

CHAPTER 1

INTRODUCTION TO HEALTHCARE FINANCE

THEME SET-UP: CAREERS IN HEALTHCARE MANAGEMENT

If you are using this book, you either are working in healthcare or are interested in a career in healthcare. Of course, numerous career opportunities are available in clinical fields, including medicine, dentistry, nursing, and occupational and physical therapy, which some of you are already practicing or will enter on graduation. However, most of you are considering careers in healthcare management. In addition, many clinicians find themselves balancing both clinical and administrative roles, and so healthcare management knowledge is important.

According to the Association of University Programs in Health Administration, an education in healthcare management will prepare you to enter the exciting and challenging healthcare field, the largest in the United States, representing more than 11 million jobs. Healthcare executives have the opportunity to make a significant contribution to improving the health of the population and to work in one of tens of thousands of healthcare organizations throughout the United States and the world.

An education in healthcare management can take you in many different directions. Career options for healthcare managers have never been more diverse or exciting. The kind of entry-level jobs offered to a college graduate varies in terms of the individual's interests, skills, and experience. Today,

an estimated 300,000 people serve in healthcare management positions (from entry level to middle management to leadership) and in organizations of all sizes (from a practice with several people to a major corporation that employs thousands). After gaining the requisite experience, many healthcare management graduates are in a position to shape the future of healthcare in the United States and across the globe.

All that probably sounds good, but what types of organizations might be interested in hiring a healthcare management graduate? By the end of the chapter, you will have an idea of the settings available. See if any of them appeal to you.

LEARNING OBJECTIVES

After studying this chapter, you will be able to do the following:

- Define the term *healthcare finance* as it is used in this book.
- Discuss the structure of the finance department, the role of finance in healthcare organizations, and how this role has changed over time.
- Describe the major players in the healthcare sector.
- List the key issues currently facing healthcare managers.

1.1 INTRODUCTION

In today's healthcare environment, where financial realities play an important role in many, if not most, decisions, healthcare managers at all levels must understand the fundamentals of finance and how that knowledge is used to enhance the financial well-being of the institution. In this chapter, we introduce you to the rationale that underlies this book. Furthermore, we present background information about healthcare finance and the different types of healthcare organizations. We sincerely hope that this book provides significant help in your quest to increase your professional competency in the critical area of healthcare finance.

1.2 DEFINING HEALTHCARE FINANCE

What is healthcare finance? It can be surprising to find that there is no single response because the definition of the term depends, for the most part, on the context in which it is used. Thus, your understanding should begin with learning the scope and meaning of the term *healthcare finance* as it is used in this book.

To start, recognize that healthcare finance is not about financing the healthcare system. **Healthcare financing** is a separate topic that involves how society pays for the healthcare services it consumes. This issue is a complex and politically charged, and we do not tackle it directly in this book. Of course, the manner of financing healthcare affects how hospitals and physicians are reimbursed for services and hence has a significant influence on healthcare finance.

Most users of this book will become (or already are) managers at healthcare organizations, such as medical group practices, hospitals, home health agencies, or long-term care facilities. Thus, to create a book that provides the most value to its primary users, we focused on finance as it applies in **health services organizations**. Of course, the principles and practices of finance cannot be studied in a vacuum but must be based on the realities of the current healthcare environment, including how healthcare services are financed.

In health services organizations, *healthcare finance* consists of both the accounting and financial management functions (see "Critical Concept: Healthcare Finance"). **Accounting**, as its name implies, concerns the recording, in financial terms, of economic events that reflect the operations, assets, and financing of an organization.

Healthcare financing

The system that a society uses to pay for healthcare services.

Health services organizations

Organizations that provide patient care services. Examples include hospitals, medical practices, clinics, and nursing homes. Also called providers.

Accounting

The measurement and recording of events that reflect the operations, assets, and financing of an organization.

**CRITICAL CONCEPT**

Healthcare Finance

Healthcare finance can have many different definitions, depending on the setting. For our purposes, healthcare finance encompasses the accounting and financial management functions of healthcare organizations. Accounting involves the measurement, in financial terms, of a business's operations and financial status, while financial management (corporate finance) involves the application of theory and concepts developed to help managers make better decisions. In practice, the two functions blend, with accounting generating the data needed to make sound decisions and financial management providing the framework for those decisions.

Financial management

The use of theory, principles, and concepts developed to help managers make better financial decisions.

In general, the purpose of accounting is to create and provide to interested parties—both internal (managers) and external (investors)—useful information about an organization's financial status and operations.

Whereas accounting provides a rational means by which to measure a business's financial performance and to assess operations, **financial management** (often called corporate finance) provides the theory, concepts, and tools necessary to help managers make better financial decisions. Of course, the boundary between accounting and financial management is blurred; certain aspects of accounting involve decision-making, and much of the application of financial management concepts requires accounting data.

**SELF-TEST QUESTIONS**

1. What does the term *healthcare finance* mean?
2. What is the difference between accounting and financial management?

1.3 THE ROLE OF FINANCE IN HEALTH SERVICES ORGANIZATIONS

Chief financial officer (CFO)

The senior manager (or top finance dog) in a large organization's finance department. Also called vice president—finance.

The primary role of finance in health services organizations, as in all businesses, is to plan for, acquire, and use resources to maximize the efficiency (and value) of the enterprise (see “Critical Concept: Role of Finance”). As discussed in section 1.4 of this chapter, the two broad areas of finance—accounting and financial management—are separate functions at larger organizations, although the accounting function usually is carried out under the direction of the organization's **chief financial officer (CFO)** and hence falls under the overall category of finance.

**CRITICAL CONCEPT**

Role of Finance

The primary role of finance in health services organizations is to plan for, acquire, and use resources to maximize the efficiency of the organization. This role is implemented through specific activities such as planning and budgeting.

FINANCE ACTIVITIES

Chapters 1 through 3 of this book provide foundational information that is helpful for understanding finance activities. The specific finance activities explored in the remaining chapters of this book include the following:

- ◆ *Estimating costs and profitability, planning, and budgeting.* First and foremost, healthcare finance involves evaluating the

financial effectiveness of current operations and planning for the future. Chapters 4 through 6 cover these functions.

- ◆ *Managing financial operations.* Healthcare organizations spend a lot of time managing cash and supply inventories as well as collecting money owed for services rendered. Proper management of these functions is necessary to ensure operational effectiveness and to reduce costs. Typically, managers at all levels are involved, to a greater or lesser extent, in these processes, which are discussed in chapter 7.
- ◆ *Financing decisions.* All organizations must raise funds to buy the assets necessary to support operations. Such decisions involve many issues, such as the choice between long-term and short-term debt and the use of leases versus conventional financing. Senior managers and the financial staff typically make the financing decisions, but these decisions have ramifications for managers at all levels. Business financing is the subject of chapter 8.
- ◆ *Capital investment decisions.* One of the most critical decisions managers make is the selection of new facilities (including land, buildings, and equipment). Such decisions are the primary means by which businesses implement strategic plans; hence, they play a key role in a business's financial future. Chapters 9 and 10 describe these decisions, which affect everyone in the organization.
- ◆ *Financial reporting.* For a variety of reasons, businesses must record and report to outsiders the results of operations and current financial status. This task is typically accomplished with a set of financial statements, which are explained in chapters 11 and 12.
- ◆ *Financial and operational analysis.* To achieve and maintain a high level of organizational performance, businesses must constantly monitor both financial and operational conditions and take actions as needed to ensure that goals are met. Chapters 7 and 13 address these topics.

In addition to those finance activities that involve operational managers, the following activities are accomplished primarily by the finance staff:

- ◆ *Contract management.* In today's healthcare environment, health services organizations must negotiate, sign, and monitor contracts with managed care organizations and health insurers. The finance staff typically has primary responsibility for these tasks, though operational managers clearly are affected by external contracts and must be involved in their negotiation and management.

- ◆ *Financial risk management.* Many financial transactions that take place to support the operations of a business can, in themselves, increase a business's risk. Thus, an important finance staff activity is to manage financial risk.

THE FOUR Cs

The finance activities at health services organizations may be summarized by the four Cs: costs, cash, capital, and control (see “Critical Concept: The Four Cs”).

CRITICAL CONCEPT

The Four Cs

The finance activities in healthcare organizations can be summarized by the four Cs: (1) *cost* measurement and minimization, (2) *cash* management, (3) *capital* acquisition, and (4) *control* of resources.

The measurement and minimization of costs are vital activities to the financial success of all healthcare organizations. Rampant costs, compared to revenues, usually spell doom for any business.

A business might be profitable but still face a crisis because of a shortage of cash. Cash is the lubricant that makes the wheels of a business run smoothly; without it, the business grinds to a halt. In essence, businesses must have sufficient cash on hand (or the ability to raise it quickly) to meet cash obligations as they occur. In healthcare, a critical part of managing cash is collecting money from

insurers for patient services provided. (This element is so important that some healthcare finance professors include *collections* as the fifth C.)

Capital represents the funds (money) used to acquire land, buildings, and equipment. Without capital, healthcare businesses would not have the physical resources needed to provide patient services. Thus, capital allows healthcare organizations to meet the healthcare needs of their communities.

Finally, a business must control its financial and physical resources to ensure that they are being wisely employed and protected for future use. In addition to meeting current mission requirements, healthcare organizations must plan to meet society’s future healthcare needs.

IMPORTANCE OF FINANCE OVER TIME

In times of high profitability and abundant financial resources, the finance function tends to decline in significance. For example, when most health services organizations were reimbursed on the basis of the actual costs they incurred, the role of finance was minimal. At that time, the most critical finance function was cost accounting because it was more important to account for costs than it was to control them. In response to payer (primarily Medicare) requirements, health services organizations (primarily hospitals) churned out a multitude of reports to comply with regulations and to maximize revenues. The complexities of cost reimbursement meant that a large amount of time had to be spent on cumbersome

accounting, billing, and collection procedures. Thus, instead of focusing on value-adding activities, most finance work focused on bureaucratic functions.

In recent years, however, providers have redesigned their finance functions to recognize the changes that have occurred in the health services field. Billing and collections remain important, but to be of maximum value to the enterprise, the finance function must support cost-containment efforts, managed care and other payer contract negotiations, joint venture decisions, and integrated delivery system participation. In essence, finance must help lead organizations into the future rather than merely record what has happened in the past.

Although in this book our emphasis is on finance, we must stress that all organizational functions are important. In addition to finance, managers must understand some elements of many different functions, such as marketing, facilities management, and human resource management. All business decisions have financial implications, however, so all managers (whether in operations, marketing, personnel, or facilities) must know enough about finance to incorporate financial considerations properly into the plans and decisions in their specialized areas (see “For Your Consideration: Do Nonfinancial Managers Need to Know Finance?”).

SELF-TEST QUESTIONS

1. What is the role of finance in today's healthcare organizations?
2. What are the four Cs?
3. How has the role of finance changed over time?



FOR YOUR CONSIDERATION

Do Nonfinancial Managers Need to Know Finance?

A much-debated topic at the water cooler is whether nonfinancial managers, including clinical managers, need to know much about finance. As outlined in the American College of Healthcare Executives (ACHE) 2017 Competencies Assessment Tool, healthcare managers should over time attain competencies in 21 areas of financial management. Among the areas listed are basic accounting principles, reimbursement principles, budgeting, revenue generation, performance monitoring, and applying financial planning to organizational objectives. Of course, financial management competencies represent only a small proportion of the complete list of management competencies assessed by the tool. Still, by including financial management in the assessment tool, ACHE considers it a key skill set for healthcare managers regardless of work setting or years of experience.

What do you think? Do nonfinancial general managers need financial management skills? What about clinical managers? Justify your answers.

Comptroller

The finance department manager who handles accounting, budgeting, and reporting activities.

Treasurer

The finance department manager who handles capital acquisition, investment management, and risk management activities.

Business (practice) manager

The manager responsible for the finance function in a small healthcare organization, such as a medical practice with one or a few clinicians.

1.4 THE STRUCTURE OF THE FINANCE DEPARTMENT

The structure of the finance department depends on the type (e.g., hospital, medical practice) and size of the healthcare organization. Large organizations generally structure their finance departments in the following way.

The head of the finance department holds the title of chief financial officer (CFO). (The title of vice president—finance is also used.) This individual typically reports directly to the organization's chief executive officer (CEO) and is responsible for all finance activities in the organization. The CFO directs two senior managers who help manage finance activities: the comptroller and the treasurer.

The **comptroller** (pronounced, and sometimes spelled, “controller”) is responsible for accounting and reporting activities, such as routine budgeting, preparation of financial statements, and patient accounts management. For the most part, the comptroller is involved in activities covered in chapters 4 through 7, 11, and 12 of this text. The **treasurer** is responsible for the acquisition and management of capital (funds). In other words, the treasurer must raise the funds needed by the organization and ensure that those funds are effectively used. Specific activities include the acquisition of capital, cash and debt management, lease financing, financial risk management, and endowment fund management (in not-for-profits). In general, the treasurer is involved in those activities discussed in chapters 8 through 10 and chapter 13 of this book.

In large organizations, the comptroller and treasurer have managers under them who are responsible for specific functions, such as the patient accounts manager, who reports to the comptroller, and the cash manager, who reports to the treasurer. In small businesses, many of the finance responsibilities are combined and assigned to one individual. For example, in a small group practice, the finance function is managed by one person, often called the **business (practice) manager**, who typically is supported by one or more clerks.

SELF-TEST QUESTIONS

1. Briefly describe the typical structure of the finance department in a large healthcare organization.
2. How does the size of the organization affect the finance department structure?

1.5 HEALTHCARE SETTINGS

Healthcare services are provided in numerous settings, including hospitals, ambulatory care offices and clinics, long-term care facilities, and integrated delivery systems. Before the 1980s, most healthcare organizations were freestanding and not formally linked with

other organizations. Those that were linked tended to be part of **horizontal systems**, which control a single type of healthcare facility, such as a group of hospitals or nursing homes. Recently, however, many healthcare organizations have created **vertical systems**, which control different types of providers such as medical practices, hospitals, and nursing homes.

Horizontal system

A single business entity that owns a group of similar providers, such as hospitals.

HOSPITALS

Hospitals provide diagnostic and therapeutic services to individuals who require more than several hours of care, although most hospitals are actively engaged in ambulatory (walk-in) services as well. To ensure a minimum standard of safety and quality, hospitals must be licensed by the state and undergo inspections for compliance with state regulations. In addition, most hospitals are accredited by **The Joint Commission** (previously called the Joint Commission on Accreditation of Healthcare Organizations). Joint Commission accreditation is a voluntary process intended to promote high standards of care. Although the cost to achieve and maintain compliance with standards can be substantial, accreditation provides eligibility for participation in the Medicare and Medicaid programs, and hence most hospitals seek accreditation (chapter 3 discusses Medicare and Medicaid).

Recent environmental and operational changes have created significant challenges for hospital managers. For example, many hospitals are experiencing decreasing admission rates and shorter lengths of stay, resulting in reduced revenues and excess capacity. On the other hand, hospitals in fast-growing areas are hard-pressed to keep ahead of patient demand. In addition, all hospitals are being pressured to reduce costs by reimbursement rates that fail to keep up with inflation and to assume greater risk in their contracts with payers.

Hospitals differ in function, length of patient stay, size, and ownership. These factors affect the type and quantity of assets, services offered, and management requirements and often determine the type and level of reimbursement. Hospitals are classified as either general acute care facilities or specialty facilities.

General acute care hospitals provide general medical and surgical services and selected acute specialty services. Such hospitals, which account for the majority of hospitals, have relatively short lengths of stay, typically a week or less. **Specialty hospitals**, such as psychiatric, children's, women's, rehabilitation, and cancer facilities, limit the admission of patients to specific ages, sexes, illnesses, or conditions. The number of specialty hospitals has grown significantly in the past few decades because of the belief that such hospitals can provide better patient services than can hospitals that treat all conditions. In addition, specialty hospitals often experience lower costs than general hospitals because they do not require the overhead associated with providing many different types of services.

Hospitals vary in size from fewer than 25 beds to more than 1,000 beds; general acute care hospitals tend to be larger than specialty hospitals. Although economists do not all agree, the general belief is that the optimal hospital size is about 400–500 beds. Smaller hospitals do not benefit from economies of scale, while larger hospitals are too

Vertical system

A single business entity that owns a group of related, but not identical, providers, such as hospitals, medical practices, and nursing homes.

The Joint Commission

The accreditation body for hospitals and other health services organizations.

General acute care hospital

A hospital that treats all conditions that require a relatively short hospitalization (e.g., fewer than 30 days).

Specialty hospital

A hospital that treats patients with a common characteristic or condition, such as a children's or a cancer hospital.

big to manage efficiently (have diseconomies of scale). Small hospitals, those with fewer than 100 beds, tend to be located in rural areas. Many rural hospitals have experienced financial difficulties in recent years because they have less flexibility than large hospitals, limiting their ability to lower costs in response to tightening reimbursement rates. Most of the largest hospitals are academic health centers or teaching hospitals. These hospitals offer a wide range of services, including tertiary care, which consists of specialized services for patients with unusually severe, complex, or uncommon problems.

Government hospital

A hospital owned by a government entity. Federal hospitals are owned by the federal government, while public hospitals are owned (or funded) by state or local governments.

Private not-for-profit hospital

A hospital that is not governmental but is operated for the exclusive benefit of the community.

Investor-owned hospital

A hospital that is owned by investors who benefit financially from its operation. Also called a for-profit hospital.

Hospitals are classified by ownership as governmental, private not-for-profit, or investor owned. **Government hospitals**, which make up about 22 percent of all hospitals, are broken down into federal and public (nonfederal) entities. Federal hospitals, such as those operated by the uniformed services or the US Department of Veterans Affairs, serve special purposes. Public hospitals are funded wholly or in part by a city, county, tax district, or state. In general, federal and public hospitals provide substantial services to indigent patients. In recent years, many public hospitals have converted to other ownership categories (primarily, private not-for-profit) because local governments have found it increasingly difficult to fund healthcare services and at the same time provide other necessary public services.

Private not-for-profit hospitals are nongovernmental entities organized for the sole purpose of providing inpatient healthcare services. Because of the charitable origins of US hospitals and a tradition of community service, roughly 73 percent of all private hospitals (58 percent of all community hospitals) are not-for-profit entities. In return for serving a charitable purpose, these hospitals receive numerous benefits, including exemption from federal and state income taxes, exemption from property and sales taxes, eligibility to receive tax-deductible charitable contributions, favorable postal rates, favorable tax-exempt financing, and tax-favored annuities for employees.

The remaining 27 percent of private hospitals (21 percent of all community hospitals) are **investor-owned hospitals**, whose owners (typically shareholders) benefit directly from the profits generated by the business. Historically, most investor-owned hospitals were owned by physicians, but now most are owned by large corporations, such as HCA (Hospital Corporation of America), which owns approximately 174 hospitals in the United States and England; CHS (Community Health Systems), which owns nearly 137 hospitals; and Tenet Healthcare, which owns 77 hospitals. Unlike not-for-profit hospitals, investor-owned hospitals pay taxes and forgo the other benefits of not-for-profit status.

Despite the expressed differences in mission between investor-owned and not-for-profit hospitals, not-for-profit hospitals are being forced to place greater emphasis on the financial implications of operating decisions than in the past. This trend has raised concerns in some quarters that many not-for-profit hospitals are failing to meet their charitable mission. As this perception grows, some people argue that these hospitals should lose some, if not all, of the benefits associated with their not-for-profit status. (Chapter 2 discusses the differences between investor-owned and not-for-profit hospitals in detail)

Hospitals are labor intensive because they provide continual nursing supervision to patients, in addition to the services given by other clinical, professional, and semiprofessional staff members. Physicians petition for privileges to practice in hospitals. While they admit and provide care to hospitalized patients, most physicians are not hospital employees and hence are not directly accountable to hospital management. However, physicians retain a major responsibility for determining which hospital services are provided to patients and how long patients are hospitalized. Thus, physicians play a critical role in determining a hospital's costs and revenues and hence its financial condition.

AMBULATORY (OUTPATIENT) CARE

Ambulatory (outpatient) care encompasses services provided to patients who are not admitted to a hospital or nursing home. Traditional outpatient settings include clinics, medical practices, hospital outpatient departments, and emergency departments. Nontraditional settings, such as home health care, ambulatory surgery centers, urgent care centers, diagnostic imaging centers, rehabilitation and sports medicine centers, and clinical laboratories, have emerged and are seeing substantial growth. The latest innovation in ambulatory care is the retail clinic, a small clinic operated in a retail store (such as Wal-Mart) and staffed by a physician assistant or nurse practitioner. Compared to hospital-based services, these innovative settings offer patients more amenities and convenience and, in many situations, lower prices. For example, urgent care and ambulatory surgery centers are typically less expensive than their hospital counterparts because hospitals have higher overhead costs. (The same lower-cost logic applies to urgent care centers and retail clinics compared to medical practices.)

Many factors have contributed to the expansion of ambulatory services, with technology leading the way. Often, patients who once required hospitalization because of the complexity, intensity, invasiveness, or risk associated with certain procedures can now be treated in outpatient settings. In addition, health insurers have encouraged providers to expand their outpatient services by requiring authorization for inpatient services and instituting payment mechanisms that provide incentives to perform services on an outpatient basis.

Finally, starting a business that provides outpatient care is easier than starting a new hospital. Ordinarily, ambulatory facilities are less costly to operate and less frequently subject to licensure and certificate-of-need (CON) regulations (exceptions are hospital outpatient units and ambulatory surgery centers) than are hospitals, and they generally are not accredited. (Section 1.6 of this chapter discusses licensure and CON regulation in detail.)

As outpatient care consumes an increasing portion of the healthcare dollar and as efforts to control outpatient spending are enhanced, the traditional role of the ambulatory care manager is changing. Historically, ambulatory care managers have handled routine management tasks such as billing, collections, staffing, scheduling, and patient relations,

Ambulatory (outpatient) care
Care that is provided to patients who are not institutionalized. Typical settings include physicians' offices, outpatient surgery centers, and walk-in clinics.

while the owners, often physicians, have tended to the important business decisions. However, a more complex healthcare environment, coupled with growing competition, is forcing managers of ambulatory care facilities to become more sophisticated in making business decisions, including finance decisions.

LONG-TERM CARE

Long-term care

Care that is provided in either an institutional or outpatient setting that covers an extended period.

Long-term care consists of healthcare (and some personal care) services provided to individuals who lack all or some functional ability, specifically in the activities of daily living such as eating, bathing, and locomotion. This type of care usually covers an extended period and may be given as an inpatient or outpatient service. Although the most common users of long-term care are the elderly, the services are available to individuals of all ages.

Individuals become candidates for long-term care when they become too mentally or physically incapacitated to perform daily living tasks and when their family members are unable to provide the help needed. Long-term care is a hybrid of healthcare and social services. Nursing homes are a major provider of such care.

Nursing home care is offered at three levels: (1) skilled nursing, (2) nursing, and (3) residential care. Skilled nursing facilities (SNFs) provide the level of care closest to hospital care. Services must be provided under the supervision of a physician and must include 24-hour daily nursing care. Nursing facilities (NFs) are intended for individuals who do not require hospital or SNF care but whose mental or physical conditions require daily continuity of one or more medical services. Residential care facilities are sheltered environments that do not provide professional healthcare services. Thus, most health insurance programs do not provide coverage for residential care.

Long-term care facilities are more abundant than hospitals. However, SNFs and NFs are smaller than hospitals, with an average of about 100 beds, compared with about 160 beds for hospitals. Large, for-profit, long-term care companies exist (such as Brookdale Senior Living, which operates 1,121 facilities across the United States), but many nursing homes are mom-and-pop operations. Nursing homes are licensed and inspected by states, which also license nursing home administrators. Although The Joint Commission accredits nursing homes, only a small percentage of these facilities obtain accreditation because it is not required for reimbursement and the standards to achieve accreditation are much higher than licensure requirements.

The long-term care field has experienced tremendous growth in recent decades. In 1960, long-term care accounted for only 1 percent of US healthcare expenditures, but by 2012 it accounted for more than 9 percent. Demand increases are anticipated, as the percentage of the US population aged 65 or older is expected to grow from 15 percent in 2016 to 24 percent in 2060. The elderly are disproportionately high users of healthcare services in general and are major users of long-term care in particular.

Although long-term care is often perceived as nursing home care, many new services are less institutional, such as adult day care, life care centers, and hospice programs. These services tend to offer a higher quality of life, although they are not necessarily less expensive than institutional care. Home health care, provided for an extended period, is an alternative to nursing home care but is not as readily available in many rural areas. Furthermore, third-party payers, especially Medicare, have sent mixed signals about adequately paying for home health care. In fact, many home health care businesses have been forced to close in recent years as a result of a new, less generous Medicare payment system.

Finally, many Americans suffer from a long-lasting or chronic illness (from the Greek word *chronos*, meaning time). Some chronic diseases, such as cancer, can be life-threatening. Other chronic illnesses, such as asthma and diabetes, while often incurable, can be managed by the patient for many years with proper care.

In the traditional system, the treatment of chronic illnesses was fragmented, with primary care physicians, specialists, hospitals, and other providers separately contributing their services without much planning or coordination with the other parties. Today, practitioners have finally recognized that the most effective way to provide chronic care is using a long-term integrated approach, wherein a single case manager is responsible for the patient's care, regardless of the setting.

INTEGRATED DELIVERY SYSTEMS

Many healthcare experts have extolled the benefits of providing hospital care, ambulatory care, long-term care, and business support services through a single **integrated delivery system** (see “Critical Concept: Integrated Delivery System”). The potential benefits of such a system include the following:

- ◆ Patients are kept in the corporate network of services (**patient capture**).
- ◆ Providers have access to managerial and functional specialists, such as reimbursement and marketing professionals.
- ◆ Information systems that track all aspects of patient care, as well as insurance and other data, can be developed more easily than under a disjointed care model, and the costs to develop them can be shared.
- ◆ Larger, multipurpose organizations have better access to capital.
- ◆ The ability to recruit and retain management and professional staff is enhanced.
- ◆ Healthcare insurers can be offered a complete package of services (one-stop shopping).

Patient capture

The concept that once a patient enters the system (e.g., a doctor's office), all services needed by that patient should be provided in the system.

- ◆ A full range of healthcare services, including chronic disease management and health-status improvement programs, can be better planned and delivered to meet the needs of a defined population. Many of these population-based efforts typically are not offered by stand-alone providers.
- ◆ Incentives that encourage all providers in the system to work together for the common good of the system can be created, which has the potential to improve quality and control costs.

**CRITICAL CONCEPT****Integrated Delivery System**

An integrated delivery system consists of a number of different types of healthcare organizations, such as hospitals, clinics, and nursing homes, owned and operated as a single entity. Although integrated delivery systems offer the opportunity to coordinate all aspects of patient care under a single umbrella, their complexity makes the overall management process much more difficult than in smaller organizations that focus on one type of service.

Although integrated delivery systems can be structured in many ways, the defining characteristic of such systems is that the organization has the ability to assume full clinical responsibility for the healthcare needs of a defined population. Because state laws typically mandate that the insurance function can be assumed only by licensed insurers, integrated delivery systems typically contract with insurers rather than directly with employers. Sometimes, the insurer, often a managed care plan, is owned by the integrated delivery system itself, but generally it is separately owned. In contracts with some insurers, the integrated delivery system receives a fixed payment per

plan-covered life and hence assumes both the financial and clinical risks associated with providing healthcare services.

To be an effective competitor, integrated delivery systems must minimize the provision of unnecessary services, because additional services create added costs but do not necessarily result in additional revenues. Thus, the objective of integrated delivery systems is to provide all needed services to its member population in the lowest-cost setting (see “Practice in Healthcare: What We Spend on Healthcare”). To achieve this goal, integrated delivery systems invest heavily in primary care services, especially prevention, early intervention, and wellness programs. Thus, clinical integration among the various providers and components of care is essential to achieving quality, cost efficiency, and patient satisfaction.

In spite of the benefits of integration, health system executives have found that managing large, diverse enterprises is difficult. In many cases, the financial and patient care gains predicted were not realized, and some integrated delivery systems formed in the 1990s have broken up. However, healthcare reform legislation has created additional incentives that have fostered the creation of a new type of integrated delivery system, the accountable care organization. We discuss this new form of provider, along with other features of reform, in chapter 3.



PRACTICE IN HEALTHCARE

What We Spend on Healthcare

Most people think that healthcare spending in the United States is out of control. For example, in 2015, almost 18 percent of the nation's total value of goods and services (gross domestic product [GDP]) was spent on healthcare. The proportion of GDP devoted to healthcare is expected to rise to more than 20 percent by 2025, an amount greater than the anticipated expenditure for housing and food combined. In effect, rapidly rising healthcare costs are squeezing out the spending on other goods and services. By comparison, most other industrialized nations, such as Germany, England, and Canada, currently spend about 8 to 10 percent of their GDP on healthcare.

Where does all this money go? Data from 2015 indicate that Americans spend healthcare dollars this way:

| | |
|--|---------------|
| Hospital care | 32.3% |
| Physician and other clinical services | 22.5% |
| Prescription drugs | 10.1% |
| Public health, research, and facilities | 7.3% |
| Administrative costs | 7.9% |
| Long-term care | 4.9% |
| Other health and personal care | 5.1% |
| Dental care | 3.7% |
| Durable and nondurable medical equipment | 3.4% |
| Home health care | 2.8% |
| Total | <u>100.0%</u> |

As you can see, the largest area of healthcare expenditure is hospital care; the second largest, physician and other clinical services, includes diagnostic imaging, outpatient surgeries, physical therapy, and chiropractic care. Combined, hospitals and ambulatory care providers consume more than half of each healthcare dollar.

The next biggest healthcare expense, at 10.1 percent, is prescription drugs. The proportion spent on prescription drugs is expected to increase over time as more and more individuals gain access to insurance programs that cover prescription drugs. However, commentators expect the increase in spending on prescription drugs to be mitigated by the increasing use of lower-cost generics and the potential for large insurers to negotiate lower prices.

(continued)

This is an unedited proof.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.copyright.com



PRACTICE IN HEALTHCARE

What We Spend on Healthcare (continued)

Almost 8 cents of each healthcare dollar is spent on administrative costs. In 2015, more than \$3.2 trillion was spent on healthcare, and about \$252 billion of that money paid for government and insurance company administrative costs. Administrative costs can be defined and measured in numerous ways, but regardless of how they are measured, these costs eat up a great deal of money. Estimates vary, with some reaching more than 30 percent when all administrative costs, including those at provider organizations, are considered. One persuasive argument for establishing a universal or national healthcare system is that it can dramatically reduce administrative costs and hence make more money available for patient services.

Will we ever get healthcare spending under control? While there are current efforts aimed at reducing costs, predicting the long-term outcome of this problem is impossible. What we do know is that it cannot continue to grow at the current rate without causing financial damage to other parts of the economy. Thus, sooner or later, additional action will have to be taken.

Source: This Practice in Healthcare is based on National Health Expenditure data from the Centers for Medicare & Medicaid Services. See www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html.

1.6 REGULATORY AND LEGAL ISSUES

Healthcare services are subject to many regulations. For example, pharmacy services are regulated by state and federal laws, and radiology services are highly regulated because of the handling and disposal of radioactive materials. Entry into the healthcare sector is also heavily regulated. Examples of such regulation include licensure, certificate of need (CON), and rate setting and review programs.

States require **licensure** of certain healthcare providers in an effort to protect the health, safety, and welfare of the public. Licensure regulations establish minimum standards that must be met to provide a service. Many types of providers are licensed, including entire facilities (e.g., hospitals and nursing homes) and individuals (e.g., physicians, dentists, nurses, even some managers).

Licensed facilities must submit to periodic inspections and review activities. Such reviews focus more on physical features and safety than on patient care and outcomes, although progress is being made to change this practice. Thus, licensure has not necessarily ensured that the public will receive high-quality services (see “For Your Consideration: Medical Malpractice”).

This is an unedited proof.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.copyright.com



FOR YOUR CONSIDERATION

Medical Malpractice

Many people have criticized the medical malpractice system in the United States for being expensive, adversarial, unpredictable, and inefficient. Physician advocacy groups claim that 60 percent of malpractice claims are dropped, withdrawn, or dismissed without payment, and only a small percentage of malpractice suits result in monetary awards. Yet, the direct cost of these suits, along with the incentive for providers to practice *defensive medicine*, significantly increase the cost of patient care. In total, an estimated 2–10 percent of healthcare costs are a result of the current malpractice system. Proponents of the current system say that it encourages providers to be more aware of patients' medical needs, creates incentives for the development of improved equipment and procedures, and provides a means for patients who have been wronged to seek compensation for damages.

What do you think? Should the current system be changed? If so, what are some potential changes? (Some observers have put forth such ideas as limiting lawyers' fees, capping awards for noneconomic damages, and decreasing the statute of limitations.)

Critics of licensure contend that it is designed to protect providers, not consumers. For example, licensed paramedical professionals (e.g., physician assistants, dental hygienists) usually are required to work under the supervision of a physician or dentist, making it impossible for paramedical professionals to compete with physicians or dentists. Despite the limitations of licensure, it is undoubtedly here to stay.

Certificate-of-need regulation was enacted by Congress in 1974 in an effort to control growing healthcare costs (see “Critical Concept: Certificate of Need”). CON legislation required providers to obtain state approval on the basis of community need for construction and renovation projects that either relate to specific services or exceed a defined cost threshold. This attempt to control capital expenditures by controlling expansion and preventing duplication of services lasted less than a decade before the Reagan administration began to downplay CON regulation and promote cost controls through competition. However, CON regulation, in one form or another, still exists in roughly 35 states.

Critics of CON regulation argue that it does not provide as much control over capital



CRITICAL CONCEPT

Certificate of Need

A certificate of need (CON) is the approval required by many states before a new healthcare facility can be constructed. CON proponents claim the system helps control costs by preventing excess capacity. Critics, however, contend that CON regulation impedes competition and the spread of new technologies while protecting established providers, even those that do not operate efficiently.

Cost-containment programs

State programs that require providers (primarily hospitals) to submit budgets each year for approval.

Professional liability

The responsibility of organizations and individuals who provide professional services, such as hospitals and physicians, for losses that result from malpractice.

expenditures as originally envisioned and that it increases costs by requiring additional administrative expenditures when new facilities are needed. Perhaps the biggest criticism of CON is that it creates a territorial franchise for the services it covers; that is, it creates barriers for new entities entering markets, even though the new businesses may be more cost efficient and offer better patient care than the existing ones.

In addition to CON, many states enacted **cost-containment programs** at the time when most healthcare reimbursement was based on costs. By the late 1970s, nine states had mandatory cost-containment programs, and many other states had voluntary programs (those that did not mandate compliance). The primary tool for cost-containment programs is the *rate-review system*.

Three types of rate-review systems have been used: (1) detailed budget reviews with approval or setting of rates; (2) formula methods, which use inflation formulas to set target rates; and (3) negotiated rates, which involve joint decision making between the provider and the rate setter. Some states that use rate-review systems have reduced the rate of cost increase to below the national average, while others have failed to do so. However, rate review, as a sole means of cost containment, has been criticized because it does not address the issue of demand for healthcare services.

The primary legal concern of healthcare providers is **professional liability**. Malpractice suits are the oldest form of quality assurance in the US healthcare system, and today such suits are used to an extreme extent. Many people believe that the United States is in the midst of a malpractice insurance crisis. Total malpractice premiums, which have remained stable or decreased over the past five years, have been passed on to healthcare purchasers. On average, physicians pay \$24,500 on malpractice premiums, although some specialist physicians pay malpractice premiums of more than \$100,000 per year! However, the total number of paid medical claims and the amount of paid for malpractice claims has been steadily decreasing over the past decade.

Although providers in some states have achieved tort reforms, malpractice litigation continues to be perceived as inefficient because it diverts resources to lawyers and courts and creates disincentives for physicians to practice high-risk specialties and for hospitals to offer high-risk services. In addition, such litigation encourages the practice of defensive medicine, whereby physicians overuse diagnostic services in an effort to protect themselves from liability.

Professional liability is the most visible legal concern in healthcare, but the sector is subject to many other legal issues, including the typical general liability and antitrust claims. In addition, healthcare providers are confronted with unique ethical issues, such as the right to die or to prolong life, that are often resolved through the legal system.

**SELF-TEST QUESTIONS**

1. What are some forms of regulation in the healthcare sector?
2. What is the most pressing legal issue facing healthcare providers today?

1.7 CURRENT CHALLENGES

In recent years, the American College of Healthcare Executives (ACHE) has conducted an annual survey of CEOs regarding the most critical concerns of healthcare managers. Financial concerns have headed the list of challenges in every year since the survey began in 2002. When asked to rank their specific financial concerns in 2015, CEOs listed the transition from fee-for-service to a value-based payment system as their primary challenge, with adequate reimbursement from Medicaid and bad debt also near the top of the list. (Reimbursement is discussed in chapter 3.)

Just as ACHE surveyed its CEO members, the Healthcare Financial Management Association surveyed CFOs in 2017 regarding their concerns for the future. Their most pressing issue was need for increased investments in technology to improve revenue cycle management. Aside from increased budgets, CFOs cited the need to leverage technology better to link clinical and financial opportunities in order to optimize performance. Another top concern among the CFOs was the increase in uncompensated care as patients assume more responsibility for payments through high-deductible health plans.

Taken together, these surveys confirm the fact that finance is of primary importance to today's healthcare managers. The remainder of this book is dedicated to helping you confront and solve these issues.

SELF-TEST QUESTION

- What are some important issues facing healthcare managers today?

THEME WRAP-UP: CAREERS IN HEALTHCARE MANAGEMENT

What are some settings that require healthcare management graduates? The largest employers of healthcare managers are hospitals. In the United States, about 5,000 community hospitals, as well as Veterans Affairs, military, and public health facilities, are in operation. In hospitals, healthcare managers are needed in a multitude of functional areas, such as operations, marketing, human resources (personnel), facilities, information technology, and finance. About 40 percent of all healthcare management graduates initially take positions at hospitals. Most start their careers in operations, while some find they are better suited for one of the other functional areas and move quickly into specialized staff positions.

Another career opportunity is in medical practice management. Almost 1 million physicians practice in the United States in settings that range from one-physician (solo) practices to large group practices (such as Mayo Clinic, which has more than 3,800 physicians). Physicians practice within specialties, the largest of which is internal medicine. Other specialties include cardiology (heart), dermatology (skin), pediatrics (children), and surgery.

This is an unedited proof.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.copyright.com

Some group practices consist of only one specialty, while other practices include physicians from several specialties (multispecialty practices). Obviously, the larger the group practice, the greater the need for management expertise.

The structure of the management staff at large group practices is similar to that at hospitals, while small practices may have only a practice manager and a few clerks. In addition to physician practices, other healthcare professionals, such as physical therapists and psychologists, may own stand-alone medical practices that require managerial skills beyond those possessed by the clinicians. The bottom line is that healthcare organizations need managers, and the larger the organization, the greater the need.

As the population ages and life expectancy increases, the requirement for long-term care will continue to grow at a rapid rate. As of 2014, about 15,600 nursing homes operated in the United States. These facilities require significant managerial expertise to prosper in an era of financial constraints, as do other institutional providers.

A multitude of career opportunities is also available in insurance, health services research, consulting, public health, and even homeland security.

Regardless of your specific healthcare management goals, knowledge of the fundamentals of healthcare finance is a critical skill. This book will help you obtain this professional competency.

KEY CONCEPTS

This chapter provides an introduction to healthcare finance. Here are the key concepts:

- The term *healthcare finance*, as it is used in this book, refers to the accounting and financial management principles and practices used in healthcare organizations to ensure the financial well-being of the enterprise.
- The *primary role of finance* in healthcare organizations, as in all businesses, is to plan for, acquire, and use resources to maximize the efficiency and value of the enterprise.
- Finance activities generally include the following: (1) *estimating costs and profitability, planning and budgeting*, (2) *financial operations management*, (3) *financing decisions*, (4) *capital investment decisions*, (5) *financial reporting*, (6) *financial and operational analysis*, (7) *contract management*, and (8) *financial risk management*.
- Finance activities can be summarized by the *four Cs*: costs, cash, capital, and control.
- The size and structure of the finance department in healthcare organizations depend on the type and size of the provider.
- The finance department in large provider organizations is generally led by a *chief financial officer (CFO)*, who typically reports directly to the chief executive officer

(CEO) and is responsible for all finance activities in the organization. Under the CFO are the *comptroller (controller)*, who is responsible for accounting and reporting activities, and the *treasurer*, who is responsible for the acquisition and management of capital (funds).

- In large organizations, the comptroller (controller) and treasurer direct managers with responsibility for specific functions, such as the *patient accounts manager*, who reports to the comptroller, and the *cash manager*, who reports to the treasurer.
- In small healthcare businesses, the finance responsibilities are combined and assigned to one individual, often called the *business (practice) manager*.
- All business decisions have *financial implications*, so all managers (whether clinical or in operations, marketing, personnel, or facilities) must know enough about finance to incorporate its implications into their specialized decision processes.
- Healthcare services are provided in numerous settings, including hospitals, ambulatory care facilities, long-term care facilities, and even the home.
- Hospitals differ in function (*general acute care vs. specialty*), length of stay, size, and ownership (*government vs. private, for-profit vs. not-for-profit*).
- *Ambulatory care*, also known as *outpatient care*, encompasses services provided to noninstitutionalized patients. Outpatient settings include medical practices, hospital outpatient departments, ambulatory surgery centers, urgent care centers, diagnostic imaging centers, rehabilitation and sports medicine centers, and clinical laboratories.
- *Long-term care* entails healthcare services provided for an extended period, including inpatient, outpatient, and home health care, often with a focus on mental health, rehabilitation, or nursing home care.
- *Home health care* brings many of the same services provided in ambulatory care settings into the patient's home.
- The defining characteristic of an *integrated delivery system* is that it has the capability of providing all healthcare services needed by a defined population.
- Entry into the healthcare sector is heavily regulated. Examples of regulations include *licensure, certificate of need (CON), and rate setting and review programs*.
- Legal issues, such as *malpractice*, are prominent in discussions about controlling healthcare costs.
- Two recent surveys of healthcare executives confirm that healthcare managers view financial concerns as their most important current issue.

In chapter 2, we continue our discussion of foundation concepts and move on to finance-related topics, such as business basics, forms of organization, and taxes.

END-OF-CHAPTER QUESTIONS

- 1.1 a. What does the term *healthcare finance* mean, as it is used in this book?
b. What are the two broad areas of healthcare finance?
c. Why is it necessary to have a book on healthcare finance as opposed to a generic finance book?
- 1.2 a. Briefly discuss the role of finance in the healthcare field.
b. Has this role increased or decreased in importance in recent years?
- 1.3 a. Briefly describe the following healthcare settings:
 - Hospitals
 - Ambulatory care
 - Home health care
 - Long-term care
 - Integrated delivery systemsb. What benefits are attributed to integrated delivery systems?
- 1.4 What role does regulation play in the healthcare sector?
- 1.5 What is the structure of the finance function in healthcare organizations?
- 1.6 What is the primary legal issue facing providers today?

This is an unedited proof.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.copyright.com