. The practice manager projects that there will be an average of two visits per internal medicine patient, one visit per gynecology patient, and three visits per pediatric patient per year.

The practice manager also assumes that visits will not be spaced out evenly over the year, as seasonal fluctuations generally affect health care providers. Therefore she reviews the last three years' data to determine the percentage of patient visits in each month and uses those percentages to forecast monthly visits for 2004. Table 1.6 illustrates patient visits broken out by month. If a practice manager wanted to perform additional demographic analysis he or she could research the additional indicators listed in Table 1.7.

TABLE 1.3. ACTUAL AND PROJECTED VISITS FOR 2003 AND 2004.

Specialty/Department	Actual Patient Visits 2003	Projected Patient Visits 2004	Projected Increase
Internal medicine	7,352	7,573	3%
Gynecology	2,241	2,375	6
Pediatrics	9,421	9,798	4
TOTAL VISITS	19,015	19,746	

Note: Due to rounding, the numbers in this table may be slightly different from those computed by calculator.

TABLE 1.4. PROJECTED POPULATION IN HIGHGROVE SERVICE AREA FOR 2004.

Male	
<1 year	789
1–8 years	930
9–17 years	8,882
18–44 years	20,645
45–64 years	6,864
65 years and older	3,921
Female	
<1 year	965
1–8 years	1,137
9–17 years	9,106
18–44 years	21,143
45–64 years	6,974
65 years and older	3,677
TOTAL POPULATION	85,033

$85{,}033 \times 2.09$ visits per year $\times$ 11.11% = 19,746

Note: Population figures projected for 2004 from 2000 Census. Due to rounding, the numbers in this table may be slightly different from those computed by calculator.

TABLE 1.5. PROJECTED INCOME LEVELS IN HIGHGROVE SERVICE AREA FOR 2004.

Income Level (per family)	No. of Families
<$10,000	2,527
$10,000–$24,999	5,276
$25,000–$34,999	3,720
$35,000–$49,999	5,450
$50,000–$74,999	7,393
$75,000–$99,999	3,942
$100,000–$149,999	3,617
$150,000–$199,999	1,118
$200,000 and over	972
TOTAL FAMILIES IN SERVICE AREA	34,015

Note: Income figures projected for 2004 from 2000 Census.

TABLE 1.6. PROJECTED PATIENT VISITS BY MONTH FOR 2004.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Internal medicine	695	688	568	568	568	695	568	568	639	625	695	695	7,573
Gynecology	179	225	174	179	179	225	179	225	225	225	181	179	2,375
Pediatrics	900	895	895	736	735	750	750	750	750	842	895	900	9,798
TOTAL VISITS	1,774	1,808	1,637	1,483	1,482	1,670	1,497	1,543	1,614	1,692	1,771	1,774	19,746

Note: Due to rounding, the numbers in this table may be slightly different from those computed by calculator.

TABLE 1.7. INDICATORS FOR ADDITIONAL ANALYSIS.

Indicator	What This Tells You
Increase in sales and employment of top employers in the area	Whether the population is likely to be growing or declining in the near future
New home construction and sales of new homes	Whether additional families are moving to the area
New office construction and office rentals	Whether new businesses are moving to the area
Managed care plans in the market and their enrollment	Whether the practice's percentage of market share from various major plans has increased or decreased
Changes in population's average age, income, and education level	Whether the services offered by the practice are consistent with market needs
Services offered by competitors	Whether there are things your practice is overlooking that might be natural offshoots of current service offerings

Step 2. Not all patient visits require the same level of effort. To reflect the different levels of effort involved, the practice manager converts the patient visits to relative value units (RVUs). The RVUs can then be used to forecast revenue and to forecast the labor and supplies needed to support patient visits. As discussed earlier, many practices use the RBRVS scale for both their Medicare and non-Medicare patients. Although a practice manager could develop more precise estimates of the level of effort with time and motion studies and of supplies consumption by keeping detailed records, use of the RBRVS scale will generally yield information sufficiently precise for practice purposes. In addition some practices may prefer to simplify the calculation and use only one level of visit, assigning it an average time. For simplicity, Highgrove's practice manager groups the CPT codes into three work levels and uses historical data to determine the percentage of patient visits that typically fall into each level, as illustrated in Table 1.8. Again, each RVU equals fifteen minutes. Table 1.9 illustrates how total visits and RVUs break down by specialty for the month of January.

TABLE 1.8. PERCENTAGE OF PATIENTS IN EACH WORK LEVEL BY SPECIALTY FOR JANUARY.

Work Level RVUs	Internal Medicine	Gynecology	Pediatrics
1	15%	20%	10%
2	55	55	75
3	30	25	15
	100%	100%	100%

TABLE 1.9. TOTAL VISITS AND RVUs BY SPECIALTY FOR JANUARY.

	%	Visits	RVUs
Internal medicine			
Level 1	15%	104	104
Level 2	55	382	764
Level 3	30	209	627
TOTAL		695	1,495
Gynecology			
Level 1	20	36	36
Level 2	55	98	196
Level 3	25	45	135
TOTAL		179	367
Pediatrics			
Level 1	10	90	90
Level 2	75	675	1,350
Level 3	15	135	405
TOTAL		900	1,845
TOTAL ALL SPECIALTIES		1,774	3,707

Creating the Revenue Budget

Step 3. The practice manager reviews the practice's contractual arrangements to see if reimbursement amounts for services have changed from the previous contract period. It is important to understand both gross and net revenue. Although a payer will rarely pay a practice's full charges, it is important to have an estimate of those charges so that the practice is aware of the discounts it is giving to various payers and the amount of uncompensated or charity care it is providing.

Highgrove's charges are set at approximately two times the RBRVS conversion factor ($36.79 for 2003). The practice manager calculates an average charge per RVU for the practice of $74. Multiplying the average charge per RVU times the anticipated number of work level RVUs gives the practice manager an estimate of gross charges. To compute net charges the practice manager uses contract terms to determine how much of those charges will be paid. She groups the practice's various reimbursement arrangements into four different buckets, placing similar contracts together.

PERSPECTIVE 1.1. CHARITY CARE.

A portion of the uncompensated or charity care in this country is provided by physicians. Along with hospitals, community centers, health departments, and free clinics, they are part of America's safety net. However, physicians' ability to provide such care is decreasing. A Center for Studying Health System Change issue brief gives some of the reasons for that decrease:[a]

- More physicians are employees today, rather than owners of practices, and they have less control over their time.
- Practices are facing financial pressures from lower payment schedules and losses on managed care risk-sharing contracts.
- Time pressures are increasing due to heavier administrative burdens caused by third-party payer requirements.

According to this report, the percentage of physicians providing charity care decreased from 76 percent to 72 percent between 1996–97 and 1998–99. The average number of hours per month given to charity care decreased from 11.1 to 10.6 during that time period.

[a] Center for Studying Health System Change, "Physicians Pulling Back from Charity Care," *Issue Brief* 42, Aug. 2001.

PERSPECTIVE 1.2. STRATEGIES FOR SETTING BUDGETS.

Setting charges is often a subjective process. Group practices may apply various strategies. One strategy is to set charges on the high side to ensure that no money is "left on the table" when dealing with third-party payers who reimburse a percentage of total charges. Another strategy is to set charges on the low side to minimize the economic burden placed on self-pay patients as well as those patients who must satisfy an annual deductible each calendar year. Practice managers should balance these considerations as well as carefully analyze activity level costs when making pricing decisions.

Highgrove sees patients who are covered by a variety of payment arrangements. The majority are discounted charges patients but Highgrove also has patients covered by flat fee and capitated contracts. Very few of Highgrove's patients pay full charges. Approximately 2.5 percent of patients receive charity care. A health plan pays Highgrove $17 per member per month (pmpm) for each of the 1,200 patients that are covered by capitated contracts. Table 1.10 illustrates a portion of Highgrove's fee schedule converted to RVUs.

TABLE 1.10. CPT CODES CONVERTED TO WORK LEVEL RVUs AND CHARGES PER PAYER TYPE.

CPT Code Modifier	Work Level RVUs	Gross Charge per Visit	Discounted Fee Schedule	Flat Fee Payer
Adult codes[a]				
99201	1	$ 74	$ 63	$50
99211	1	74	63	50
99241	1	74	63	50
99213	3	222	189	50
99395	1	74	63	50
99396	2	148	126	50
99397	2	148	126	50
Pediatric codes[b]				
99392	2	148	126	50
99393	2	148	126	50
99394	2	148	126	50

[a] American Medical Association.

[b] American Academy of Pediatrics.

PERSPECTIVE 1.3. SHORTCUT FOR CONSTRUCTING REVENUE BUDGETS.

Some practice administrators may wish to shortcut the revenue budgeting process by simply estimating total visits and multiplying that number by the average amount of revenue per visit from the prior year. The resulting revenue figure can be adjusted for anticipated changes in payer mix and known changes in reimbursement level.

The difference between gross and net charges or contractual allowances can then be evaluated as a percentage of charges to determine the amount that will not be collected on each contract, as illustrated in Table 1.11. Table 1.12 summarizes the practice's revenue budget for January.

TABLE 1.11. PROJECTED GROSS AND NET REVENUE PER PAYER PER SPECIALTY FOR JANUARY.

	Internal Medicine				
	5% of Visits Full Charges	**45% of Visits Discounted Charges**	**30% of Visits Flat Fee**	**20% of Visits Capitated**	**Total**
RVUs	75	671	448	299	1,495
Charge per RVU	$74	$74	$74	$74	
	$5,550	$49,654	$33,152	$22,126	$110,482
Contractual allowance (incl. charity care)	(2,775)	(7,448)	(22,722)	(1,726)	(34,671)
Reimbursement					
50% charity care	$2,775				2,775
85% of charges		$42,206			42,206
$50 per visit			$10,430		10,430
$17 pmpm[a]				$20,400	20,400
TOTAL NET REVENUE					$75,811
PERCENTAGE DISCOUNT	50%	15%	68.5%	7.7%	31.3%

	Gynecology		
	85% of Visits Discounted Charges	**15% of Visits Flat Fee**	**Total**
RVUs	312	55	367
Charge per RVU	$74	$74	
	$23,088	$4,070	$27,158
Contractual allowance	(3,462)	(2,793)	(6,255)
Reimbursement			
85% of charges	$19,626		19,626
$50 per visit		$1,277	1,277
TOTAL NET REVENUE			$20,903
PERCENTAGE DISCOUNT	15%	69%	

continues

TABLE 1.11. *(Continued)*

	Pediatrics			
	5% of Visits Full Charges	**75% of Visits Discounted Charges**	**20% of Visits Flat Fee**	**Total**
RVUs	92	1,384	369	1,845
Charge per RVU	$74	$74	$74	
	$6,808	$102,416	$27,306	$136,530
Contractual allowance (incl. charity care)	(3,404)	(15,362)	(17,046)	(35,812)
Reimbursement				
50% charity care	$3,404			3,404
85% of charges		$87,054		87,054
$50 per visit			$10,260	10,260
TOTAL NET REVENUE				$100,718
PERCENTAGE DISCOUNT	50%	15%	62.4%	

Note: Due to rounding, *t*he numbers in this table may be slightly different from those computed by calculator.

[a] Highgrove receives capitated payment of $17 pmpm for 1,200 patients.

TABLE 1.12. REVENUE BUDGET FOR ALL SPECIALTIES FOR JANUARY.

	Internal Medicine	**Gynecology**	**Pediatrics**	**Total**
Gross revenue	$110,482	$27,158	$136,530	$274,170
Contractual allowance	(31,896)	(6,255)	(32,408)	(70,559)
Charity care	(2,775)	—	(3,404)	(6,179)
NET REVENUE	$ 75,811	$20,903	$100,718	$197,432

Creating the Expense Budget

Labor is the largest expense of the physician practice. The total nonphysician labor budget may represent 60 percent of operating costs. According to the Medical Group Management Association (MGMA) cost survey for 2002, for internal medicine groups total personnel costs (both physician and nonphysician) were approximately 79 percent of total costs.[10] Most of the labor expense takes the form of salaries and benefits for medical and administrative personnel. Physician compensation, which is discussed more fully in Chapter Thirteen, may consist of a base salary and benefits as well as an incentive or bonus component. Other medical personnel as well as administrative personnel will typically be compensated with base salary plus benefits.

Step 4. The Highgrove practice manager prepares a projection of the full-time equivalent (FTE) employees that she expects to have for the coming year. Each nonphysician employee's benefits are approximately 15 percent of the employee's salary. The practice manager also factors in a 4 percent raise for the employees, effective January 1. Physicians' compensation is a combination of salary, benefits, and incentive compensation. Tables 1.13 and 1.14 illustrate Highgrove's budgeted compensation for physician and nonphysician personnel for 2004.

Step 5. The practice manager builds the budget based on the FTE count from the previous year. In order to see whether more or fewer FTEs are needed for the volume of RVUs projected for 2004, she performs an analysis based on that anticipated

TABLE 1.13. BUDGETED PHYSICIAN COMPENSATION FOR 2004.

	Salary	Benefits	2004 Increase	Bonus	2004 Projected Total
Physician 1	$140,000	$21,000	$6,440	$17,500	$184,940
Physician 2	127,000	19,050	5,842	15,875	167,767
Physician 3	132,000	19,800	6,072	16,500	174,372
Physician 4 (½ time)	65,000	9,750	2,990	2,000	79,740
Physician 5 (¾ time)	90,000	13,500	4,140	5,000	112,640
TOTAL PHYSICIAN COMP.	$554,000	$83,100	$25,484	$56,875	$719,459

TABLE 1.14. BUDGETED NONPHYSICIAN COMPENSATION FOR 2004.

	Salary	Benefits	2004 Increase	2004 Projected Total
LPN 1	$ 52,500	$ 7,875	$ 2,415	$ 62,790
LPN 2	49,500	7,425	2,277	59,202
LPN 3	43,000	6,450	1,978	51,428
LPN 4	42,000	6,300	1,932	50,232
LPN 5	40,000	6,000	1,840	47,840
TOTAL CLINICAL COMP.	$227,000	$34,050	$10,442	$271,492
Practice administrator	57,000	8,550	2,622	68,172
Office staff 1	25,000	3,750	1,150	29,900
Office staff 2	25,000	3,750	1,150	29,900
TOTAL ADMIN. COMP.	$107,000	$16,050	$ 4,922	$127,972
TOTAL NONPHYSICIAN COMP.	$334,000	$50,100	$15,364	$399,464

volume. Given the intensity level required by Highgrove's patients, the average visit consumes approximately two RVUs. Also, Highgrove requires that physicians see from eighteen to twenty-four patients per day, representing thirty-six to forty-eight RVUs. This RVU amount includes both direct patient care and the time it takes to document the visit in the chart, call in prescriptions, and perform other administrative tasks. Tables 1.15 and 1.16 illustrate that, based on this requirement, the current number of physicians could meet the demand.

Given the prior year's experience, Highgrove estimates that its nurses can see from fourteen to sixteen patients per day, representing twenty-eight to thirty-two RVUs. This RVU amount includes both direct patient care and administrative time.

From the analysis in Tables 1.15 and 1.16 it is evident that Highgrove will need approximately 3,700 RVUs of nursing time for January. Because the amount of RVUs staff must cover is not likely to be the same each month, a shortfall for a given month is best handled by using variable labor. The practice manager decides to ask the current nurses whether they want to work overtime or whether they prefer to have temporary nurses come in to make up shortfalls. As the staff meeting is more than a month away, the practice manager decides to budget $30 an hour for the required hours. Table 1.17 illustrates the amount of variable labor needed for the month of January.

TABLE 1.15. MAXIMUM RVUs PER MONTH FOR CLINICAL EMPLOYEES.

	Internal Medicine	Gynecology	Pediatrics	All Specialties
Physician FTEs	1.75	0.5	2	
Max. RVU requirement per day	48	48	48	
Days per month	20	20	20	
Max. RVUs for month	1,680	480	1,920	4,080
LPN FTEs				5
Max. RVU requirement per day				32
Days per month				20
Max. RVUs for month				3,200

TABLE 1.16. RVUs FOR JANUARY.

Internal medicine	1,495
Gynecology	367
Pediatrics	1,845
TOTAL RVUs	3,707

TABLE 1.17. VARIABLE LABOR REQUIREMENTS FOR JANUARY.

Maximum RVUs covered by FTEs	3,200
Total RVUs for January 2004	3,707
Surplus (shortfall) RVUs	(507)
Hours (@ 4 RVUs an hour)	127
Rate for variable labor per hour	$30
Variable labor in dollars	$3,810

General operating costs typically consist of information technology costs, medical and surgical supply costs, building and occupancy costs, professional liability costs, depreciation on furniture and equipment, interest on debt outstanding, administrative supply costs, and promotion and marketing costs.

Step 6. The practice manager creates a budget for general operating costs by examining each line item of the prior year's budget and adjusting it for changes expected in 2004. Table 1.18 illustrates the comparison of budgeted to actual costs for 2003 and the budget for 2004.

Step 7. The practice manager compiles the information (the revenue and expense budgets) for the operating budget and sends the document to the physician-owners and other stakeholders to review. Table 1.19 illustrates Highgrove's operating budget for 2004.

PERSPECTIVE 1.4. EXPENSE BUDGETS RIGHT ON TARGET.

Expenses can quickly get out of hand in a large physician practice. One way to keep that from happening is to budget using national benchmarks for all expense categories and then to monitor frequently, comparing budgeted amounts to actual amounts. Our practice uses the MGMA cost survey benchmarks for cardiovascular/thoracic surgery and cardiology practices. For example, the 2002 report states that mean general and administrative salaries for 2001 were $15,368 per FTE physician. Mean medical surgery and supply costs for 2001 were $4,606. Understanding reasonable costs per budget line item and holding the line on those costs has helped our practice achieve its budget with less than 2 percent variation for the last several years.

Source: Contributed by Teresa L. Edwards, executive administrator, Cardiac & Thoracic Surgical Associates, Richmond, Virginia.

PERSPECTIVE 1.5. BALANCING MISSION AND MARGIN IN AN ACADEMIC MEDICAL PRACTICE: A MULTIDIMENSIONAL BUDGETING TOOL.

Patient care, teaching, research, and service are all integral parts of the mission of the Department of Family Medicine at the University of North Carolina (UNC) at Chapel Hill. The department, through its Family Practice Center (FPC), provides over 45,000 primary care visits each year, helps to educate about 640 UNC medical students, 24 residents, and 16 annual part-time faculty development fellows across the country, and maintains almost $2 million in external funding each year, including research done directly in the department and through multidisciplinary research centers on the UNC campus.

Balancing these divergent missions has been a challenge at both the departmental level and the individual faculty level. To help bring order to the chaos, the departmental leadership created a spreadsheet-based faculty time management system, nicknamed the "grid." The grid assists in allocating individual faculty time across mission activities while ensuring that aggregate faculty time is sufficient to cover needs within each mission area. This multidimensional tool serves several needs that help to balance mission and margin:

- *Planning and budgeting tool.* Clinical work is broken into clinic sessions in the grid. The grid also includes inpatient attending weeks per year, nights on call per year, and other miscellaneous clinical activities. It provides an aid for clinical scheduling as well as a sophisticated budget modeling tool. The grid automatically recalculates patient visits, clinic revenue, and clinic variable costs based on changes in total faculty clinic sessions. The grid serves as a master inventory of faculty, their total FTEs for the fiscal year, and their salary and benefit costs.
- *Resource management tool.* The grid's ability to track individual faculty time across diverse mission activities allows for more informed decision making by the departmental leaders and by individual faculty members. The department uses the grid as a central tool for negotiating current faculty activities as well as for creating job descriptions for incoming staff. Each faculty member has access to a public version of the grid, enabling faculty to view FTE allocation impacts for a number of possible career scenarios. The grid lends itself to enhancing faculty accountability by tracking clinical sessions but also helps to protect faculty from being committed to activities over and above 100 percent FTE.

- *Mission litmus test.* The grid supports a systems-planning approach to balancing the multiple mission activities and goals of the department as well as the preferences of individual faculty in the context of limited resources. It aids in trend analysis over time to identify total faculty FTEs and associated costs applied to each mission area, providing a powerful tool for identifying disparities between actual resource allocation and departmental vision, mission, and value statements.

In addition to serving these primary needs, the grid has improved faculty solidarity by allowing peers to better understand the work of others in the department, which can be seen by all faculty on the grid public version. Finally, the grid helps to frame debate regarding the value of diverse mission areas and provides a context for meeting the challenges of an ever-changing external environment.

Source: Adapted from A. J. Daugird, J. E. Arndt, and P. R. Olson, "A Computerized Faculty Time-Management System in an Academic Family Medicine Department," *Academic Medicine,* 2003, *78*(2), 1–8.

Step 8. After the operating and capital budgets are approved, the practice administrator finalizes the cash budget. A review of the practice's collection information for the past two years reveals that the practice has an average of forty-two days in accounts receivable. The practice's history shows collection rates as follows:

Collections in month of service	50 percent
Collection in month of service + 1	30 percent
Collection in month of service + 2	15 percent
Collection in month of service + 3	5 percent

The practice's revenue under capitated contracts has been $20,400 per month ($17 pmpm × 1,200 members). Revenue under discounted charge arrangements and flat fee contracts for the last three months of 2003 was

October	$168,435
November	$170,525
December	$171,500

TABLE 1.18. BUDGETED GENERAL OPERATING COSTS FOR 2003 AND 2004.

	2003 Budget	2003 Actual	Variance Over (Under)	2004 Budget	Comments for 2004 Budget
Information tech.	$69,530	$70,251	$721	$70,921	2% inflation increase
Med. & surg. supplies	35,174	35,539	365	35,877	2% inflation increase
Building & occupancy	117,500	117,500	—	123,375	5% rent increase
Depreciation expense	40,900	41,324	424	46,283	Purchase of additional equipment
Interest expense	27,000	27,000	—	36,000	Additional debt—computer
Admin. supplies	40,900	41,324	424	41,718	2% inflation increase
Prof. liability	163,600	163,600	—	176,688	8% premium increase
Other insurance premiums	11,452	11,571	119	11,681	2% inflation increase
Prof. fees	71,984	72,731	747	73,424	2% inflation increase
Marketing & promotion	29,448	27,350	(2,098)	30,037	2% inflation increase
Bad debt expense	96,520	92,514	(4,006)	98,450	2% inflation increase
TOTAL	$704,008	$700,704	$(3,304)	$744,454	

TABLE 1.19. OPERATING BUDGET FOR 2004.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Revenue													
Gross revenue	$274,170	$275,724	$263,440	$233,174	$232,952	$253,006	$235,246	$242,276	$249,676	$263,588	$269,804	$268,768	$3,061,824
Charity care	(6,179)	(9,926)	(9,484)	(8,394)	(8,386)	(9,108)	(8,469)	(8,722)	(8,988)	(9,489)	(9,713)	(9,676)	(106,534))
Contractual allowance	(70,559)	(68,931)	(65,860)	(58,294)	(58,238)	(63,252)	(58,812)	(60,569)	(62,419)	(65,897)	(67,451)	(67,192)	(765,456)
NET REVENUE	197,432	196,867	188,096	166,486	166,328	180,646	167,966	172,985	178,269	188,202	192,640	191,900	2,186,142
Salaries & benefits													
Physician comp. & benefits	59,955	59,955	59,955	59,955	59,955	59,955	59,955	59,955	59,955	59,955	59,955	59,955	719,459
Other clinical salaries & benefits	22,624	22,624	22,624	22,624	22,624	22,624	22,624	22,624	22,624	22,624	22,624	22,624	271,492
Part-time or contract clinical labor	3,810	3,810	3,810	3,810	3,810	3,810	3,810	3,810	3,810	3,810	3,810	3,810	45,720
Admin. salaries & benefits	33,289	33,289	33,289	33,289	33,289	33,289	33,289	33,289	33,289	33,289	33,289	33,289	399,464
TOTAL SALARIES & BENEFITS	119,678	119,678	119,678	119,678	119,678	119,678	119,678	119,678	119,678	119,678	119,678	119,678	1,436,135
Operating costs													
Information tech.	5,910	5,910	5,910	5,910	5,910	5,910	5,910	5,910	5,910	5,910	5,910	5,910	70,921
Med. & surg. supplies	2,990	2,990	2,990	2,990	2,990	2,990	2,990	2,990	2,990	2,990	2,990	2,990	35,877
Building & occupancy	10,281	10,281	10,281	10,281	10,281	10,281	10,281	10,281	10,281	10,281	10,281	10,281	123,375
Depreciation expense	3,857	3,857	3,857	3,857	3,857	3,857	3,857	3,857	3,857	3,857	3,857	3,857	46,283
Interest expense	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	36,000
Admin. supplies	3,477	3,477	3,477	3,477	3,477	3,477	3,477	3,477	3,477	3,477	3,477	3,477	41,718
Prof. liability	14,724	14,724	14,724	14,724	14,724	14,724	14,724	14,724	14,724	14,724	14,724	14,724	176,688
Other insurance premiums	973	973	973	973	973	973	973	973	973	973	973	973	11,681
Prof. fees	6,119	6,119	6,119	6,119	6,119	6,119	6,119	6,119	6,119	6,119	6,119	6,119	73,424
Marketing & promotion	2,503	2,503	2,503	2,503	2,503	2,503	2,503	2,503	2,503	2,503	2,503	2,503	30,037
Bad debt expense	8,204	8,204	8,204	8,204	8,204	8,204	8,204	8,204	8,204	8,204	8,204	8,204	98,450
TOTAL OPERATING COSTS	62,038	62,038	62,038	62,038	62,038	62,038	62,038	62,038	62,038	62,038	62,038	62,038	744,454
TOTAL EXPENSES	181,716	181,716	181,716	181,716	181,716	181,716	181,716	181,716	181,716	181,716	181,716	181,716	2,180,592
Income before taxes	15,716	15,151	6,380	(15,230	(15,388)	(1,069)	(13,750)	(8,731)	(3,447)	6,486	10,924	10,184	7,227
Income taxes	(315)	(303)	(128)	304	307	21	275	174	69	(130)	(219)	(204)	145
NET INCOME	$15,401	$14,848	$6,252	$(14,926)	$(15,051)	$(1,048)	$(13,475)	$(8,557)	$3,378	$6,356	$10,705	$9,980	$7,082

Note: Due to rounding, the numbers in this table may be slightly different from those computed by calculator.

Because expenses are generally incurred ratably over the year, the assumption is that an equal amount of cash flows out of the practice each month. Tax expense is negligible and therefore not included in the cash budget. The practice has a policy that requires the cash available to be 40 percent of the next month's cash outflow. Accordingly the cash budget shown in Table 1.20 is prepared. Cash in excess of requirements, if significant, should be moved to an interest-bearing vehicle.

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To review, budgeting is the beginning of the planning and control cycle. It can be performed with as much or as little detail as is practical for the physician practice. Although it can be a daunting task in the face of all that the practice manager has to do, time spent in the budgeting process can pay dividends to the practice by enhancing profitability.

The budgeting process can be broken into the following eight steps:

1. Create a statistics budget to forecast the demand for services for the year in units of service.
2. Convert units of service to relative value units.
3. Review payer contracts to identify any changes to reimbursement that will affect revenue for the budget year. Translate the relative value units into revenue.
4. Prepare the labor budget for physicians, nonphysician clinical employees, and administrative employees.
5. Forecast the need for part-time or contract labor. Translate these requirements into dollars.
6. Create a budget for general operating costs.
7. Aggregate the revenue and expense components of the budget and distribute to stakeholders for review and comment.
8. Integrate the capital budget and prepare the cash budget.

In the midst of all that the practice manager has to do, budgeting can be an intimidating assignment. However, budget preparation, if viewed as a plan for action and broken into manageable tasks, can be an informative process. Ideally, the budget is a tool for translating the goals and objectives of the practice for the year into dollars. The annual budgeting process offers a key opportunity for analyzing the strategic plan of the organization and ensuring that the allocation of practice resources is in alignment with this plan. Monitoring the practice's actual results of operations against the budget, as further outlined in Chapter Six, can help the practice stay on course.

TABLE 1.20. CASH BUDGET FOR 2004.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Collections in month of svc. (50%)	$88,516	$88,234	$83,848	$73,043	$72,964	$80,123	$73,783	$76,293	$78,935	$83,901	$86,120	$85,750
Collections from prior month (30%)	51,450	53,110	52,940	50,309	43,826	43,778	48,074	44,270	45,776	47,361	50,341	51,672
Collections from 2 mos. prior (15%)	25,579	25,725	26,555	26,470	25,154	21,913	21,889	24,037	22,135	22,888	23,680	25,170
Collections from 3 mos. prior (5%)	8,422	8,526	8,575	8,852	8,823	8,385	7,304	7,296	8,012	7,378	7,629	7,893
Capitated revenue	20,400	20,400	20,400	20,400	20,400	20,400	20,400	20,400	20,400	20,400	20,400	20,400
TOTAL CASH INFLOW	194,367	195,994	192,318	179,073	171,168	174,599	171,450	172,296	175,257	181,928	188,170	190,886
Total salaries & benefits	119,678	119,678	119,678	119,678	119,678	119,678	119,678	119,678	119,678	119,678	119,678	119,678
Operating expenses	62,038	62,038	62,038	62,038	62,038	62,038	62,038	62,038	62,038	62,038	62,038	62,038
Remove noncash expenses												
Depreciation expense	(3,857)	(3,857)	(3,857)	(3,857)	(3,857)	(3,857)	(3,857)	(3,857)	(3,857)	(3,857)	(3,857)	(3,857)
Bad debt expense	(8,204)	(8,204)	(8,204)	(8,204)	(8,204)	(8,204)	(8,204)	(8,204)	(8,204)	(8,204)	(8,204)	(8,204)
TOTAL CASH OUTFLOW FROM OPERATIONS	169,655	169,655	169,655	169,655	169,655	169,655	169,655	169,655	169,655	169,655	169,655	169,655
Cash generated for month from ops.	24,712	26,340	22,663	9,419	1,513	4,944	1,796	2,641	5,602	12,273	18,515	21,231
Capital expenditures						35,000						
Beginning cash balance	67,862	67,862	67,862	67,862	67,862	67,862	67,862	67,862	67,862	67,862	67,862	67,862
Cash available	92,574	94,210	90,534	77,290	69,384	37,815	69,666	70,512	73,473	80,144	86,386	88,625
Cash requirements for next month	67,862	67,862	67,862	67,862	67,862	67,862	67,862	67,862	67,862	67,862	67,862	75,000
Cash excess (needed)	24,712	26,340	22,663	9,419	1,513	(30,056)	1,796	2,641	5,602	12,273	18,515	13,625
Cash transferred to money market acct.	$24,712	$26,340	$22,663	$9,419	$1,513		$1,796	$2,641	$5,602	$12,273	$18,515	$13,610
Cash borrowed						$30,056						

Discussion Questions

1. Discuss the trade-offs to be considered when choosing between adequate projections and accurate projections in the budgeting process.
2. Compare and contrast the advantages and disadvantages of incremental and zero-based budgeting.
3. Discuss how the ability to match revenues with expenses through the accrual accounting method benefits practice managers.
4. Propose five potential sources of information for performing a demographic survey.
5. Discuss the purpose of the revenue budget.
6. Identify three methods for projecting changes in practice expenses.
7. List several key stakeholders in the budgeting process.

Web Resources

PowerPoint presentation

Answers to discussion questions

Case study

Notes

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Suggested Reading

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