

**PROFIT CENTERS IN CLINICAL CARE DEPARTMENTS:  
AN IDEA WHOSE TIME HAS GONE**

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## **PROFIT CENTERS IN CLINICAL CARE DEPARTMENTS: AN IDEA WHOSE TIME HAS GONE**

In recent years, profit centers have proliferated in both teaching and community hospitals. Originating in the early 1900s in the private sector, they were introduced to hospitals in the mid-1970s, when Robert Heyssel used them as part of a highly successful turnaround effort at Baltimore's Johns Hopkins Hospital.

The underlying idea is to encourage physician chiefs of service to manage their departments like small businesses. If all chiefs do a good job, the hospital will earn a surplus, which can be used to upgrade facilities, replace equipment, expand programs, and engage in other activities that require substantial equity capital.

If a hospital is to use profit centers successfully, however, it must resolve several philosophical, organizational, and accounting matters. Unless the senior management team addresses these matters carefully, there can be a variety of unintended consequences. Indeed, as I argue below, many hospitals would benefit from converting their profit centers into standard expense centers.

### **PHILOSOPHICAL ISSUES**

Designating clinical care departments, such as surgery, medicine, and pediatrics, as profit centers is only a preliminary step. A hospital's senior management team then must address two philosophical issues: decision-making latitude and cross-subsidization.

#### **Decision-Making Latitude**

Will clinical care chiefs have relatively unfettered authority to pursue a "profitable" case and payer mix for their departments? If so, the hospital may find that it has compromised its strategy. Suppose, for example, that the chief of surgery recruits only certain kinds of specialists so as to tilt the department's case mix in a more profitable direction. He or she also may decide to use commercial payers to subsidize free care. By contrast, the chief of pediatrics may not have the luxury to subsidize free care with commercial payers, and thus may (however subtly) encourage uninsured patients to use another hospital.

One potential result is that the hospital will have both a fractionated strategy in terms of the kinds of patients it treats, and an inconsistent free-care policy. The strategy to serve certain disease conditions, for example, will be frustrated by a clinical chief who minimizes the number of patients with those conditions so as to improve the department's "bottom line." And, the hospital's free-care policy will differ from department to department depending on each department's financial circumstances.

#### **Cross-Subsidization**

Most hospitals, recognizing that, say, cardiovascular surgery and orthopedics are inherently more lucrative than pediatrics or psychiatry, have their financially strong departments subsidize their weaker ones. Under this model, the hospital uses some of the revenue from the "rich uncles" to subsidize the care given to patients by the "poor nephews."

But a cross-subsidization approach is not a panacea. To use it successfully, a hospital must answer two questions: "how much?" and "who decides?" The intensity of the feelings inherent in a poorly managed cross-subsidization model, is illustrated by a cardiovascular surgeon in a large medical center located in the northeast U.S. who blurted out one day "I'm tired of subsidizing those lazy pediatricians!"

Clearly, then, a cross-subsidization model must be accompanied by a process—conducted by senior management, usually at budget time—that not only determines the amounts of the subsidies, but also assures subsidy *providers* that their contributions are helping enhance the hospital's overall strategy. At the same time, the process needs to result in a commitment from subsidy *recipients* to run their departments within the constraints of the agreed-upon support.

### **ORGANIZATIONAL ISSUES**

There are two organizational issues to be resolved by a hospital using profit centers. The first concerns clinical *service* (sometimes called ancillary) departments, mainly pathology, radiology, and anesthesiology. The second, the role of clinical care departments in a service line strategy.

## **Clinical Service Departments**

The problem with establishing profit centers in clinical service departments arises because, in a DRG payment environment, only clinical care departments earn revenue. A hospital's senior management team must then decide whether a portion of it should go to the clinical service departments in exchange for processing lab tests, providing radiological procedures, and the like. If so, the hospital needs a system of transfer prices.

A transfer price is the amount that, say, the department of medicine pays the department of pathology for a complete blood count. Under a transfer pricing system, the department of pathology earns revenue from two sources: sales to non-DRG payers at "market prices," and sales to clinical care departments at transfer prices.

Two related questions emerge. First, should a clinical service department attempt to earn a surplus from internal sales, or simply break even? Second, should clinical care departments be allowed to purchase a test or procedure from outside the hospital if they are dissatisfied with the transfer price?

## **Service Lines**

Many hospitals have begun to shift their strategies toward service lines, such as oncology, cardiology, or women's health. A key element of this shift is the need for several historically independent departments to collaborate in providing patients with coordinated, comprehensive, timely care. For an oncology service line to be successful, for example, it must assure that surgical and medical oncologists, pathologists, radiologists, geriatricians, social workers, hospice nurses, and others abandon their individual professional perspectives, and work in a collaborative, mutually respectful, manner, with a focus on a patient's overall needs.

In addition, if its service-line strategy is to be successful, a hospital must recognize that its service lines are, in effect, profit centers, and its clinical care departments—like its clinical service departments—provide services at transfer prices to the service lines. As might be imagined, this can be an angst-inducing change, and one not easily accepted by most clinical care department chiefs. In short, a service line strategy implies that both clinical care and clinical service departments be designated as standard expense centers. They no longer are responsible for the volume or mix of patients, nor for prices charged to payers, nor for payer mix. Unfortunately, many hospitals that have shifted to a service line strategy have not made this conversion. The result is dueling profit centers, with considerable confusion over who has bottom line responsibility.

## **ACCOUNTING ISSUES**

From an accounting perspective, the success of a responsibility center arrangement can be evaluated in terms of two criteria: fairness and goal congruence. Fairness means that each responsibility center manager has reasonable control over the elements of the profit equation (price, payer mix, case mix, volume, variable costs per unit, and fixed costs) for which he or she is responsible. Goal congruence means that each manager, pursuing the best interests of his or her responsibility center, is simultaneously pursuing the best interest of the hospital overall.

### **Fairness**

Many hospitals that designate clinical care departments as profit centers do not give managers of those centers (the chiefs of service) an ability to control several elements of the profit equation. Some, perhaps confusing full-cost accounting with responsibility accounting, continue to allocate the hospital's overhead to the profit centers, despite the fact that the chiefs have no ability to control the associated expenses. Although it would be relatively easy to establish transfer prices for those administrative service departments with an output unit (such as dietary, laundry, and housekeeping), they do not do so, thereby failing to give a clinical chief the ability to control the amount of the administrative service department's expenses that are included in his or her profit center, while simultaneously failing to give the administrative service departments an incentive to control their costs.

Similarly, some hospitals exclude chiefs of service from price negotiations with managed care payers, thereby denying them the ability to exert control over a key element of the profit equation. While no chief can have complete control over prices, a hospital that included its chiefs of service in price negotiations would at least be giving them some influence over this element of the equation. No profit center arrangement is entirely fair, but a key task for senior management is to make it as fair as possible.

## Goal Congruence

A lack of goal congruence can be seen in several ways, such as when a clinical care department, in pursuit of a satisfactory surplus, avoids treating low-income or poorly insured patients, when one element of the hospital's mission is to treat those patients. More concretely, consider the situation shown in Exhibit 1. In this example, the pediatrics department bills a third-party payer \$11 for a test that is required in conjunction with a diagnostic workup. The \$11 covers the time spent by nurses assisting the patient, the processing of paperwork by the administrative staff, the supplies needed for the test, and the time spent by a physician reporting the results to the patient, plus the cost of the lab work.

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### Exhibit 1. A Collision of Fairness and Goal Congruence

	<u>Pediatrics Department</u>	<u>Pathology Lab</u>	<u>Hospital Overall</u>
<b>Option 1 - Tests done by Pathology Lab</b>			
Revenue	\$11.00	\$6.00	\$11.00
Variable cost	<u>6.00</u>	<u>2.00</u>	<u>2.00</u>
Contribution to fixed costs	\$ 5.00	\$4.00	\$ 9.00
<b>Option 2 - Tests done by Outside Laboratory</b>			
Revenue	\$11.00	\$0.00	\$11.00
Variable cost	<u>4.50</u>	<u>0.00</u>	<u>4.50</u>
Contribution to fixed costs	\$ 6.50	\$0.00	\$ 6.50

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In an effort to improve fairness, the hospital has allowed its clinical care chiefs to purchase this and other basic lab work from freestanding facilities. Here, the chief of pediatrics reduced the cost of lab work from \$6.00 (the pathology lab's transfer price) to \$4.50 (the outside lab's charge). However, because the variable cost of the test in the pathology lab (\$2.00) is below the charge of the outside laboratory, the cost to the hospital is higher than if the test were conducted in house. Thus, the overall contribution to the hospital's fixed costs falls from \$9.00 to \$6.50. The result is a violation of the goal congruence criterion: what is good for the pediatrics department is not good for the hospital.

There is no easy solution to this problem. If the hospital requires pediatrics to purchase tests from the in-house lab, it will have reduced the chief's ability to control the department's costs, thereby violating the fairness criterion. The hospital also would violate the fairness criterion if it required the in-house lab to charge pediatrics the same amount as the outside lab (since it would have inhibited the lab's ability to control its revenue).

This conundrum can arise any time one responsibility center in an organization provides goods or services to another. Some organizations accept the loss of goal congruence, assuming that the expanded decision-making latitude given to profit center managers will assist them to perform well, and that their enhanced performance will override the goal-congruence losses when all elements are considered. Others will simply inform their profit center managers that not all of life is fair, and require in-house purchases (but at what price?) Some organizations will treat the price discrepancy as an indicator that something is awry, and initiate an inquiry into the reasons for the difference.<sup>1</sup>

## RESOLVING THE ISSUES

To address the above issues, a hospital's senior management team must ask four specific questions. Although related, they can be addressed individually.

### 1. Should Our Clinical Care Departments be Profit Centers or Standard Expense Centers?

When a chief of service lies awake at 3:00am, what financial matters does the senior management team want him or her to worry about? Profit center managers will worry about price, payer mix, case mix, volume, variable cost per case, and fixed costs. By contrast, when a clinical care department is a standard expense center, its chief will be concerned only with whether the department's physicians are treating patients in accordance with the appropriate clinical pathway or disease management protocol. Similarly, chiefs of clinical service departments will focus on the cost per test or procedure.

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<sup>1</sup> In academic accounting, tenure has been granted to professors based on their work in transfer pricing! The issues are complex.

To illustrate the change in thinking, consider the situation depicted in Exhibit 2, in which the department of medicine is a standard expense center. The department's original expense budget was \$3,676,350, based on its anticipated case mix, volume, variable expense per case, and fixed expenses.

### Exhibit 2. A Simplified Flexible Budget Report for a Department of Medicine

<b>Original Budget</b>	<b>DRG 089</b>	<b>DRG 014</b>	<b>DRG 096</b>	<b>DRG 140</b>	<b>Total</b>
Number of cases	300	200	100	50	650
Variable expenses per case	\$2,800	\$3,150	\$1,955	\$1,205	
Total variable expenses	\$840,000	\$630,000	\$195,500	\$60,250	1,725,750
Fixed expenses					<u>1,950,600</u>
Total expenses					\$3,676,350
<b>Flexible Budget</b>	<b>DRG 089</b>	<b>DRG 014</b>	<b>DRG 096</b>	<b>DRG 140</b>	<b>Total</b>
Actual number of cases	275	250	100	75	700
Budgeted variable expenses per case	\$2,800	\$3,150	\$1,955	\$1,205	
Flexed variable expenses	\$770,000	\$787,500	\$195,500	\$90,375	1,843,375
Total fixed expenses					<u>1,950,600</u>
Flexed budget					\$3,793,975
<b>Actual Results</b>	<b>DRG 089</b>	<b>DRG 014</b>	<b>DRG 096</b>	<b>DRG 140</b>	<b>Total</b>
Number of cases	275	250	100	75	700
Variable expenses per case	\$2,952	\$3,346	\$2,166	\$1,673	
Total variable expenses	\$811,800	\$836,500	\$216,600	\$125,475	1,990,375
Total fixed expenses					<u>1,985,100</u>
Total expenses					\$3,975,475
<b>Variance Computations</b>	<b>DRG 089</b>	<b>DRG 014</b>	<b>DRG 096</b>	<b>DRG 140</b>	<b>Total</b>
Variable expense spending variances	(\$41,800)	(\$49,000)	(\$21,100)	(\$35,100)	(\$147,000)
Fixed expense spending variance					<u>(34,500)</u>
Total spending variance					(\$181,500)

Since the department cannot control its case mix or volume, the budget must be "flexed" each reporting period, based on the actual number and mix of cases seen by the department's physicians. The flexed budget of \$3,793,975 results from multiplying the actual number of cases for each DRG by its budgeted variable cost, and adding budgeted fixed costs. It is greater than the original budget because there were more patients, fifty of whom were for the highest cost DRG.

The actual results show that the department spent \$3,975,475 during the reporting period, resulting in a negative spending variance of \$181,500. As indicated, the department overspent on each case type, and also on its fixed expenses for the period.

## 2. Does Our Responsibility Center Structure Match Our Strategy?

If a hospital adopts a service line strategy, it needs to shift the profit center focus to its service lines. Under these circumstances, both clinical care and clinical service departments are appropriately designated as standard expense centers, and their financial performance is measured by means of a flexible budget, as shown in Exhibit 2. In effect, price, payer mix, case mix, and volume are considered to be outside their control. They need only provide the requested services at the agreed-upon transfer price.

Some organizations will address the fairness/goal congruence conundrum shown in Exhibit 1 by using a two-part transfer price: one element is for fixed costs and the other for unit variable costs. The fixed cost portion is paid monthly, and is designed to cover "standby" capacity, whereas the variable cost portion is volume and mix dependent.<sup>2</sup> By mitigating a service-providing center's incentive to increase its volume to help cover its fixed costs, a two-part transfer price helps to improve goal congruence.

<sup>2</sup> For details of how a two-part transfer price can work, see Young, David W., "Two-Part Transfer Pricing Improves IDS Financial Control," *Healthcare Financial Management*, 51:8 (August 1998).

### **3. Do We Use Transfer Prices for Administrative Service Centers?**

A hospital's administrative service centers fall into two categories: those with a measurable output unit and those without. Laundry, housekeeping, and dietary are examples of the former, whereas the executive office suite, human resources and fiscal affairs are examples of the latter. Neither needs to be allocated. In Heyssel's model at Johns Hopkins, service centers with measurable output units used transfer prices, while those without had their costs incorporated into profit centers via a "shared agreement," i.e., a fixed amount agreed to at budget time, that did not change even if a service center's actual expenses exceeded its budget. The result was a movement toward fairness, and greater cost-control incentives for administrative service center managers.

### **4. How Must Our Reward System Change if We Use Standard Expense Centers?**

With a profit center structure, clinical care chiefs can manipulate many variables to improve bottom line performance. By contrast, a standard expense center manager has only two: the resources used to treat each DRG and the department's fixed costs. Since the budgeted resources per DRG (length of stay, tests, procedures, medications) supposedly represent an optimal care pattern, a reduction would not normally be considered desirable. "Good performance" means managing care so that, for all patients treated during the period, actual costs coincide with the flexible budget.

One possible approach, then, is to reward departments for achieving the flexible budget (but not for beating it). In addition, as many hospitals are discovering, rewards can be given for improved *non-financial* performance. Regardless of their basis, these rewards can come in a variety of ways: bonuses to high-performing employees, preferential status for capital equipment requests, funding support for residents to attend conferences, or even special parking spaces. With a little creative thinking, the list could be quite long.

## **WHITHER PROFIT CENTERS**

A fundamental management maxim emerging from the work of the late Alfred Chandler, in his study of the history of four major U.S. corporations, was that "structure follows strategy." Many hospitals have shifted their strategies in recent years toward service lines, but they have not changed their responsibility center structures to fit the new strategic focus. Indeed, by continuing to designate their clinical care departments as profit centers, they impede their ability to make the new strategy successful.

Converting clinical care departments to standard expense centers will require senior management commitment. The affected chiefs of service almost certainly will resist the change, viewing it (perhaps appropriately) as a lessening of their power. However, being standard expense centers allows them to focus on what they know best (clinical care guidelines) and gives them more time to devote to their research and teaching. With an appropriate redesign of the incentive compensation system, the shift should not be too difficult.