TAKING SERVICE LINE P&L'S TO THE NEXT LEVEL

Anne Farmer, Vice President

For most healthcare organizations that have a Decision Support system, one of the initial objectives for the system was service line profitability reporting. However, not all would say that their system has completely fulfilled this promise. Despite the fact that a large number of healthcare organizations have invested considerable amounts of time and expense in implementing Decision Support systems, many still do not have the capability to produce service line profitability reports in a timely manner. In some facilities, service line P&L's are in fact being produced from the Decision Support system (DSS), but there is reluctance to make any critical decisions based on the analysis, due to concerns about the accuracy of the data. Another common scenario is one in which the DSS is being used for only a part of the analysis, with other calculations done offline because a number of factors have not been incorporated in the DSS model. Whether the obstacle is timeliness or inaccuracy, there can be several reasons for the holdup:

- Previous efforts at rolling out service line reports may have resulted in skepticism about the accuracy and some difficult questions from service line and department managers. (What about teaching costs? What about GME payments? Does my department get credit for bad debt recoveries?)

- The financial management team may not have a comfort level with net revenue calculations from the contract management module, and thus is not ready to use net revenue from DSS in a profit/loss analysis.

- The cost accounting data is not maintained as it needs to be, due to a lack of resources, or to the fact that cost accounting is part of another department such as Budgeting, where it takes a back-seat during a good portion of the year.

- There are too many caveats to the cost accounting and net revenue information.

- An audit process is not in place to verify the cost and net revenue data on an ongoing basis.

There is a need in many healthcare organizations to enhance the accuracy of service line reporting, so that the output is credible as well as timely. Top-level allocations using arbitrary statistics will not produce accurate information for decision-making. Increasingly, organizations are now focusing on achieving accuracy of cost and net revenue information at the patient and service line level, and are taking the extra steps to ensure this accuracy.

COST ACCOUNTING CONSIDERATIONS

There are several strategies that will improve the accuracy and timeliness of cost information as part of service line profitability analysis.

Assigning direct costs to service lines: The accuracy of direct costs by service line is, of course, dependent on the cost accounting standards in place. Are RCC's (ratios of cost to charge) being used to assign costs to the charge code (i.e. service item) level, or has

the organization gone through a process of collecting cost accounting data from the clinical and department managers? The necessary resources should be in place to ensure that the cost standards are kept up-to-date. Wherever feasible, automated interfaces should be developed: For example, costs of O.R. supplies as well as drugs can be updated on a monthly basis if these interfaces are in place.

Patient-specific costing: Although charge codes have been the traditional intermediate product in a cost accounting system, and the means of assigning direct costs to the patient level, some organizations are supplementing their cost accounting systems with additional data, at the patient level, to enhance the accuracy of cost information. Examples would include:

- Operating Room: Bringing in data from an O.R. system to provide detailed staffing information for each surgery, as well as supplies used (non-chargeable as well as chargeable supplies).

- Nursing: Integrating acuity or nursing intervention data to assign nursing costs to the patient level, and thus reflect patient-to-patient variability.

- Transitional Care/Subacute Unit: Using RUG's levels to assign TCU nursing costs to patients based on an assessment of acuity.

- Maternity: Calculating laboring minutes to assign costs of the Maternity department to moms based on actual times (vs. the single charge code for a "normal delivery", which assigns one flat cost to all deliveries, based on an average delivery time).

The common thread among these costing strategies is that they represent patient-specific costing efforts and will enhance the accuracy of cost information at the patient and service line level.

Move costs from indirect to direct: Certain costs that directly support clinical departments, but happen to flow through non-revenue producing departments, should be considered part of the direct cost of a service line. Examples would include: Radiology Support (transcriptionists, file clerks, etc.), Lab Information Systems, and Clinical Administration departments such as Psych Admin or Cardiac Admin.

Letting these costs flow through the cost model as overhead would result in a misrepresentation of the direct costs (and hence contribution margin) of service lines.

In addition, there may be other costs that are expensed to overhead cost centers, but in fact should be treated as direct costs. These would include:

- Major movable equipment depreciation
- FICA and other benefits
- Teaching costs (the portion of intern/resident/faculty time that is patient care, vs. admin or educational)

"Assign" overhead costs – vs. "allocate" : Although activity-based costing (ABC) has not taken off in healthcare as it did in other industries in the 1990's, healthcare has borrowed some of the ABC concepts over the past several years. Healthcare organizations have

made an effort in their costing systems to move away from top-down, arbitrary allocations of overhead costs, and towards a more accurate assignment of overhead costs to the appropriate departments. This means that additional data may be necessary to supplement the Medicare cost report statistics. An example might be the Safety and Security department: If 25% of security officers' time is spent patrolling the Emergency Department, this should be reflected in the assignment of this cost across departments (vs. allocating Security on the basis of square footage).

Another aspect of activity-based costing is assigning overhead and fixed costs more accurately to the patient and service line level. Organizations should review their methods of assigning overhead and fixed costs to service items. If the allocation is based on charges, then the big-ticket supplies and drugs are picking up a disproportionate amount of this cost. Some organizations have made a point of revising the allocation of overhead and fixed costs so that it is allocated only to procedures and not to service items that are chargeable supplies or purchased services.

Program-specific costs: Certain costs may relate to a particular program and, in theory, should be directed to a specific set of patients or service line. Examples would include a Diabetes Education department, to be directed to diabetic patients, and Organ Acquisition costs, to be assigned directly to organ transplant cases. Even if a separate revenue department, with its own billing codes, has not been set up, there are methods within DSS to assign these costs to the appropriate patients.

NET REVENUE CONSIDERATIONS

Contract management systems: A comprehensive Decision Support system includes a contract management module that will calculate net revenue (i.e. expected payment). On the other hand, some healthcare organizations have opted for contract management systems that are not part of the DSS, but rather are a supplemental system to the patient accounting system. If this is the case, the data from these contract management systems should nonetheless be brought into DSS, to enable profit/loss reporting in DSS.

Reconciling net revenue: When contract management systems were first introduced by DSS vendors several years ago, even the vendors acknowledged that the net revenue calculations would not be 100%. Software companies instructed DSS users to aim for a 90% level of accuracy. What makes up the other 10%? Some of this variance is due to denials, coding errors, and other issues that may not have any viable work-around within the contract management system. However, another portion of this variance is due to net revenue adjustments that are not reflected in patient accounting, because they are not at the patient account level. Rather, such adjustments are booked directly to the general ledger/financials. These include; prior year settlements, pass-through payments, capitation payments, and other lump-sum amounts.

DSS users have wrestled with various approaches to handling these adjustments. Should they be incorporated in DSS or not? Many organizations have not brought these adjustments into DSS, and hence not into service line P&L's. However, NOT including these can have an impact on service line profitability. For example, Graduate Medical Education (GME) payments most often relate to specific services/departments. If these payments are not incorporated on a P&L, the profitability of the affected service lines is understated. Such adjustments can usually be incorporated in DSS, and set up as a separate component of net revenue so that those producing reports can choose to

include or exclude such adjustments. When reporting on payment variances, for example, these adjustments would be excluded so that actual payments can be readily compared to expected.

Supplementing data: As with cost data, enhancing the accuracy of net revenue calculations can involve integrating additional data into DSS – data that may not already be part of the billing system. This data can include: outpatient APC and APG information, RUG assignments for Transitional Care Units, CMG data for Rehab, and HHRG information for Home Health.

Bad debt – to GAAP or not to GAAP?: Although a majority of organizations handle bad debt as an expense within their DSS/Cost Accounting systems, in accordance with current accounting principles, there are benefits to handling it on the net revenue side within DSS. If it is handled on the expense side, it is allocated as an overhead expense based on a statistic such as gross revenue. It cannot be payor-specific when treated as an expense. If bad debt is handled as a net revenue adjustment within DSS, it can be more accurately assigned to specific payors, as well as to certain service lines. Even more specifically, it can be assigned to particular patients if the patient account detail is available from the billing system and can be interfaced. This brings up the question of bad debt recoveries: If bad debt recoveries are available from another system, these can also be interfaced into DSS.

AUDIT PROCESSES

The importance of ongoing audit processes cannot be overstated. A set of reports for auditing both costs and net revenue needs to be developed and used during every reporting cycle.

Net revenue: Even if net revenue will not reconcile dollar-for-dollar to the financial statements, Finance still needs to go through the exercise of quantifying these variances, with an explanation for each. Explainable variances might include the following:

- Departments or services that are NOT billed within the primary billing system and thus are not part of DSS, and
- Differences between discharged vs. inhouse patients at the beginning and end of the reporting period.

Cost auditing: Ensuring that cost information is meaningful at the service line level means reviewing costs at various levels. Audit reports, as part of a costing model, are typically run at the department level. While a department-level review is important, reviews at the charge code and service line level are equally as important. Below is a suggested outline for a cost review process:

- Department cost review:
  - Direct costs, including any reclassified costs
  - Fixed/variable assumptions
  - Allocation of overhead costs

- Charge code level cost review
  - Direct costs by charge code

  - Comparison of actual cost per unit to price
  - Comparison of allocated variable cost to the variable cost standard
  - Allocation of overhead and fixed costs across charge codes

- Service line level cost review
  - Direct and indirect costs
  - Comparison of cost per case to prior period
  - Comparison to charge per case and net revenue per case

EDUCATION

Lastly, education should not be overlooked as a necessary component of the effort to improve service line profitability analysis. Users of the information need to be educated on the approaches that were taken, the key assumptions that are in place, and the data definitions.

With some effort on the part of the DSS team, the quality of service line P&L reporting can be enhanced. Removing the caveats to cost and net revenue information within the Decision Support system will take service line profitability reporting to the next level.