# Taking Service Line P&L's to the Next Level

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# OUTLINE

1. Background
   - Current Status of Service Line Analysis
   - Issues and Typical Roadblocks
2. Costing Strategies
3. Other Considerations
4. Report Examples

# DRIVERS

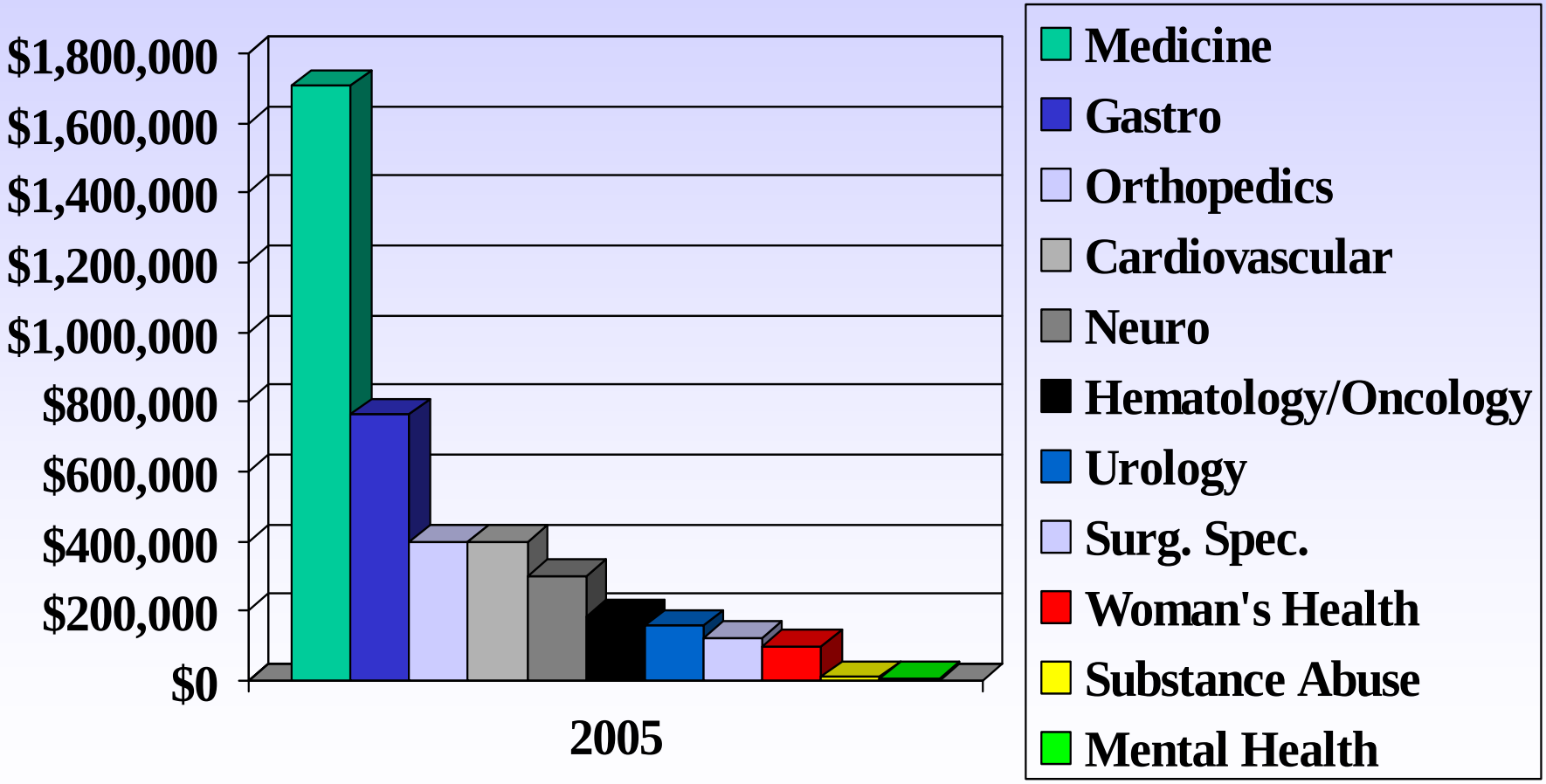
- **Competition**
- **Aging of the population / Need to plan services**
- **Mergers / re-alignment of services**

# GOALS OF SERVICE LINE ANALYSIS

- Determine contribution margin/profitability by service line
- Be able to integrate with market share information, to identify areas of opportunity and growth (or decline)
- Provide meaningful information to senior management, to enable strategic decision-making
- Build a model that can be easily maintained
- Produce reports in a timely manner, to enable trending

# *Sample*

## Inpatient Contribution Margin By Service Line



# SERVICE LINE ANALYSIS

**"*Service lines are back*." (March 2004 HFM article)**

**What's different this time around?**

> **"Service line strategy is not viewed as just a marketing function this time around. This time, senior managers seem to be on board, and they realize that the concept not only hold great financial promise, but also offers potential for gaining a competitive edge."**
>
> **"The second wave of service-line strategy - driven by more competitive forces and constrained payment - is likely to garner greater attention and improved execution as it is seen as more organizationally pervasive and market relevant."**

**E. Preston Lee, *Divide and Compete: A New Look at Service Lines,* Healthcare Financial Management: March 2004.**

# SERVICE LINE ANALYSIS

**What's different this time around?**

- **Service Line Definitions: We've had more experience with defining service lines, and now understand the need for service line definitions to be;**

  ***Data driven,***
  ***Market comparable***
  ***Logical from an organizational perspective*.**

- **Profit/Loss Analysis: More attention is being paid to accuracy of assigning both costs and net revenue to the service line level.**

# POTENTIAL ROADBLOCKS

- **Skepticism about the accuracy of the data.**
- **The Financial Management team is not comfortable with the net revenue calculations.**
- **Not ready to use net revenue from the Decision Support System ("DSS") in a profit/loss analysis.**
- **DSS is used for part of the analysis, with other calculations done offline.**
- **The Cost Accounting data is not adequately maintained.**
- **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 on-going basis.**

# PAYMENTS ("NET REVENUE") IN U.S. HEALTHCARE: A PRIMER

**Payments come from a number of insurers:**

- **Medicare: healthcare for elderly (age 65+), through Federal government**
- **Medicaid: healthcare for indigent/underprivileged, funded primarily by the states, with partial funding from the Federal government**
- **Managed Care insurance plans (also referred to as HMO's or "Health Maintenance Organizations"): Insurers that pay negotiated rates for services, based on a contract with the hospital or provider**
- **Workers Compensation: healthcare for job-related injuries and illnesses (all employers over a certain size are required to carry this insurance)**
- **Commercial insurance plans: Insurers that do not necessarily have a contract with the hospital and will pay based on the bill (charges) or a percentage thereof.**

***For timely service line profit/loss reports, a hospital needs a method of estimating payments for ALL patients that have been treated. Hence, a contract management" system is often used to calculate net revenue.***

# ACTION PLAN

- **Enhance the accuracy of service line reporting so that the output is credible as well as timely.**
- **Adjust top level allocations and statistics.**
- **Focus on accuracy of cost and net revenue information at the patient and service line level.**
- **Take the extra steps to ensure this accuracy.**
- **Develop a plan for maintenance and ongoing auditing of the DSS results so that requests for service line information can be quickly turned around.**

# COST ACCOUNTING STRATEGIES TO CONSIDER

**PHASE I: DEPARTMENT-LEVEL COSTING**

- **Move costs from indirect to direct**
- **Assign overhead costs (vs. allocate)**

**PHASE II: SERVICE ITEM AND PATIENT COSTING**

- **Assign direct costs to service lines**
  - ***Accurate cost standards***
  - ***Patient-specific costing***
- **Assign program-specific costs**

# DEPARTMENT COST STRATEGIES: MOVE COSTS FROM INDIRECT TO DIRECT

- **Costs that directly support clinical departments, but flow through overhead departments should be reclassified as direct costs.**

- **If costs are classified as overhead in the cost model, this results in a misrepresentation of the direct cost and hence, contribution margin, of the service line.**

- **Examples include:**
  - **Radiology Support (transcriptionists, file clerks, etc.)**
  - **Lab Information Systems**
  - **Clinical Administration; e.g. Psych Admin, Cardiac Admin**

- **Other costs to consider classifying as direct include:**
  - **Major moveable equipment depreciation**
  - **Payroll taxes and other employee benefits**
  - **Teaching costs (the portion of intern/resident/faculty time that is patient care vs. admin or educational)**

# DEPARTMENT COST STRATEGIES:
# "ASSIGN" OVERHEAD COSTS VS "ALLOCATE"

**Borrowing from "ABC" (Activity Based Costing)**

**DEPARTMENT LEVEL:**

**Move away from the top-down, arbitrary allocations of overhead cost towards a more accurate assignment of overhead costs to the appropriate departments.**

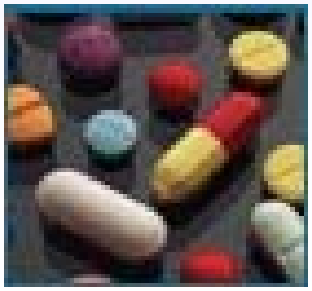
**This approach will require additional data collection to supplement the Medicare cost report statistics**

***Example: 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.***

# SERVICE ITEM COSTING STRATEGIES: DEVELOP AND MAINTAIN COST STANDARDS

- **Collect data from the clinical and department managers**
  - **Cost standards should be kept up-to-date, by working with department managers to keep abreast of changes in technology, methodology and supplies used.**
  - **Automated interfaces should be developed wherever possible.**

***O.R. supply costs as well as drug costs can be updated on a monthly basis if these interfaces are in place***



# SERVICE ITEM COSTING STRATEGIES: PAY ATTENTION TO OVERHEAD AND FIXED COSTS

**Assign overhead and fixed costs more accurately to the patient and service line level**

- **Review 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 these costs.***

  ***Some organizations make 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.***

# PATIENT-SPECIFIC COSTING

- **Charge codes have been the traditional "intermediate" product in a cost accounting system.**
- **The "final" product is the PATIENT, and accuracy of costs at the patient level is the end goal.**
- **Consider supplementing the cost accounting system with additional patient level data;**

  **Operating Room - times by position, actual supplies used**

  **Nursing - acuity data / nursing interventions**

  **Transitional Care/Subacute Unit - patient classification data (SNAP)**

  **Maternity - labor times (calculated from mom's admission time and baby's delivery time)**

- **Improving *patient-specific* costing efforts is the common thread among these strategies.**

# PATIENT COSTING STRATEGIES: PROGRAM-SPECIFIC COSTS

- **Certain costs may relate to a particular program and should be directed to a specific set of patients or service line.**

  **Examples:**
  - **Diabetes Education Department directed to diabetic patients**
  - **Organ Acquisition costs directed to organ transplant cases**

***Even if a separate patient care department with its own billing codes has not been set up, there often are methods within the DSS to assign these costs to the appropriate patients.***

# DEFINING SERVICE LINES

- **DRG's are most often used to classify inpatients**
- **Clinical Subspecialties are a good starting point - see next page for Yale groupings of HCFA (e.g. Medicare) DRG's**
- **Outpatient: Medical Service or Location or Department**
- **Physician Specialty or other Physician grouping**

***(Caveat: does not enable comparative or market-share reporting)***

## Clinical Subspecialties*

| SUBSPECIALTY | | CMS (V21.0) DRGs |
|---|---|---|
| CODE | NAME | |
| 01 | Cardiology | 115-118; 121-145; 515-518; 525-527; 535-536 |
| 02 | Dentistry | 168-169; 185-187 |
| 03 | Dermatology | 271-273; 283-284 |
| 04 | Endocrine | 294-301 |
| 05 | Gastroenterology | 174-184; 188-190; 202; 204-208 |
| 06 | General Medicine | 416-4232; 447-455; 462-467 |
| 07 | General Surgery | 146-167; 170-171; 191-201; 257-270; 276-282; 285-293; 344-345; 392-394; 400-402; 406-408; 415; 424; 439-446; 461; 480-483; 486-487; 493-494; 504-513; 539-540 |
| 08 | Gynecology | 353-365; 368-369 |
| 09 | Hematology | 395-399 |
| 10 | Neonatology | 385-391 |
| 11 | Nephrology | 316-322; 325-327; 331-333 |
| 12 | Neurology | 009; 012-026; 031-035,524 |
| 13 | Neurosurgery | 001-003; 006-008; 027-030; 484; 528-534 |
| 14 | Obstetrics | 370-384 |

**(continued on next page)**

| | | |
|---|---|---|
| 15 | Oncology | 010-011; 064; 082; 172-173; 203; 274-275; 346-347; 366-367; 403-405; 409-414; 473; 492 |
| 16 | Ophthalmology | 036-048 |
| 17 | Orthopedics | 209-213; 216-220; 223-230; 232-241; 243; 248-255; 471; 485; 491; 496-503; 519-520; 537-538 |
| 18 | Otolaryngology | 049-063; 065-074 |
| 19 | Psychiatry | 425-432; 433; 521-523 |
| 20 | Pulmonary | 078-081; 085-093; 096-102; 475 |
| 21 | Rheumatology | 242; 244-247; 256 |
| 22 | Thoracic surgery | 075-077; 083-084; 094-095; 103-109; 495 |
| 23 | Urology | 302-315; 323-324; 328-330; 334-343; 348-352 |
| 24 | Vascular surgery | 110-111; 113-114; 119-120; 478-479 |
| 25 | HIV Infections (Princ. Diagnosis Only) | 488-490 |
| 26 | Transplant (pending) | 103; 302; 480; 495; 512; 513 |

* Research Document, "Assignment of Diagnosis Related Groups Using ICD-9-CM Codes to Clinical Specialties." Yale School of Organization and Management, Health Systems Management Group (HSMG), Robert B. Fetter, Principal Investigator.

# PROFIT AND LOSS: SUMMARY

*by Service Line*

| | Gross Revenue | Less Deductions | Net Revenue | Direct Fixed Costs | Direct Variable Costs | Support Fixed Costs | Support Variable Costs | Overhead Costs | Total Costs | Profit/ Loss | Contribution Margin |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Cardiology | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx |
| Orthopedics | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx |
| Oncology | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx | xxxxxxx |
| | | | | | | . | | | | | |
| | | | | | | . | | | | | |

**PRODUCT LINE FINANCIAL STATEMENT**

| | Cardiac | Medical | Mental Health | Neuro | Obstetrics | Oncology | Orthopedics | Surg Other |
|---|---|---|---|---|---|---|---|---|
| **GROSS REVENUE** | | | | | | | | |
| **PATIENT SERVICE CHARGES:** | | | | | | | | |
| INPATIENT CHARITY | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| INPATIENT COMMERCIAL | 0 | 126,904 | 0 | 0 | 20,851 | 0 | 0 | 85,188 |
| INPATIENT HMO | 91,568 | 469,776 | 0 | 29,755 | 47,152 | 20,366 | 43,440 | 153,920 |
| INPATIENT INDIGENT | 87,907 | 1,189,217 | 66,925 | 80,657 | 21,060 | 39,431 | 120,315 | 539,670 |
| INPATIENT MEDICAID | 571,240 | 5,191,219 | 225,687 | 184,093 | 2,410,179 | 171,266 | 423,176 | 2,198,141 |
| INPATIENT MEDICARE | 2,780,710 | 14,627,091 | 123,600 | 1,286,036 | 25,686 | 1,408,177 | 1,949,276 | 5,652,592 |
| INPATIENT PPO | 356,987 | 1,666,529 | 16,894 | 136,138 | 271,805 | 181,919 | 320,412 | 1,546,716 |
| INPATIENT PRIVATE | 11,176 | 544,860 | 55,387 | 46,285 | 87,699 | 15,202 | 49,113 | 292,293 |
| INPATIENT WORK COMP | 0 | 172,747 | 0 | 0 | 0 | 0 | 187,328 | 13,848 |
| **TOTAL PATIENT REVENUE** | **3,899,588** | **23,988,343** | **488,493** | **1,762,964** | **2,884,433** | **1,836,362** | **3,093,060** | **10,482,369** |
| **NET REVENUE** | | | | | | | | |
| INPATIENT CHARITY | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| INPATIENT COMMERCIAL | 0 | 59,876 | 0 | 0 | 17,566 | 0 | 0 | 73,334 |
| INPATIENT HMO | 12,113 | 240,209 | 0 | 6,816 | 23,030 | 16,039 | 18,003 | 27,359 |
| INPATIENT INDIGENT | 26,910 | 433,990 | 26,492 | 28,845 | 5,337 | 11,618 | 43,665 | 197,453 |
| INPATIENT MEDICAID | 211,718 | 2,029,908 | 104,728 | 71,659 | 1,049,467 | 78,055 | 183,303 | 940,100 |
| INPATIENT MEDICARE | 677,081 | 3,098,265 | 21,826 | 374,995 | 2,072 | 357,791 | 438,109 | 1,365,252 |
| INPATIENT PPO | 273,237 | 809,773 | 7,212 | 92,106 | 85,023 | 169,217 | 117,403 | 844,823 |
| INPATIENT PRIVATE | 0 | 21,490 | 11,173 | 8,287 | 0 | 0 | 15,991 | 39,728 |
| INPATIENT WORK COMP | 0 | 64,242 | 0 | 0 | 0 | 0 | 38,221 | 2,284 |
| NET PATIENT REVENUE | **1,201,059** | **6,757,754** | **171,432** | **582,709** | **1,182,493** | **632,720** | **854,695** | **3,490,333** |
| DSH PAYMENTS | 5,405 | 49,115 | 2,135 | 1,742 | 22,803 | 1,620 | 4,004 | 20,797 |
| SETTLEMENTS - PRIOR YEAR | 68,473 | 360,184 | 3,044 | 31,668 | 632 | 34,676 | 48,000 | 139,192 |
| **TOTAL NET PATIENT REVENUE** | **1,274,937** | **7,167,054** | **176,611** | **616,119** | **1,205,929** | **669,016** | **906,699** | **3,650,322** |
| OTHER REVENUE | 13,240 | 74,429 | 1,834 | 6,398 | 12,523 | 6,948 | 9,416 | 37,908 |
| **TOTAL REVENUE** | 1,288,177 | 7,241,483 | 178,445 | 622,517 | 1,218,453 | 675,964 | 916,115 | 3,688,231 |
| **OPERATING EXPENSES** | | | | | | | | |
| DIRECT EXPENSES | 688,506 | 4,045,225 | 90,195 | 329,794 | 1,136,842 | 320,218 | 577,499 | 1,885,828 |
| **CONTRIBUTION MARGIN( DEFICIT)** | 599,671 | 3,196,258 | 88,250 | 292,723 | 81,610 | 355,746 | 338,616 | 1,802,402 |
| OVERHEAD EXPENSES | 308,330 | 1,856,062 | 40,858 | 154,206 | 481,061 | 147,092 | 264,065 | 832,116 |
| **NET INCOME (LOSS)** | 291,341 | 1,340,196 | 47,393 | 138,517 | (399,451) | 208,654 | 74,551 | 970,286 |

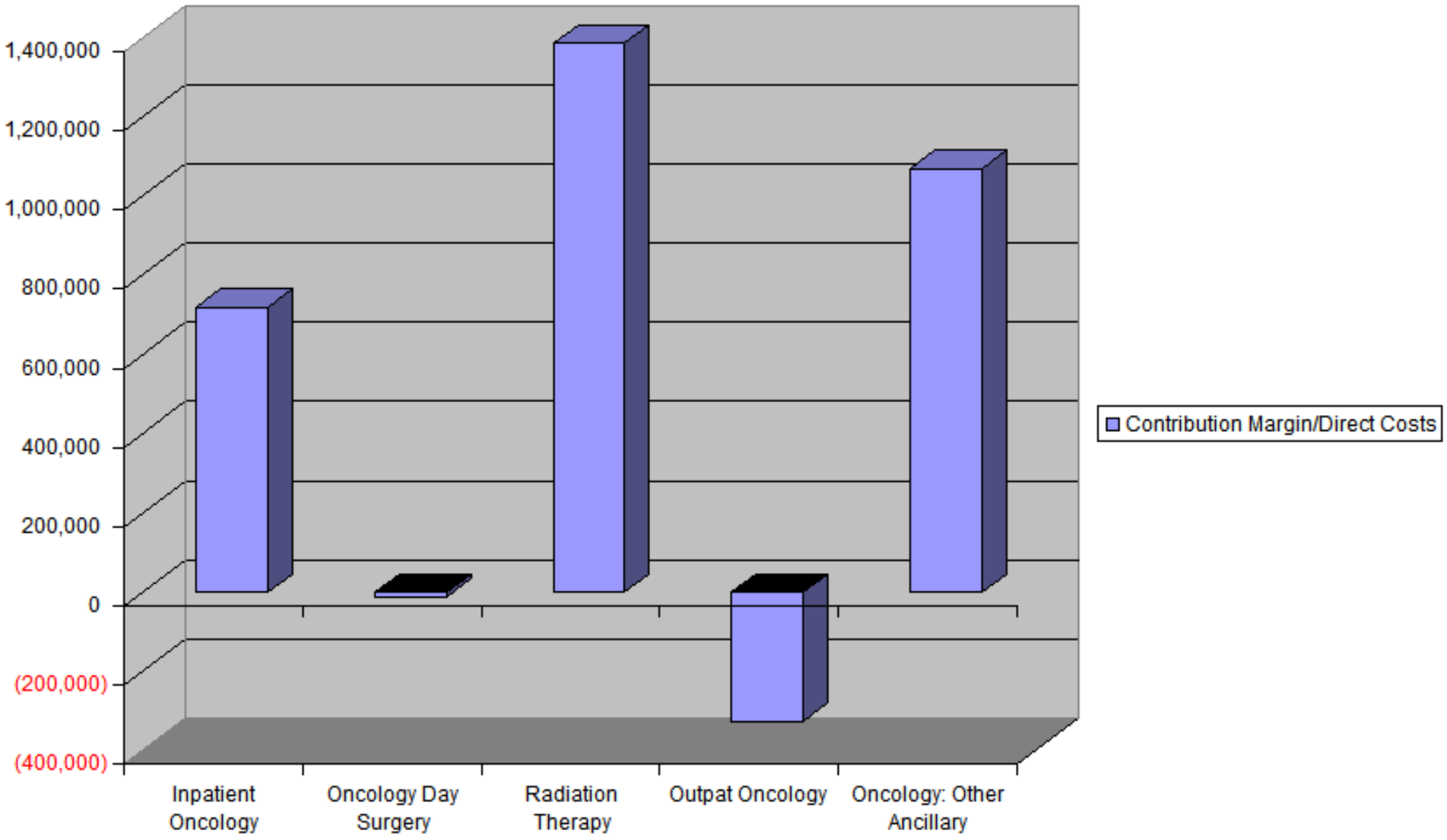
# CONTRIBUTION MARGIN BY SERVICE LINE

| *Cardiology* | FY2005 Jan-Dec |
|---|---|
| Revenue | |
| Inpatient | XXXXXX |
| Outpatient | XXXXXX |
| Total Net Patient Service Revenue | XXXXXX |
| | |
| Direct Expenses: | |
| Inpatient: | |
| Salary and Wages | XXXXXX |
| Fringe Benefits | XXXXXX |
| Supplies and Expenses | XXXXXX |
| Purchased Services | XXXXXX |
| Professional Fees | XXXXXX |
| Subtotal Inpatient Expenses | XXXXXX |
| | |
| Outpatient: | |
| Salary and Wages | XXXXXX |
| Fringe Benefits | XXXXXX |
| Supplies and Expenses | XXXXXX |
| Purchased Services | XXXXXX |
| Professional Fees | XXXXXX |
| Subtotal Outpatient Expenses | XXXXXX |
| | |
| Total Direct Expenses | XXXXXX |
| | |
| Total Direct Contribution Margin | XXXXXX |
| | |
| Key Statistics: | |
| Inpatient Cases | XXXXXX |
| Inpatient Net Revenue/Case | XXXXXX |
| Inpatient Direct Expense/Case | XXXXXX |
| Inpatient Contribution Margin/Case | XXXXXX |
| | |
| Outpatient Volume | XXXXXX |
| Outpatient Net Revenue/Case | XXXXXX |
| Outpatient Direct Expense/Volume | XXXXXX |
| Outpatient Contribution Margin/Case | XXXXXX |

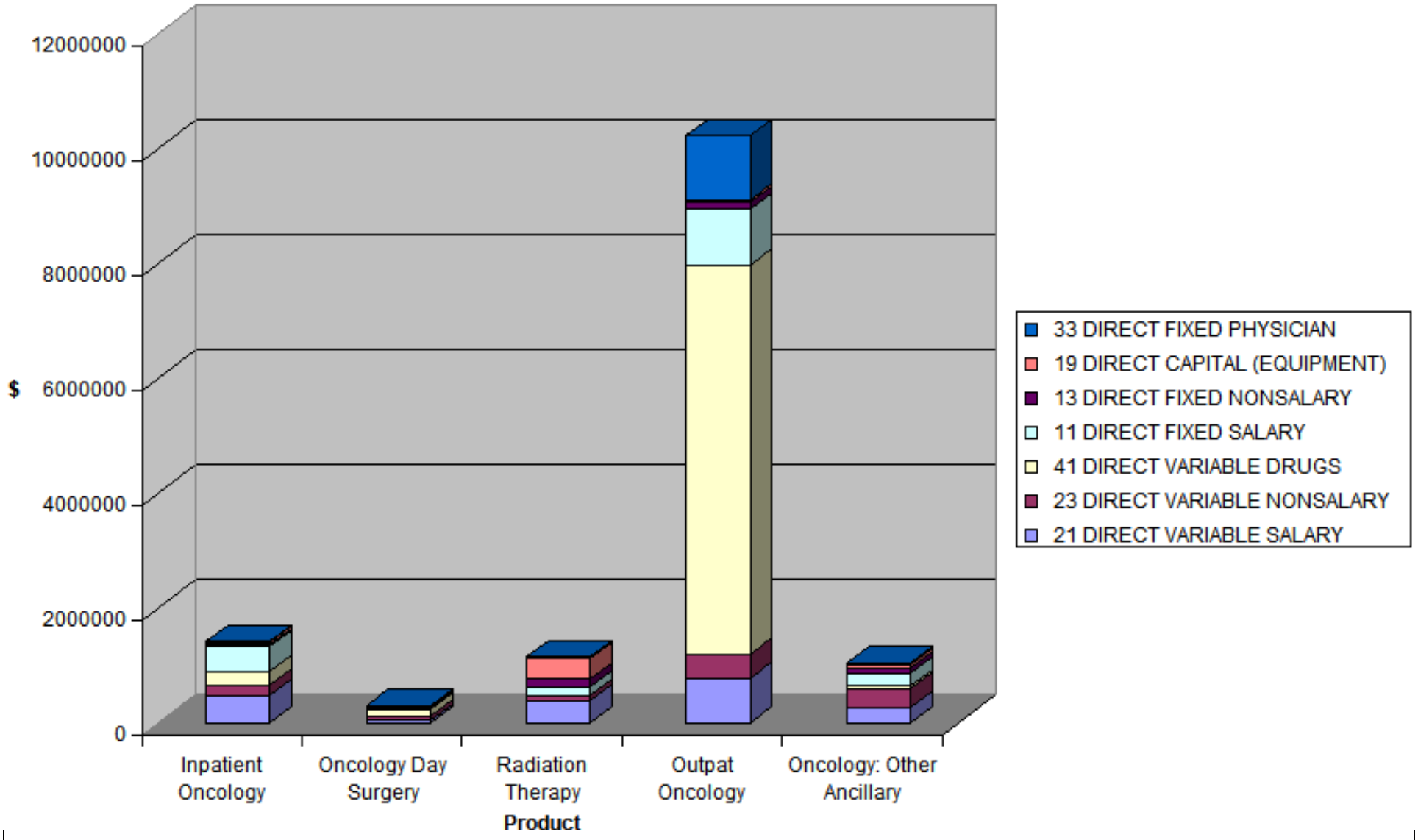
## *ONCOLOGY PROFIT/LOSS*
## *FY2006 Preliminary*

| | Inpatient Oncology | Oncology Day Surgery | Radiation Therapy | Outpat Oncology | Oncology: Other Ancillary | Total Oncology |
|---|---|---|---|---|---|---|
| Cases | 303 | 252 | 1,619 | 6,236 | 11,337 | 19,747 |
| Charges | 4,518,906 | 1,058,087 | 5,388,007 | 27,201,547 | 9,862,224 | 48,028,771 |
| Projected Payments | 2,127,933 | 281,573 | 2,526,396 | 9,907,173 | 2,099,756 | 16,942,831 |
| Variable Expenses | | | | | | |
| 21 DIRECT VARIABLE SALARY | 469,716 | 39,784 | 382,731 | 780,695 | 259,167 | 1,932,093 |
| 23 DIRECT VARIABLE NONSALARY | 191,007 | 82,603 | 89,894 | 408,945 | 337,233 | 1,109,682 |
| 41 DIRECT VARIABLE DRUGS | 228,309 | 114,293 | 1,933 | 6,779,770 | 41,781 | 7,166,086 |
| Total Variable Expenses | 889,032 | 236,680 | 474,558 | 7,969,410 | 638,181 | 10,207,861 |
| Fixed Expenses | | | | | | |
| 11 DIRECT FIXED SALARY | 434,100 | 36,193 | 146,717 | 975,313 | 224,835 | 1,817,158 |
| 13 DIRECT FIXED NONSALARY | 34,646 | 6,785 | 133,774 | 115,736 | 96,831 | 387,772 |
| 19 DIRECT CAPITAL (EQUIPMENT) | 44,873 | 6,067 | 357,373 | 41,840 | 58,727 | 508,880 |
| 33 DIRECT FIXED PHYSICIAN | 6,960 | 7,510 | 29,482 | 1,129,516 | 13,261 | 1,186,729 |
| Total Fixed Expenses | 520,579 | 56,555 | 667,346 | 2,262,405 | 393,654 | 3,900,539 |
| Total Direct Expenses | 1,409,611 | 293,235 | 1,141,904 | 10,231,815 | 1,031,835 | 14,108,400 |
| Contribution Margin/Direct Costs | 718,322 | (11,662) | 1,384,492 | (324,642) | 1,067,921 | 2,834,431 |
| Per Case | 2,371 | (46) | 855 | (52) | 94 | |
| Indirect Expenses (& Statistic Used) | | | | | | |
| 1001 CAPITAL-BLDG & FIXED (Sq Ft) | 101,671 | 9,823 | 177,551 | 188,625 | 69,184 | 546,854 |
| 1003 EMPLOYEE BENEFITS (FTE's) | 144,298 | 13,600 | 76,679 | 362,896 | 96,698 | 694,171 |
| 1004 FICA/PENSION (Salary $) | 98,444 | 9,721 | 59,454 | 259,814 | 72,277 | 499,710 |
| 1006 MANAGEMENT COST CTR (Mgmt Sal $ | 21,757 | 2,687 | 30,681 | 139,347 | 21,939 | 216,411 |
| 1007 ADMIN & GENERAL (Expenses) | 139,900 | 25,926 | 111,085 | 928,520 | 109,694 | 1,315,125 |
| 1009 PATIENT ACCOUNTING (Gross Rev) | 40,983 | 7,403 | 43,707 | 194,035 | 102,804 | 388,932 |
| 1016 MAINTENANCE & REPAIRS (Sq Ft) | 115,440 | 10,844 | 200,958 | 212,262 | 79,044 | 618,548 |
| 1026 MEDICAL RECORDS (Time Study) | 25,671 | 7,863 | 48 | 761,877 | 6,868 | 802,327 |
| Other Indirect | 436,128 | 39,130 | 207,200 | 966,138 | 196,977 | 1,845,573 |
| Total Indirect Expenses | 1,124,292 | 126,997 | 907,363 | 4,013,514 | 755,485 | 6,927,651 |
| Total Expenses | 2,533,903 | 420,232 | 2,049,267 | 14,245,329 | 1,787,320 | 21,036,051 |
| Profit (Loss) | (405,970) | (138,659) | 477,129 | (4,338,156) | 312,436 | (4,093,220) |
| Per Case | (1,340) | (550) | 295 | (696) | 28 | |

## *Oncology Contribution Margin*



## Direct Expense Breakout



## Detail by Payor: Outpatient Oncology
## FY2006 Preliminary

| | MEDICARE | MEDICAID | MANAGED CARE PAYORS | BLUE CROSS HMO | ALL OTHERS | TOTAL Outpat Oncology |
|---|---|---|---|---|---|---|
| CASES | 3,350 | 274 | 433 | 584 | 1,595 | 6,236 |
| VISITS | 6,080 | 764 | 857 | 1,274 | 3,298 | 12,273 |
| | | | | | | |
| CHARGES | 12,303,365 | 2,025,231 | 2,198,988 | 3,386,417 | 7,287,546 | 27,201,547 |
| | | | | | | |
| EXPECTED PAYMENTS | 3,674,540 | 274,518 | 954,135 | 1,569,201 | 3,890,758 | 10,363,152 |
| ACTUAL PAYMENTS | 3,024,622 | 162,573 | 700,737 | 1,550,844 | 3,373,614 | 8,812,390 |
| PROJECTED PAYMENTS * | 3,512,860 | 262,439 | 912,153 | 1,500,156 | 3,719,564 | 9,907,173 |
| ACCOUNT BALANCES | 2,188,206 | 346,674 | 251,523 | 42,638 | 572,866 | 3,401,907 |
| | | | | | | |
| DIRECT FIXED COSTS | 1,042,125 | 164,753 | 161,267 | 274,623 | 619,637 | 2,262,405 |
| DIRECT VARIABLE COSTS | 3,502,620 | 621,103 | 661,147 | 1,036,014 | 2,148,529 | 7,969,413 |
| TOTAL DIRECT COSTS | 4,544,746 | 785,855 | 822,413 | 1,310,638 | 2,768,165 | 10,231,818 |
| INDIRECT COSTS | 1,839,155 | 295,079 | 300,414 | 491,895 | 1,086,977 | 4,013,520 |
| TOTAL COSTS | 6,383,901 | 1,080,935 | 1,122,827 | 1,802,533 | 3,855,142 | 14,245,337 |
| | | | | | | |
| CONTRIBUTION MARGIN | (1,031,886) | (523,416) | 89,740 | 189,519 | 951,399 | (324,644) |
| PER CASE | (308) | (1,910) | 207 | 325 | 596 | (52) |
| PER VISIT | (170) | (685) | 105 | 149 | 288 | (26) |
| | | | | | | |
| GAIN/LOSS PROJECTED PMTS LESS COSTS | (2,871,041) | (818,496) | (210,674) | (302,376) | (135,577) | (4,338,164) |
| PER CASE | (857) | (2,987) | (487) | (518) | (85) | (696) |
| PER VISIT | (472) | (1,071) | (246) | (237) | (41) | (353) |

## *CONTRIBUTION MARGIN: OUTPATIENT ONCOLOGY*