



FINANCIAL MANAGEMENT SERIES

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Operational Budgeting for Community Health Centers

Developing the annual budget is one of the most important activities a community health center undertakes. The preparation of the budget allows the health center to assess current year performance, identify major trends, and determine how trends will play out in the coming budget year and the impact of trends on the health center.

This Information Bulletin examines preparation of the budget and:

- ◆ Clarifies the budget preparation process.
- ◆ Identifies data that should be collected to develop an accurate budget.

STEP 1: REVIEW HISTORICAL INFORMATION

In order to determine where the health center is going, it's important to understand where you've been. Thus, the basis for the budget should be historical data in addition to current year information. Key factors that a health center should review are:

- ◆ Staffing
- ◆ Provider Productivity
- ◆ Payor Mix

Staffing

Health centers should review current full time equivalent (FTE) positions and salaries, as well as planned changes in staffing. In reviewing historical staff costs, it is very important to understand the impact of the employee vacancy rate in the historical period. Keep in mind that vacancies among providers have an impact on both costs and revenues.

Provider Productivity

Understanding the number of visits per FTE allows the health center to

assess if the center is at capacity, or if additional visits can be added to the projections without adding to provider FTEs. If productivity in the historical period was lower than expected, it is necessary to understand the causes of the low productivity before projecting higher productivity in the budget.

Provider	Type	FTE	Annual Visits
Jones	MD	1.0	3,950
Smith	MD	.8	3,000
Hawkins	NP	1.0	2,470
West	CSW	1.0	1,950
Total			11,470

Payor Mix

Medicaid typically pays substantially higher amounts per visit than other payors. In addition, Medicare reimbursement per visit is typically higher than that from commercial or self-pay patients. Thus even a small shift in visit payor mix will have a large impact on the health center's revenue. Understanding what is driving the payor mix, and what short and long term trends are in effect, is essential to accurately projecting revenue going forward.

While understanding total visits is important, keep in mind that for revenue calculation purposes, visits will need to be divided among payor categories and by visit type (e.g. the clinical social worker visits may be reimbursed at a different rate than the physician visits for some payors).

Another key consideration is the number of capitated visits. While the health center revenue will be the same regardless of the number of capitated visits, it is important to allocate visits to the capitated payor class, so that the visits are not double-counted for one of the fee-for-service payor classes.

to calculate is net revenue per visit after allowance for doubtful accounts. This number is calculated by payor, by type of service, by looking at prior year net revenue (*i.e.* gross charges minus contractual allowances), adjusted for adjusted for bad debt (which is a cash item, the accrual name for this is allowance for doubtful accounts). Year over year changes in net revenue per visit should be made for expected changes in reimbursement, such as MEI for Medicaid PPS visits, the new Medicare rate for Medicare FQHC visits, and changes to contracts/fee schedules for commercial payors.

STEP 2: DEVELOP VISIT ASSUMPTIONS

The number of visits performed by the health center will drive both revenue and expense. The visit projection links directly to provider staffing and productivity. The biggest mistake that health centers make in projecting visits is to show year over year increases in visits/productivity, without corresponding changes to health center operations. Visits should be projected by provider, to ensure that productivity makes sense, and that they are categorized into the right type. A sample visit report might look like:

STEP 3: REVENUE PROJECTIONS

Net Revenue per Visit

Once visits, payor mix and type of visit are calculated, the next key consideration is reimbursement rates. Each payor may have a different set of rates for medical, dental, mental health, and other types of visits; therefore it is necessary to break down your revenue projections at this level. The key number

Gross Charges

The next step is to calculate gross charges. The health center should adjust prior year gross charges per visit for any changes in the fee schedule. Since the Code of Federal Regulations (CFR) dictates that you should charge patients the same amount regardless of payor class, use the same charge per visit for all payors unless you can document differences in levels of service amongst payors. In addition, a good health center financial practice is that charges should at least approximate your costs.

Gross Charges to Net Revenues

Next calculate the difference between gross charges and net revenue. If your charges are based on cost, this calculation will show the health center's revenue shortfall on commercial contracts. For self-pay and Medicaid patients, this will approximate total sliding fee/Medicaid disallowances, which are used to calculate a key Bureau of Primary Health Care uses to measure 330 grant performance (ratio of uncompensated care to BPHC receipts).

Allowance for Doubtful Accounts

The next step is to calculate allowance for doubtful accounts. A well run community health center Finance Department should be reconciling accounts receivable from its practice management system and general ledger at least annually (and many health centers reconcile it as frequently as monthly). Doing so produces a bad debt percentage (bad debt writeoffs divided by prior period revenue) which can be applied to revenue projections.

Grants, Contracts, Miscellaneous Revenue, and Interest Income

These items should be budgeted conservatively – *i.e.*, if the current grant or contract expires in the projection period, is it going to be renewed? If the answer is yes, it is fiscally prudent to budget it at current year amounts. Also, do not

budget new grants and contracts until they have actually been approved, otherwise you may find yourself needing to make up these shortfalls in other areas.

STEP 4: EXPENSE PROJECTIONS

Compared to revenue budgeting, a health center should be more certain of expenses, since you have a greater level of control over these items. In addition, due the large number of fixed staff and fixed costs, expenses may be less volatile than visits and revenue.

Recognizing the largely fixed nature of expenses, it is probably best to budget expenses using two approaches: a bottom up approach for staffing expenses, and an incremental approach for other than personnel services (OTPS) expenses.

The staffing budget should be based on actual salaries and FTEs. The basis for staffing FTEs should be your current employee roster (in order to determine each individual's FTE it may be necessary to capture historical data, as the level of usage of part-time employees may vary from month-to-month). While it is appropriate to include currently vacant positions in the next year's budget, the budget should also include a vacancy factor to account for positions that are unfilled over the course of the year. This vacancy factor should be based on historical experience. Lastly, the provider FTEs for expenses should equal the provider FTEs for visits.

For many health centers, fringe benefits are the second largest expense after salaries. Since certain fringe benefit expenses are capped or fixed per FTE (such as Medicare payroll tax or health insurance premium costs), some health centers calculate two fringe benefit rates – one for providers (who are more highly compensated than other employees), and one for all other employees. Health insurance costs have been rising rapidly, so the fringe rate in the budget should include any changes to health benefit expenses.

While there are more line items for OTPS expenses, typically they account for only 25 – 35% of a health center's budget. Therefore, they do not need to be budgeted at the same level of detail as compensation expenses. Different approaches may be appropriate for different OTPS line items, as follows:

- ◆ Contracts or schedules: certain expenses – rent, interest, depreciation, maintenance contracts, etc. – may be on a fixed schedule that allows for easy projection of actual expenses.
- ◆ Incremental: involves starting with current year expenses, and then adding incremental costs. These incremental costs could include trending for inflation, adding on known marginal expenses, or specific add on units.
- ◆ Per unit: involves calculating expenses on a per unit basis, such as:

Per visit

Per square foot

Per FTE

STEP 5: RECONCILE TO WHOLE

After developing the revenues and expenses, you will be able to calculate the health center's bottom line. The first question to ask is: Does this bottom line make sense? If a health center that is breaking even in the current year is projected to make or lose \$1 million next year, it's important to determine what is driving this huge swing in financial performance. Remember that in creating a budget you are making multiple assumptions, and the cumulative weight of overly optimistic or pessimistic assumptions will lead to projection results that may not be realistic.

Health centers should also project out their balance sheet and cash

flow. This exercise would include measuring the impact of proposed capital expenditures, as well as special efforts such as paying off debt, or reducing patient accounts receivable. If the health center has ambitious plans to expand, it should first ensure, through the financial projections, that it will have sufficient cash throughout the year. Many health centers are also recognizing the need to build financial reserves, and are determining in the budgeting process what steps need to be taken to achieve better than breakeven results.

STEP 6: MONITORING TOOLS

Budgeting should not be seen as a fixed, one-time activity that gets for-

gotten over the course of the year. It's very important to measure actual health center performance against the budget. Variances against budget will show where management's expectations have not come to pass, which will both give advance warning of potential problems, as well as a clear indication that it may be time to change plans, even to do a revised budget. Many organizations create a 4+8 budget that combines the first four months of actual results, with a re-projected eight months. This exercise will give the health center a much better picture of how it will end up the year, by showing the impact of current trends as well as changes to the annual plan.

The budget creates a guideline for setting priorities at the beginning of the year and maintaining those priorities throughout the year.



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