SEVENTH EDITION

INTRODUCTION TO THE Financial Management of Healthcare Organizations

MICHAEL NOWICKI

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I dedicate this book to my parents who, by their actions more than their words, instilled in me the value of lifelong learning. From my mother, I learned that effort is a reward in itself. From my father, I learned that correct answers count, always.

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PREFACE

Introduction to the Financial Management of Healthcare Organizations is intended to be the primary textbook in introductory courses in healthcare financial management at both the undergraduate and graduate levels as well as a reference book for program graduates and other practicing healthcare managers. The purpose of this book is to introduce students and managers in positions other than finance to the fundamental concepts and skills necessary to succeed as managers in an increasingly competitive employment environment.

For instance, program graduates find employment in a variety of healthcare settings. Therefore, the focus of this book—as well as the title of the book—extends beyond the hospital. Program graduates consistently report a deficiency in quantitative skills; this book includes problems representing key concepts. Traditional-age students report a need to apply the quantitative skills introduced in financial management. To address both of these concerns, this book includes mini-case studies within chapters, practice problems at the ends of many chapters, and a comprehensive case study at the end of the book.

Introduction to the Financial Management of Healthcare Organizations is part of Health Administration Press's Gateway to Healthcare Management series. The textbooks in this series are geared specifically to students who are new to healthcare management.

In this edition, Part I includes an overview of financial management; the organization of financial management, including updated information on job responsibilities and salaries; financial analysis and management reporting; and the tax status of healthcare organizations, including the most recent court cases differentiating for-profit and not-for-profit hospitals.

Part II includes information about third-party payers and payment methodologies; Medicare and Medicaid, including updated laws pertaining to these public programs as

well as federal government settlements with providers on fraud and abuse allegations; cost accounting and analysis; and reimbursement, including charge setting.

Part III covers the management and financing of working capital; the management of the revenue cycle, including the distinction between the revenue cycle and accounts receivable; and materials management.

Part IV focuses on resource allocation and includes strategic, strategic financial, and operational planning; budgeting; and capital budgeting.

Finally, Part V provides an analysis of trends that will affect healthcare organizations in the future, including healthcare cost projections and the need for entitlement reform. The Affordable Care Act (ACA) of 2010 and the Medicare Access and CHIPS Reauthorization Act (MACRA) of 2015 are discussed throughout the book but more prominently in Parts II and V.

Each part of the book includes its own recommended reading list. A running glossary of important terms accompanies each chapter and is compiled at the end of the book; a list of acronyms used in the text is also included at the end of the book. At the end of every chapter, important points and discussion questions encourage students to summarize what they are learning and put it into their own words. The chapters are modular to allow instructors to either delete specific chapters or assign the chapters in an order based on individual preference or classroom requirements.

I hope you find *Introduction to the Financial Management of Healthcare Organizations* relevant, current, and easy to understand.

Acknowledgments

I would like to gratefully acknowledge those who assisted me in this seventh edition: my wife, Tracey, and our kids, Hannah and David, who have often sacrificed time with Dad so that I could write; my many students over the years, who have challenged me to find a better way to explain, teach, and evaluate the understanding of difficult concepts; Thamarai Selvi Sundararajan, my graduate assistant, who helped proofread the book and provided the valuable supplemental materials; Texas State University for continuing to support faculty research efforts; and Dick Clarke, president emeritus of HFMA, who in ways too numerous to mention has always supported my academic career. Finally, special thanks to those at Health Administration Press who have made this seventh edition what it is.

—Michael Nowicki

Instructor Resources

This book's instructor resources include a test bank of multiple choice questions; additional short-answer and fill-in-the-blank questions; PowerPoint slides in both outline and Socratic formats; and answer guides for the in-book discussion questions, mini-cases, and end-of-book case.

For the most up-to-date information about this book and its instructor resources, go to ache.org/HAP and browse for the book by its title or author name.

This book's instructor resources are available to instructors who adopt this book for use in their course. For access information, please e-mail hapbooks@ache.org.

PART I

FINANCIAL MANAGEMENT

CHAPTER 1

FINANCIAL MANAGEMENT IN CONTEXT

No matter where you are in the healthcare finance arena, there are opportunities to move things forward, to act, to resist complacency, to refuse to allow yourself to think that things won't ever change. As finance professionals we all have strengths that will serve our organizations well in these times of change.

Debora Kuchka-Craig, 2011 chair of the Healthcare Financial Management Association

Learning Objectives

After completing this chapter, you should be able to do the following:

- Understand the purpose of healthcare organizations
- Relate the purpose of healthcare financial management to the purpose of the organization
- Understand the objectives of healthcare financial management
- Apply quality assessment to healthcare financial management
- Apply organizational ethics to healthcare financial management
- Examine the value of healthcare financial management to the management functions and the changing face of healthcare
- Review background accounting, economics, and statistics information (appendixes 1.1, 1.2, and 1.3)

Introduction

Successful organizations, whether for-profit, not-for-profit, or governmental, have two things in common: (1) a congruent and well-understood organizational purpose, and (2) a functional management team. The purpose of this introductory chapter is to describe financial management in healthcare organizations within the context of organizational purpose and a competent management team.

Organizational Purpose

Organizational purpose is often determined by the owner. While a community-owned, not-for-profit healthcare organization's purpose is to provide healthcare services to the community, a corporate-owned (via stockholders) for-profit healthcare organization's purpose is to provide profit for the owner.

By necessity, most organizations have more than one organizational purpose. For instance, even though a not-for-profit healthcare organization's purpose is to provide healthcare services to the community, the organization must survive economically—meaning that it must generate sufficient revenue to offset expenses and allow for growth. A for-profit healthcare organization's purpose is to provide profit for the owner; however, the organization must meet its customers' needs—meaning it must keep the physicians, patients, employers, and insurance companies satisfied.

Most healthcare organizations also have secondary purposes—for example, many government-owned healthcare organizations provide large-scale medical education programs.

To maintain congruence, the management team must communicate the organizational purpose or purposes not only to the employees but also to owners, customers, and other important constituents. When multiple purposes are present, the management team must prioritize the purposes.

Healthcare Management Team

In its broadest context, the objective of healthcare management is to accomplish the organizational purposes. Doing so is not as simple as it sounds, especially if the healthcare organization's purposes are "to provide the community with the services it needs, at a clinically acceptable level of quality, at a publicly responsive level of amenity, at the least possible cost" (Berman, Kukla, and Weeks 1994, 5). Healthcare managers must identify, prioritize, and often resolve these sometimes contradictory purposes in a political environment that involves the organization's governing board and medical staff; in a regulatory environment that involves licensing and accrediting agencies; and in an economic environment that involves increasing competition, resulting in demands for lower prices and higher quality.

management functions
The key functions of a manager, including planning, organizing, staffing, directing, and controlling.

Competent healthcare managers attempt to accomplish the organizational purposes by planning, organizing, staffing, directing, and controlling (called the **management**

functions) and through communicating, coordinating, and decision making (called the **management connective processes**). For more information on the management functions and connective processes, see *Dunn and Haimann's Healthcare Management* (Dunn 2016).

management connective processes Management functions that connect elements of the healthcare organization, including communicating, coordinating, and decision making.

With the exception of nursing home administrators, no licensure requirements are needed to be a practicing healthcare manager. However, facility-accrediting organizations such as **The Joint Commission** require healthcare managers to possess such education and experience as required by the position. Moreover, formal educational programs for healthcare management do exist at both the undergraduate and graduate levels. Undergraduate programs can seek program review and approval from the Association of University Programs in Health Administration. Graduate programs can seek program review and accreditation from the Commission on Accreditation of Healthcare Management Education. Furthermore, healthcare managers can seek membership and certification in professional associations, including the American College of Healthcare Executives (ACHE), which has more than 48,000 members, more than 9,000 of whom are certified as Fellows of the American College of Healthcare Executives (FACHE) (ACHE 2016a).

The Joint Commission The primary accrediting body for healthcare organizations.

Purpose of Healthcare Financial Management

The purpose of healthcare financial management is to provide accounting and finance information that helps healthcare managers accomplish the organization's purposes. No licensure requirements are needed to be a practicing healthcare financial manager. Facility-accrediting organizations such as The Joint Commission rarely provide requirements for healthcare financial managers; they often hold the organization's chief executive officer (CEO) responsible for financial management.

Formal educational programs for healthcare financial management are not common and usually exist as postgraduate certificate programs. The chief financial officers of most large healthcare organizations possess a master's degree in business administration, a bachelor's degree in accounting, and a certificate in public accounting and have healthcare experience. For formal continuing education and certification in healthcare financial management, healthcare financial managers can seek membership and certification in healthcare professional associations, including the **Healthcare Financial Management Association (HFMA)**. HFMA has more than 40,000 affiliates, including 1,332 certified healthcare financial professionals (CHFPs) and 1,663 members certified as fellows of the Healthcare Financial Management Association (FHFMA) (HFMA 2016b).

Healthcare Financial Management Association (HFMA) Association of healthcare financial managers; confers four certifications: certified revenue cycle representative, certified technical specialist, certified healthcare financial professional, and fellow of the Healthcare Financial Management Association.

Accounting

Accounting is generally divided into two major areas: *financial accounting* and *managerial accounting*. The primary purpose of **financial accounting** is to provide accounting information, generally historical in nature, to external users, including owners, lenders, suppliers, the government, and insurers.

financial accounting A type of accounting that provides historical accounting information to external users.

CRITICAL CONCEPTS
Measurements

Healthcare financial managers monitor many measurements. Among the most common are the following:

- *Admissions*: The number of patients, excluding newborns, accepted for inpatient service
- *Average daily census*: The average number of inpatients, excluding newborns, receiving care each day during the reporting period
- *Average length of stay (ALOS)*: Derived by dividing the number of inpatient days by the number of admissions
- *Occupancy rate*: The ratio of average daily census to the average number of statistical (set up and staffed for use) beds

Accounting information prepared for external use must follow formats established by the American Institute of Certified Public Accountants (AICPA) and other, similar organizations and must follow generally accepted accounting principles used for standardization. The 1996 *AICPA Audit and Accounting Guide for Health Care Organizations* (AICPA 1996) established four basic financial statements that hospitals should prepare for external users:

1. A consolidated balance sheet
2. A statement of operations
3. A statement of changes in equity
4. A statement of cash flows

managerial accounting
A type of accounting that provides accounting information, generally current or prospective in nature, to internal users.

The primary purpose of **managerial accounting** is to provide accounting information, generally current or prospective in nature, to internal users, including managers. Such accounting information supports the planning and control management functions. In this way, managerial accounting is the link between financial accounting and the manager. Managerial accounting, or accounting information prepared for internal use, requires no prescribed format and therefore varies greatly among organizations. Managerial accounting

topics such as budgeting and inventory control require knowledge of economics, statistics, and operations research.

Many managerial accountants believe that **cost accounting**—the study of costs, including methods for classifying, allocating, and identifying costs—is either synonymous with or a subset of managerial accounting. Others argue that cost accounting includes all managerial accounting and also requires some financial accounting. Cost accounting and managerial accounting also include topics that could be considered finance.

cost accounting
The study of costs, including methods of classifying, allocating, and identifying costs.

Finance

Historically, the purpose of finance has been to borrow and invest the funds necessary for the organization to accomplish its purpose. Today, the purpose of finance is to analyze the information provided by managerial accounting to evaluate past decisions and make sound assessments regarding the future of the organization (Finkler 2003). Finance uses techniques such as **ratio analysis** and **capital analysis** and requires knowledge of financial and managerial accounting (see appendix 1.1), economics (see appendix 1.2), statistics (see appendix 1.3), and operations research. Exhibit 1.1 shows the relationship of finance to the aforementioned supporting disciplines.

ratio analysis
Evaluation of an organization's performance by computing the relationships of important line items in the financial statements.

capital analysis
A process to determine how much a capital expenditure will cost and what return it will generate.

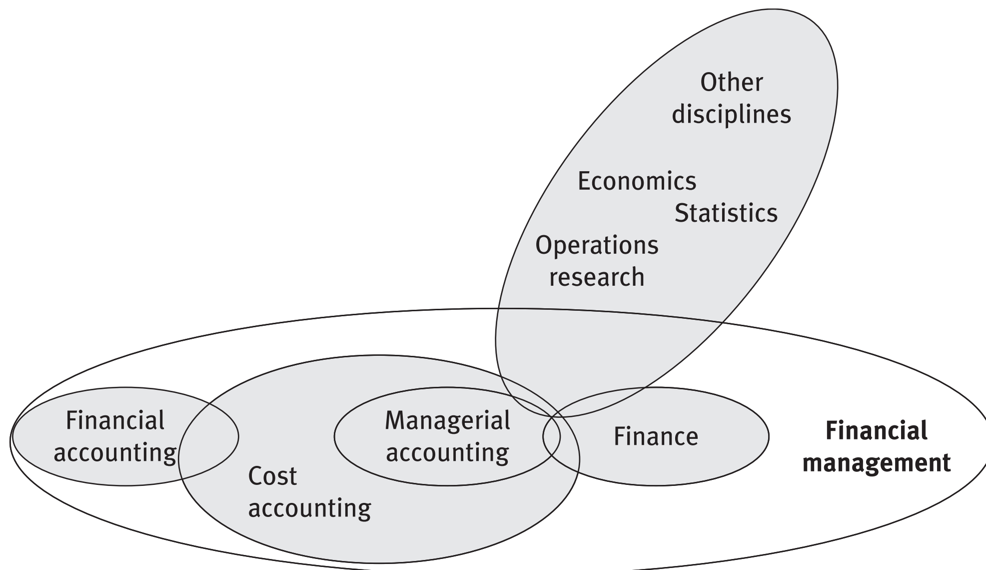

Exhibit 1.1
Financial Management Relationships

Major Objectives of Healthcare Financial Management

In this section, we will examine six major objectives of healthcare financial management: (1) to generate income, (2) to respond to regulations, (3) to facilitate relationships with third-party payers, (4) to influence the method and amount of payment, (5) to monitor physicians, and (6) to protect tax status.

Generate Income

While the purpose of healthcare financial management is to provide accounting and finance information that assists healthcare management in accomplishing the organization's objectives, all organizations have at least one objective in common: to survive and grow. Organizations in other industries might refer to this objective as maximizing owners' wealth; healthcare organizations typically refer to it as maintaining community services. In either event, the organization will be of little use if it cannot afford to continue to operate.

Therefore, the most important objective of healthcare financial management is to generate a reasonable **net income** (i.e., the difference between collected revenue and expenses) by investing in assets and putting the assets to work.

net income
The difference between collected revenues and expenses; a reasonable amount is considered the most important objective of healthcare financial management.

Respond to Regulations

Although financial management in healthcare organizations has similar objectives to that of organizations in other industries, different objectives also exist. The government regulates healthcare to a significant degree because healthcare organizations are in a position to take advantage of the sick and the elderly; regulation protects individuals who cannot protect themselves. Federal, state, and local governments pay more than 55 percent of all health insurance expenditures and therefore have a vested interest in ensuring that government money is well spent (Martin et al. 2016). Healthcare organizations must also be accredited or certified to qualify for reimbursement from many third-party payers and to qualify for loans from certain lenders. Therefore, the second objective of healthcare financial management is to respond to the myriad of regulations in a timely and cost-effective manner.

Facilitate Relationships with Third-Party Payers

third-party payer
An agent of the patient (the first party) that contracts with a provider (the second party) to pay all or a portion of the bill to the patient.

The third objective of healthcare financial management is to facilitate the organization's relationship with each **third-party payer**, such as an insurance company, that will pay all or a portion of the bill. Private health insurance, Medicare, and Medicaid account for more than 82 percent of all personal health consumption expenditures (Martin et al. 2016). Financial management must be responsive to third-party payers and in many ways must treat third-party payers as customers because the third party pays the bill. At the same time,

financial management must be attentive to the patient because the patient has influence over the third-party payer and in some cases may be partially responsible for the bill.

Influence Method and Amount of Payment

The fourth objective of healthcare financial management is to influence the method and amount of payment chosen by third-party payers. Third-party payers are becoming increasingly aggressive in asking healthcare organizations for discounts if they provide large numbers of patients. In certain cases, healthcare organizations are discounting prices below costs to maintain market share.

Some third-party payers, such as Medicare, are asking healthcare organizations to assume part of the financial risk for the patient by agreeing to a **prospective payment**, or, in other words, agreeing in advance to a price for providing care to a patient. Healthcare organizations lose money if they provide care that costs more than the prospective payment.

Some third-party payers are asking healthcare organizations to assume risk by agreeing to a **capitated price** (i.e., a price per head or subscriber) before the subscriber actually needs care. Capitated prices put healthcare organizations at risk for the cost of care, if needed.

prospective payment
A payment system in which a healthcare organization accepts a fixed, predetermined amount to treat a patient, regardless of the true ultimate cost of that treatment. Diagnosis-related groups (DRGs) are one type of prospective payment; Medicare pays hospitals a fixed amount for an episode of treatment based on that treatment's DRG.

capitated price
A healthcare payment system in which an organization accepts a monthly payment from a third-party payer for each individual covered by that payer's plan, regardless of whether a given individual is treated in a given month. Also known as *capitation*, it provides a financial incentive to a healthcare organization to keep its population from using more healthcare services than necessary because the organization profits only if the total cost of treating the specified population falls below the total capitated price provided by the third-party payer.

Monitor Physicians

The fifth objective of healthcare financial management is to monitor physicians and their potential financial liability to the organization. In 2015 (the most recent year for which data were available at time of publication), professional services including physicians, dentists, and other professionals accounted for 30.9 percent of all personal healthcare expenditures (Martin et al. 2017). However, physicians influence much of the healthcare spending that is not directly attributed to them. For example, physicians order the patient admission, the diagnostic testing and treatment for the patient, and the patient discharge. Healthcare financial management must ensure through the utilization review process that physician ordering patterns are consistent with what the patient needs. In addition, healthcare financial management must ensure through the credentialing process and the risk management process that the healthcare organization using more healthcare has minimized its exposure to legal liability for a physician's possible negligent actions.

Protect Tax Status

The sixth major objective of healthcare financial management is to protect the organization's tax status. For-profit healthcare organizations seek ways to reduce their tax liability, and not-for-profit healthcare organizations try to protect their tax-exempt status. Protecting tax-exempt status has become more difficult as state and local governments seek new

MINI-CASE STUDY

Suppose you were recently hired to manage a new primary care physician's office. The physician's office will be located downtown in a major metropolitan area with significant competition. You need to establish the organization's purpose and financial objectives. What items should you consider in establishing the organization's purpose? What organizational purpose should you suggest to the physician owners? What should the financial objectives of the organization be?

revenue sources, and tax-exempt status has come under judicial and public scrutiny (see chapter 4).

Quality Assessment and Healthcare Financial Management

The healthcare industry has long had difficulty with defining quality:

> Quality . . . you know what it is, yet you don't know what it is. But that's self-contradictory. But some things are better than others. That is, they have more quality. But when you try to say what that quality is, apart from the things that have it, it all goes poof! There's nothing to talk about. But if you can't say what quality is, then for all practical purposes, it doesn't exist at all. But for all practical purposes it does exist. What else are the grades based upon? Why else would people pay fortunes for some things and throw others in the trash pile? Obviously, some things are better than others . . . but what's the 'betterness?' . . . So round and round you go, spinning mental wheels and nowhere finding any place to get traction. (Pirsig 1974, 179)

Since the 1970s, healthcare organizations have responded to serious pressure to define quality. In the early 1970s, accrediting agencies and third-party payers applied this pressure. In the late 1970s and early 1980s, the consumer movement added pressure. In the late 1980s through the present, competition has added pressure. Economists predict that the pressure will continue as competition drives prices to their lowest—and relatively equal—point, and the market will force healthcare organizations that survive to compete on quality in addition to price. Healthcare organizations have responded to this pressure with two contrasting strategies: either a proactive strategy that attempts to adopt a comprehensive view of quality or a reactive strategy that attempts to limit views of quality to views developed by others.

Proactive Strategy

Healthcare organizations that have adopted a proactive strategy have developed multiple measures of quality, including direct and indirect measures that go beyond the minimum measures required by accrediting organizations (Conrad and Blackburn 1985). Direct measures of quality assume that the organization can define and measure quality itself. These measures include the following: