Make Better Management Decisions Through Financial Data

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The Basis for Our Reimbursement

Understanding the Conversion Factor and MIPS impact on your revenue projections.
Knowing How You Are Paid

Virtually every payer contract in the practice is a function of the Relative Value System and related to Medicare reimbursement in some manner.

Payment terms are most often expressed

• As a percentage of the Medicare allowable
• As a conversion factor that is applied to the Medicare RVU system.
Brief Review of the RVU Structure

• The total Relative Value for each CPT has three components.
  • Physician Work
  • Practice Expense
  • Malpractice

• Those unit values are the same for the entire US.

• However, each of the 300+ regions of the U.S. has a set of geographic adjustment factors. These factors are multiplied times each of the three unit values to derive the total locally adjusted RVU.
Components

- The Relative Value Units for the CPT Code (RVUs)
  - Set by the AMAs RVS Update Committee (The RUC)
- The Geographic Practice Cost Indices (GPCI)
  - An Index exists for each of the three RVU Components.
  - Manhattan New York gets a PE CF of 1.175 and all of Kansas gets a .907 PE CF.
- The Conversion Factor (CF)
  - Congress establishes the annual Medicare Conversion Factor around which all carriers base their Conversion Factors
ANATOMY OF THE CODE
CATARACT *aka how we get paid*

<table>
<thead>
<tr>
<th></th>
<th>National</th>
<th>Portland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work Units</td>
<td>8.52</td>
<td>8.52</td>
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<tr>
<td>Work GPCI</td>
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<td>1.01</td>
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<tr>
<td><strong>Adjusted Work Units</strong></td>
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<td><strong>8.61</strong></td>
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<tr>
<td>Practice Expense Units</td>
<td>9.04</td>
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<tr>
<td>Practice Expense GPCI</td>
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<td>1.054</td>
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<tr>
<td><strong>Adjusted Practice Expense</strong></td>
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<td><strong>9.53</strong></td>
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<tr>
<td>Medical Malpractice Units</td>
<td>.60</td>
<td>.60</td>
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<tr>
<td>Medmal GPCI</td>
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<td>.783</td>
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<tr>
<td><strong>Adjusted Medmal Units</strong></td>
<td></td>
<td><strong>.47</strong></td>
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<tr>
<td><strong>Total Adjusted RVUs</strong></td>
<td><strong>18.16</strong></td>
<td><strong>18.61</strong></td>
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# How MIPS Works

<table>
<thead>
<tr>
<th>Description</th>
<th>Portland</th>
<th>MIPS Bonus</th>
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<tbody>
<tr>
<td>Total Adjusted RVUs</td>
<td>18.61</td>
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<tr>
<td>Medicare CF - 2019</td>
<td>$36.0391</td>
<td></td>
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<tr>
<td>Allowable</td>
<td>$670.44</td>
<td></td>
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<tr>
<td>Sequestration – 2% on Provider Portion</td>
<td>-$10.73</td>
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<tr>
<td>What We Get Paid</td>
<td>$659.71</td>
<td>$659.71</td>
</tr>
<tr>
<td>MIPS – Plus 1.88%</td>
<td></td>
<td>Only Applies to Fee For Service Medicare Patients</td>
</tr>
<tr>
<td>Payment</td>
<td></td>
<td>$669.79</td>
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</table>
How Will MIPS Work?

Payment Adjustments: MIPS, APMs

<table>
<thead>
<tr>
<th></th>
<th>2016-18</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2026</th>
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<tbody>
<tr>
<td>Fee Updates</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>MIPS (Merit-Based Incentive Payment System)</td>
<td>4%</td>
<td>5%</td>
<td>7%</td>
<td>9%</td>
<td>0.25 MIPS</td>
<td>0.75% APMs</td>
</tr>
<tr>
<td>APMs (Alternative payment models)</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>5% bonus stops after 2024</td>
</tr>
<tr>
<td>Additional Funding</td>
<td>Up to $500 million authorized every year for additional MIPS bonuses of up to 10% for exceptional performance (2019-2024) – minimum of .5% for eligible clinicians who score 70 or higher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Maximum for Ophthal 1.88%

Zero Sum Game

MIPS is a budget neutral program

AMERICAN ACADEMY OF OPHTHALMOLOGY
# Why Eye Codes Pay More Than E&M Codes

<table>
<thead>
<tr>
<th></th>
<th>99214</th>
<th>92014</th>
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<tbody>
<tr>
<td>Physician Work Units</td>
<td>1.50</td>
<td>1.42</td>
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<tr>
<td>Practice Expense Units</td>
<td>1.46</td>
<td>2.09</td>
</tr>
<tr>
<td>Med Malpractice Units</td>
<td>.10</td>
<td>.06</td>
</tr>
<tr>
<td>Total Unit Value</td>
<td>3.06</td>
<td>3.57</td>
</tr>
<tr>
<td>Conversion Factor – 2018</td>
<td>36.0391</td>
<td>36.0391</td>
</tr>
<tr>
<td>National CMS Allowable</td>
<td>$110.28</td>
<td>$128.66</td>
</tr>
</tbody>
</table>

*For demonstration only, not to infer that the two codes “cross walk” to each other.*
Where to Find the Values

Contract Offerings

Financial Points to Review
Evaluating New Contract Opportunities

• The Conversion Factor for 2019 is $36.04 or .13% greater than 2018 $35.99.

• All contract offerings should be reviewed for their relation to the $36. The carriers are by and large using the RVU system and relate their offerings to the CMS CF.

• Contracts should be reviewed within context of Financial Class - Medicare Advantage, Medicaid, Commercial, etc.
Evaluating New Contract Opportunities

• What year of RVU values are being used?

• Are the local GPCI factors being applied to the national RVUs? Are you winning or losing?

• What is the Conversion Factor?

• Are all providers paid the same Conversion Factor rate?

• Are there different Conversion Factors for different plans from the same carrier?

See Checklist in Materials
Making Data Driven Capital Decisions
Determining Incremental Revenue
Capital Purchase Considerations

The decision of when and how to update or add technology to the practice is a significant one. Most practices will make one or more capital purchases during the course of a year.

Planning for capital expenditures is equally (or even more) important as budgeting the operating expenses of the practice.
Consider Why You Are Purchasing

Will there be incremental revenue?

- To update diagnostic technology
- To add a revenue generating service
- To improve the patient experience
- To maintain EMR and billing infrastructure
**Analyze the Return on Investment**

<table>
<thead>
<tr>
<th>Example Return on Investment - OCT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Instrument Cost</strong></td>
<td>$61,000</td>
</tr>
<tr>
<td><strong>Other Costs:</strong></td>
<td></td>
</tr>
<tr>
<td>Shipping and Install</td>
<td>$2,000</td>
</tr>
<tr>
<td>Maintenance Fee for Four Years (first year is warrantied)</td>
<td>$14,000</td>
</tr>
<tr>
<td>Maintenance Fee for Three Years</td>
<td></td>
</tr>
<tr>
<td>Total Costs</td>
<td>$78,250</td>
</tr>
<tr>
<td>Assuming no other incremental costs</td>
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</tr>
<tr>
<td><strong>Useful Life</strong></td>
<td>5 years</td>
</tr>
<tr>
<td><strong>Annual Cost ($78,250/5 years)</strong></td>
<td>$15,650</td>
</tr>
<tr>
<td><strong>Your Expected Utilization</strong></td>
<td>40/month</td>
</tr>
<tr>
<td>92133 – 25 patients</td>
<td></td>
</tr>
<tr>
<td>92134 – 15 patients</td>
<td></td>
</tr>
<tr>
<td><strong>Payable by Medicare?</strong></td>
<td></td>
</tr>
<tr>
<td>92133 - $38.52</td>
<td></td>
</tr>
<tr>
<td>92134 - $42.28</td>
<td></td>
</tr>
<tr>
<td><strong>Resulting Annual Revenue</strong></td>
<td>$19,166</td>
</tr>
<tr>
<td>(300 * $38.52 plus 180 * $42.28)</td>
<td></td>
</tr>
<tr>
<td><strong>Return on Investment %</strong></td>
<td>22.46%</td>
</tr>
</tbody>
</table>

**Common Pitfalls**

- Shipping, install, table and training
- Fees to interface to the EMR
- “Incremental” staff costs
- Space is usually already available and not likely an incremental cost.
- Additional supplies
- Are you financing? If so, the interest is an additional cost.
- Are you purchasing the Service Agreement?

These Other Costs need to be added to the Annual Cost of the instrument.
Useful Life

Medical equipment may be depreciated for tax purposes in a variety of ways including straight-line over five years, accelerated in the early years or entirely written off in the year of acquisition. What is important for determining your ROI is not the tax treatment but rather how long the instrument will have value to your practice. For instance, do you anticipate you will use the new OCT for five years? If so, that is the useful life you should use for the ROI calculation.

<table>
<thead>
<tr>
<th>Hypothetical Return on Investment - OCT</th>
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<tbody>
<tr>
<td>Instrument Cost</td>
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<tr>
<td>Other Costs:</td>
</tr>
<tr>
<td>Shipping and Install</td>
</tr>
<tr>
<td>Maintenance Fee for Four Years</td>
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<tr>
<td>(first year is warranted)</td>
</tr>
<tr>
<td>EMR Interface</td>
</tr>
<tr>
<td>Total Costs</td>
</tr>
<tr>
<td>Assuming no other incremental costs</td>
</tr>
</tbody>
</table>

Useful Life
5 years
Annual Cost ($78,250/5 years) $15,650

Your Expected Utilization
92133 – 25 patients
92134 – 15 patients
40/month

Payable by Medicare?
If so what is the nat’l allowable?
Other payers may pay more or less.
92133 - $38.52
92134 - $42.28

Resulting Annual Revenue
(300 * $38.52 plus 180 * $42.28) $19,166

Return on Investment % 22.46%
The ROI for a diagnostic instrument is a lot easier to determine than say a FEMTO laser or a new office.

What kind of capital investments are you thinking about?
Avoid Purchasing in a Vacuum

Planning for the large expenditures you will need to make in the next one-to-two years will help you prioritize. For instance, it is possible that you would want to update/add a lane of equipment, need to replace a computer server and have a diagnostic instrument all in a short period of time.

Anticipating needs and grouping financing into one loan can save time and fees.

*This process will set you on the way to annual capital budgeting.*
Expansion Decisions

Data needed to assess the opportunity.
Key Data Points You Need to Make a Good Strategic Decision

• Current Patient Access
• Revenue per Encounter for an MD
• Revenue per Encounter for an OD
• Projected Additional Encounters
Assessing Current Access

• How much time passes between the making of new patient appointments and when they are seen?

• When is your third next available new/dilated patient appointment slot?

• Are you appointing your new patient referrals within 3 days and seeing them within 10 – 15 days?
Revenue per Encounter

Nearly all ophthalmic proceeds originate with an exam.

Yes there are exceptions.

Total Annual Revenue

Total Annual Encounters
Calculating Revenue per Encounter

**Include**
- Exams
- Testing
- Surgical services
- Contact lens fitting fees

**Do Not Include**
- ASC facility fees
- Optical shop or lab revenue
- Contact lens sales
- Injectable Retina Drugs
Calculating Encounters

- One code per patient visit (encounter).
- Do not include hospital or emergency room visits.
- Include complimentary visits (refractive surgery consults).

<table>
<thead>
<tr>
<th>New Patient Codes</th>
<th>Established Patient Codes</th>
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<tbody>
<tr>
<td>92002</td>
<td>92012</td>
</tr>
<tr>
<td>92004</td>
<td>92014</td>
</tr>
<tr>
<td>99201-99205</td>
<td>99211-99215</td>
</tr>
<tr>
<td>Consult Codes</td>
<td>Post-Op Code - 99024</td>
</tr>
<tr>
<td>99241-99245</td>
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</tbody>
</table>
Generic Numbers
What’s Your Number?

Revenue Per Encounter

MDs

$205

Revenue Per Encounter

ODs

$115
Projecting “New” Encounters

• Analyze the potential for new patients – Census.gov
  • Age and other demographics of the population
• Where are the competitors located?
• Where are the primary care referral sources located?
• How many of your patients come from that area now?
• Are you adding volume or just moving volume?
• Are you planning to hire a new MD/OD or both?
Crunching the Numbers

- How many days/week will the MD be there?
- How long will the ramp-up be?
- Average MD Receipts per Encounter – $205?
- Two days/week – 35 patients/day – 70 Encs times $205
- Average OD Receipts per Encounter – $115?
- 4.5 days/week – 25 patients/day – 112 Encs times $115
Things to Remember

• Ramp up time for volume and collections.
  • An all new location can take a year to have full schedules.
  • Receipts should start to come in within 45 days.
  • Receipts will be slower on a new MD but not as much if you have the credentialing done.

• Easy to understate the technology costs.

• What kind of diagnostic services are you providing?

• Will there be an Optical Shop?
Things to Remember

• Will there be an Optical Shop?
  • If so, anchor the space with an OD in office 4.5 days/week

• What technology will you offer?
  • Very much depends on the amount of MD/OD time to be scheduled in the space.

• Don’t forget to count all of those additional technology licenses, service agreements and interfaces in your cost projections.
Analyzing the Costs of Adding Services or Volume

• A significant portion of your Operating Costs are fixed and will not change should you decide to add appointment slots, purchase an instrument or add an OD.

• Estimate the number of services to be provided and their “relative value”

• Estimate the additional revenue from the services.
What is the incremental contribution of an MD or an OD?

• First, calculate breakeven

• Look at costs:
  • Salary, bonus, benefits, employer’s taxes
  • Extra staff time needed
  • Other costs (advertising, printing, signs, etc.)
  • Opportunity costs (less production by other providers)

• Then look at revenues needed to cover costs
  • Costs ÷ projected collections per patient encounter = breakeven number of patients needed
  • Example: Salary $250,000 + other costs of $50,000 = $300,000 ÷ $200 per patient = 1500 patients per year needed, ÷ 185 clinic days = 8.1 patients per day average. Do we have enough demand to provide 8+ patients a day?

• After breakeven, what is the incremental contribution?
  • Collections: $500,000
  • Costs: $300,000
  • Contribution: $200,000 Where does this money go?
New equipment – does it pay for itself?

- Calculate breakeven:
  - Fixed Costs:
    - Loan or lease payments
    - Annual maintenance
    - Opportunity costs
    - Other costs
  - Variable costs (procedure cards, tips)
  - Revenues
    - Reimbursement per use
  - Breakeven = Fixed costs ÷ (Reimbursement per use – variable costs per use)
    - $50,000 fixed costs ÷ ($60 reimb. - $10 use cost) = 1,000 uses per year to breakeven

- Project cash flow if we exceed breakeven
  - What if we have 1,500 uses?
    - 500 additional uses X $50 = $25,000 incremental cash flow

- What about equipment that doesn’t generate reimbursement?
Key Question

How do the top 10% of ophthalmology practices differ from typical practices?

Ranked 88* cataract/anterior segment/comprehensive ophthalmology practices by income per full time equivalent ophthalmologist in 2017. Used only figures for clinical practice — no optical or ASC income was included.

*Data taken from 2018 AAO/AAOE Benchmarking Survey
Benchmark Process

- Identified the top 10% of practices and calculated the median results for this group.
- Identified the practices from 25-75% and the median of their results.
- Identified the bottom 25% of practices and median results from this group.
- Compared each of these three groups to identify differences and what we can learn.
Percentiles

Top 10%  25th-75th Percentiles  Bottom 25%

90th   70th   50th   30th   10th

Median = midpoint of the range
Income per Full Time Equivalent Ophthalmologist

- Top 10th: $1,296,991
- 25th-75th: $458,653
- Bottom 25th: $213,658

Total MD income ÷ # FTE MDs
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<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>$22,299,212.07</td>
<td>$11,357,639</td>
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<tr>
<td></td>
<td>$11,680,140.34</td>
<td>$7,796,015</td>
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<td>$44,273,740.80</td>
<td>$34,215,513</td>
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<tr>
<td></td>
<td>$22,031,789.50</td>
<td>$16,307,391</td>
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</table>

What???
Overhead ratio must be lower?

Total operating expenses ÷ total collections

- Top 10th: 52%
- 25th-75th: 58%
- Bottom 25th: 67%

Total operating expenses ÷ total collections
And a smaller proportion of their collections goes to pay staff, right?

Total fully burdened non-provider staff costs ÷ total collections
So, the top tier practices get by with fewer staff members per doctor?

<table>
<thead>
<tr>
<th>Tier</th>
<th>FTE Non-Provider Staff ÷ Total FTE MDs and ODs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 10th</td>
<td>5.67</td>
</tr>
<tr>
<td>25th-75th</td>
<td>5.33</td>
</tr>
<tr>
<td>Bottom 25th</td>
<td>4.44</td>
</tr>
</tbody>
</table>

Total FTE non-provider staff ÷ total FTE MDs and ODs
Well, if they have more staff – they must pay them less, right?

<table>
<thead>
<tr>
<th>Quartile</th>
<th>Average Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 10th</td>
<td>$49,073</td>
</tr>
<tr>
<td>25th-75th</td>
<td>$45,176</td>
</tr>
<tr>
<td>Bottom 25th</td>
<td>$42,613</td>
</tr>
</tbody>
</table>

Total non-provider staff gross payroll ÷ total FTE non-provider staff.
Then they must have more MDs to split the overhead between?
So, what is the key difference?

Top 10th: $1,625,059
25th-75th: $950,512
Bottom 25th: $482,933

Total professional collections ÷ total FTE MDs
How do those doctors produce so much?

Top 10th: 5,264
25th-75th: 5,023
Bottom 25th: 3,607

Total MD encounters ÷ total FTE MDs (Encounters are exams)
How do those doctors produce so much?

Total MD collections ÷ total MD encounters
Their high production means very efficient use of staff

Total collections ÷ total FTE non-provider staff
What is the Secret Sauce of Top Tier Practices?

- High patient demand for services
- Highly productive doctors
- Patient flow spread over fewer doctors
- Sufficient quantity and quality of staff to allow the doctors to be productive
- Focus on profitable activities