### INTRODUCTION

It will be important to understand where I have been and the structures that I have managed under. They have shaped the business models I favor.

<table>
<thead>
<tr>
<th>Medical School</th>
<th>My Role</th>
<th>Public/Private</th>
<th>Relationship to Parent</th>
<th>Practice Plan</th>
<th>Legal Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rutgers New Jersey Medical School</td>
<td>Dean’s Finance Office</td>
<td>Public</td>
<td>Financial</td>
<td>Integrated</td>
<td>Separate Not-For-Profit Corporation</td>
</tr>
<tr>
<td>University of New Mexico</td>
<td>Dept of Medicine Administrator</td>
<td>Public</td>
<td>Financial</td>
<td>Integrated</td>
<td>Owned by University</td>
</tr>
<tr>
<td>University of Arizona</td>
<td>Dept of Medicine Administrator</td>
<td>Public</td>
<td>Financial</td>
<td>Integrated</td>
<td>Separate Not-For-Profit Corporation</td>
</tr>
<tr>
<td>University of Florida</td>
<td>Dept of Medicine Administrator</td>
<td>Public</td>
<td>Financial</td>
<td>Integrated</td>
<td>Separate Not-For-Profit Corporation</td>
</tr>
<tr>
<td>University of Arkansas for Medical Sciences</td>
<td>College of Medicine Chief Financial Officer</td>
<td>Public</td>
<td>Financial</td>
<td>Integrated</td>
<td>Owned by University</td>
</tr>
</tbody>
</table>
Med School Organizational Characteristics

Characteristics that drive and control the revenue streams of medical schools.

FY2014 MEDICAL SCHOOL COUNT

- 141 Medical Schools recognized by the LCME

Using average revenue, private medical schools are larger, have a larger proportion of clinical revenue and higher tuition rates, than public schools.

FINANCIAL RELATIONSHIP TO PARENT UNIVERSITY

- Financially Autonomous
- Financially integrated with University
- Invested Institute
- Other

80% 8% 6% 5%

Dean's control, risk, and autonomy.

Med School Organizational Characteristics

DEAN'S RESPONSIBILITIES OTHER THAN THE MEDICAL SCHOOL

- Other Responsibilities
- Faculty Practice Plan
- Faculty Practice Plan, Hospital or Health System

85% 12% 3%

FINANCIAL LANDSCAPE

- Dean's with no faculty practice plan oversight generally have limited ability to manage compensation, and significant changes in investment strategies
- The Dean's ability to make decisions regarding use of hospital's margin greatly increases the medical school's ability to invest in the academic missions (research, education and clinical quality)
Revenues Supporting Medical Schools

FY2014 Revenue Streams

<table>
<thead>
<tr>
<th>Public Medical Schools (Count 78)</th>
<th>Private Medical Schools (Count 52)</th>
<th>Public vs Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Plans</td>
<td>Hospital Purchased Services</td>
<td>36%</td>
</tr>
<tr>
<td></td>
<td>Federal Grants</td>
<td>19%</td>
</tr>
<tr>
<td></td>
<td>Medical School Endowment</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>Federal Government Support</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>Tuition and Fees</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td>Other Grants</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Endowments</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Gifts</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>All Other Sources</td>
<td>4%</td>
</tr>
<tr>
<td>Mean Total Revenue</td>
<td></td>
<td>$639 M</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$1,061 M</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-$422 M</td>
</tr>
</tbody>
</table>

The average private medical school is 66% larger than the average public school.

10 Year Trend of Average Total Revenue, Public vs Private

Medical Schools, both public and private have achieved steady growth of 2.6% over the last 10 years, even when adjusting for inflation (real growth).

When you put this growth together (increasing the number of medical schools and the average revenue growth of medical schools), it creates a dramatic growth trend. From 1977 to 2014 (37 years) total medical school revenue has grown 2564% or an average of 9.3% every year for 37 years.

Revenue by Source for Medical Schools, FY1977 through FY2014

This represents data for 130 fully accredited medical schools in FY2014

Total Revenue Sources $105,013,000,000

This is big business and it is growing.
Revenues Supporting Medical Schools

The financial needs of medical schools have outstripped the historical funding mechanism. In FY 1977 clinical service revenue accounted for only 20% of the total revenue, increasing to 58% in FY 2014.

Clinical Practice Plan Trends

As the fee for service models transition to value-based reimbursement models, health plans will see more and more of their revenues "at risk".

Clinical practice plan growth tops the charts for both public and private. Remember total revenue growth is 2.6% overall, thus other revenue streams are growing at a reduced rate or not growing.

Federal Grants and Contracts Trend

Using a "constant dollar" perspective, the grant resources have reduced over the last 10 years. Again, leaving clinical revenue as the prime pump for fueling growth and new initiatives.
The NIH budget has been relatively flat for decades, increasing competition for existing grants and forcing researchers to seek new funding streams.

Given the loss of federal grant revenue, it is easy to understand the increased competitive nature of grant applications. Often long-time funded research faculty must re-invent themselves into full-time clinicians.

Tuition and Fees Trend

Despite this revenue stream contributing very little proportionally to a medical school's total resources, medical schools have continually made this conscious decision to raise rates at these levels.

BUDGETING PRINCIPLES
Budgeting Models

If you have seen one Medical School’s budget model, you have seen one Medical School’s budget model.

Budgeting Principles

**Budgeting Principle #1:** Responsibilities must be assigned, authority delegated and accountability implemented

- Cannot spend what you don’t have [the concept of “spend now and ask for forgiveness” weakens your position to make meaningful impact to the institution and vice-versa]
- Revenue allocation is based on output, priority, and not historical spending [if resources are not allocated based on output, output is not meaningful and will not drive performance]
- “Use-it-or-lose-it” budgeting [Otherwise called, “expense based budgeting”; discourages mindful spending habits; potentially punishes departments twice]

**Budgeting Principles…continued**

- Departments/divisions/sections exceeding expectations must be rewarded [excellence must be recognized and incentivized]
- Limit year-over-year changes [departments need guardrails to ensure principles can be followed; “fairness” does not trump political influence]
- Profitable services will subsidize less profitable services [in order to manage within today’s highly specialized environment, “eat-only-what-you-kill” will drive discord]
- Revenues, expenses, and productivity measures must be transparent and as real-time as possible [creates trust, an accountable culture, gives leaders the tools to assess performance, engages system in process improvement; encourages and develops data driven decisions]

**Budgeting Principles…continued**

- Revenues [resources] and taxes must be spread using consistent metrics [helps to establish a predictable environment; enables leaders to more easily develop investment opportunities; major annual changes create mistrust]
- Overhead units, such as chair’s offices, must be held accountable and transparent [this is a common source of mistrust, and can help to repair it]
- Whatever is done, it needs to be done consistently [major annual changes only bring uncertainty and will tire and overwhelm the institution]
Building the Case of Your New Program

In case you didn’t catch the message earlier, the clinical mission is the funding stream for the majority of incremental education and research initiatives.

Other funding streams occasionally available to chairs and chiefs to grow research and education initiatives include:
- Start-up packages
- Foundation, endowment and gift spendable balances
- Special state-appropriation
- Hospital subsidy support
- Department positive margin or positive budget variance

Depending on your institutional/departmental budgeting principles these principles may or may not resonate for your individual situation.

Avoiding Business Plan Pitfalls

These pitfalls will focus on outlining clinical revenues as the funding mechanisms for new faculty or new initiatives

1. Must prove incremental revenue

   Such a simple concept, but rarely acknowledged

   16,000 wRVUs
   +
   4,000 wRVUs
   =
   20,000 wRVUs

   In total generating 16K wRVUs or an average of 4K wRVUs each.

Building the Case of Your New Program

Every leader Dean, Department Chair, Division Chief has their own philosophies that you must learn and adapt to.

Answer the questions they want you to answer, even your ideas are better then theirs.

When building the case for a new faculty or any new initiative, there are many common pitfalls, when not addressed, create delays or reactive disapprovals.

If these pitfalls are acknowledged within the business plan up-front, it will provide a more full picture for those reviewing and approving, which should expedite an answer.

The expedition of "YES" and the expedition of "NO"
Avoiding Business Plan Pitfalls

These pitfalls will focus on outlining clinical revenues as the funding mechanisms for new faculty or new initiatives

- Must prove incremental revenue
  a) Clinic and procedural revenue is usually easier to justify by pointing to patient appointment wait times, new vs return patient ratios, year-over-year growth, positive budget clinic volumes, etc.
  b) Inpatient revenue is tougher; must show growth by annual trends, opening of additional medicine beds, new affiliate partner to increase transfers, etc.
  c) First year should always have a ramp-up period; no faculty will be 100% productive the first year (e.g. learning systems, growing patient panels, and collection lags of 30 to 90 days)
- Actual duties must equal or exceed assignments across all missions: Clinical FTE of 0.80 FTE with only 5 ½ day clinical session is not fully assigned

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Avoiding Business Plan Pitfalls

These pitfalls will focus on outlining clinical revenues as the funding mechanisms for new faculty or new initiatives

- Don’t use down-stream-revenue for the proforma; acknowledge down stream revenue through referral counts, especially trends over time; subspecialists and the hospital already count these revenues for their business plans
- If PA/ARNP/APRN do not bill independently, then their revenue is already included in physician billing revenue;
- Add in an overhead rate for the college, departmental, and clinic, if applicable (e.g. dean’s taxes); this will give a more realistic projection of the departmental or divisional financial impact

...continued

Avoiding Business Plan Pitfalls

These pitfalls will focus on outlining clinical revenues as the funding mechanisms for new faculty or new initiatives

- Productivity and compensation must be in alignment (e.g. if compensation at the 50thile benchmarks, then productivity must be at or above the 50thile benchmark)
- Don’t use benchmarks to set base salary; most compensation benchmarks represent total compensation (base + supplement + incentive, including VA salary)
- Most compensation benchmarks, such as AAMC salary survey, include all faculty within a given rank; avoid use these benchmarks to set compensation standards for graduating providers

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Avoiding Business Plan Pitfalls

These pitfalls will focus on outlining clinical revenues as the funding mechanisms for new faculty or new initiatives

- When using academic wRVU benchmarks, such as UHC or academic MGMA, don’t discount provider clinical FTE for clinical teaching roles, such as inpatient attending or a fellows clinicational activity with residents, fellows and medical students
- Don’t add incremental teaching time to each new faculty without adjusting current faculty assignments; just hiring a new faculty does not in-and-of-itself create more teaching need
- With all new initiatives and new hires, it is best practice to outline measurable outcomes; this helps to ensure expectations are in alignment
Thank You

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