Budgeting: Principles and Pitfalls*

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*Stolen with permission from: Budgeting Principles, Alan K. David, MD
Medical School Revenue

1. Medical Services / Professional Billing – now largest source of medical school revenue (50-60%)
   - 2500 % ↑ in 30 years (9.3%/yr)
   - Others sources – much more modest growth
   - Private medical schools rely on clinical income more than public schools

2. NIH overall funding – nearly flat for last 10 years

3. Tuition/Fees - ↑ 3-4% compound annual growth rate
Know the source of Dean’s Funds

• No Clinical Practice Plan – limited resources or fixed
• Practice Plan → Dean’s tax – Chair packages / flexibility
• Share in Hospital Margin → more resources (usually)
• University allocation – usually limited or fixed
Budgeting Principles

1. Know all your sources of revenue well – what is stable and what is likely to change and why

2. Revenues, expenses per segment of the department must be transparent
   • i.e. Clinical revenue more likely than not subsidizes teaching, administration, and research

3. Transparency → Trust

4. Spend allocated dollars first → flexible dollars last

5. Learn to say ‘no’ or ‘not now’
Budgeting Principles (cont’d)

6. Expansion / New Ventures -> sustainable?
   - Approval of expanding an ongoing program or initiating a new effort:
     - What is measurable value?
     - How will it be sustained? (demonstration of incremental revenue – even if start-up packages used to start with).
   - Clinical programs: define measurable outcomes in addition to wRVUs (e.g. access, quality)

7. Productivity alignment with Compensation
   - Fair market value – clinically derived #
     - How to use this in faculty with .3 clinical FTE and .3 resident supervision FTE?
   - Beware of standards – MGMA/AAMC/UHC
     - (Know how they are derived – how similar they are to your situation)
   - Beware of % comp vs. % productivity benchmarks
Budgeting Principles (cont’d)

8. Research
   • Know institutional rules about return of indirects to – department/PI/% or not at all (rare source of flexible funds)
   • Budget for transition bridge funding
   • Research enterprise does not pay for itself – needs to be subsidized
     • Rule of thumb: 20% subsidy ($100,000 grant requires $120,000 to complete)

9. Define Position Duties and Concomitant % Effort
   • 1.0 Clinical FTE = # sessions, # shifts, # patients/session, etc.
   • Program Director – 0.3 clinical / 0.3 precepting/ 0.7 teaching administration
   • New Researcher – 0.6 research /0.2 clinical /0.2 teaching
   • Beware of undefined ”protected time”
   • Clearly document expectations for % effort (comp agreement, contract, letter of offer, annual work plan)
Budgeting Principles (cont’d)

10. Understand P&L / Accrual budgeting vs Cash Budgeting
   • Accrual – budget for a year/comparisons to previous year ‘actual’ etc. Better for longer-term picture
   • Cash – Actual Revenue/Expense report with margin for a month or a quarter. Reflects current resources available

11. Define an incentive/bonus compensation plan for the department
   • Have a faculty committee do it with your Business Administrator's help
   • Don’t chair it or be on it
   • Provide guidelines including a set aside as a chair discretionary fund
   • Make clear plan is subject to committee and overall approval (vote)
   • Subject to final approval by chair and probably the institution
Budgeting Principles (cont’d)

Hire a really smart, really trustworthy Business/Department Administrator who has or can develop great credibility with institutional finance/business people.

Then, you will be financially successful!