"Net One, Net Two"

The Primary Care Network Income Statement

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The strategic value versus the costs of hospitals owning primary care practices is being debated in hospital and health system administrative offices all across the country. The challenges of such ownership are complex, and the track record of most hospitals in this arena is far from sterling. Despite the challenges, however, there are some hospitals that are well on their way to achieving the competitive advantage and sustainable practice operations originally envisioned by senior management and board members. While losses for most primary care practices hover around $100,000 per physician, per year, these few hospitals are seeing their losses reduced substantially and potentially eliminated altogether.

Fundamental to the progress these hospitals are experiencing is the development of a financial and statistical reporting tool that properly reflects the primary care network business from a managerial accounting perspective. A basic component of this perspective is acknowledging and separating practice operating expenses from the additional costs of creating a "network" of practices. Some experienced hospital-owned primary care networks achieve this separation by producing a monthly income statement with two net income lines, often referred to as "Net One" and "Net Two." Separating operating and network expenses yields tremendous insight for management, physicians, and staff as they address the challenges of improving a network's financial performance.

Successful network owners have come to understand that the primary care network business is not the hospital business. They have resisted the temptation to account for practices as another department of the hospital, using the hospital's accounting classifications and the hospital's income statement format. Instead, they have built or adopted tools that will provide network leadership with the ability to understand this new business, benchmark their status and monitor the success of their strategies to improve network financial performance.

A primary care network income statement must accomplish several key objectives. First, designing a statement to provide all the stakeholders with a clear picture of practice operations is the primary objective. Second, the statement must allow for easy benchmarking with national medical practice industry performance ratios. Third, financial reporting must be simple enough for all the stakeholders to understand and trust. Finally, financial statements must distinguish between individual practice operations (Net One) and the costs of forming and maintaining a primary care network (Net Two). Each of these objectives will be reviewed in the following paragraphs.

Reporting Network Performance

All primary care network stakeholders, from board members to site managers, must clearly understand the nature of the primary care network business. Board members, senior leadership and network administration must develop appropriate expectations

based upon a new set of performance measures, which differ from those they are used to seeing in hospital board meetings. Since primary care practices have high fixed costs (85% or more) and low profit margins, network leadership (physicians and administration) must aggressively manage both the revenue and cost sides of the income statement in order to achieve viable financial operations. Aggressive management requires an effective financial management tool. Adequate financial and statistical reporting is built around an income statement presented in terms that relate specifically to the primary care business.

On the revenue side, the income statement must provide performance indicators for management and physicians in several key areas. These areas include, practice volume, physician productivity, payer mix, procedure coding, and monitoring the effectiveness of receivables management. The expense side of the report must support ratio analysis of key expenses, including provider compensation and benefits, non-provider compensation and benefits, building occupancy, and clinical supplies. These four factors usually account for the majority of costs per patient visit. An income statement that focuses on these key revenue and expense factors is the most critical tool for establishing appropriate expectations among stakeholders, understanding variances from expected performance, developing action plans to correct variances and monitoring the effectiveness of these corrective actions.

Benchmarking Practice Performance

Critical to success in the primary care business is the ability to benchmark financial performance between sites within the network, as well as to industry norms. Benchmarking first requires the "correct" classification of accounts that roll up into line items for easy comparison to industry standards. Data collected by the Medical Group Management Association (MGMA) and the American Medical Group Association (AMGA), among others, serve as reasonably reliable industry benchmarks. The information is usually available in ratio format (which eliminates differences in cost of living) and in straight dollars. Several key ratios can help management and physicians target areas of weakness in their revenue and cost structures. Examples of these key ratios are presented as Exhibit A. Benchmark data are frequently available by practice size and specialty, making comparisons even more useful.

Building Trust in the Data

"Employed" physicians, particularly those who have been in private practice, understand the importance of practice financial performance. They are used to seeing a periodic cash-basis income statement and understand the implications of productivity, collections, and cost control. Most of them can readily discuss their private practice financial experience, including the number of daily patient visits they needed to cover their

overhead. These former entrepreneurs can also influence their less experienced clinical peers, with whom they have credibility. Very importantly, as partners with management, doctors can help identify the barriers to practice profitability and develop solutions they are committed to implementing. They can accomplish all this, if, and only if, they have access to credible financial and statistical information presented in terms they understand. This challenge is more difficult than it first appears since hospitals use an accrual based accounting method and most independent physicians use cash-basis accounting.

Engaging physicians in understanding accrual accounting is not difficult, if revenue and expense categories relate to their experience in the primary care business. There must be full disclosure of the logic behind allowance accounts, such as bad debt, that relate to historical or anticipated experience. Changes in accounting strategy must also be discussed with physician leaders, in advance, so they can provide input, ask questions and reset their expectations. Without such advance disclosure physicians will feel that allowance accounts are arbitrary and trust will be violated.

Accounting for "Network Overhead"

The concept of network overhead relates to the purpose behind the formation of a primary care physician network on the part of a hospital or health system. Hospitals or systems with a primary care strategy have usually formed networks to provide the "retail" access points that meet a community-needs oriented mission and/or to become indispensable to payers operating in their markets. Organizing primary care practices to

address these strategies as a network adds a layer of expense not normally experienced in a single site group or solo practice setting. For example, the challenge of communicating in a network setting is much more complex than in other settings. If a network is to develop the common vision, unified contracting, and common processes required for success, it must develop certain network management and infrastructure to accomplish these business objectives. This infrastructure has a price tag that is associated with strategic and mission objectives, including the pursuit of covered lives and premium dollars. If physicians, management and board members see these additional costs co-mingled with traditional practice operating expenses, they can easily lose perspective. If losses on what used to be a break-even business, prior to acquisition, are exacerbated by the addition of network overhead, these stakeholders can easily become frustrated over performance issues that may have little to do with practice operations. An income statement that properly separates these expenses will eliminate confusion, improve accountability, and keep all parties properly focused on the real barriers to financial viability.

The Net One, Net Two income statement is relatively simple to construct and has intuitive appeal. Net One presents all the revenue and expense for the direct practice operations. In addition to being comparable to industry norms, Net One also allows a more direct comparison to the physician's practice operations prior to acquisition.

Net Two includes the cost of creating and operating a network ("network overhead"). It incorporates the cost of developing a management infrastructure, physician recruitment

capabilities, managed care negotiation expertise and the systems needed for network operations. Also included in Net Two is the amortization of intangible assets (goodwill) resulting from purchasing established practices. This category may also include unutilized asset capacity such as a building designed for more physicians than are currently using the space. The cost of used space is an operating expense (Net One). The cost of unused space is a network investment expense (Net Two). Finally, Net Two includes the network administration and management fees required for network development. The usefulness of the Net One, Net Two approach is further illustrated below, using the concept of excess building capacity.

Many hospitals have built networks based on the assumption that primary care patients select a provider within a few miles of their home. (This assumption can easily be verified by examining the zip codes of primary care patients in urban and suburban settings.) Frequently, as part of a hospital or system strategic initiative to expand market share or increase indispensability, a primary care provider is placed in a new geographic area. Assuming senior management expects to grow the new practice from one physician to four physicians over a period of four to six years, they are likely to lease or build a facility sized to serve the planned physician group. Under normal accounting methods, the entire cost of building occupancy would be allocated to the new "solo" practice. The Net One, Net Two method places only one-fourth of the building occupancy expense above the Net One line (the direct operating expense). Since three-fourths of the expense relates to the facility's *strategic purpose*, it falls below the line in Net Two as "network overhead." This approach provides a more realistic view of the success of the first

practice, against industry benchmarks. Very importantly, allocating building occupancy expense in this way allows the physician and site manager to be held accountable for setting and achieving realistic financial targets for the first practice – particularly breaking even. Senior management of the network and the hospital/health system can be held accountable for Net Two, which costs should be associated with the success of strategic initiatives that drive network development (i.e., covered lives, system indispensability, mission achievement, etc.)

It is important to emphasize that the Net One, Net Two income statement design does not "hide" any expenses associated with the development and management of a primary care network. Instead, it categorizes these expenses more effectively, from a management accountability and benchmarking standpoint. The initial financial goal is, of course, to have all primary care practices break even at the Net One level, as they did before they were acquired. Practices can even be modestly profitable at the Net One level and offset some portion of the network overhead. Ultimately, however, the expenses falling between Net One an Net Two (which could run as high as $20,000 to $30,000 per physician, per year) must be justified by the strategic return on investment. This strategic return will be measured in terms of premium dollars (a portion of which can cover network overhead), system indispensability, due to geographic coverage or negotiating strength, and achievement of mission objectives such as primary care access.

Summary

The primary care network income statement is possibly the most critical tool in primary care network management. A well-designed statement supports the development of appropriate expectations on the part of all stakeholders. It helps management understand the strengths and weaknesses of the network, and each of its sites, by comparing those sites to network and industry benchmarks. An effective statement helps both physician and non-physician leaders focus their improvement efforts on the areas of greatest operational leverage. Finally, a Net One, Net Two income statement helps place accountability for performance in the proper sphere. Operations leadership is accountable for Net One. Strategic senior leadership is accountable for Net Two.