FEATURE STORY

Steven H. Berger

10 ways to improve healthcare cost management

If your hospital hasn't been achieving cost *savings*, maybe you need to make—or renew—a commitment to cost *management*.

AT A GLANCE

As a healthcare CFO, you know that effective financial control has enormous impact on a hospital's bottom line. But how do you maintain that financial control? Well, a few simple improvements in cost management techniques—assigning accountability, adopting useful monitoring and reporting methods, and reducing resource consumption, among others—can reap significant benefits.

Although not new in the lexicon of healthcare buzzwords, "cost management" is currently being tossed around in discussions of ways to help improve hospital bottom lines. CEOs are showing up at conferences that feature cost management topics, and COOs are pinning down CFOs for one-on-one primers on where the money is "hidden." Meanwhile, CFOs are scrambling to locate that elusive pot of cost management gold at the end of the rainbow.

Several issues are at the heart of managing cost: the quality of a healthcare organization's overall management, cost accounting issues that affect cost management, techniques that help organizations to save "real money," and tools that can help organizations achieve cost-management goals.

Cost Management as a Subset of General Management

Before we can discuss cost-management improvement techniques, it is important to recognize that cost management is a subset of overall management. As such, cost management will be only as good as the general management techniques applied throughout the organization. This is not a small matter. In any organization, the quality of the overall management determines whether cost-management techniques—or any other management techniques, for that matter—will succeed or fail.

First, it is imperative that the organization set management goals. This may seem simplistic; however, experience has shown that many organizations' management goals are contained within their budgeted expense line items. Such "goals" are not particularly helpful because they have been set in a fixed budgeting methodology, which does not take into account higher or lower volumes—a key element in the success or failure of a healthcare organization. Best-practice organizations set goals for cost per workload unit across the spectrum and have developed excellent reporting and monitoring techniques to ensure that their managers are meeting those goals.

Another primary requirement for effective management—one that is often overlooked, unfortunately—is accountability. Although many organizations

claim to perform cost management, they haven't always assigned accountability for the results. Accountability means the organization has developed consequences, both positive and negative, for the managers responsible for achieving the organization's goals. Positive consequences include salary increases as well as incentive compensation; negative consequences include discipline, remediation, retraining, demotion, and even dismissal if goals are not met.

Improvement 1: Enforce accountability. Ensure that the healthcare system adopts management accountability techniques that include specific positive and negative consequences for achieving (or not achieving) goals. Ask the following question: Have any managers been demoted or dismissed from the organization over the past two years for not meeting cost-management goals? If not, it may be because your organization has exemplary managers, but it may also be that accountability is lacking and the managers are aware that they are not required to meet the organization's goals—a sure sign that the organization will not be able to thrive.

Improvement 2: Monitor goals in a timely manner. Adopt effective monitoring techniques that highlight the goals and actual outcomes. Report these results to the affected parties on a periodic basis that allows managers and executives to rationally discuss results. The reports should be produced daily, weekly, monthly, quarterly, or annually as appropriate. For example, labor productivity should be reported as often as daily (even shift by shift), while payroll analysis is reported according to the payroll schedule.

Improvement 3: Report results using a balanced scorecard technique. On a monthly basis, develop and report financial and other results (clinical, operational, volumes, patient satisfaction) in a balanced scorecard format—that is, with aggregate information reported on a cover page with drill-downs to specific indicators. These reports should be developed at both the organization and department manager levels. To achieve its cost management goals, the organization needs to set those goals, monitor the results, and report the results to the appropriate managers in a simple yet powerful way.

BRILLIANT HOSPITAL BALANCED SCORECARD

Financial Perspective	**2.19**	**Needs Improvement**
Return on net assets	3.60	Good
Competitive position	0.83	Unsatisfactory
Volume growth	1.00	Poor
Reduced cash outlays	3.50	Good
Improved cash receipts	2.00	Needs Improvement
Customer Perspective	**2.20**	**Needs Improvement**
Patient satisfaction	2.20	Needs Improvement
Internal Perspective	**3.31**	**Good**
Product innovation	3.00	Good
Perfect orders (reduce errors)	2.50	Needs Improvement
Quality indicators	4.00	Excellent
Clinical outcomes	3.75	Good
Learning and Growth	**3.00**	**Good**
Strategic awareness	3.00	Good
Leadership surveys	3.20	Good
Mandated education hours per employee	2.80	Needs Improvement

Brilliant Overall Performance	**Score**	**Weight**	**Weighted Score**
Financial Perspective	2.19	25%	0.55
Customer Perspective	2.20	25%	0.55
Internal Perspective	3.31	25%	0.83
Learning and Growth	3.00	25%	0.75
Total Score		**2.67**	**Needs Improvement**

Cost Accounting Issues Affecting Cost Management

If a healthcare organization is seriously considering cost management, it must adopt a cost accounting system that is reliable, verifiable, understandable, and useful to the final user—the manager who will be held accountable for the results.

Cost accounting involves determining whether costs are variable (costs that vary in direct proportion to changes in volume of operations) or fixed (costs that do not vary with volume changes). These types of costs have significant impact on the organization's cost base. Cost accounting also involves determining whether costs are direct (directly related to the user department) or indirect (also known as overhead costs).

Knowing which costs are direct and indirect allows an organization to set standards relating to how much overhead (or support) costs it wants to carry, in relation to the costs allowed for revenue-producing departments. In this way, the organization knows it is spending the right amount for overhead costs, and is able to manage those costs.

Improvement 4: Establish a goal for overhead costs as a percentage of total costs. Doing so will allow individual hospital organizations to objectively evaluate the resources being consumed for services that support the revenue-generating operation. Overhead costs generally should not exceed 40 percent of total costs.

Improvement 5: Adopt flexible budgeting. Flexible budgeting ensures management accountability at the cost-per-unit-of-service level. Healthcare organizations need to consider adopting flexible budgeting and reporting techniques that allow administration and management to understand whether differences between budgeted and actual costs are related to a variance in the reported volumes or other elements, such as rate or efficiency variances. Flexible budgeting techniques remove volume as a variance factor by using cost per unit of service as a value, allowing the organization to focus its attention on the other areas.

Unscientific surveys suggest that less than 50 percent of hospitals have adopted flexible budgeting as a management technique. One reason often mentioned by CFOs and CEOs is a lack of comfort with flexible budgeting outcomes. For example, when volumes are down in a hospital department, flexible budgets will allow lower amounts of variable cost in that department's budget column. Thus, to stay within budget parameters, the managers must spend less money, or their performance against the goal will be unfavorable. Administrators typically like this side of the flexible budgeting equation because it allows them to make sure that managers have spent fewer dollars. However, these same administrators generally do not like the budget to provide more money, as when the volumes go up. Thus healthcare organizations often choose to retain fixed budgeting techniques. (If used properly, fixed budgeting would still take volumes into account.)

Improvement 6: Adopt benchmarking. Use benchmarking to set goals around the cost per unit of service.

Improvement 7. Develop percentile goals. When setting benchmarks, particular care should be taken regarding what percentile the organization will use. For example, most benchmarks are reported as the median results of the total number of organizations in the sample. If there are 99 hospitals in the sample, the results of the 50th hospital value (sorted in descending order) would be reported as the median (the 50th percentile). Still, that means that 49 hospitals achieved better results and 49 hospitals achieved worse. Administrators need to decide if they want to set goals at the median or better; best practice hospitals typically set goals between the 75th and 90th percentile. With percentile goals in increasing increments over time, the hospital can strive for, and achieve, continuous improvements in its cost per unit of service.

Cost Management Techniques that Can Save Real Money

It is important to remember that having a number of technical components (fixed/variable costs, direct/indirect costs, flexible/fixed budgeting) in place does not guarantee great or even good cost management. Healthcare organizations still need to get down to the nitty-gritty cost-management techniques that save the hospital "real money," defined as dollars that can be saved through reduction in labor or supplies.

Among these techniques, the two areas that offer the greatest opportunity for cost management are labor productivity and reductions in resource consumption.

Improvement 8: Determine labor ratio goals. Develop and use labor productivity management techniques to support the overall labor ratio and benchmark practice staffing ratios.

DRG 89 (SIMPLE PNEUMONIA), VARIABILITY OF PHYSICIAN VARIABLE COSTS FIRST QUARTER 2004

Physician Name	Cases	Length of Stay	Gross Revenue per Case	Expected Payment per Case	Variable Cost per Case	Contribution Margin	Fixed Cost per Case	Net Margin	Quarterly Difference between Actual VC per Case and Best Practice
Dr. Jones	8	7.14	13,610	6,244	4,205	2,039	2,701	(662)	9,640
Dr. Smith	7	5.54	10,453	4,052	3,189	863	3,771	(2,908)	1,323
Dr. Brown	6	7.33	15,325	5,404	3,414	1,990	2,617	(627)	2,484
Dr. Garcia	5	10.67	22,255	9,898	6,633	3,265	4,874	(1,609)	18,165
Dr. Chen	5	5.33	8,225	4,884	3,000	1,884	2,391	(507)	--
Others	53	5.92	12,059	5,865	3,364	2,501	3,620	(1,119)	19,292
Total	**84**	**6.51**	**13,076**	**5,899**	**3,606**	**2,293**	**3,475**	**(1,182)**	**50,904**

Labor is the largest component of cost in hospitals. According to information released in July 2003 by bond rating agency Fitch IBCA, the median percentage of salaries, contract labor, and fringe benefits divided by total operating revenue (labor ratio) across its more than 200 rated not-for-profit hospitals is 52 percent. In comparison, the 200-hospital HCA for-profit system has reported on its web site a level of approximately 40 percent over most of its existence. This dramatic 12-point variance highlights the major difference between not-for-profit and for-profit hospital management.

The author has discussed the reasons for the difference with hundreds of for-profit and not-for-profit financial and operating administrators in the financial management classes he has conducted over the past several years. The three principal reasons are:

- The for-profit systems are setting goals around this labor ratio.
- The for-profit systems are using management accountability to achieve the goals.
- The for-profit systems are using labor productivity management systems on a minimum daily basis to monitor the results of the set goals.

Unscientific survey results indicate that only 20 to 30 percent of not-for-profit hospitals have adopted labor productivity management techniques, and even fewer are aware of the all-important labor ratio. It is imperative that hospitals focus on labor costs and develop and implement plans to reduce them, according to benchmarks and best practices.

Improvement 9: Reduce resource consumption. Develop and implement action plans that move to reduce areas of excess resource consumption, as derived from benchmarks and best practices. Hospitals tend to use resources haphazardly. For example, patients with the same diagnosis can consume widely varying resources, contributing to significant excess costs to hospitals. The largest contributors to this variability are physicians, most of whom established their practice patterns during their medical school and residency training.

Hospitals have abundant opportunities to manage costs through clinical resource cost reviews, particularly at the individual physician level. With the right tools, hospitals can perform physician reviews that include net revenues, relevant costs (fixed, variable, direct, indirect), contribution margins, and net margins. The outcomes are often surprising. If the goal is to reduce consumption of resources, it is relatively easy, with the proper information, to determine the variability of the cost components controlled by each physician. The table above shows a striking variability among the top five attending physicians treating DRG 89—simple pneumonia.

Imagine if Dr. Jones, the physician with the most cases (eight) during the first quarter of the year, were able to reduce his variable cost per case from $4,205 down to the mean, $3,606. That alone would decrease the "real" variable costs in the hospital from $33,640 ($4,205 × 8) to $28,848 ($3,606 × 8), or a difference of $4,792. Over a full year, the difference amounts to $19,168. Further,

WANT TO CONTROL COSTS EVEN FURTHER?

For a list of HFMA technical documents, audio webcasts, seminars, and articles pertaining to cost control, go to www.hfma.org/resource/cost_control.htm.

COST-MANAGEMENT TECHNIQUES THAT CAN SAVE REAL MONEY

- Outsourcing
  - Food services
  - Environmental services
  - Plant operations
  - Information technology
  - Clinical services
- Use of pharmaceutical and medical supply formularies
- Establishment of a committee to evaluate new medical products
- Supply chain management
  - Supply chain automation (e-commerce)
  - Inventory management (reduced warehousing, increased just-in-time processing)
  - Accounts payable and supply chain audits
- Use of operational audits to support cost management efforts
- Overhead cost reduction review and analysis
- Training that supports cost-management efforts

imagine if all the physicians in this grouping were able to reduce their variable costs to the level of Dr. Chen, at $3,000 per case. The difference between the current variable costs and the internal "best practice" costs would be $203,616 ($50,904 × 4), for just five physicians, over one year, for one DRG. It is obvious that the savings opportunities are substantial.

Cost Management Tools that Help Hospitals Meet Their Goals

Healthcare organizations that practice cost management will find their cost base shrinking, both in cost per unit of services and total costs. But to realize the benefits of those reductions, organizations will likely need to invest in automated tools designed to process large amounts of cost data and report value-added results to the user. A variety of effective tools on the market allow the reviewer to develop information and reports to determine financial outcomes at physician, payer, patient, and clinical levels.

Improvement 10: Purchase and use effective cost-management tools. To achieve high-level outcomes, the following tools are mandatory:

> A cost-accounting system, developed at the chargemaster level, designed to provide information at the procedure code level for direct, indirect, variable, and fixed costs

> A contract-management system, designed to provide immediate and accurate net revenue information at the patient level

> A decision-support system, designed (through the use of drill-down capabilities) to allow end-users to manipulate cost accounting, contract management, budgeting, and benchmark data to produce information they believe will be productive in reducing the clinical cost variability and potentially change physician patterns of resource consumption

Again, unscientific class survey results indicate only about 30 percent of hospitals have availed themselves of contract-management systems. Thus, at least 70 percent of hospitals are not maximizing their information levels, nor do they have the systems to do so. Those healthcare executives must ask, "How can we expect our hospital to improve its financial and clinical outcomes if we do not have the information to manage it?"

Summary

Hospitals have substantial opportunities to manage their costs effectively and efficiently. Some hospitals are practicing cost management, others have invested in certain tools to assist in the effort, and still others have not yet fully committed to a cultural change that demands accountability and provides a full range of tools and techniques to ensure success. Those hospitals that have made the commitment to cost management have realized that the opportunities for improvement are abundant and proven. ■

About the author

Steven H. Berger, FHFMA, CPA is founder and president of Healthcare Insights, LLC, Libertyville, Ill, and a member of HFMA's First Illinois Chapter.

Questions and comments about this article may be sent to the author at sberger@hcillc.com.