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Assessing the Financial Health of Your Dermatology Practice

Most dermatologists entering into private practice give little thought to the fact that they will be managing a business; not only managing a business, but operating it in the most regulated industry in the world. Those doctors already in practice may or may not have acquired the knowledge and skill of successful business owners. Many doctors take for granted that if they do well for their patients, the patients will send them enough money so that even if they do not have a clue about debits and credits, they will still earn a substantially better-than-average living. Much of the time this laissez faire approach works out, but it is most certainly not assured. And it certainly does not get the best results for the doctor's efforts. The better course is to take charge of your business and bend your efforts to make the business a success. Superlative clinical care puts the soap in the box, so to speak, but the box very often is what attracts the sale. The quality of care only guarantees the re-sale or, in the dermatologist's case, the return visit.

Assess, Then Plan

It behooves dermatologists to pay close attention to their business. Paying attention to your practice's fiscal health means more than firefighting day-to-day problems, such as being sure you get paid and that there is enough money in the account to cover payroll. It involves planning. Dealing with day-to-day concerns may keep the practice on an even course, so long as there are no major bumps in the road. But sudden changes in reimbursement, shortages of skilled staff or the inability to acquire expensive new technology can turn an unprepared practice on its ear.

Actual planning yields great dividends. In one halcyon client situation, the practice's gross income has increased by a compound average growth rate of over 20% from 1986 through 2000. This result was principally due to diligent planning and investment in the practice. Planning lets you make progress. And make no mistake, it can be hard work, certainly more difficult than patient care.

When a dermatologist tracks charges or collections or overhead, all that is being attended to is seeing that things do not get out of line. When they do, the doctor or manager makes adjustments. This essentially amounts to maintaining the status quo. However, any look at "real" businesses shows that maintaining the status quo is not enough. New York Stock Exchange traded companies do not earn high two and three digit price-to-earnings ratios for maintaining the status quo; they earn those valuations for growth prospects, both real and perceived. While you likely are not aspiring to be the next hot initial public offering, there is great value in running a practice on sound business principles and that includes looking for growth opportunities.

Many practices today benefit from sophisticated office managers. These are the people who should largely be putting out the day-to-day fires. This frees up the physician to act as an executive and engage in serious financial and management planning. And there are new tools readily available to help both managers and doctor-executives deal with those business responsibilities. Certainly, the relational databases in the newer medical practice management and electronic medical record computer packages provide data and resources that have not been available heretofore.

Knowing What You Can Know

Unfortunately, most medical practice computer systems are used to perhaps 40% of their capacity. In recent client situations, we encountered practices that could not produce zip code analyses of their patient base, productivity reports by provider or referrals by referring source. In each case, the information was in the computer, but practice personnel had never taken the time to learn how to use many features of their system; and, more to the point, the managing doctors had never insisted on it.

So, the first step in assessing your practice's financial status is to find out what you can know. Review your computer software operations manuals to see what information is available, either in standard reports or by special requests. Only when you know what is available, can you decide what is actually important enough to look at.

Do not settle for reports that are pages long "because that's how the system prints them." Instruct your staff to reduce the reams of paper to relatively short reports that give you the essential data. If you want to examine the details, you can always do so; but the important thing is not to get lost in too much information.

After learning what you can know, decide what you want to know. Essentially that is how and why does your practice function the way it does and produce the results that it does. What sources or patients produce how much and what kind of business for the practice? What services add to profitability? Which practice locations contribute how much patient traffic?

Analytical Tools

A solo dermatologist's practice may not seem very complicated, but there is much more to it than meets the eye. Add a second, third or more doctors or non-physician providers and the complexity increases dramatically. So, in addition to having the proper data, physician managers will need to arm themselves by understanding the tools available and how to use them.

Accounting

Unfortunately, and without meaning to make your eyes glaze over, this requires that we discuss accounting. And worse, we must discuss cash basis accounting versus accrual accounting.

Before the 1980s, many practitioners thought that if they ended the year with more money in their bank account than they had at the start of the year, they had done well. In actuality, those doctors didn't know how well they had done.

Consider this example: Suppose you pay yourself \$10,000 more this year than last and ended the year with the same amount in the practice's checking account. How is your business doing? Better? Not necessarily. What if accounts payable, that is what you owe vendors, increased by the same \$10,000? Then you are behind the eight ball. You incurred roughly an additional \$4,000 in personal income tax to pay yourself a net of \$6,000, and you still owe \$10,000 to your vendors! This scenario is easily possible given the expense of Botox® and other drugs routinely used in dermatology practices. A similar result can happen if you pay yourself a year-end bonus on December 31 but staff payroll is due on January 3.

Then consider this example: Suppose you pay yourself \$10,000 more this year than last and your payables haven't changed. Do you have a more valuable business? Not if your accounts receivable have shrunk by \$10,000 or more.

The point is that cash basis (really, federal income tax cash basis) accounting doesn't give you a proper view of the practice's finances. Accrual accounting takes into account the credit functions of the business. Your overall financial condition can change significantly based on those credit functions—what people owe you and what you owe others.

Virtually every private medical practice reports its taxes on a cash basis. And that is the way it should be. But for financial planning, you should consider whether the cash basis numbers are good enough or whether you should convert those numbers to at least estimated accrual basis figures. The more complicated your practice, the greater the need.

Converting from Cash to Accrual

Converting from cash basis to an estimated accrual basis is relatively simple. The following steps will get you in the ballpark with requiring an accountant's green eye shade:

On the balance sheet:

Add collectible accounts receivable to the assets.

Add prepaid malpractice insurance to the assets (if you paid malpractice for the full year in January and it is July, you have an asset equal to half the malpractice premium).

Add accounts payable to the liabilities.

Add earned, but unpaid, salaries to the liabilities.

On the income statement, accrual accounting assumes you have income when your legal right to that income matures (i.e., when you deliver the service rather than when you get paid) and you have an expense when you incur the liability, not when you pay the bill.

Add collectible accounts receivable as of the date of the income statement to year-to-date cash collections and subtract collectible accounts receivable as of the beginning of the year.

Include in expenses unpaid bills and earned, but unpaid, salaries.

When would you ever want to use accrual basis numbers? Whenever you are dealing with a bank. Banks, by and large, do not understand medical practices, and they do not understand cash basis accounting. They look at the cash basis balance sheet, and there is no equity. So doctors (and their spouses) invariably end up personally guaranteeing practice debt; yet, with enough equity in receivables, it doesn't have to be that way.

You also should use accrual accounting for internal financial reporting purposes if you are in a large practice. This is appropriate to accurately measure various financial ratios that help assess practice financial health, such as your debt-to-equity ratio and your current ratio.

Full Absorption Accounting Versus Incremental Cost

A goodly number of California practices got into fiscal hot water in the middle 1990s because they took on capitated contracts on an incremental cost analysis. They assumed that since their basic practice paid the rent, malpractice and staff, any additional income from the new contract would fall almost directly to the bottom line. But that is not the way medical practice overhead works!

Those doctors were correct in thinking that very little overhead varies directly with patient volume. They were incorrect in thinking that any overhead that was not variable was fixed. In reality, there is very little fixed overhead. Instead, the bulk of the costs are semi-fixed or "stepped." When you build a medical practice, that practice has constraints; the system can only serve a limited number of patients before you must increase the size of the system—by adding more personnel, equipment or space.

So, suppose you are deciding on a compensation arrangement for a new doctor joining your practice. If you want to pay based upon a percentage of collections, with rare exceptions, you should not use an incremental overhead analysis. The new doctor will need all the resources that you do. On the other hand, if you are structuring an incentive arrangement over a base salary, you might want to use an incremental analysis once you have all the additional base costs covered.

Fixed overhead does not vary with the level of activity in the practice. For example, malpractice insurance premiums are the same regardless of the number of patients seen. Variable overhead changes with the amount of patient activity. Typically, for example, the cost for clinical supplies rises and falls in lockstep with the number of patient office encounters.

Budgets

Budgets are a financial plan. Your practice should have two—an operating budget and a capital budget. Operating budgets are your plan for income and expense in an upcoming year or years. During the year, you measure actual results against budgeted results. If actual results are different from budget, that is not necessarily bad. If the difference is significant (positive or negative), you simply want to know why. Good results can then be repeated and poor results avoided.

There are two ways to develop an operating budget—incremental forecasting and zero based budgeting. You should use both. With incremental forecasting, last year's actual results become the budget once they are modified for known changes like reimbursement changes, increased rent or changes in health insurance premiums.

This works fine, but every third or fourth year it pays to develop a budget from the ground up—zero based budgeting. With this approach, each income and expense category is broken down to its component parts and justified from zero to the desired expenditure amount. This more rigorous methodology lets the practice manager spot anomalies in the practice's finances, such as costs that haven't been shopped recently, expenses that can be reduced with new technology or irrational variations in income streams.

Be sure to budget physician salary and other doctor compensation items. If you do not include these "costs," you cannot measure whether the practice is performing at better or worse-than-expected levels.

Capital budgets are a different animal. Every dermatology practice should know that its hardware, software, telephone system, lasers, reception area furniture and whatnot will need replacement. A capital budget lets the practice plan for these expenditures over several years in the future. The idea should be to allow no surprises in the required outlays, while maintaining steady free cash flow for the physician-owners.

Chart of Accounts

Your chart of accounts is a list of the categories for classifying income, expenses, assets and liabilities in your general ledger and, ultimately, for your financial statements. How these classifications have been set by you or your accountant will determine what information is available on the financial statements.

If you have one general category called "salaries," you won't have a clue whether you are over- or under-paying staff. If you have one category for insurance, you won't be able to easily see the change in malpractice costs versus health insurance costs versus business insurance. Carefully evaluate what you want to know and establish your chart of accounts accordingly.

Avoid common mistakes in establishing a chart of accounts:

Segregate staff, non-physician provider, non-owner physician and physician-owner costs including wages, retirement contributions and fringe benefit costs.

Track reimbursed business expenses, such as CME or auto expenses in sub-accounts by physician or provider.

Segregate insurance costs into malpractice, general business and fringe benefit costs.

Segregate supplies into office supplies and clinical supplies. For very expensive clinical supplies consider using sub-categories.

Use sub-accounts for different offices, providers or lines of business depending on what you want to track.

Be certain to treat patient refunds as a revenue reduction rather than an expense. Similarly cost of goods sold (e.g. cosmetics) should be treated differently depending on the purpose: for productivity measurement, cost of goods sold (CGS) reduces collections; for comparison to industry averages, CGS is a clinical supply cost.

Comparison to the Averages

It is difficult to assess practice results in a vacuum. And even benchmarking techniques to compare results against industry averages leave a lot to be desired. In dermatology, there is an unusually wide degree of variation in clinical work hours, mix of medical versus cosmetic services, invested capital (in high-end equipment) and other variations.

Nonetheless, at least once a year, you should compare your practice results with industry averages and with your own results from prior years. As with actual results compared to budget, the idea is not that a variation from industry is bad or wrong. It is a question of knowing where your results differ from the norm and deciding whether or not that is acceptable. For example, we dealt with a practice recently where the sole owner preferred to pay his staff at about twice the going rate. The decision was conscious and essentially boiled down to the way the doctor preferred to spend his money. On the face of things, there is absolutely nothing wrong with that since he knew what he was doing and how that made his results different from the peer group. Interestingly though, it did cause a new associate to leave the practice, since the associate (bonused on increased net income) was not so interested in supporting the staff fair-market pay.

How Does Your Practice Match Up?

| | Dermatology Industry (4 Physician) | Your Results |
|----------------|---------------------------------------|--------------|
| Gross Charges | \$4,825,020 | |
| Receipts | \$3,623,672 | |
| Staff Salaries | \$ 649,224 | |
| Rent | \$ 165,684 | |
| Taxes | \$ 100,168 | |
| Total Expenses | \$1,725,100 | |
| Net Profit | \$1,898,572 | |

*Data from the Society of Medical-Dental Consultants and the National Association of Healthcare Business Consultants

Financial Monitoring

Financial monitoring is just that, monitoring. As managing physician, you should get a summary each week and reports each month that tell you where the practice stands and allows you to make decisions on the short-term needs of the practice. Generally, it is a good idea to get your weekly report on Friday. That way, you can spend the weekend sorting out any really serious problems that may crop up.

Weekly Monitoring

Quick Ratio: Target ratio is 1.5. This ratio measures the practice's ability to pay its obligations as they become due.

$$\frac{\text{Cash + Collectible Accounts Receivable}}{\text{Current Liabilities (including payroll due in one month and loan payments due within 12 months)}}$$

Cash On Hand: Target is 1.5 months' expenses; when changes are planned (e.g., conversion to a new computer system, increase to 3.5 months' expenses).

Work Output Trendline: Target is practice specific, measured versus budget and by provider. Measure patient charges or, preferably, relative value unit-based patient charges for the week, four-week moving average and year to date—all versus budget.

Overall Days' Charges in Accounts Receivable: Target is 45 days (which, when compared with other industries, is not all that good. Physician industry average is greater than 60). Report the last four data on a four-week moving average basis to spot positive or negative trends. So, if today is May 14, the four-week moving averages for 4/23, 4/30, 5/7 and 5/14 would be reported. The moving average helps smooth out variations due to vacations and other normal absences. The formula is:

$$\frac{\text{Accounts Receivable}}{\text{Annual Charges}/365}$$

What else? Clinical hours by provider? Patient encounters? Staff overtime?

Whether you monitor a practice indicator weekly, monthly, quarterly or yearly depends on how critical the indicator is and how susceptible to change it is. Also, remember that a picture is worth a thousand words. Whenever possible, have your staff graph the data; trends and exceptions are more quickly and easily identified and give a sense of proportion when displayed pictorially.

Another issue is timeliness of the reporting. Weekly reports should be essentially up to the minute or, at worst, as of the previous day. Monthly reports should certainly be within 10 days of the close of the period. Waiting for a financial report that comes in three months after the fact destroys the urgency of a bad situation and inhibits change for the better. Also remember that what you measure will drive results. The mere fact that you are looking at some measure frequently improves performance when your staff understands what you are measuring and watching.

Monthly Reporting

Profit and Loss Statement (Income Statement): Income and expense measured against budget and/or prior year to date. Consider income/expense breakdowns by location and income breakdowns by provider and line of service (cosmetics, MOHS, general medical, etc). Expense variances should be measured in absolute dollars and as a percentage of revenues.

Days' Charges in Accounts Receivable by Payer: Reports should include the last six months' data. Watch for negative trends; an increasing number of days' charges outstanding may suggest financial difficulty at the payer end—and time to bail out from that contract.

Aged Accounts Receivable: How old are your receivables versus industry standards? According to industry reports, here is the average breakdown:

| | |
|-------------|-----|
| 0-30 days | 44% |
| 31-60 days | 17% |
| 61-90 days | 9% |
| 91-120 days | 6% |
| >120 days | 24% |

Note that this average is not healthy and that most industries measure >90 days as the cut-off point.

Collection Ratios:

Gross Collection Ratio: Target 75% in most markets

YTD collections/YTD charges

This measure is mostly meaningless except as an internal benchmarking. It loses its touchstone each time fees are changed.

Net Collection Ratio: Target 95+%

Patients by Source: If referrals from a particular referring doctor fall off dramatically, you know something is wrong and should likely address it proactively. Similarly, if a new dermatologist opens practice and you see referrals decline, extra attention might be bestowed to repatriate the referrer who is testing new waters. But you only know these things if you are measuring them! Monthly statistics compared with prior year or prior year-to-date figures work best.

While weekly and monthly reporting is fairly standard, other reports are less standard. Some practices choose to monitor a different item each month so that the financial indicator gets looked at once a year at a minimum. Other practices prefer quarterly reporting.

Many practices are sensitive to this data, but they do not measure it. The objective is to measure by fact, not by gut instinct. Too often gut instinct is wrong. In performing practice operational evaluations, we often ask the owner-doctors about cachement area, patient-base socio-economic status and similar questions. It is not unusual to receive responses that differ by more than 100%. The doctors don't know—they are just guessing!

Periodic or Quarterly Reporting

Numbers of New Patients: Target 20% of all patient visits at a minimum. Measure by location, provider, payer, service or diagnosis. Use trending analysis.

Patient Service: Number of no-shows; next available new and established patient appointment by provider; patient complaints (by provider).

Yields: Generally the number of bellwether events over the number of patient visits that can generate the event, e.g., surgical procedures/visits.

Work Effort: On average _____ RVUs per Dermatologist.

Critical Measures

Some financial measures are more critical than others, although in most cases they do not change dramatically very often. Still, they are worth looking at every year.

Debt-to-Equity Ratio: While too many doctors inappropriately avoid debt financing, a few go overboard. About the maximum safe debt-to-equity ratio (measured on an accrual basis) is one to one. For a growing practice, a debt-to-equity ratio of .5 to 1 is certainly comfortable.

Revenues to Net Equipment: Measured on an accrual basis; target "best" year's result. This measure can spot the slacking off of enthusiasm for a particular modality, inappropriate redistribution of work leading to lower productivity and, on the other extreme, failure to reinvest in newer equipment.

Revenues to Working Capital (Accrual Basis): As your practice expands, you need more grease to oil the machine:

$$\frac{\text{Revenues}}{\text{Current Assets minus Current Liabilities}}$$

Current assets are cash, receivables, prepaid expenses and other assets that will turn into cash or another current benefit within a year. Current liabilities are those liabilities that are currently owed and payable within a year.

E&M Visit Distribution: Coding obviously depends on what you do, what you document and what you check off on the encounter form. Still, matching up against the benchmarks should lead you to ask, "If we are different, why are we different?"

| | | |
|-------|-------|-------|
| 99201 | 99211 | 99241 |
| 99202 | 99212 | 99242 |
| 99203 | 99213 | 99243 |
| 99204 | 99214 | 99244 |
| 99205 | 99215 | 99245 |

Take this data with a moderate grain of salt: it is based on Medicare patients only and recognize that certified coders disagree at least 56% of the time on proper E&M coding.

Payer Mix: Evaluate collections by payer versus the RVUs generated by the payers' patients and versus the number of a payer's subscribers.

Market Share: How many of your patients are insured by a particular insurer? How many of that insurer's subscribers are your patients? Market share often determines the balance of power in contract negotiations. And, yes, you *can* negotiate (if you know how)!

Conclusion:

There are certainly measures that can be important to your practice other than those detailed here. The basic idea—which is a key to success—is to measure and manage your business based upon facts, rather than feeling. The corollary to that axiom is to get data timely so that actual problems can be fixed before they become part of your practice's culture.

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