The Clinic Technical Assistance Center
EFFICIENT PRACTICES. EFFECTIVE CARE.

FINANCIAL BENCHMARKING TOOL GUIDE

The following guide has been written as a supplement to the training modules from the Business Effectiveness Assessment Module (BEAM) training series, which specifically explain how to understand and utilize the Clinic Technical Assistance Center's Financial Benchmarking Tool. Throughout this guide, each major lesson from the specific modules is laid out in chronological order.

What is the Financial Benchmarking Tool?

The Financial Benchmarking Tool is an Excel-based financial modeling and planning tool designed to:

1. Identify and quantify the key variables that impact an Article 31 outpatient clinic's financial performance.
2. Model different scenarios by modifying variables to better understand the relationships between those variables and the effect they have on a clinic's financial performance.
3. Set benchmark standards for the variables with the confidence that meeting the benchmarks will result in the desired financial performance.

The Benchmarking Tool represents the synthesis of a financial budget and a diagnostic financial model. This allows you to plan for staffing and programming needs, while simultaneously testing the model under different scenarios to observe the impact it has on your bottom line.

The modules provided are as follows:

Module 1	The Tabs of the Financial Benchmarking Tool
Module 2	Orientation to Financial Benchmarking Tool
Module 3	Indirect Costs
Module 4	Direct Cost
Module 5	Conversion and Analysis of CPT Weights
Module 6	Effective Utilization of CPT Units
Module 7	Analyzing Overall Model for Effective Decision-Making
Glossary	Key Terms; included terms have an asterisk* next to them throughout the document

Acknowledgements: Special thanks to Kafui Nukator, Chloe Ettari, and Irene Chung for their critical work in enabling the publication of this guide.

Module 6: Effective Utilization of CPT Units

This module discusses the importance of diversifying the **Service Mix*** by distributing services across the billable **CPT*** codes, as represented by a percentage breakdown of total services. In doing so, clinics can determine how efficiently they are providing services (average CPT weight per contact); what gaps in services they could address (e.g. adding groups); current revenue; and how the services they currently provide align with their available resources. Both the CPT Tab on the CTAC Financial Model and on the CTAC Service Mix Calculator (posted after this training was aired) can be used to look at and model various scenarios with these different variables. Click here to view the video or slides.

One of the major themes covered in this training module was the **CPT Service Mix.*** Service mix is different than the **payer mix*** variable, which is comprised of your different payers and their differing reimbursement rates. The goal of a service mix is to give you a weighted average of the expected revenue per CPT unit generated in your clinic, as well as the average CPT weight per contact.

The Average **CPT*** weight reflects the overall average of Contacts per Service CPT Weight. It represents the overall avg CPT weight of the services provided and does not reflect upon the actual time spent providing the services. That would be considered productivity, which measures the efficiency of the agencies available billable time measured by the total Weighted CPT Units provided divided by the Clinical **FTE's***.

For example: Provider A whose Avg CPT Wgt is .6206 vs. Provider B whose Avg CPT Wgt is .9202 does not reflect on the efficiency of the provider, but reflects the overall type of services provided. It would be expected that Provider A would produce more billable visits since the services they provided (.6206) take less time than Provider B (.9202).

When the model is calculating the revenue (after you have entered your **payer mix***), it does so as per 1 CPT unit of service (payment/CPT weight) and therefore you can calculate the payment per CPT unit.

APPENDIX I: Glossary of Key Terms

Available Weeks per Year (Psychiatrists): The number of weeks in the fiscal period that your psychiatric staff is hired to work at your clinic.

Average Annual Cost per Direct Care Staff: Salary

Bottom Line (Operating Margin): The total revenue for the clinic in a given fiscal period, minus its total costs.

Controllable indirect costs: Includes personal services, associated fringe benefits, staffing, equipment, and supplies, etc.

CPT (Current Procedural Terminology): Roughly the percentage of an hour that is allotted to a specific procedure (given that a psychiatrist does not need to be present). It is weighted to include enough time for the procedure and spare time to complete the paperwork associated with delivering a service.

Direct costs: Pertain to your employee staffing requirements for providing clinical services. Include salaries (adjusted to direct care full time equivalents), fringe expense, and contracted fee for service direct care payment.

Financial Model: Abstract representation of a clinic's operations displayed in Excel.

FFS/Consultant Unit per Hour: The amount of CPT units generated per hour of fee for service care.

Fringe Expense: The fringe expense % of gross pay = (total mandated + total non-mandated fringe benefit costs) / (personal services cost).

FTE: Full-Time Equivalent.

Hourly Consultant/FFS rate: The average hourly rate of the fee for service staff.

Hours per Week: The number of hours in a standard work week.

Indirect costs: Come from each clinical position's indirect care salary. This is automatically calculated for each position once their Full Time Equivalents (FTEs) and % of direct care is entered into the Employee Direct Care Tab and Fee for Service Tab.

Non-controllable indirect care costs: Include rent, electric costs, insurance, and fringe benefits.

Other Revenue: Includes other miscellaneous revenue that the clinic brings in.

Payer Mix: represents the percentage of your patient-based billable service payment providers and the reimbursement rate from each. This yields a weighted average of the revenue per Current Procedural Terminology (CPT) Unit equal to 1.0.

Psych Units per Hour: The number of psychiatric care CPT Units generated by your psychiatric staff within one hour.

Ratio of Billable Hours to Total Paid Hours: Ratio of the amount of time spent in providing billable services in a time period divided by the total number of paid hours in the same time period (including work and leave time).

Service Mix: The mix of different types of services that are provided. Looking at your service mix can allow you to understand the combined average CPT weights provided based upon your normal mix of services.

Surplus/Loss: Refers to the operating margin. This is the total costs subtracted from the total revenue. (After subtracting sick time, vacation time and other time) divided by the total number of paid hours in a fiscal period (work week in hours multiplied by the number of weeks in the fiscal period).

Total cost: Sum of your direct costs and indirect costs.

Total Indirect Care Cost: Total Indirect Personal Services + Fringe Benefits + FFS Indirect Care Cost + Sum of the Inputs (Other Operating Expenses, Equipment, and Rent) + Administrative Overhead.

% of Non-Direct Psychiatrist Time: The percentage of your total psychiatric staff's hours that are spent on indirect care.

APPENDIX II: Key Drivers of the Model

Key drivers of the model refer to the most sensitive variables within the model. These variables are the specific figures and values that you plugged in earlier to complete the Benchmarking Tool. Of all the variables that you have plugged in, the key drivers are a handful of inputs that illustrate the greatest impact on your bottom line.

The Key Drivers of the Financial Model include:

- **Fringe benefit*** expense
- Work week in hours
- Indirect care cost
- Productivity (ratio of billable hours to total hours)
- Distribution of time between indirect care and direct care responsibilities for supervisory staff
- Percentage of Medicaid/Medicaid Managed care

Common Diagnoses

Some of the most common diagnoses for operational inefficiencies include low productivity, high **indirect care costs***, and the distribution of costs between direct and indirect care.