

FEATURE STORY

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back to basics

5 ways to pick low-hanging fruit

Hospital finance leaders should perform a few analyses to reduce their labor and supply chain expenses.

Consensus is strong that hospital payment (per capita and/or total) will decline over the next few years. Consensus is less strong on how much the drop will be, with various sources mentioning figures ranging from 5 to 20 percent. But for hospitals, whose median operating margin is 2.6 percent, the possibility of even a 5 percent payment decrease is a rallying cry for improved cost management and revenue capture.

For years, hospital leaders have worked to improve their organizations' financial health, focusing on lowering labor and supply costs and improving revenue cycle performance. However, hospitals still have ample opportunity to improve their operating margins. For example, research has shown that a majority of hospitals have as much as a 20 percent labor expense opportunity and a 25 to 30 percent supply chain expense opportunity. Moreover, HFMA research has shown that moving from the median to the top quartile in just two revenue cycle performance indicators—days in accounts receivable and cash collection—can add millions to the bottom line.

Experience from hundreds of training engagements suggests that despite their efforts to improve their financial health, hospitals could execute some basic cost-cutting and revenue-capture steps more effectively. When faced with the pressing need to maintain or improve margin in the face of payment cuts, before taking more drastic steps, hospitals should review these basic practices to ensure they are being implemented effectively and are bringing the desired results.

AT A GLANCE

Five areas of potential cost reduction related to labor and the supply chain are:

- > Overtime actual to budget biweekly analysis
- > Overtime actual trend (to budget) analysis
- > Overtime actual total individual employee costs
- > Actual monthly supply chain expenses compared with budget by chart of accounts code and detail analysis
- > Actual monthly analysis by individual vendor and detail analysis

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Several low-hanging fruit opportunities are available to hospitals and health systems, including five related to labor and supply chain expenses that finance executives can explore immediately. The analysis can be performed by using commercially available business intelligence software or even standard Excel spreadsheets.

Opportunities to Reduce Labor Expenses

To understand the significance of opportunities to reduce labor expenses, healthcare finance executives should use a hospital labor metric that has great meaning, is simple to compute, and is highly useful in tracking budget targets and their outcomes:

$$\frac{\text{Salary, Benefits, and Contract Labor Costs}}{\text{Total Revenues}}$$

OVERTIME EARNINGS CODE: EFFICIENCY AND RATE VARIANCES	
OPERATING ROOM Cost Center	
Overtime Earnings Code by Pay Period	PP 24
Actual Hours	117.53
Budgeted Hours	179.00
HOURS - Variance	(61.47)
HOURS - Efficiency Variance Percentage	(52.35%)
Actual Average Hourly Rates	\$40.57
Budgeted Average Hourly Rates	\$40.06
RATES - Variance	\$0.51
RATES - Variance Percentage	1.28%
Actual Total Dollars	\$7,170.00
Budgeted Total Dollars	\$4,768.30
DOLLARS - Variance	(\$2,401.70)
DOLLARS - Variance Percentage	(50.37%)

Total revenues are defined as Net Patient Service Revenues plus Other Operating Revenues.

Fitch Ratings has been reporting medians for this metric for many years. In August 2011, the median for all Fitch-rated hospitals was 50.8 percent, which means that the median hospital is using 50.8 percent of its total revenues to staff the organization. This benchmark is valuable for 501(c)(3) hospitals. However, the 50.8 percent pales when compared with the 40.6 percent metric outcome (for the quarter ending March 31, 2012) for HCA, the largest U.S. acute care (investor-owned) hospital operator. In fact, the 10.2 percent difference between Fitch's median benchmark and HCA's metric creates a greater than 20 percent competitive advantage (10.2 percent ÷ 50.8 percent = 20.1 percent). This is a significant difference and represents a dramatic opportunity for the many hospitals operating near, at, or above the 50.8 percent level. It should also be noted that for every 1 percent reduction in the labor ratio, the operating margin will increase by 1 percent, showing that all U.S. hospitals can benefit from reducing their labor ratio.^a

Although the labor ratio has two parts—costs as a numerator and revenues as a denominator—both of which offer opportunities, the first and best place to look for positive movement of the labor ratio is in a hospital's premium pay. Overtime (at a 50 percent premium), extra part-time or float pools (at perhaps a 25 percent premium), and agency labor (at up to a 200 percent premium) provide the best opportunities for improvement. And although hospitals long have been attempting to make improvements in these areas, the high labor ratios indicate that more can be done. The following three analyses provide hospital executive teams with considerable information to help them take action.

a. It is important to note that all of these metrics are based on the 2010 GAAP standards, when the provision for bad debts was considered an expense. In 2012, when the provision becomes a deduction from revenue—thus reducing total revenues—the metric results are likely to rise approximately 4 percent. In the March 2012 HCA example used above, the difference is 3.9 percent.

Overtime actual to budget biweekly analysis.

Sometimes hospitals are unable to control their overtime because they lack the information required to monitor the outcomes on a timely, reliable basis. They should be able to calculate two ratios for analytic purposes: efficiency variance and rate variance.

Efficiency variance is essentially the productivity variance. This calculation represents the hours per unit of services actually used compared with the budgeted hours per unit of services for the overtime earning code.

The rate variance calculation represents the dollars per unit of services actually spent compared with the budgeted dollars per units of services.

Healthcare finance executives who can calculate these outcomes instantly every two weeks should determine whether their hospital can efficiently perform these additional analyses:

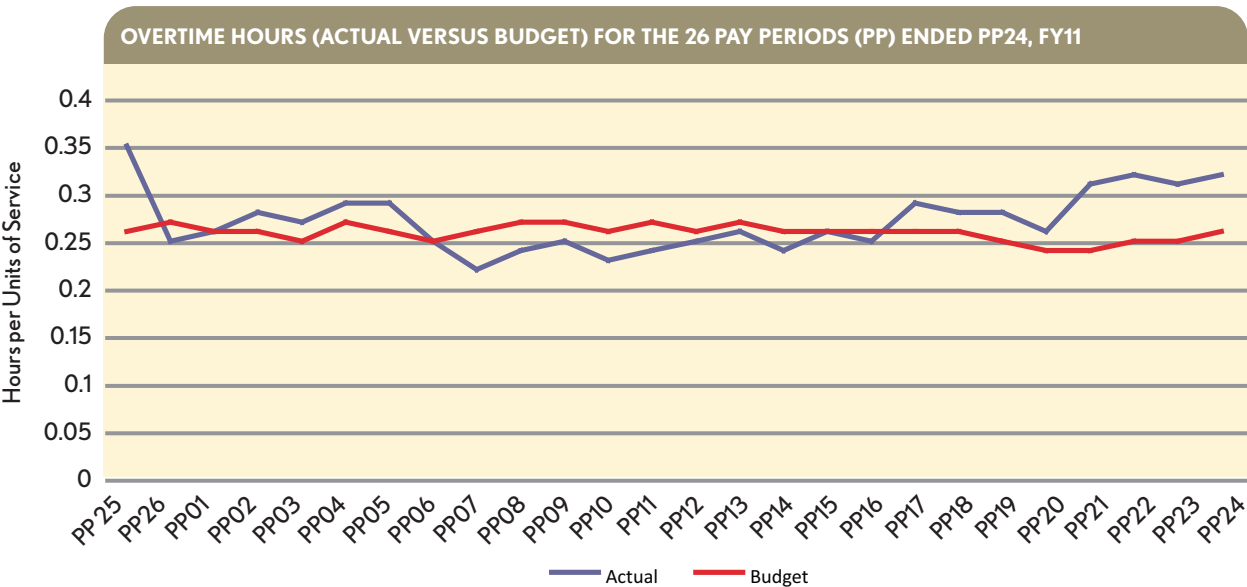
- > Calculate these two ratios instantly (10 minutes after the hospital’s biweekly labor data report becomes available).
- > Calculate these data for every department, and at the subdivision, division, administrative, and executive levels.
- > Report the results to those individuals responsible at the department, subdivision, division,

Finance executives who are not performing these analyses efficiently and effectively have significant opportunities to reduce their labor ratio.

administrative, and executive levels in a format that allows them to drill down to the job code and individual employee levels.

- > Generate biweekly labor alerts to the managers responsible for any noncompliance and their managers.

Finance executives who can generate all of the above data should ensure that the managers are staying compliant with the organization’s goals. Finance executives who are not performing these analyses efficiently and effectively have significant opportunities to reduce their labor ratio and should take the steps necessary to perform these analyses.



ABC MEDICAL CENTER TOTAL OVERTIME DOLLARS AND HOURS, FOR THE 24TH PAY PERIOD OF 2011—YEAR TO DATE

Employee Name	Dollars Paid	Hours Paid	Job Name	Department
Joseph Brown	\$12,350	228	RN, Charge Nurse	Neonatal ICU
Melvin Jones	\$11,256	263	RN, Staff Nurse	Cath Lab
Farrah McGillicuddy	\$10,378	198	Home Care Supervisor	Home Health Services
Thomas White	\$8,139	277	Communications Specialist	Ambulance Services
Malcolm Smith	\$7,885	245	Paramedic	Ambulance Services
Total*	\$780,693	23,640		

*Only initial data are indicated here, for illustrative purposes. Complete data summarized in total figures are not shown.

Overtime actual trend (to budget) analysis.

Similarly, healthcare finance leaders should generate and monitor overtime information at the department, subdivision, division, administrative, and executive levels. This analysis should be performed for actual and budget information for total dollars, hours per units of service (productivity), average hourly rates, and dollars per units of services. To perform either of these two analyses, hospitals need to budget their labor expenses at the department level for all of their earning codes. This biweekly budgeting does not often take place at U.S. hospitals at this time (according to author’s class surveys), so this is an area that will need to be implemented to attain the required information. To simplify this task, commercial products exist for automating all of the budgeting, data gathering, and reporting elements mentioned, allowing for instant information retrieval.

Tracking this information over time gives finance executives the information needed to make informed decisions.

Overtime actual total individual employee costs analysis.

The area that offers perhaps the best opportunities for improvement is the analysis of individual employees’ actual overtime expenses at any time throughout the year for both pay period and a year-to-date basis. To effectively pick the low-hanging fruit, hospitals need to determine where the overtime is being spent and by whom, with the ability to sort and parse the data on the fly.

Data can be generated through downloads from the payroll system to Excel spreadsheets, although this process is time-consuming and introduces the possibility of errors. As a result, many hospital finance departments are not providing this information to their leaders. Yet the analysis can detect actionable information, such as which 10 employees are being paid the most overtime and what departments they work in. With this information, the organization’s leaders can investigate why this situation is occurring.

Significant overtime dollars can be reduced when executives receive detailed data and can track how much and where money is being spent.

The above analysis can be performed for any earning code, such as regular pay, on-call, sick, holiday, vacation, and even education hours, which is underanalyzed in many hospitals.

Success with these three analyses for reducing the labor ratio depends on an organization having a culture that supports the performance of these types of analyses, dissemination of data to the management team, actions for improvement, rewards for successful achievement, and consequences for unfavorable results. Millions of dollars are at stake regardless of an acute care hospital’s size, location, or type.

Opportunities to Reduce Supply Chain Expenses

Like labor expenses, supply chain waste can be reduced. Again, it is possible to report a viable

metric that can be used to establish and monitor goals. This supply chain expenses ratio is similar to the labor ratio, using the same denominator:

$$\frac{\text{All Supply Costs (including Pharmaceuticals, Medical, Office, Food, and Other)}}{\text{Total Revenues (same definition as in the Labor Ratio)}}$$

In this case, available benchmarks for not-for-profit, 501(c)(3) hospitals over the past few years suggest that median results tend to range from 16 to 21 percent. Let’s call the average 18 percent. Yet once again, investor-owned hospitals are far below the median, ranging from 12 to 14 percent. The difference between a high-performing hospital at 12 percent and a median hospital at 18 percent is 33 percent (6 percent ÷ 18 percent)—a significant margin. And although it is understandable to suggest that hospitals with a heavy orthopedic practice will have a higher ratio outcome because of the higher cost associated with implants, it is important to remember that these hospitals’ revenues should also be proportionately higher due to the orthopedic revenues.

The supply chain ratio offers hospitals two additional revenue-cycle improvement opportunities.

Actual monthly supply chain expenses compared with budget by chart of accounts code and detail analysis.

Although monthly chart of accounts line item information is available for analysis through departmental profit-and-loss statements, few of the commonly licensed general ledger systems in

the hospital industry allow users to easily and instantly drill down to the individual details (where all the action takes place) to determine where too much money has been spent.

Hospitals face this limitation whether they have adopted a fixed or flexible (volume-variable) budgeting method. As a result, there is no way to easily understand, within individual hospital departments, how much payment went to high-cost versus low-cost items or high-cost versus low-cost vendors.

This is where the low-hanging fruit grows. And this is where it needs to be picked. As long as department managers and finance staff cannot easily, quickly, and individually produce reports (electronically), with drill-down capabilities to capture this information, these 30 percent expense-reduction opportunities will remain on the tree getting moldy.

Actual monthly analysis by individual vendor and detail analysis. The opportunity above addresses actionable information at the departmental level. For this low-hanging fruit opportunity, the hospital needs the same type of information, but at the organizational level. As with the ability to determine instantly which employee has the most overtime, this analysis allows hospitals to identify their most costly vendors. Further, easily performed drill-down analysis can then produce actionable information for decisions on expense reduction.

ACTUAL MONTHLY SUPPLY CHAIN EXPENSES COMPARED WITH BUDGET BY CHART OF ACCOUNTS CODE AND DETAIL ANALYSIS

Operating Room
For the Year to Date Period Ending Dec. 31, 2011

	December 2010 Actual YTD	December 2011 Fixed Budget YTD	December 2011 Flex Budget YTD	December 2011 Actual YTD	Variance Actual 2011 to Flex Budget
Medical-Surgical Supplies—Billable	\$1,941,556	\$1,942,335	\$1,849,913	\$2,060,196	(\$210,283)
Details of the Actual Amount by:					
- Accounts Payable					\$690,789
- Journal Entries					\$1,369,395
- Purchase Orders (Supporting the Journal Entries)					
- Inventory (Supporting the Journal Entries)					
Details can be aggregated and sorted instantly for actionable analysis					

TOTAL MEDICAL SUPPLIES BILLABLE BY ACCOUNT CODE, ALL DEPARTMENTS

ABC Medical Center
For the 12 Months Ending Dec. 31, 201: Year to Date

Vendor	Description	Amount	Detailed Amount	Department
LMN Healthcare House		\$104,222		Operating Room
	Aortic Valve		\$26,000	
	Bone Graft		\$24,500	
	Spinal Stimulator		\$21,450	
ZYX Medical Supply		\$91,466		Cath Lab
	Cath Guide Wire		\$15,000	
	Electrodes		\$13,250	
K & K Surgical Supply		\$67,500		Operating Room
	Sleeve, Composite Knee		\$17,500	
	Power Source		\$14,800	
Surgronics		\$66,601		Operating Room
	Pain Pump System		\$19,800	
	Adhesive Bond		\$16,500	
	Vagus Nerve Generator		\$11,390	
Bishop Supplies		\$52,708		Cath Lab
	Power Source		\$9,450	
	Guide Wires		\$8,290	
	Balloon		\$6,730	
Total*		\$3,690,175		

*Only initial data are indicated here, for illustrative purposes. Complete data summarized in total figures are not shown.

With this information, finance executives and department managers can make change-management decisions that will help them achieve real savings. These analyses also can be performed with a series of Excel spreadsheets or much more easily and timely with commercially available software.

Next Steps for Finance Leaders

In this era of downward payment pressure, hospital finance leaders need to ensure that their cost-control efforts are based on good data, timely and sound analysis, and a culture of continuous improvement. The five basic analyses in this article—performed efficiently and consistently—can help them identify opportunities for

significant savings. Of course, making the calculations is only the first step. Hospital finance leaders then need to ensure the information is reported, acted on, and monitored to be sure savings are maintained and new opportunities are identified.

About the author



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