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Jonathan J. Clark

improving hospital budgeting and accountability a best practice approach

If your organization is struggling to achieve its budget targets, your budget process itself may be the culprit. It may also hold the solution.

AT A GLANCE

Best practices in setting and managing healthcare organization budgets include:

- > Using comparative benchmarks
- > Setting accurate, high-performance department budgets
- > Establishing a culture of accountability
- > Managing expenses
- > Monitoring variances and requiring corrective action plans
- > Employing a balanced scorecard

Like many health systems, the University of Utah Hospitals & Clinics has struggled to achieve its operating budget targets. For instance, during FY1997-2003, UUHC was successful in meeting its budgeted operating margin targets in only three of those seven years. As a result, it realized a lower-than-expected average annual operating margin of 1.63 percent (1.13 percent lower than its average annual budget target of 2.76 percent).

During that period, UUHC spent, on average, \$15.8 million more each year than was budgeted for—representing a 5.3 percent average budget variance. However, a closer look revealed that \$7.7 million of the \$15.8 million constituted necessary expenses attributed to unforeseen volume growth after the budgets were initially set. The other \$8.1 million can, in general terms, be attributed to a failure to control the budget.^a

“We did a study of healthcare organizations over several years to determine what ‘good to great’ organizations were doing differently in their budget process than the ‘bad’ organizations—or those that were improving the least. A strategic plan was their key for success in determining capital requirements and setting pro formas. This is the palpable difference between good and bad organizations: Good organizations have a strategic plan that targets a specific operating target they ‘have to’ achieve to fund projects and their vision of the future. It was a ‘gap’ that they were after, or the cash they needed to generate to build their plan and fund their aspirations and dreams. The gap became their driving will to change, driven by a vision for success.”

—Tom Day, Healthcare Management Council, Needham, Mass.

a. Between FY1997 and FY2003, UUHC’s revenue growth of 50 percent outpaced its volume growth of 31.5 percent. However, UUHC’s expense growth of 52.5 percent outpaced its revenue growth by 2.5 percent. Multiplying the 2.5 percent by total operating expenses over the seven-year span shows that UUHC spent, on average, \$7.8 million each year in additional, nonvolume-related operating costs. Dividing the \$7.8 million by 96 percent, to add a 4 percent margin to each dollar of cost (i.e., the expected 104 percent net ROI for each dollar of cost for academic hospitals), shows that UUHC really spent \$8.1 million each year in additional, nonvolume-related operating costs.

Although it can be argued that the extra money needed to be spent, it is hard to conclude that it was necessary to spend an additional \$56.7 million (approximately \$8.1 million per year over the seven-year time period). Such an amount represents a huge cash outlay, eaten up in operations rather than strategically deployed in capital investments to further the institution's teaching, research, and patient care missions.

To help UUHC achieve optimal financial performance, Richard Fullmer, UUHC's executive director, hired Gordon Crabtree, former managing director of finance for the Salt Lake 2002 Olympic Organizing Committee, as UUHC's CFO and financial coach. Crabtree had helped make the Salt Lake 2002 Olympics a great financial success for Utah by leaving a several-hundred-million-dollar surplus and facility legacy. He has focused some of his early effort at UUHC on the operating budgeting process, the backbone of all financially healthy institutions.

Among other things, Crabtree is improving UUHC budgeting results by setting budgets based on a strategic point of view to fund future growth and operations. His approach is to first set the volume or revenue side of the budget and then balance it by driving down the cost side and by providing managers with the following year's budgets based on historical performance to hold costs down. Crabtree manages the budget through educating hospital management about budgeting and finance, offering incentives to stay within budgets, holding budget variance meetings with managers, and requesting corrective action plans from managers whose budgets are outside targets.

In just two years, Crabtree and his finance team have already helped UUHC achieve improved financial results. For instance, in FY04, UUHC achieved a 3.12 percent operating margin (1.06 percent above the 2.06 percent budgeted margin target). In addition, UUHC spent only \$4.9 million over budget in costs. In fact, only \$0.7 million of the \$4.9 million was attributed to a failure to control the budget, while the other \$4.2 million were necessary costs attributed to

"The strategic plan is the classic thing that evaluates market share, demographics, services, competitors, individual programs and their individual market shares, and contribution margins. Then the plan defines specific areas of opportunities and challenges and determines where to invest the money. When you bring budget targets to managers in the context of expanding your cancer center or something like that, you get them to buy in to the future plan of the hospital. You should focus on the profitability levels to generate internal capital and access to external capital. Organizations should integrate the strategic plan to the financial plan and the financial plan to the budget and capital allocation. Most organizations don't create that integration, because the budget process is a political process. But the strategic plan should be integrated with an overall financial plan. Then the budget becomes year one of the financial plan. The financial plan quantifies the strategic plan in terms of capital, revenue, and costs. You come up with baseline projections and build a financial plan for each initiative. Then decide what correct portfolio of the strategies work—which to pursue, the timing, and capital allocation of these strategies."

—Jason Sussman, Kaufman, Hall & Associates, Northfield, Ill.

unforeseen volume increases from the point at which the budget was initially set.

As most managers are aware, the operating budgeting process comprises two parts—budget setting, in which budgets are established prior to the beginning of each fiscal year, and budget management, in which budgets should be monitored and controlled. If either is not properly executed, year-end financial results can be problematic and expectations can be missed.

Best practice budgeting includes, among other steps, setting accurate budgets, establishing accountability, monitoring variances, and managing expenses. The following is a summary of best practice budgeting principles assembled for UUHC based on a review of the Advisory Board's 2003 document *Disciplined Growth: Instilling a Culture of Financial Accountability*, and interviews conducted with various healthcare consulting firm executives, hospital CFOs, and hospital budget managers. The principles are categorized into the budget setting and budget managing processes.

Budget Setting

Basing the budget on a strategic plan. The hospital budget should be based on a five-year strategic plan to understand its capital needs and gain

buy-in and managerial support for budget targets. The strategic plan should be integrated into a financial plan that calculates cash, debt, capital, and profitability requirements to fund routine and five-year strategic plans and maintain financial integrity. The first year of the finance plan is the current year's budget. Academic hospital budgets should be set to obtain at least a 3 percent to 5 percent operating margin target.

Collaborating with internal organizations. The hospital budget should be based on the mission, strategy, and financial plan of the entire health system. For instance, in an academic setting, this should include the school of medicine and faculty practice organization. In this case, the dean or vice president of health sciences should be heavily involved in the hospital budgeting process to understand, influence, and oversee school and hospital budgets that are ultimately intertwined. The hospital should understand and accurately budget for the flow of funds to the school of medicine, so it knows what specific dollars are going to what missions, and understands the sources of those dollars.

Projecting conservative volumes with physician involvement. The hospital should work with physicians, the faculty practice organization, or the school of medicine to make accurate budget projections, particularly with volumes and revenue. Volume projections should be kept conservative and should not be used to balance the budget. Medical directors should be held accountable to volume projections each quarter.

"You need to be very conservative in budget projections by not letting volumes run the budget. If you are trying to hit a 3 percent margin, you might say, 'We have to cut \$1M to get it.' However, others will ask, 'How many admissions is that?' It's easier for them to get to the 3 percent margin by adjusting the revenue side rather than the expense side. Many organizations are too optimistic on revenue or volume projections, and they balance the budget on the revenue side rather than on the expense side. When they get into a jam and have to cut expenses, they just increase the revenue projection."

—Quint Studer, The Studer Group, Gulf Breeze, Fla.

Presenting and owning the budget. Once the budget and operating margin target are finalized, the CEO and senior management, as a unified team, own the budget and are accountable for meeting it. The CFO and the finance department do not own it. The CEO presents the annual budget and operating target to the entire management team to endorse the budget and establish the expectation of obtaining it. The CEO should also communicate the methodology and need basis for setting the targets to gain buy-in and support from hospital management.

Using comparative benchmarks annually. External cost and productivity benchmarking should be performed annually to help set appropriate cost per unit of service and productivity standards. Benchmarks should be used once a year to find cost savings opportunities to identify areas to fill

"CFOs can't possibly survive if there is no board and CEO support. The forces are already against them. The board members should have the imperative and expectation that they are going to hit their budget. Persistently not hitting the budget results in a change at the top. Unless the board lays down this kind of law that clearly, then the 15 department chairs and the physicians are already against you. Getting that support from the board is critical. And the CEO pretty much follows the board."

—John Short, PhD,
Phase 2 Consulting, Salt Lake City

the budget "gap." Yearly performance improvement, from current levels of performance, should be at least 25 percent of the benchmark goal until it is achieved. Accurate comparison groups should be used at the cost center and line-item levels to ensure data are normalized.

Setting accurate, high-performance department budgets. Finance should give department managers their budget targets (not vice versa), based on historical performance, external benchmarks, and overall budget goals. High-performance budget expectations should be set for all departments, both profitable and unprofitable, to increase contribution margin and decrease losses. Labor,

"The departments, not finance, are responsible for the budget. The leadership team holds the departments accountable. Our culture here is that the CEO holds everyone accountable. Finance does not assume that role. The CEO holds the hammer."

—William Dinsmoor,
University of Nebraska, Omaha, Neb.

supply, and other budgeted costs per workload unit should be evaluated and reset in order to improve consistently low-performing departments.

Leveraging the finance department. The finance department should function as a support and resource to the operational vice presidents by providing financial data, variance reports, operating statements, and other information. Financial or budget analysts should be assigned to specific departments to learn the uniqueness of each department and establish a single point of contact, for increased efficiency. The finance department should be responsible for providing mandatory budget, general finance, and cost accounting training and education to all department managers and directors.

Budget Managing

Establishing a culture of accountability. Senior management should have a firm resolve about reaching the budget targets they set. Budget meetings should involve a department manager and director who meet with a budget team

"Typically, for most hospitals, the budget process involves senior management focusing on the losing departments and trying to get them to break even, or at worst case, shutting them down. It is critical that hospital management never take its sight off all the departments—winners and losers alike. Every single department in the hospital should be closely managed all the time. That oversight is the responsibility of senior management. The profitable departments become more profitable, and the unprofitable departments become less unprofitable. How do you know, for instance, that the operating room or radiology should not be making a lot more money than they are? The pressure of running those departments well should be just as strong and consistent as the pressure of increasing the management of poorly run departments. High-performance budgets should be set for all departments. All should contribute to the overall strategic and financial target of the institution."

—David Hefner, Computer Sciences Corp., El Segundo, Calif.

consisting of the appropriate vice president, the CFO, budget director, and controller to instill senior leadership accountability into the process. Job descriptions for managers and higher positions should contain business and budget management requirements and expectations, against which performance can be measured and reviewed. Senior management should explain to managers that they will be evaluated and held accountable in year-end review meetings in

"We issue monthly variance reports and require monthly explanations to those variances. It has to be done monthly. I get a very thick report each month with a detailed analysis showing lab, surgery, and supplies. The report is drilled down to show me variances. Our leadership council meets and reviews action plans. If you are out of budget, they are in your face to get you back in place. Action plans are required by the operational vice presidents depending on the variance."

—Dennis Herrick, William Beaumont Hospital, Royal Oak, Mich.

which salary increases and job security can be affected, and that meeting budgets is not simply a goal but a managerial requirement.

Managing expenses. Department managers should primarily focus on expenses rather than gross revenue. A dollar of savings is a dollar to the bottom line, whereas a dollar of revenue is much less. Net revenue and contribution margin should not be reported on department operating statements because they are estimated and inaccurate, and can lead to poor decision making. Individual department budgets should reflect cost savings

opportunities from cost-cutting or revenue enhancement initiatives to hold managers accountable for realizing the savings.

Rolling budgets are important in reforecasting year-end results. As managers exceed budget expectations early in the year, they should hold

"We also have a weekly budget management group, or 'margin management group,' consisting of the CEO, CFO, and senior vice presidents who meet every Monday for three hours to go over budgets, variances, action plans, and decisions where we rebid contracts, etc. We also call managers with large variances into these meetings. You can call it our 'behavior modification program.'"

—Michael Burke, Duke University, Durham, N.C.

to those early gains throughout the year. Monitoring costs against external benchmarks is most practical and carries more impact on an annual basis rather than quarterly.

Using flex budgets. Department budgets should be flexed, tie back to the hospital's master budget, and incorporate volume-adjusted staffing grids that are based on standards of productivity and costs per unit of service.

Monitoring variances and requiring corrective action plans. Volume-adjusted variances should be monitored monthly and made available to other department managers and directors for peer review. Variance explanations should be required monthly, and corrective action plans should be required within one week of variance reports. To heighten accountability, senior leadership should require department directors and managers to prepare and present action plans with specific timelines and tasks at senior leadership meetings.

Evaluating new position requests. The approval process for hiring new FTEs should include the CEO (or COO), CFO, vice president, and budget director. The process should ensure that labor costs per unit of service do not increase and that they stay within benchmarks.

"The typical problem I see in the budget process is that budget season is open season for getting new positions. The focus should be on strategic issues, not adding three FTEs in this cost center, or five FTEs in that cost center."

—Tom Honan, Hunter Group, Chicago

"There should be a balance among lowering cost, improving quality, and improving satisfaction. Nursing also needs a quality report card that shows volume information, staffing, nurse-to-patient ratios, and quality indicators. Each month, this management tool should be given to nurse managers. You can't focus only on cost, but should look at cost, quality, and satisfaction."

—Pat Cooper, Quorum Health Resources, Brentwood, Tenn.

Employing a balanced scorecard. Cost containment and cost reduction should be balanced with improving quality as well as patient and employee satisfaction when reviewing management performance.

Rewarding and recognizing management. Management should be rewarded and recognized for exceeding budget expectations based on a balanced scorecard (50 percent of the bonus is often tied to finances and 50 percent to quality). A typical bonus structure is 10 percent of salary for directors, 20 percent for vice presidents, and 25 percent for COOs and CEOs. Managers' bonuses should be 50 percent of those of directors.

Conclusion

Viewing budgeting as a two-part process—budget setting and budget managing—and implementing best practice principles within each part can help hospitals generate better year-end financial results that can be invested in teaching, research, and patient care, and improve financial viability. ●

About the author



Jonathan J. Clark is administrative director of operations, University of Utah Hospitals & Clinics, Salt Lake City, and consults for Phase 2 Consulting. Questions or comments about this article may be sent to him at jon.clark@hsc.utah.edu, or at jjclark@phase2consulting.com.