UNIVERSITY OF ROCHESTER MEDICAL CENTER

**OPERATING BUDGET PROCESS**

**PROVIDER MODEL**

 **FISCAL YEAR 2020/2021**

*Now that you have completed* ***Provider Maintenance****, you are ready to begin budgeting in the Provider Model.*

***Provider Model***

*The Provider Model is a Medical Center Wide Projection and Budgeting tool. No Company (SMH, MFG, SMD, or SON) is exempt from this component of the budgeting process. The goal of the Provider Model tool is to capture Effort, wRVUs, Compensation, Revenue, and Cases by Provider (Physicians, CRNA’s, and APPs). These components are all accessed via the different views located in the tool bar. Existing providers will automatically appear in the Provider Model. For incremental NEW providers, the information is built in a BIP (Business Improvement Plan) and then will be fed into Provider Model once approved. For replacement providers please complete the Template for Adding Replacement Providers form and submit to your Finance Liaison. The Liaison will then add the provider to the Provider Model.*

***Providers (View 0)***

*Listed in this view are all of the Faculty and APPs included in the Provider Model. Please make sure this is an accurate all-inclusive list prior to getting started. If not, contact your Finance Liaison. If you have a prior year BIP with an unmapped provider the name will appear with “****~PY Unmapped BIP Provider”*** *added to the beginning of the name.  These positions must be budgeted for in the Provider Model.*

***Effort Distribution (View 1)***

* *For Effort, you will be identifying how a physician is spending his or her time on the following activities: Clinical, Admin, Research, Academics, and Other. This information is important when modeling compensation alignment as well as determining the appropriate allocation of pay across companies and FAO’s. If you have any questions about what defines these categories, please refer to the, “Effort Definition,” document below.*
* *In addition to completing the allocation of 100% effort across category, please include any applicable Administrative roles. When looking at pay variations, it is important to understand how pay is influenced by an Administrative or Leadership role. The system includes a drop down menu for generic roles. Include additional specifics in the comment section.*
* *In reporting, effort %’s input by category are converted to an FTE by category based on a calculation utilizing standard hours (i.e. Full-time or Part-time). For example if you have a provider that is 100% Clinical but part-time 20 hours, you will input 100% in Axiom, and the report will convert this to a .50 Clinical FTE.*

***wRVUs (View 2)***

* *wRVUs are used to: Analyze productivity and calculate revenue. This year HB wRVU’s have also been loaded and will appear in a separate line called SMH HB or HH HB.*
* *The provider model allows you to budget both target and incentive wRVUs (if applicable). Please include projections for FY20 and budget for FY21.*
* *HB Revenue is calculated separate from Provider Model, so you will not see charges or revenue related to HB pulled into Axiom.*

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***Compensation (View 3)***

* *New: Please pay close attention to compensation for Administrative Roles. Admin roles should be charged to SMH or SMD dependent upon the function. For those departments already under a funds flow model, you may have already implemented this accounting. For all other departments, please budget appropriately based on % of effort spent on these roles.*
* *When budgeting provider compensation, keep in mind alignment. The overall goal is to align provider compensation to at least -15%tile, however, this is dependent upon leadership review and Medical Center affordability. A Provider Compensation Tool Kit is currently under construction, but will be available the first week of January. This will be located within the Provider Maintenance. You can use this tool to model compensation and productivity compared to your department specific benchmark surveys. Input into Provider model the compensation assumptions you know of today based on your Chair directives, and we will collectively review with you how this input translates to alignment and what next steps are required.*

***Revenue (View 5)***

* *Axiom is loaded with your current July-November Net Revenue per RVU per provider. This is locked. Your divisional Finance Liaison will be working with you to review this number and make modifications as needed.*

 ***Cases (View 6)***

* *For inpatient case discharges and operating room cases you will need to input the expected FY21 budget by provider and location.  Incremental cases in Provider Model will be automatically calculated by comparing a straight-line projection of FY20 July-November cases with the FY21 input budget.  Any budgeted variations in incremental cases (increases or decreases) must have a comment added in the Provider Model.*
* *An operating room case is a surgical encounter performed in the operating room that incorporates one in room time and one out of room time.  The case is “credited” to the primary surgeon in the case and are extracted from OpTime (eRecord OR application).  An inpatient case is when a patient comes from home, IP unit or ED and is admitted to IP unit for more than one night stay.  An outpatient case is when a patient comes from home and goes home same day or is admitted for 23-hour observation.*
* *An inpatient case discharge is an inpatient encounter with a patient discharge.  The case is “credited” to the discharging provider in the record.  Cases are captured in EPIC and reported out of McKesson.  An additional budget questionnaire will be distributed during the budget process for completion to better understand the changes in budgeted discharges.*

***ALL Other activity in your provider file***

* *Keep in mind that the provider model is based on Billing Provider. Since the implementation of EPIC, the majority of Billing providers are Physician or APPs but on occasion a wRVU or revenue may be attributed to a resident, fellow or other health care provider. This activity will appear on the All Other Report (URB308).*
* *Please contact your finance liaison for help in how to budget this additional revenue.*

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**Running Reports**

* *There are several reports available to use to reconcile and review what has been loaded into Axiom. The provider model is organized primarily by HR Division Department, so within that model you will have activity that crosses Companies and Cost Center Heirarchies.*
* *Reports can help you review if the data makes sense – comparing history, YTD, and budgeted activity.*
* *Data can be sliced by using the Refresh button in the tool bar and selecting Provider Group, Company, Cost Center or Heirarchy, or FAO.*
* *Additionally data can be narrowed down by using the Change View. For example if you only want to look at wRVU’s, there is a view available.*
* *Please reach out to any Finance Liaison for help regarding reporting. Listed below are the recommended reports to run and review:*
	+ *URB301 List of Providers*
	+ *URB303 Provider Budget Summary by FAO – multiple views accessible through Change View*
	+ *URB304 Provider Budget Summary by Provider – multiple views through Change View*
	+ *URB306 Case Budget by Provider*
	+ *URB307 Cases by Provider – OR to Inpatient Analysis*
	+ *URB308 All Other Provider Activity*
	+ *URB310 Case Actuals Tie Out*

***Check-list***

* *New this year – we have added a check-list for Provider Model. This is to help ensure that all components have been budgeted and reviewed. This must be completed and emailed to your Finance Liaisons in each Company – MFG, SMH, and SMD.*
* *Provider model files and the Provider model check list should be reviewed with your assigned Finance Liaison during January. The recommended goal is to have the Provider Model component completed by mid-February. We recognize that changes may still occur to the provider models as you move through the remainder of the budget process.*

**There is a Provider Quick Reference Card (under the Training section) to assist new users in navigating through the system.**

***For Reference***

 **Effort Definition**

**Clinical**

* + All billable physician activity (surgical time, scheduled clinics, inpatient services, hospital rounding), including activities with learners present
	+ Direct patient contact
	+ Indigent care
	+ Supervision of residents/fellows while seeing patients
	+ Chart review, documentation, and other office work related to clinical activity

**Administration**

* + Department chair or chief duties
	+ GME program administration
	+ Medical director activities
	+ Other specified and defined time for hospital or practice administration

**Research**

* + Funded research activity (salary supported by grant)
	+ Unfunded clinical research (protected time)
	+ Grant/proposal writing
	+ Other professional development/scholarly activities (e.g.,papers)

**Academics**

* + Didactic teaching
	+ Lectures and Grand Rounds
	+ Student mentoring

**Contract/other**

* + External health systems contract with UR for professional services. Although this faculty effort might relate to clinical effort, if UR does not bill and collect for these professional services (e.g., faculty time purchased at an hourly rate), and individual faculty are not credited with collections and WRVUs, then this effort should be tracked separately.