**UNIVERSITY OF ROCHESTER MEDICAL CENTER**

**OPERATING BUDGET PROCESS**

**PROVIDER MODEL INSTRUCTIONS**

**FISCAL YEAR 2025/2026**

*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, HH 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 they will be included without a named provider.  These positions must be budgeted for in the Provider Model.*

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

* *For Effort, you will be identifying how a provider (Faculty and APP) is spending their time on the following activities: Clinical, Admin, Research, Academics, and Contract/Other. This information is important when modeling compensation alignment as well as determining the appropriate allocation of pay across companies and FAO’s. Please refer to the updated “Effort Definition” section on page 5, as additional activities have been added to each Effort category. Carefully review the differences between Administrative and Academic activities when allocating Effort between those two categories. These categories apply for both Faculty and APPs.*
* *In addition to completing the allocation of 100% effort across categories, 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. Administrative roles are generally supported by EITHER protected Administrative Effort OR a stipend. 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.*
* *The provider model allows you to budget both target and incentive wRVUs (if applicable). Please include projections for FY25 and budget for FY26.*
* *Incentive wRVUs should represent an achievable target, not a stretch goal, and should align with budgeted Incentive Compensation.*
* *HB wRVU’s will appear in a separate line called SMH HB or HH HB. However, HB Revenue is calculated separate from Provider Model, so you will not see charges or revenue related to HB pulled into Axiom.* ***It is still imperative to do a projection and budget for HB RVUs.***
* *Ensure base and incentive wRVUs are budgeted in the appropriate FAO based on where the clinical work will take place.*
* *NEW: Currently wRVUs are spread to the months based on days. If you would like to adjust the spread for ramp up, seasonality, or planned vacations – use the Incentive Row to make adjustments. For example, you may want to -200 in the month of July, but add 200 the month of November. Please just make sure your adjustments net to zero across the row.*

*If you are a department that uses the incentive wRVU row already, contact your finance liaison and we will help you make the spread adjustments.*

*NEW: If you increase wRVUs greater than a 3% increase, please provide explanation.*

***Compensation (View 3)***

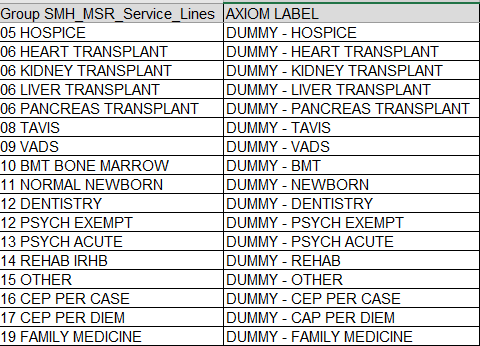
* *Please pay close attention to compensation for Administrative Roles. Admin roles should be charged to SMH, MFG or SMD dependent upon the function. Programmatic departmental roles should be charged to a distinct Admin FAO, if available. Please budget appropriately based on % of effort spent on these roles.*
* *When budgeting provider compensation, keep in mind alignment. The overall goal is to align provider compensation to +/-10%tile, however, this is dependent upon leadership review and Medical Center affordability. At a minimum, the mean alignment across each department and division should be within +/-10%tile even if individuals may stray outside those bounds. Compensation Tool Kit Reports are available in Provider Maintenance to model compensation and productivity compared to your department specific benchmark surveys (URB309 Provider Toolkit Report). 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.*
* *NEW: If Provider compensation increases are greater than 3% please provide explanation.*
* *NEW: The wage and salary program has not yet been announced, but for now please include a 3% increase for APPs and Physician Assistants. Staff wage and salary will be added via a driver when the program has been announced.*
* *Ensure that the FTE allocations by FAO align as much as possible with the Effort Distribution inputted in View 1.*
* *Input incentive compensation at the FAO level. The goal is for the incentive pool for each department and division to be at least 10% of Total Compensation.*
* *Compensation for clinical activity should be budgeted in a way that aligns with the revenue stream generated by that clinical activity and the associated effort. This would supersede historical commitments that direct expense to a company not associated with the clinical activity (compensation should be charged to the company/FAO where the professional revenue is recorded).*
* *Any changes from SMH/MFG to SMD or vice versa will need review by Finance leadership. Transfers between SMH and MFG that follow funds flow do not require additional review.*

***Revenue (View 5)***

* *Axiom is loaded with your current July-Nov Net Revenue per 2021 CMS 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 FY26 budget by provider and location.  Incremental cases in Provider Model will be automatically calculated by comparing a straight-line projection of FY25 July-November cases with the FY26 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 attending physician at discharge.  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.  Please note that for inpatient case discharges some specialties are not budgeted/reported down to the provider level (as seen on the MSR Report). As a result, inpatient case discharges within the following specialties should be excluded from individual provider case budgets. To budget these specialties as a group please work directly with decision support.*



***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). Also, if any providers have left their activity will also appear in the All Other Report.*
* *Please contact your finance liaison for help in how to budget this additional revenue.*

**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 Hierarchies.*
* *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 Hierarchy, 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*
  + *URB309 Provider Toolkit Report*
  + *URB309 Provider Toolkit Report by FAO*
  + *URB310 Case Actuals Tie Out*

***Check-list***

* *The goal of the Provider Model Check List 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 by the end of 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 and care to patients enrolled on clinical trials
  + Phone calls/telemedicine visits with patients, caregivers and other providers even when not billed by the provider
  + Direct patient contact
  + Interpretation of diagnostic clinical data relating to the care of a patient
  + Indigent care
  + Care coordination and supervision of residents/fellows, RNs and APPs while seeing patients
  + Chart review, documentation, preparing and signing orders, review and signature of home health care paperwork, and other office work related to clinical activity
  + Meetings focused on review and recommendations on individual patients

**Administration**

* + Department chair or chief duties
  + GME program administration
  + Medical director activities
  + EPIC Physician Builder role activities
  + Supervision of professional or technical staff (excluding GME trainees) while not providing patient care
  + Preparation for and attendance at internal administrative meetings
  + Quality Assurance, Diversity and Inclusion, Regulatory, and other activities
  + Other specified and defined time for hospital or practice administration

**Research**

* + Funded research activity (salary supported by grant), including foundational work to establish feasibility/baseline data, activities maintaining compliance around specific research projects, data collection and analysis, writing progress reports or papers on specific research projects, and supervising staff/mentoring trainees in a specific project
  + Unfunded clinical research (protected time)
  + Grant/proposal writing
  + Serving on the IRB or other research-oriented committees
  + Peer review of grants
  + Other professional development/scholarly activities (e.g., papers)

**Academics**

* + Didactic teaching of GME trainees and preparation for meetings or classroom sessions related to didactic teaching
  + Extra-departmental teaching or course directorships
  + Peer review of journal articles, editing of book chapters and journal articles
  + Lectures, Grand Rounds and other CME activities
  + 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.