Healthcare Finance 101

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Polling Question 1:
Are you currently in the healthcare industry at some capacity?

a. Yes

b. No

c. Maybe

d. Are you crazy?

Agenda

1. Who are the Players
2. Reimbursement
3. Revenue Cycle
4. Management Reports & Industry Benchmarks
5. Financial Statements & Trending

WHO ARE THE PLAYERS?

Who is CMS?

- The **Centers for Medicare and Medicaid Services (CMS)** has an enormous affect on determining the rate at which medical services are provided, and as such also has a **major influence on private insurance companies**.
- CMS dates back to the signing into law of the Medicare and Medicaid programs by President Lyndon Johnson in 1965 to accomplish:
  - To improve the administration of both Medicare and Medicaid programs
  - To improve Medicaid's staffing
  - To create an administrative foundation in anticipation of a national health insurance program
  - To reduce the two-tiered system which was felt by many to favor the Medicare program over the Medicaid program
- Helps the State with:
  - Medicaid
  - Children's Health Insurance Program (CHIP)
  - HIPPA
  - Regulations regarding standards in Nursing Homes and Lab Quality

Who are the Providers?

- Hospitals
- Physician Practices and Clinics
- Ancillary
- “Stand alone” Services
- Long Term Care Facilities (LTAC)
- Skilled Nursing Home or Nursing Home
- Integrated Healthcare Systems

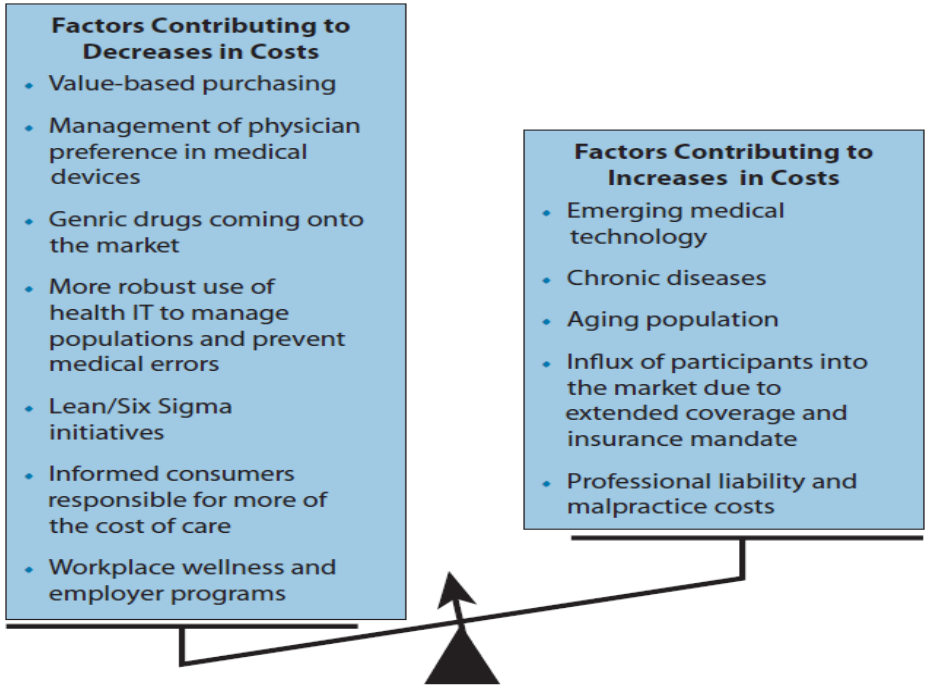
Who Pays for Healthcare and How?

- Consumers
  - Direct
  - Co-Pays, Co-Insurance and Deductibles
  - Insurance Premiums
- Insurance Industry (aka Commercial)
- Government
  - Medicare, Medicaid and Veterans Affairs (VA)
- Employers
  - Premiums for Insurance or Self Insurance of Employee Group

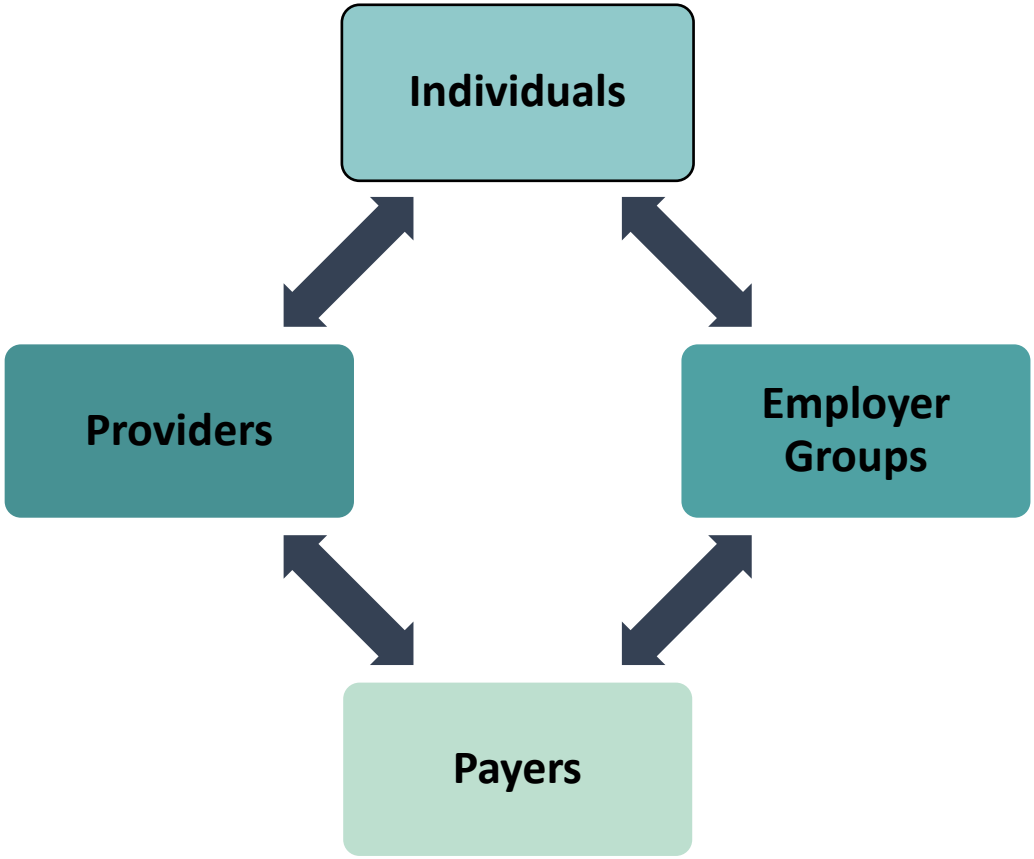
Factors Affecting the Cost of Care

Receiving the APPROPRIATE CARE
At the APPROPRIATE SETTNG
At the APPROPRIATE TIME

Will ultimately reduce costs . . .



So How Does This Work?



Polling Question 2:
If my claim is denied for a “non covered service”, whose fault is it?

a. Provider

b. Employer

c. CMS

d. Insurance

e. Myself

REIMBURSEMENT

Precision to Reimbursement

- International Classification of Disease (ICD-10) – Diagnosis and Treatments
  - Provides justification of procedures and services provided by physician
  - Assists in establishing medical necessity for services and/or procedures
  - Serves as an indicator in measuring the quality of healthcare delivered

Sample of Diagnosis Codes

ICD-10-CM Diagnosis Codes

+ section notes

A00.0 - B99.9	1. Certain infectious and parasitic diseases (A00-B99)
C00.0 - D49.9	2. Neoplasms (C00-D49)
D50.0 - D89.9	3. Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)
E00.0 - E89.89	4. Endocrine, nutritional and metabolic diseases (E00-E89)
F01.50 - F99	5. Mental, Behavioral and Neurodevelopmental disorders (F01-F99)
G00.0 - G99.8	6. Diseases of the nervous system (G00-G99)
H00.011 - H59.89	7. Diseases of the eye and adnexa (H00-H59)
H60.00 - H95.89	8. Diseases of the ear and mastoid process (H60-H95)
I00 - I99.9	9. Diseases of the circulatory system (I00-I99)
J00 - J99	10. Diseases of the respiratory system (J00-J99)
K00.0 - K95.89	11. Diseases of the digestive system (K00-K95)
L00 - L99	12. Diseases of the skin and subcutaneous tissue (L00-L99)

Hospital Acute Inpatient Services

- The **Inpatient Prospective Payment System (IPPS)** governed by CMS.
- Each discharge is assigned to a **Medicare Severity Diagnosis-Related Group (MS–DRG) or simply DRG**
- Payment rates are calculated using a base dollar amount, first adjusted for local input prices, then multiplied by the MS–DRG relative weight.

Sample DRGs

Medicare Severity Diagnosis Related Group

ICD-10 MS-DRG v37.0 (2020)

Code(s)	Description
001 - 017	PRE-MDC
020 - 103	MDC 01: DISEASES & DISORDERS OF THE NERVOUS SYSTEM
113 - 125	MDC 02: DISEASES & DISORDERS OF THE EYE
129 - 159	MDC 03: DISEASES & DISORDERS OF THE EAR, NOSE, MOUTH & THROAT
163 - 208	MDC 04: DISEASES & DISORDERS OF THE RESPIRATORY SYSTEM
215 - 320	MDC 05: DISEASES & DISORDERS OF THE CIRCULATORY SYSTEM
326 - 395	MDC 06: DISEASES & DISORDERS OF THE DIGESTIVE SYSTEM
405 - 446	MDC 07: DISEASES & DISORDERS OF THE HEPATOBILIARY SYSTEM & PANCREAS
453 - 566	MDC 08: DISEASES & DISORDERS OF THE MUSCULOSKELETAL SYSTEM & CONN TISSUE
570 - 607	MDC 09: DISEASES & DISORDERS OF THE SKIN, SUBCUTANEOUS TISSUE & BREAST
614 - 645	MDC 10: ENDOCRINE, NUTRITIONAL & METABOLIC DISEASES & DISORDERS
652 - 700	MDC 11: DISEASES & DISORDERS OF THE KIDNEY & URINARY TRACT
707 - 730	MDC 12: DISEASES & DISORDERS OF THE MALE REPRODUCTIVE SYSTEM
734 - 761	MDC 13: DISEASES & DISORDERS OF THE FEMALE REPRODUCTIVE SYSTEM

Outpatient Hospital Services

- The **Outpatient Prospective Payment System (OPPS)** governed by CMS.

- Each discharge is assigned to an **Ambulatory Payment Classification (APC).**

- Payment rates are calculated using a base dollar amount, first adjusted for local input prices, then multiplied by the relative weight for each APC.

Sample APCs

C-APC	CY 2020 APC Group Title	Clinical Family
5072	Level 2 Excision/Biopsy/Incision and Drainage	EBIDX
5073	Level 3 Excision/Biopsy/Incision and Drainage	EBIDX
5091	Level 1 Breast/Lymphatic Surgery and Related Procedures	BREAS
5092	Level 2 Breast/Lymphatic Surgery and Related Procedures	BREAS
5093	Level 3 Breast/Lymphatic Surgery and Related Procedures	BREAS
5094	Level 4 Breast/Lymphatic Surgery and Related Procedures	BREAS
5112	Level 2 Musculoskeletal Procedures	ORTHO
5113	Level 3 Musculoskeletal Procedures	ORTHO
5114	Level 4 Musculoskeletal Procedures	ORTHO
5115	Level 5 Musculoskeletal Procedures	ORTHO
5116	Level 6 Musculoskeletal Procedures	ORTHO
5153	Level 3 Airway Endoscopy	AENDO
5154	Level 4 Airway Endoscopy	AENDO
5155	Level 5 Airway Endoscopy	AENDO
5163	Level 3 ENT Procedures	ENTXX
5164	Level 4 ENT Procedures	ENTXX
5165	Level 5 ENT Procedures	ENTXX
5166	Cochlear Implant Procedure	COCHL
5182	Level 2 Vascular Procedures	VASCX
5183	Level 3 Vascular Procedures	VASCX
5184	Level 4 Vascular Procedures	VASCX
5191	Level 1 Endovascular Procedures	EVASC
5192	Level 2 Endovascular Procedures	EVASC

Physician Services

- The **Physician Fee Schedule** governed by CMS.
- **Current Procedure Terminology (CPT)** is the code used for procedures by a physician for medical records, insurance claims, and statistical purposes.
- Each CPT service has a **Relative Value Unit (RVU)** assigned that reflects amount of physician work, practice expenses, and liability insurance costs.
- The physician **Work RVU (wRVU)** is a “neutralized” way to quantify and compare the productivity of physician because it eliminates variables such as fee schedules or geographical costs.
- Payment rates are calculated using an RVU value, first adjusted for local input prices, then multiplied by a standard dollar amount (the conversion factor).

Sample CPTs and wRVUs

Description	Codes and "Typical" Time				
Office or Other Outpatient Services, new patient	99201 10 min	99202 20 min	99203 30 min	99204 45 min	99205 60 min
Office or Other Outpatient Services, established patient	99211 5 min	99212 10 min	99213 15 min	99214 25 min	99215 40 min
Office or Other Outpatient Consultations, new or established patient	99241 15 min	99242 30 min	99243 40 min	99244 60 min	99245 80 min
Inpatient Consultations	99251 20 min	99252 40 min	99253 55 min	99254 80 min	99255 110 min

CPT		Description	wRVU
99201		Office/outpatient visit new	0.48
99202		Office/outpatient visit new	0.93
99203		Office/outpatient visit new	1.42
99204		Office/outpatient visit new	2.43
99205		Office/outpatient visit new	3.17
99211		Office/outpatient visit est	0.18
99212		Office/outpatient visit est	0.48
99213		Office/outpatient visit est	0.97
99214		Office/outpatient visit est	1.50
99215		Office/outpatient visit est	2.11
99217		Observation care discharge	1.28
99218		Initial observation care	1.92
99219		Initial observation care	2.60
99220		Initial observation care	3.56
99221		Initial hospital care	1.92
99222		Initial hospital care	2.61
99223		Initial hospital care	3.86

Generic Reimbursement Methods

- Regardless of the payer, there are only a limited number of methods used to reimburse providers.

- Methods fall into two broad categories:
  - **Fee-for-service (FFS).** Here, reimbursement is tied to the amount of services provided. FFS reimbursement has three primary bases:
    - Cost based
    - Charge based
    - Prospective payment based
  - **Capitation.** Here, reimbursement is tied to the patient population (number of enrollees) and is paid on a PMPM basis.

FFS: Cost-Based Reimbursement

- Payer pays all *allowable costs* incurred in providing services.
- Typically, periodic interim payments are made, with a final reconciliation at the end of each year.
- Medicare used this method in its early years (1966-1983).

FFS: Charge-Based Reimbursement

- Payer pays billed charges for services rendered to covered patients.
  - Payment is made on the basis of chargemaster prices.
  - Historically, all third-party payers paid for services on the basis of charges.
- Some payers still use charges as the payment method, but often negotiate a discount from full charges.

FFS: Prospective Payment

- Prospective payment methods have a fixed amount determined beforehand that is, at least in theory, unrelated to either costs or charges.
- Prospective payment may be:
  - Per procedure
  - Per diagnosis (DRG)
  - Per diem (per day)
  - Bundled (episode) across providers

Capitation Payment

- Payment is not tied to utilization but rather to the number of covered lives.

- Payment to providers usually is made on **a per member per month (PMPM)** basis.
  - Fixed fee for each member enrolled, regardless of the amount or intensity of services provided.
  - Payment may be to a single provider or to a health system responsible for all care.

- Some *accountable care organizations* (*ACOs*) pay providers a capitated rate that is tied to quality of care.

Who Decides the Payment $?

CPT		Description	wRVU	Medicare Reimbursement
99201		Office/outpatient visit new	0.48	***$26.09***
99202		Office/outpatient visit new	0.93	***$49.82***
99203		Office/outpatient visit new	1.42	***$74.65***
99204		Office/outpatient visit new	2.43	***$127.69***
99205		Office/outpatient visit new	3.17	***$166.83***
99211		Office/outpatient visit est	0.18	***$9.14***
99212		Office/outpatient visit est	0.48	***$25.40***
99213		Office/outpatient visit est	0.97	***$50.67***
99214		Office/outpatient visit est	1.50	***$78.06***
99215		Office/outpatient visit est	2.11	***$110.30***
99217		Observation care discharge	1.28	***$71.68***
99218		Initial observation care	1.92	***$98.57***
99219		Initial observation care	2.60	***$134.20***
99220		Initial observation care	3.56	***$182.80***
99221		Initial hospital care	1.92	***$100.34***
99222		Initial hospital care	2.61	***$135.90***
99223		Initial hospital care	3.86	***$199.94***

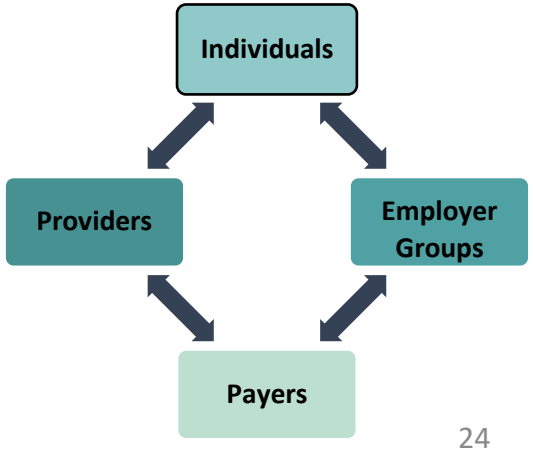
Note: Geographic (GPCI) shown is Rest of Texas for the Medicare 2020 Fee Schedule

Rounding It Out

- Chargemaster - List of services with corresponding charges that a provider requests for providing these services

- Fee Schedules - List of services with corresponding reimbursement amounts that a provider will receive from a payer for providing these services

- Fees are payer-specific contracted prices for every individual provider



Polling Question 3:
What makes a provider out of network for a patient?

a. They are rural.

b. No payer contract in place with provider.

c. All providers are out of network.

d. Being “out of network” is cool.

REVENUE CYCLE

What is Revenue Cycle?

All the administrative and clinical functions, processes, and software applications that contribute and manage the registration, charging, billing, payment and collections tasks associated with a patient encounter.

Revenue Cycle is the process that begins when a patient comes into the system and includes all those activities that have occurred in order to have a zero balance.

In other words, think… Zero to Zero!

Revenue Cycle Importance

- If a service is provided for cash, the revenue is immediately received.
- However, if the service is provided for credit, the revenue is not received until the payer is billed and the receivable is collected.
- The prompt and correct billing and collections process is essential to financial “fitness.”

HEALTHCARE IS THE ONLY INDUSTRY THAT YOU DON’T HAVE TO PAY BEFORE YOU RECEIVE!

REVENUE CYCLE BREAKING IT DOWN

The Revenue Cycle consists of those activities associated with providing services and collecting payment on those services.

Three primary areas of Revenue Cycle:

Front End

- Scheduling
- Financial Clearance
- Registration
- Point of Service Collections

Middle

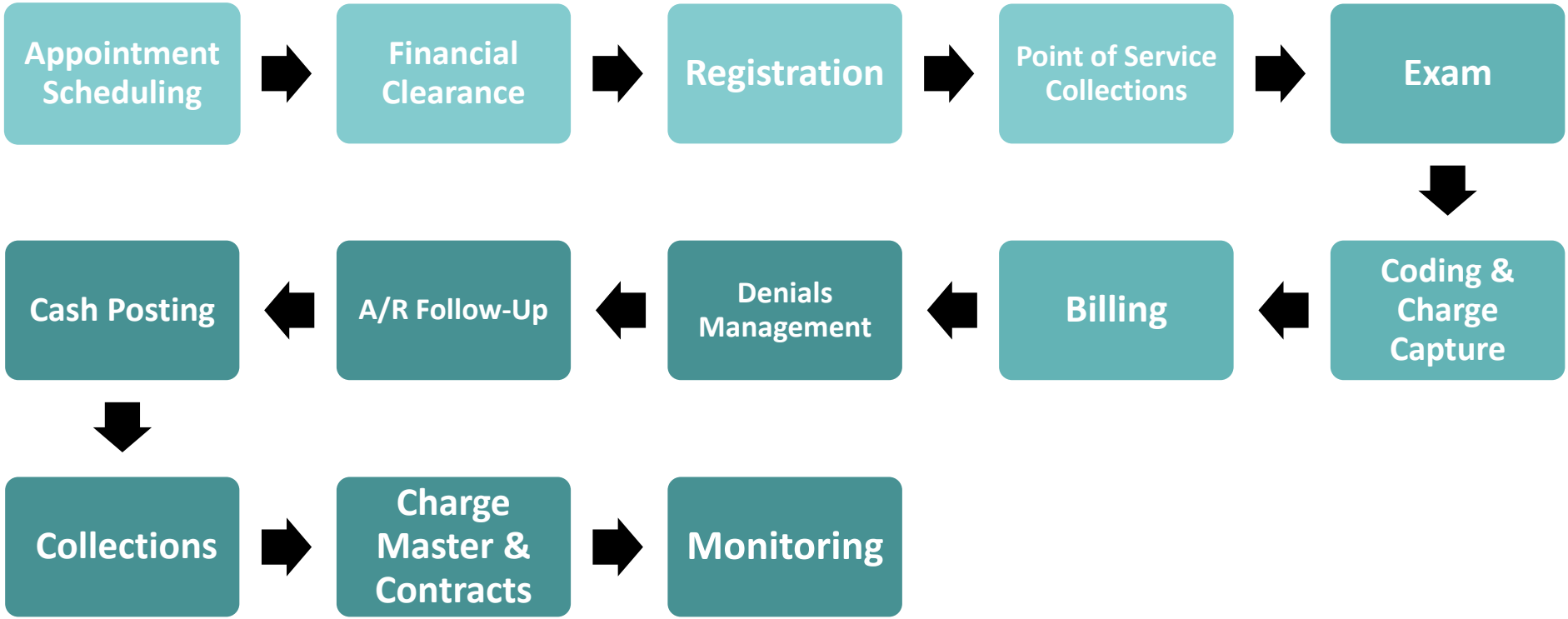
- Exam
- Coding/Charge Capture
- Billing

Back End

- Accounts Receivables
- Denials Management
- Cash Posting
- Collections
- Charge Master and Contract Management
- Monitoring

The Revenue Cycle

The revenue cycle consists of those activities and related information processing associated with providing services and then collecting payment for those services. It can be broken down into three sets of activities.



MANAGEMENT REPORTS & INDUSTRY BENCHMARKS

Practice Management Reports

- Lag Days
- Point of Service Collections
- Accounts Receivable (A/R) Aging
  - Summary
  - By Payer
  - By Provider
- Denials Report
- Activity by Provider & Location
- Top CPT Codes

Sample Lag Days

Operational Unit	2019	2018
Clinic A	4.31	7.73
Community Care Clinic	6.72	15.20
Medical Plaza	8.12	13.89
Women's Associates	8.82	24.31
Endocrinology	9.19	-
Gastroenterology	8.54	18.53
General Surgery	19.13	43.85
Urology	8.30	13.04
Vascular	8.78	60.30
Cardiology	32.32	-
Neuro and Pulm	9.61	27.16
Urgent Care	10.16	11.40

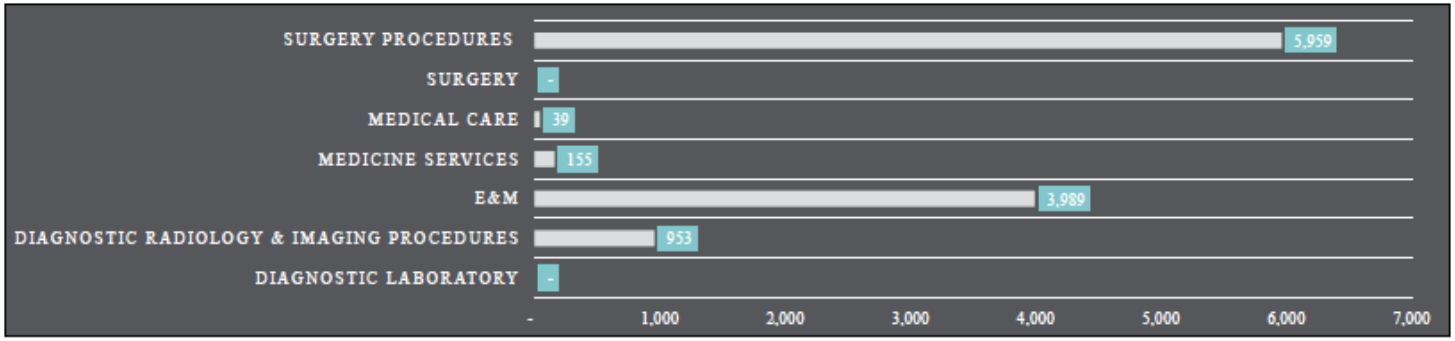
Sample CPT Analysis

Provider Detail

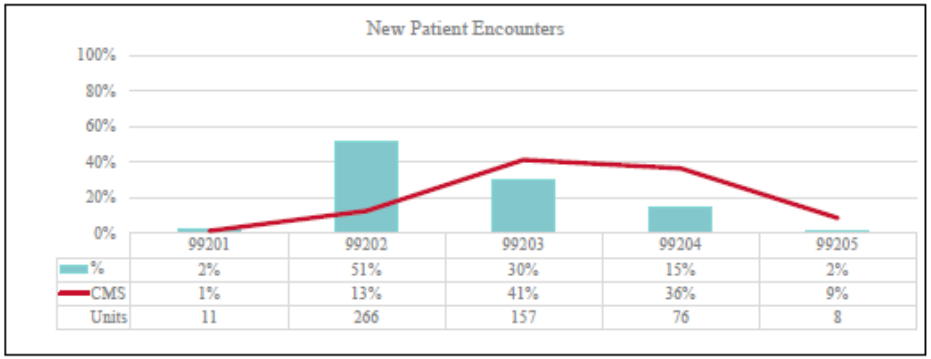
Clinic Specialty Obstetrics/Gynecology

Graphical Representation of Procedures

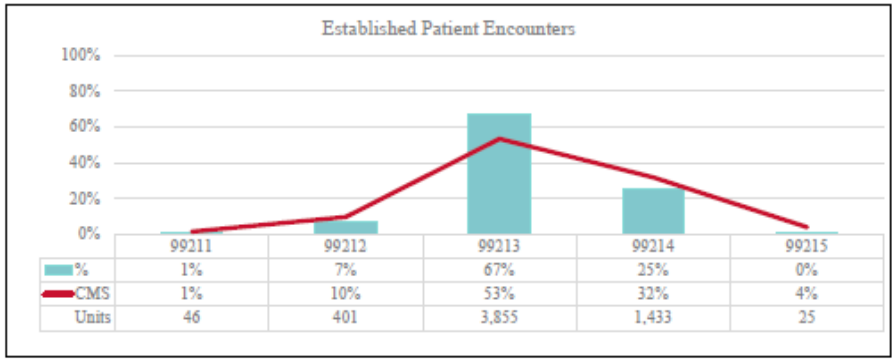
The illustration below is based on the CMS's designated categories for medical procedures. We identified the hours distribution of services provided by the Physician.



The illustrations below compare the Physicians' distribution of encounters to CMS's distribution of similar codes. The first illustrations represent the CMS distribution for the New Patient encounters while the second illustration represents Established Patient encounters.

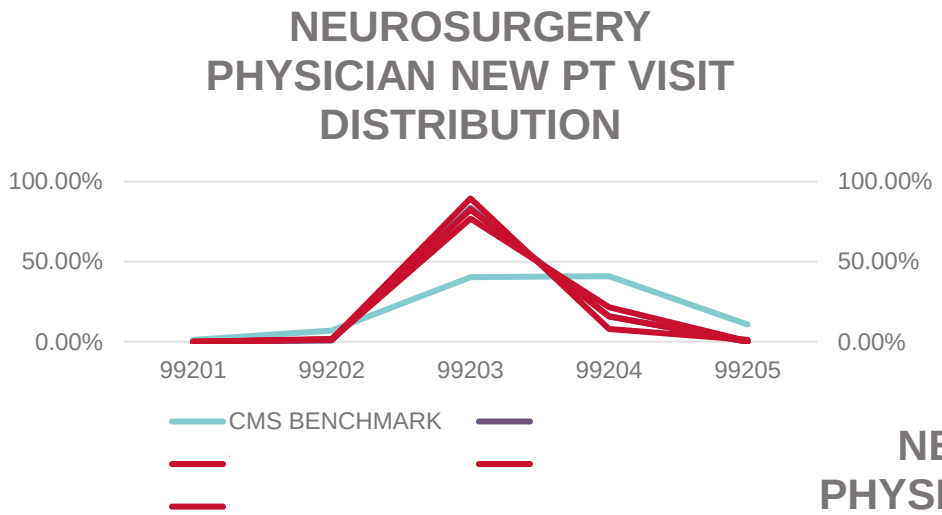


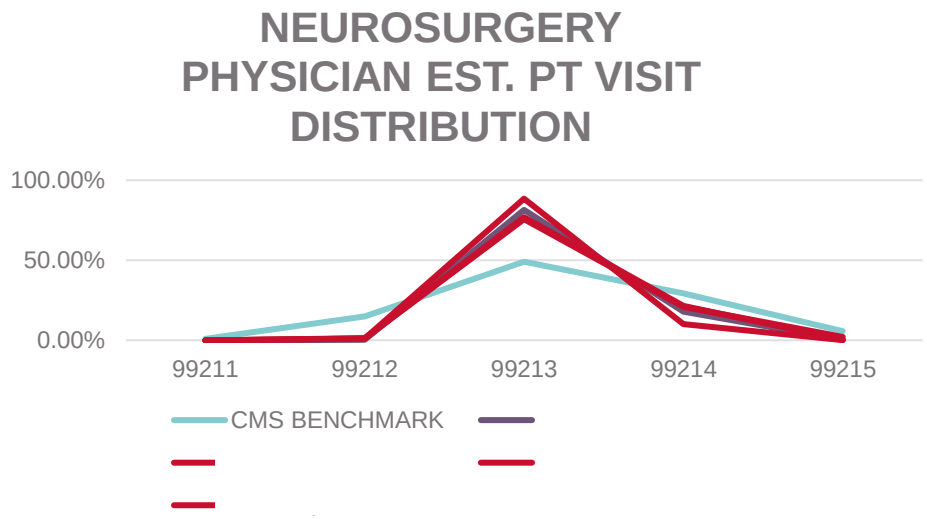
	99201	99202	99203	99204	99205
%	2%	51%	30%	15%	2%
CMS	1%	13%	41%	36%	9%
Units	11	266	157	76	8



	99211	99212	99213	99214	99215
%	1%	7%	67%	25%	0%
CMS	1%	10%	53%	32%	4%
Units	46	401	3,855	1,433	25

Sample CPT Analysis





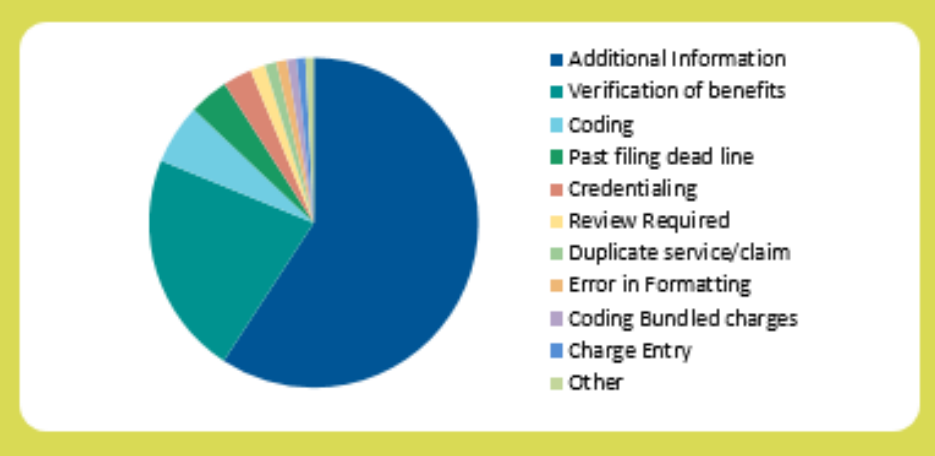
Sample Denials

Top Denial Categories

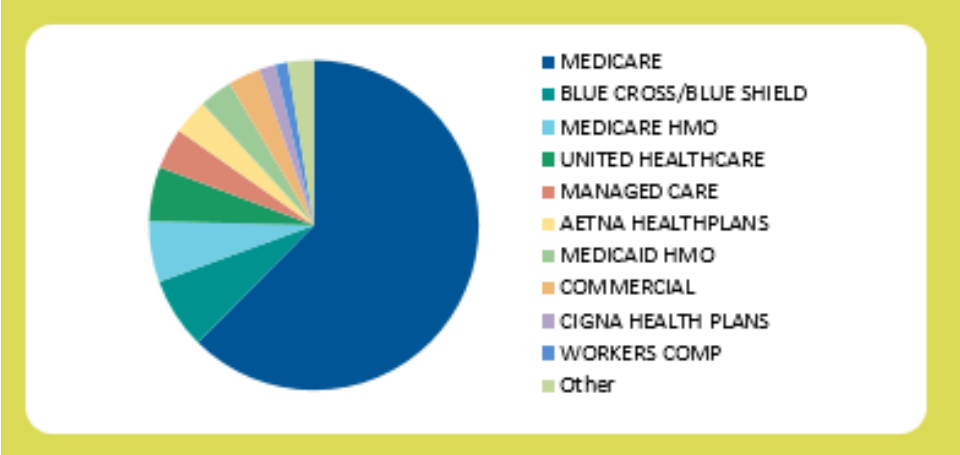
This sheet shows the top denials by category, remittance code, and remark code.

Row Labels	Count	Denied Amount
⊞Duplicate	7439	$2,218,890.49
⊞Additional Documentation Needed	21432	$2,042,263.31
⊞Eligibility/Registration	8148	$1,557,347.22
⊞Miscellaneous	6250	$1,208,908.04
⊞Authorization	3339	$1,134,799.29
⊞Non-Covered	8520	$753,860.49
⊞Informational	2350	$656,982.14
⊞Coding	1856	$650,174.67
⊞Exceeds days/Units/Frequency Limitations	652	$508,249.55
⊞Bundled	2463	$485,771.77
⊞Past Timely Filing	1443	$354,079.70
⊞Medical Necessity/Level of Care	472	$102,321.50
⊞Enrollment	237	$70,781.78
⊞*Unspecified Remit Code Category	218	$20,993.88
⊞Contract Related	338	$3,744.06
⊞Missing Claim Information	15	$3,115.20
⊞Billing Error	362	$254.00
Grand Total	65534	$11,772,537.09

Preventable Denial Overview



Preventable denials for July 2016 were $1.2M, a decrease of 45% from June 2019

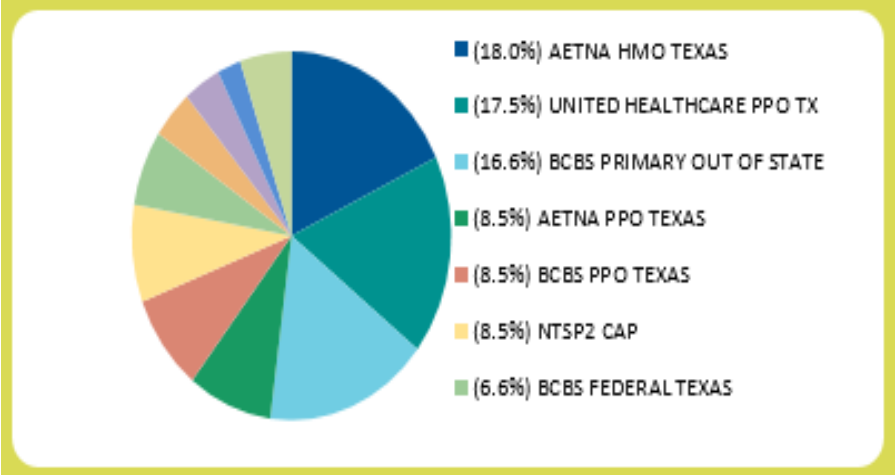


Top 10 Providers

	Denials	Related Charges
	205	$126,953
	204	$88,989
	175	$38,995
	130	$104,342
	124	$86,171
	117	$51,081
	88	$30,464
	86	$66,344
	81	$73,110
	80	$14,007
	1,039	**$472,137**

Denials Focus Dashboard

The Denials Focus Dashboard shows three areas of interest for preventable denials. These provide snapshots for an understanding of preventable denial performance related to payer, provider and category.



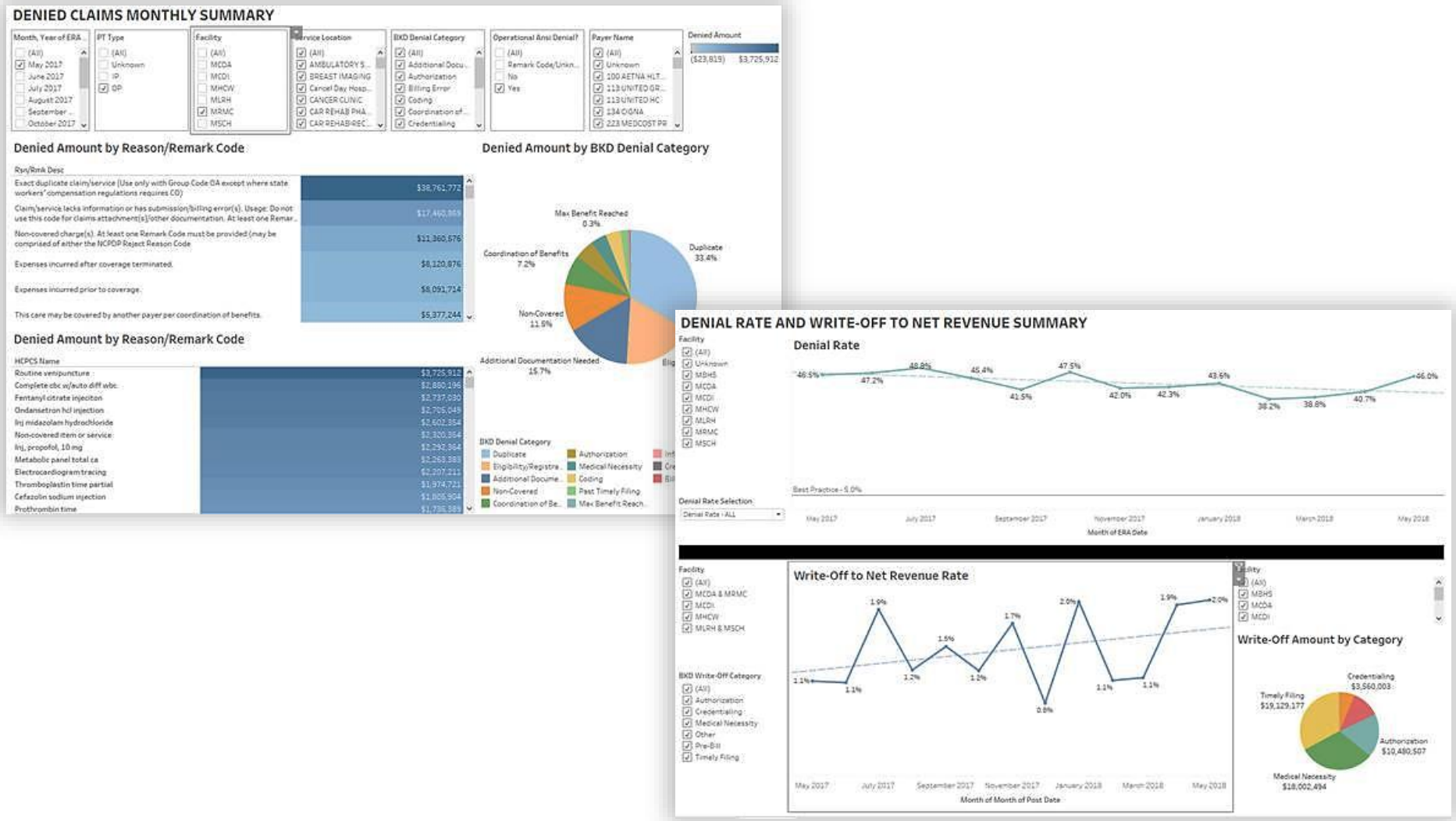
Top 10 Providers

	Denials	Related Charges
(73.0%) SLEEP CENTER DME	154	$43,011
(27.0%) SLEEP HEALERS - COMMERCIAL	57	$188,493
Total	211	$231,504

Top 10 Denial Categories

	Denials	Related Charges
(75.4%) Verification of benefits	159	$180,043
(12.8%) Past filing dead line	27	$20,545
(9.0%) Coding	19	$20,626
(2.8%) Additional Information	6	$10,290
Total	211	$231,504

Denials Management Dashboard



Sample of Aging Report by Payer

	Oct	Sep	Aug	Jul	Jun	May	Apr	
	Values							
Type	**Sum of Current**	**Sum of 30 +**	**Sum of 60 +**	**Sum of 90 +**	**Sum of 120 +**	**Sum of 150 +**	**Sum of 180 +**	**Sum of Total Owed**
BCBS	11,818,395	9,253,287	825,357	445,296	192,770	176,189	1,881,118	24,592,413
Collection Agency	34,774	57,754	70,382	157,736	923,206	1,468,189	8,388,104	11,100,145
Medicaid	1,724,266	863,120	617,754	539,853	422,265	433,271	3,398,205	7,998,734
Medicare	26,102,581	7,214,135	3,837,742	3,025,245	3,779,808	1,621,762	12,132,579	57,713,853
Other	16,831,996	5,179,171	2,568,750	1,671,888	1,720,821	1,060,538	9,002,309	38,035,474
Self Pay	2,607,558	3,245,342	3,509,543	3,119,833	2,053,455	1,378,346	6,703,550	22,617,626
Grand Total	**59,119,571**	**25,812,809**	**11,429,527**	**8,959,851**	**9,092,325**	**6,138,296**	**41,505,866**	**162,058,245**
Prior Aging	**55,148,106**	**15,373,603**	**10,193,770**	**10,317,583**	**6,913,117**	**8,131,762**	**49,963,267**	**156,041,207**
Delta	3,971,465	10,439,207	1,235,758	(1,357,732)	2,179,208	(1,993,466)	(8,457,401)	6,017,038
Change in > 90 days							**(8,271,659)**	

Reimbursement Analysis Theory

Summary of Actual Payments as a % of Medicare Reimbursement by Payer

Insurance Class	Actual Payments	Medicare Allowable	Actual as % of MC Allowable
BCBS	$ 1,414,138	$ 1,246,314	113%
Champus	17,810	16,433	108%
Commercial	955,602	598,080	160%
Managed Care	2,543,720	1,807,592	141%
Medicaid	619,033	967,421	64%
Medicare	3,215,336	3,103,927	104%
Medicare Replacement	8,698	9,998	87%
No Primary Class	498,424	372,538	134%
Other Revenue	10,412	11,687	89%
Self-Pay	6,565	92,774	7%
Workman's Comp	22,505	10,084	223%
	$ 9,312,241	**$ 8,236,848**	**113%**

Reimbursement Expectations

- Analysis is performed at assumed achievable reimbursement level as a percentage of traditional Medicare reimbursement.
- Benchmarking level set at approximately 124% of Medicare assumptions for achievable reimbursement based on current contracts.

Insurance Class Roll-Up	Actual as % of MC Allowable	Expected Reimbursement as a % of Medicare (1)
All Other	110%	115%
BCBS	113%	125%
Commercial	160%	151%
Managed Care	141%	175%
Medicaid	64%	90%
Medicare	104%	100%
	113%	**126%**
Weighted Average		**124%**

Polling Question 4:
A lag day is

a. A lazy day

b. When patient isn't improving

c. Important to cash flow

d. How long it takes for the payer to pay

e. Time consuming

Polling Question 5:
A payer will reimburse for past timely filing.

a. True

b. False

INDUSTRY BENCHMARKS

Revenue Cycle Benchmarks

Revenue Cycle Metrics			
Percentage of Insurance Verified	98%	Average days in A/R	< 50 days
Error Rates due to Front-End	< 2%	% of A/R over 90 days	< 20%
Time of Service Collections/CoPays	100%	% of A/R over 120 days	< 10%
Follow-Up Notes Documented to Account	<30 days	Payor Turn Around	10 - 15 day
Identification/Return/Overpayment Refund	< 60 days	Denial % in Total	< 10%
Date of Charge Entry to Claim Release (Lag Days)	0 - 72 hours	Denial % due to Timely Filing	0%
Claims Submission	Daily	Account Follow-Up	Every 30 - 45 days
Claim Denial/Rejection Rate	< 7%	Bad Debt Expense (% of Net Revenue)	< 2%

Distribution of A/R

Days In A/R	Cardiology	Family Med.	OBGYN	Orthopedic
0-30 Days	37.42%	58.73%	55.91%	54.74%
31-60 Days	10.78%	10.54%	11.29%	12.15%
61-90 Days	7.21%	6.90%	6.56%	8.82%
91-120 Days	4.68%	4.99%	4.84%	6.49%
121+ Days	36.81%	15.84%	14.95%	17.03%

Southern Region Specific Data

Median %s used

Source: MGMA Report, Cost Survey: 2017 Report Based on 2016 Data

Overhead as a % of NPR

Category	Cardiology	Family Med.	OBGYN	Orthopedic
Total Support Staff	24.08%	27.87%	26.94%	22.69%
Drug Supply	N/A	8.36%	5.35%	3.48%
Building & Occupancy	7.22%	9.40%	6.49%	6.32%
Prof Liability Ins	1.41%	1.61%	3.81%	2.63%
Info Technology	1.12%	1.48%	1.42%	1.85%
Medical Supplies	.48%	1.12%	1.98%	1.54%
Total Operating Cost	58.69%	71.96%	61.47%	55.05%

Southern Region Specific Data

Median %s Used

Staffing per FTE Physician

Category	Cardiology	Family Med	OBGYN	Orthopedic
Clinical Support Staff	1.51	1.99	1.66	1.40
Front Office Support	2.09	2.00	1.53	1.87
Med Assistant, Nurse Aides	.84	1.50	1.01	1.00
Total Support Staff	3.95	4.14	3.52	4.05

Median FTEs Used

FINANCIAL STATEMENTS & TRENDING

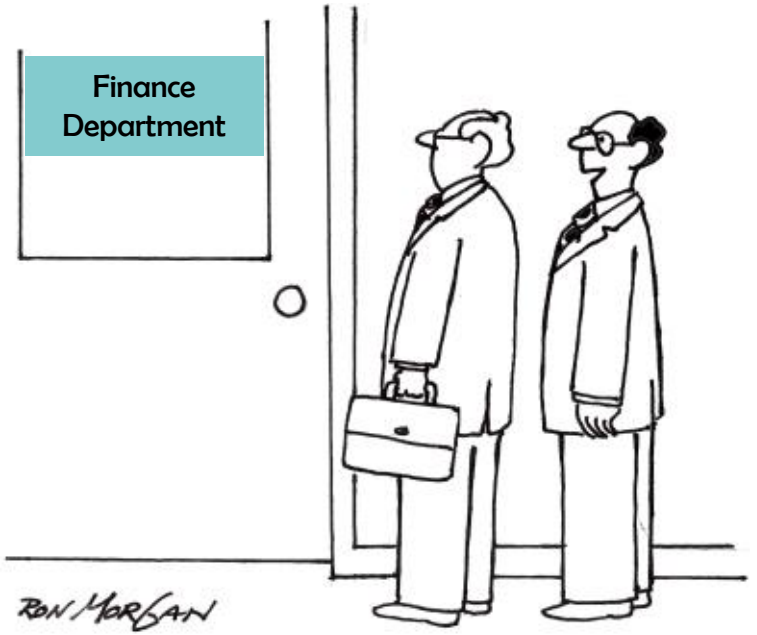
Accounting vs Finance

Accounting = Transactional

Finance = Analysis/Reporting

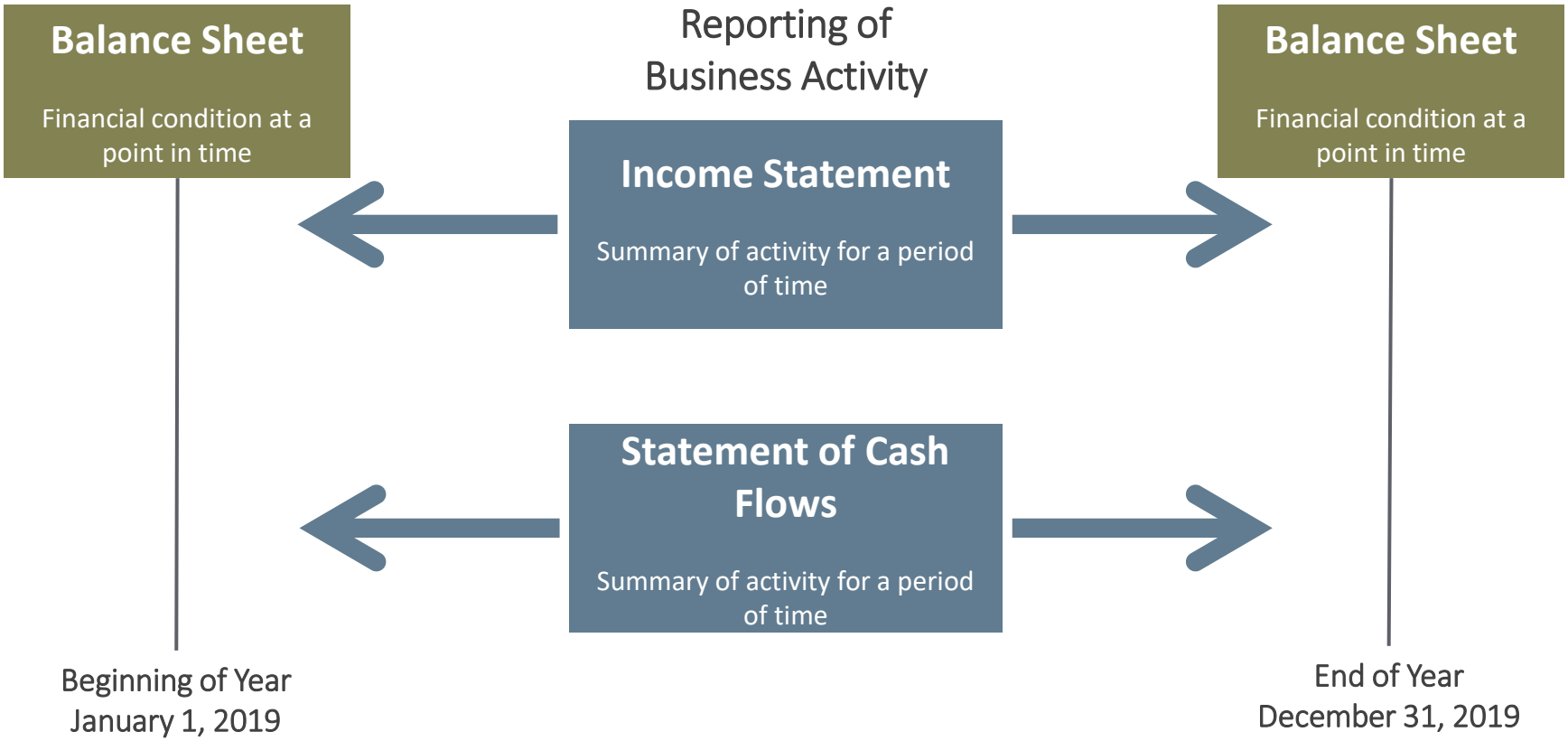
The Big 3

- Balance Sheet
- Income Statement
- Cash Flow Statement



"And this is where the *magic* happens."

Visual Summary – Financial Statements



Operating Revenue

	ACTUAL
VISITS	87,414
Patient Service Revenue	
Outpatient Revenue	$ 32,569,449
Total Gross Patient Revenue	32,569,449
Deductions From Revenue	
Bad Debt	1,485,134
Contractuals & Discounts	19,850,537
Total Deductions from Revenue	21,335,671
Net Patient Revenue	11,233,778
NPR as % of Gross Revenue	34.49%
Other Operating Revenue	303,906
Total Operating Revenue	11,537,684

Statistics

Net Patient Revenue

Total Operating Revenue

Operating Expenses and Gain/Loss

Operating Expenses	
Salaries and Wages	
Provider: Physician's	6,682,492
Provider: Midlevels	1,893,174
Supporting Staff	3,877,953
	12,453,619
Contract Labor	47,962
Benefits and Employer Taxes	2,080,158
Total Wages & Benefits	14,581,739
Pharmaceuticals	276,196
Supplies	635,581
Purchased Services	1,401,326
Management Fees	531,013
Physicians Professional Fees	96,471
Rent	910,401
Insurance	166,284
Repairs & Maintenance	46,822
Utilities	39,595
Other	498,406
Total Supplies & Other	4,602,095
Total Operating Expenses	19,183,834
Operating Loss	$ (7,646,150)
Provider FTE's	**38.9**
Loss per Provider	**$ (182,908)**

Expenses

Net Operating Margin

Statistics

How are we doing? Budget is Key

	ACTUAL	BUDGET	VARIANCE	PRIOR YEAR
VISITS	87,414	99,301	(11,887)	66,023
Patient Service Revenue				
Outpatient Revenue	$ 32,569,449	$ 34,338,670	$ (1,769,221)	$ 21,619,840
Total Gross Patient Revenue	32,569,449	34,338,670	(1,769,221)	21,619,840
Deductions From Revenue				
Bad Debt	1,485,134		1,485,134	-
Contractuals & Discounts	19,850,537	19,540,384	310,153	13,390,078
Total Deductions from Revenue	21,335,671	19,540,384	1,795,287	13,390,078
Net Patient Revenue	11,233,778	14,798,286	(3,564,508)	8,229,762
NPR as % of Gross Revenue	34.49%	43.10%	201.47%	38.07%
Other Operating Revenue	303,906	57,607	246,299	358,611
Total Operating Revenue	11,537,684	14,855,893	(3,318,209)	8,588,373
Operating Expenses				
Salaries and Wages				
Provider: Physician's	6,682,492	7,942,567	(1,260,075)	4,423,515
Provider: Midlevels	1,893,174	2,016,061	(122,887)	1,532,156
Supporting Staff	3,877,953	4,272,957	(395,004)	3,230,866
	12,453,619	14,231,585	(1,777,966)	9,186,537
Contract Labor	47,962	0	47,962	
Benefits and Employer Taxes	2,080,158	1,896,314	183,844	1,578,630
Total Wages & Benefits	14,581,739	16,127,899	(1,546,160)	10,765,167
Pharmaceuticals	276,196	250,737	25,459	255,260
Supplies	635,581	617,640	17,941	538,149
Purchased Services	1,401,326	1,315,351	85,975	956,646
Management Fees	531,013	625,008	(93,995)	380,978
Physicians Professional Fees	96,471	213,478	(117,007)	86,533
Rent	910,401	726,188	184,213	679,922
Insurance	166,284	211,293	(45,009)	107,012
Repairs & Maintenance	46,822	50,963	(4,141)	38,893
Utilities	39,595	28,019	11,576	27,470
Other	498,406	496,226	2,180	395,417
Total Supplies & Other	4,602,095	4,534,903	67,192	3,466,280
Total Operating Expenses	19,183,834	20,662,802	(1,478,968)	14,231,447
Operating Loss	$ (7,646,150)	$ (5,806,909)	$ (1,839,241)	$ (5,643,074)
Provider FTE's	**38.9**	**50.5**		**29.5**

FYE 2019

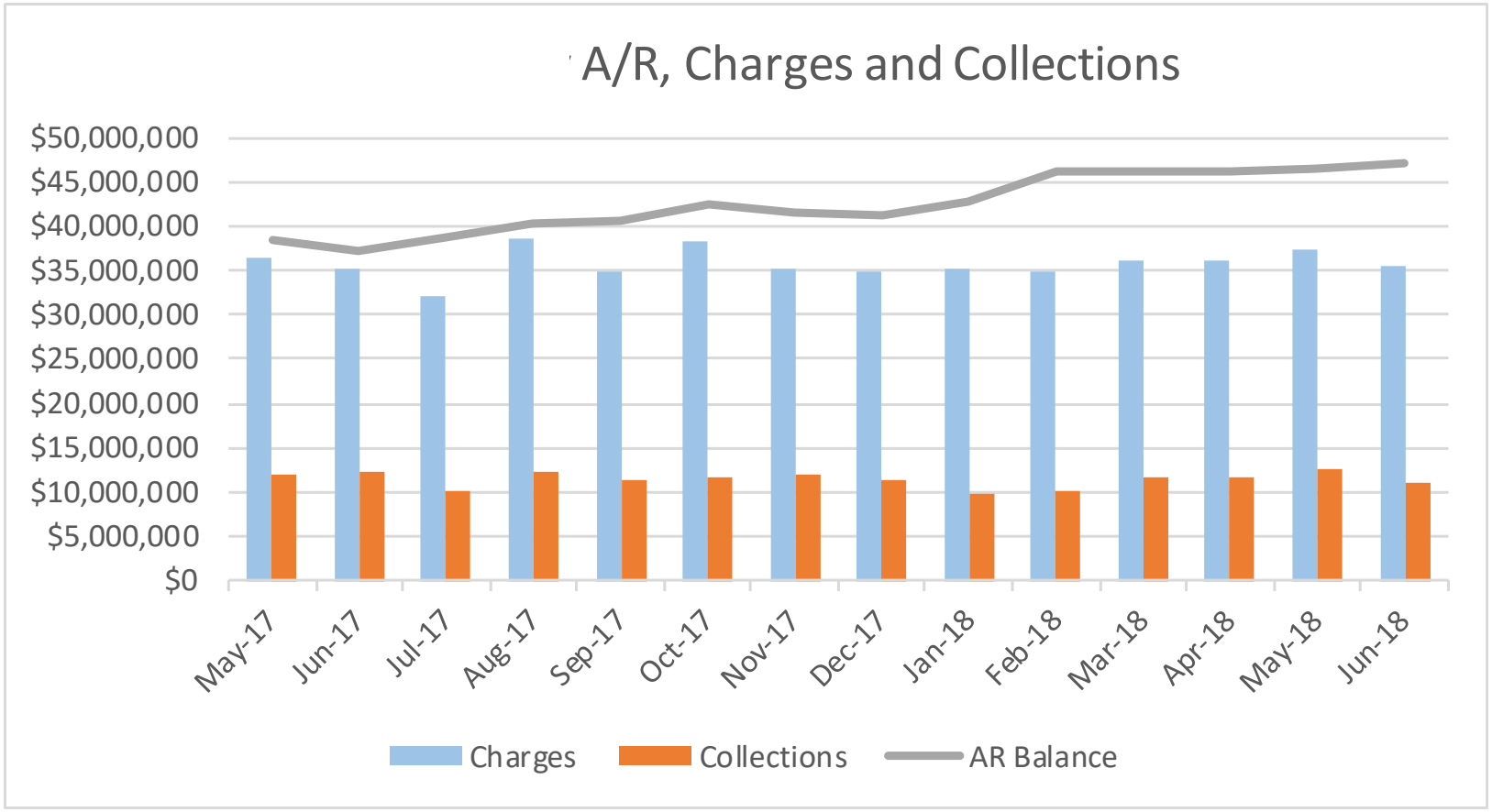
Working Days	21	22	19	21	22	16	19	20	18	22	23	19
PTO Days	1	1	1	2	0	5	4	0	3	0	0	1

Dr. XYZ

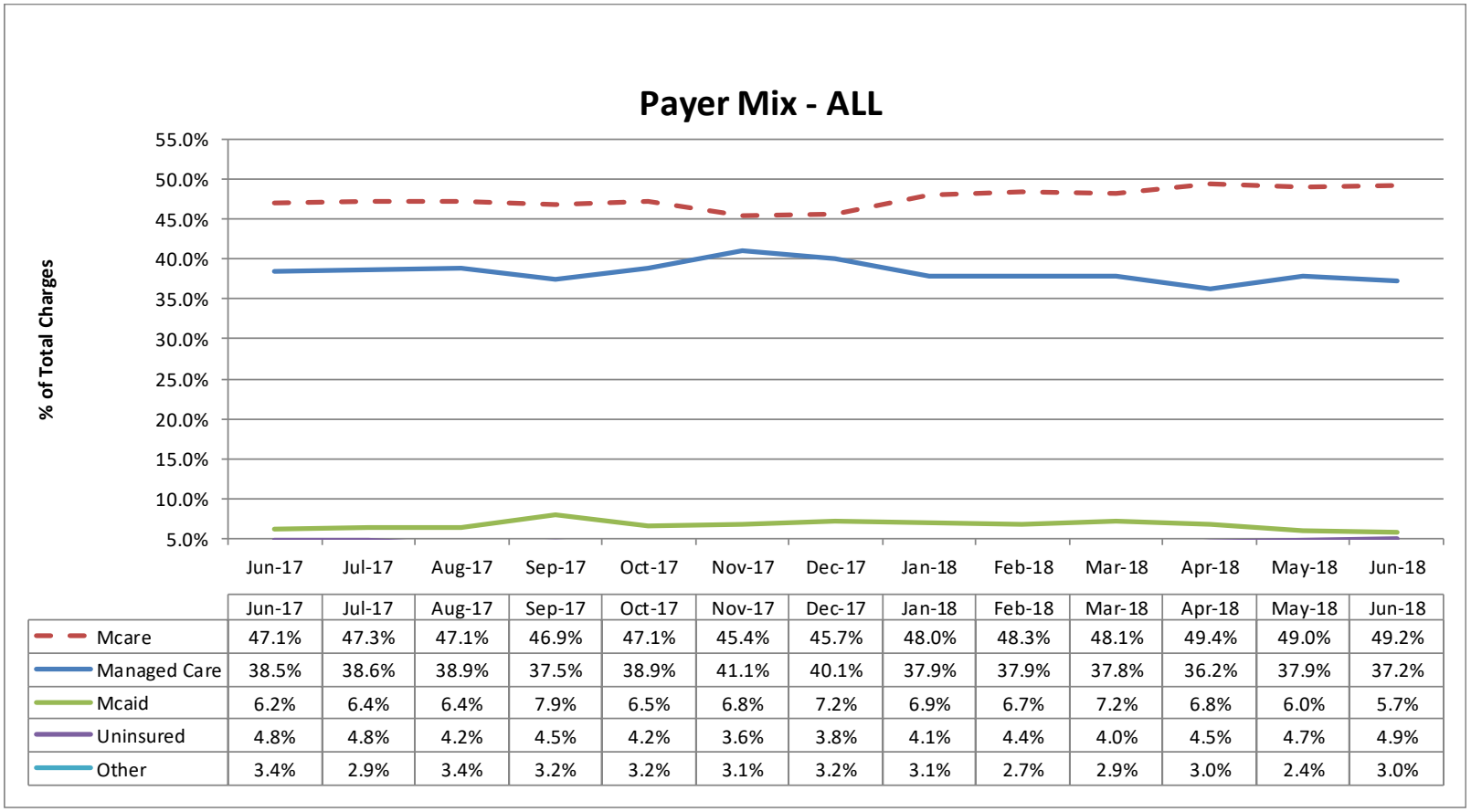
	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total	Avg/Mo	FY 2018 monthly Average
Monthly Visits226	**269**	**225**	**280**	**250**	**233**	**235**	**241**	**266**	**220**	**304**	**155**		**2,904**	**242**	**283**
Avg Visits/Day	10.76	12.23	11.84	13.33	11.36	14.56	12.37	12.05	14.78	10.00	13.22	8.16	**144.66**	**12.06**	**13.78**
Avg Visits/Hour	1.35	1.53	1.48	1.67	1.42	1.82	1.55	1.51	1.85	1.25	1.65	1.02	**18.08**	**1.51**	**1.72**
Gross Revenue															
Medicare	$ 4,225	$ 7,643	$ 5,248	$ 16,598	$ 6,601	$ 26,235	$ 8,327	$ 13,645	$ 1,925	$ 2,307	$ 12,664	$ 5,293	**$ 110,709**	***$ 9,226***	***$ 11,607***
Medicare Replacement	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Blue Cross	$ 39,566	$ 12,291	$ 31,521	$ 18,998	$ 18,412	$ 17,959	$ 10,595	$ 26,614	$ 21,469	$ 17,028	$ 37,815	$ 19,339	**$ 271,607**	***$ 22,634***	***$ 41,123***
Commercial	$ 13,738	$ 4,508	$ 18,296	$ 40,372	$ 12,949	$ 17,800	$ 6,385	$ 35,841	$ 15,371	$ 3,726	$ 9,319	$ 9,145	**$ 187,450**	***$ 15,621***	***$ 17,518***
Medicaid	$ 42,761	$ 42,975	$ 41,194	$ 48,644	$ 36,151	$ 47,644	$ 41,789	$ 56,438	$ 46,013	$ 34,686	$ 68,801	$ 36,753	**$ 543,848**	***$ 45,321***	***$ 56,114***
Self Pay	$ 7,930	$ 11,275	$ 16,656	$ 13,760	$ 7,945	$ 28,296	$ (803)	$ 9,568	$ 27,083	$ 13,162	$ 7,062	$ 8,563	**$ 150,495**	***$ 12,541***	***$ 6,966***
Managed Care	$ 37,425	$ 17,627	$ 2,037	$ 26,731	$ 2,884	$ 22,606	$ 12,069	$ 17,908	$ 36,506	$ 20,592	$ 13,978	$ 11,105	**$ 221,468**	***$ 18,456***	***$ 19,994***
Misc. Government	$ -	$ 820	$ 2,903	$ 1,799	$ 3,595	$ 413	$ -	$ 337	$ 187	$ -	$ 260	$ -	**$ 10,314**	***$ 1,289***	***$ 3,775***
Other	$ -	$ -	$ -	$ 177	$ -	$ 464	$ -	$ 413	$ -	$ 483	$ 514	$ 337	**$ 2,388**	***$ 398***	***$ 4,685***
Total Gross Revenue	$ 145,644	$ 97,139	$ 117,855	$ 167,079	$ 88,536	$ 161,416	$ 78,362	$ 160,763	$ 148,553	$ 91,984	$ 150,412	$ 90,535	**$ 1,498,277**	***$ 124,856***	***$ 157,955***
Net Revenue	$ 45,267	$ 30,191	$ 36,630	$ 51,929	$ 27,517	$ 50,169	$ 24,355	$ 49,966	$ 46,171	$ 28,589	$ 46,749	$ 28,139	**$ 465,673**	***$ 38,806***	***$ 49,076***
Management Expenses	$ 2,367	$ 1,845	$ 1,810	$ 2,088	$ 2,239	$ 1,682	$ 1,750	$ 1,712	$ 2,471	$ 1,856	$ 1,673	$ 1,412	**$ 22,905**	***$ 1,909***	***$ 2,454***
Expenses	$ 31,231	$ 39,346	$ 33,855	$ 35,833	$ 38,467	$ 32,710	$ 30,986	$ 28,355	$ 38,630	$ 37,336	$ 38,630	$ 33,053	**$ 418,432**	***$ 34,869***	***$ 39,090***
Admin Expenses	$ 7,081	$ 7,330	$ 9,446	$ 9,391	$ 9,797	$ 10,039	$ 10,647	$ 9,831	$ 9,410	$ 9,741	$ 7,558	$ 8,423	**$ 108,694**	***$ 9,058***	***$ 10,301***
Total Expense	**$ 40,679**	**$ 48,521**	**$ 45,111**	**$ 47,312**	**$ 50,503**	**$ 44,431**	**$ 43,383**	**$ 39,897**	**$ 50,511**	**$ 48,933**	**$ 47,861**	**$ 42,888**	**$ 550,031**	***$ 45,836***	***$ 51,845***
Profit/ Loss (W/O Mgmt Fee)	$ 6,955	$ (16,485)	$ (6,671)	$ 6,705	$ (20,747)	$ 7,420	$ (17,277)	$ 11,781	$ (1,869)	$ (18,488)	$ 561	$ (13,338)	**$ (61,454)**	***$ (5,121)***	***$ (314)***
Profit/ Loss (W/ Mgmt Fee)	$ 4,588	$ (18,330)	$ (8,481)	$ 4,617	$ (22,986)	$ 5,738	$ (19,027)	$ 10,069	$ (4,340)	$ (20,344)	$ (1,112)	$ (14,750)	**$ (84,359)**	***$ (7,030)***	***$ (2,768)***
Avg Net Revenue/ Visit	$ 200	$ 112	$ 163	$ 185	$ 110	$ 215	$ 104	$ 207	$ 174	$ 130	$ 154	$ 182		***$ 161***	***$ 173***
Avg Expense/ Visit	$ 180	$ 180	$ 200	$ 169	$ 202	$ 191	$ 185	$ 166	$ 190	$ 222	$ 157	$ 277		***$ 193***	***$ 190***
Avg Profit/ Loss/ Visit	$ 20	$ (68)	$ (38)	$ 16	$ (92)	$ 25	$ (81)	$ 42	$ (16)	$ (92)	$ (4)	$ (95)		***$ (32)***	***$ (17)***
Gross Patient Payments	$ 11,984	$ 13,042	$ 9,125	$ 10,428	$ 5,438	$ 7,998	$ 12,674	$ 6,264	$ 10,438	$ 18,728	$ 7,196	$ 7,474	**$ 120,790**	***$ 10,066***	***$ 8,939***
Gross Insurance Payments	$ 34,931	$ 25,371	$ 26,531	$ 33,814	$ 42,081	$ 27,895	$ 30,267	$ 27,980	$ 35,969	$ 23,932	$ 28,218	$ 23,137	**$ 360,126**	***$ 30,010***	***$ 41,965***
Charge Voids	$ -	$ (41)	$ -	$ (155)	$ (1,120)	$ (462)	$ (507)	$ (1,103)	$ (104)	$ 2,825	$ (226)	$ (74)	**$ (966)**	***$ (97)***	***$ (381)***
Charge Offsets	$ 423	$ (1,478)	$ 539	$ (2,326)	$ (1,611)	$ (1,787)	$ (4,079)	$ 1,206	$ 1,174	$ (5,077)	$ (1,268)	$ 8	**$ (14,277)**	***$ (1,190)***	***$ (1,510)***
Total Payments	**$ 47,338**	**$ 36,894**	**$ 36,195**	**$ 41,761**	**$ 44,788**	**$ 33,644**	**$ 38,355**	**$ 34,346**	**$ 47,477**	**$ 40,408**	**$ 33,920**	**$ 30,546**	**$ 465,673**	***$ 38,806***	***$ 49,076***
	32.50%	***37.98%***	***30.71%***	***24.99%***	***50.59%***	***20.84%***	***48.95%***	***21.36%***	***31.96%***	***43.93%***	***22.55%***	***33.74%***	***31.08%***		
WRVU's591	**408**	**465**	**638**	**363**	**648**	**332**	**584**	**577**	**424**	**609**	**355**		**5993**	**499**	**582**
wRVU/Monthly Visits2.61	**1.52**	**2.06**	**2.28**	**1.45**	**2.78**	**1.41**	**2.43**	**2.17**	**1.93**	**2.00**	**2.29**				

MGMA Benchmarks		Mean	10th %tile	25th %tile	Median	75th %tile	90th %tile
Obstetrics/Gynocology - 2018 Report	**Monthly Encounters**	**278**	**106**	**211**	**270**	**347**	**424**
General	**Total Encounters**	**3335**	**1,273**	**2,537**	**3,242**	**4,169**	**5,091**
	Total Collections	**$ 593,580**	**$ 259,927**	**$ 444,763**	**$ 557,690**	**$ 717,752**	**$ 941,853**
	Total Compensation	**$ 318,581**	**$ 151,857**	**$ 228,800**	**$ 293,500**	**$ 396,171**	**$ 519,176**
	WRVU's	**8458**	**4,159**	**6,304**	**8,031**	**10,260**	**13,030**
	WRVU's Monthly	**705**	**347**	**525**	**669**	**855**	**1,086**
	WRVU's to total encounters	**2.74**	**1.90**	**2.20**	**2.52**	**2.81**	**3.41**
				50	**75**	**100**	

Revenue Cycle Highlights



Payer Mix



	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Mcare	47.1%	47.3%	47.1%	46.9%	47.1%	45.4%	45.7%	48.0%	48.3%	48.1%	49.4%	49.0%	49.2%
Managed Care	38.5%	38.6%	38.9%	37.5%	38.9%	41.1%	40.1%	37.9%	37.9%	37.8%	36.2%	37.9%	37.2%
Mcaid	6.2%	6.4%	6.4%	7.9%	6.5%	6.8%	7.2%	6.9%	6.7%	7.2%	6.8%	6.0%	5.7%
Uninsured	4.8%	4.8%	4.2%	4.5%	4.2%	3.6%	3.8%	4.1%	4.4%	4.0%	4.5%	4.7%	4.9%
Other	3.4%	2.9%	3.4%	3.2%	3.2%	3.1%	3.2%	3.1%	2.7%	2.9%	3.0%	2.4%	3.0%

KPIs

One Month Ended June 30, 2018

	PRIMARY CARE						Prior Mo.
	TYLC	**PALC**	**LGVC**	**SSC**	**TXKC**	**TOTAL**	
Provider FTE - MD	70.2	10.0	17.2	7.8	3.0	108.2	108.1
Provider FTE - APP	49.2	4.4	11.6	10.1	4.1	79.4	79.8
Total	119.4	14.4	28.8	17.9	7.1	187.6	187.9
APP per MD	0.7	0.4	0.7	1.3	1.4	0.7	0.7
Support Staff FTE	317.9	45.1	117.5	65.3	20.6	566.4	567.2
Staff FTE per Prov	2.7	3.1	4.1	3.6	2.9	3.0	3.0
NOTE: Staff FTE per Prov includes only staff directly charged to clinic (excludes Admin, CBO, etc)							
WRVUs	45,548	4,886	12,421	6,751	2,236	71,842	77,475
Visits	31,147	3,769	9,173	4,596	1,556	50,241	55,095
WRVU per Visit	1.46	1.30	1.35	1.47	1.44	1.43	1.41
WRVU per Provider	381.47	339.31	431.28	377.15	314.93	382.95	412.32
Net Revenue	$4,123,635	$316,947	$953,259	$501,447	$141,589	$6,036,877	$6,076,278
Net Rev per Visit	$132	$84	$104	$109	$91	$120	$110
Net Rev per WRVU	$91	$65	$77	$74	$63	$84	$78
Net Rev per Provider	$34,536	$22,010	$33,099	$28,014	$19,942	$32,180	$32,338
Annualized Investment per Provider w/PBC	($106,213)	($200,195)	($265,717)	($130,066)	($284,335)		

"Please diagnose me with something covered by my health insurance."

"If you know how to beg, we have an opening in our Collections Department."

Your insurance only covered the removal of the damaged organ...you'll have to put the transplant in yourself!

Questions?

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Paramount Healthcare Solutions is a healthcare consulting firm focused on guiding physicians and clinics to advance and improve their reimbursement strategies, workflow processes and provider compensation methodologies in the emerging value-based environment for optimal cash realization, patient experience and overall bottom line to the organization.