Introduction to Hospital Financial Affairs

Presenter

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Today's Goals

- Revenue Sources to help you better understand how you get paid for services- Medicare
- Balance Sheet and Financial Performance Indicators
- Roles and Responsibilities of a Board Member

Health Care Finance Challenges

- Health care finances are certainly different than many industries
  - What other industry willingly accepts 20 to 30% of a bill…and is happy?
- Some unique aspects of health care finance
  - Highly regulated by government
  - Very capital intensive
  - Low margins
  - Challenge to balance community benefits with need to remain financially viable

Keys to Understanding Healthcare Finance

- Board members need to understand how you are paid
  - ❖ Medicare, Medicaid, Commercial, PPOs, etc.
- Board members need to understand all about revenues and the income statement

Key Healthcare Finance Terms

- Medicare – Insurance for the aged (generally over 65)
- Medicaid – Insurance for the poor; generally managed by the state
- Financial Class – Patient grouping based on type of third-party payer (i.e., Medicare, Medicaid, Blue Cross)
- Case Mix Index – Measure of a patient acuity; a higher case mix indicates a sicker patient
- Cost Report – Annual information filing required by Medicare and Medicaid, which reports patient statistics and costs

Key Healthcare Abbreviations

- CMS – Center for Medicare and Medicaid Services; federal agency that administers Medicare and Medicaid programs
- Novitas- Contractor for CMS that receives and pays claims to hospitals
- PPS – Prospective Payment System; most common Medicare payment system
- DRG – Diagnostic Related Group, which is used by Medicare to pay hospitals for inpatient services
- APC – Ambulatory Payment Classification, which is used by Medicare to pay hospitals for outpatient services
- DSH – Disproportionate Share Hospital payment; an add-on to Medicare and Medicaid payments to partially reimburse hospitals for high levels of indigent care
- FTE – Full-time equivalent employee, which is an employee that worked 2,080 hours

Should a Hospital (even a Hospital District) Make a Profit?

- Of course – but why?
  - Equipment and expansion
  - Physician recruitment needs
  - Special circumstances requiring large cash outlays
- How much profit is enough?
  - Average operating margins of 1.5% to 3.0%
  - Total margin (which includes investment income) should ideally be about 1% higher than the operating margin
- Did you know…
  - In many years, more than 50% of hospitals lose money from operations

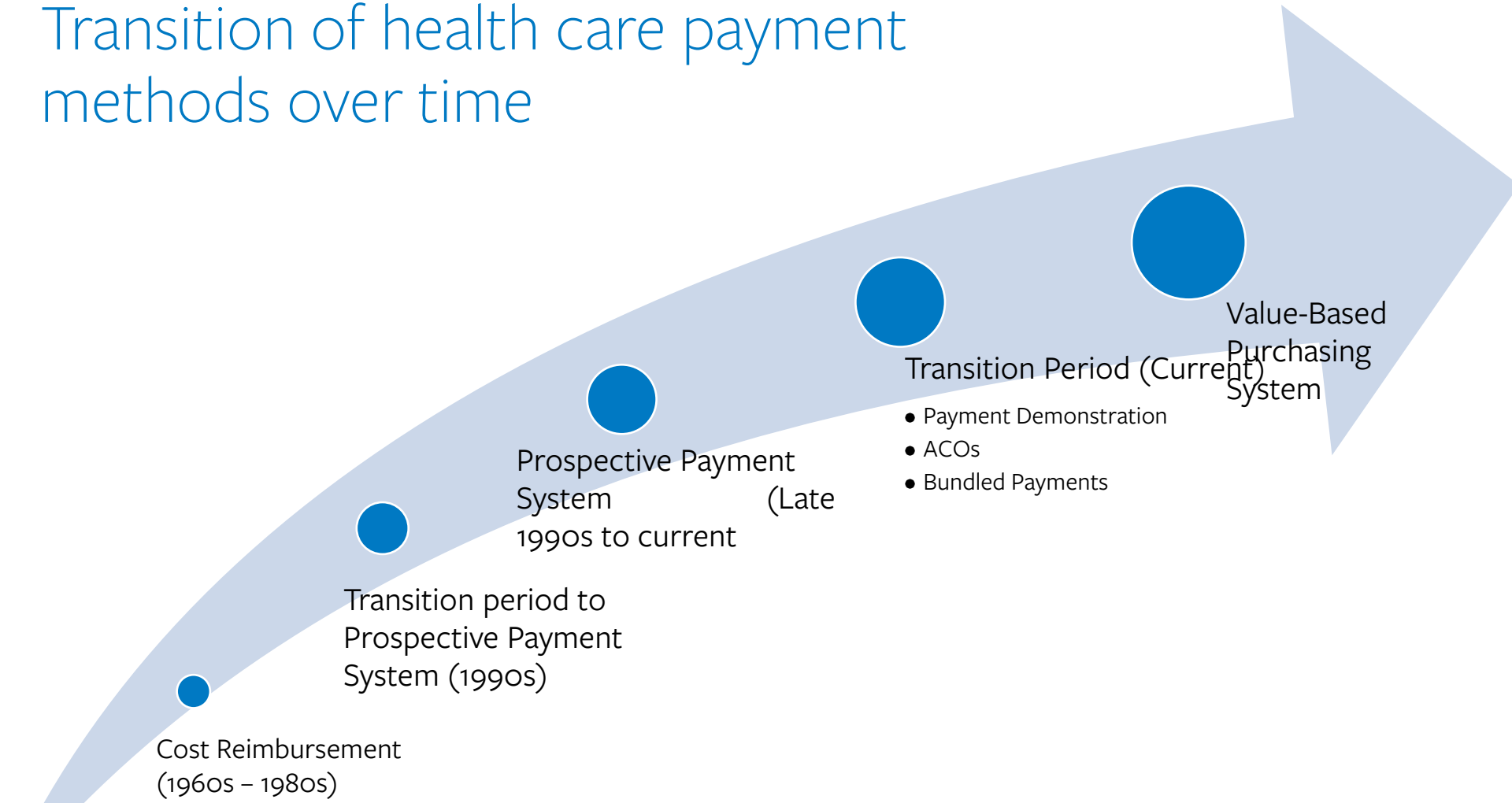
NPSR Key Terms

- Gross Charges
  - The “full” charge of a provider
  - Based on data in the Charge Description Master (CDM)
- Contractual Adjustments
  - The difference in the Gross Charge and the amount a provider has contractually agreed to accept
  - Providers cannot attempt to collect this difference
  - Most often associated with Medicare, Medicaid and managed care/commercial insurance payers
- Bad Debts and Charity
  - Amounts that a provider is allowed to collect but cannot or does not
  - Charity is usually based on documented indigent status and has little to no collection effort
  - Bad debts occur after substantial collection effort

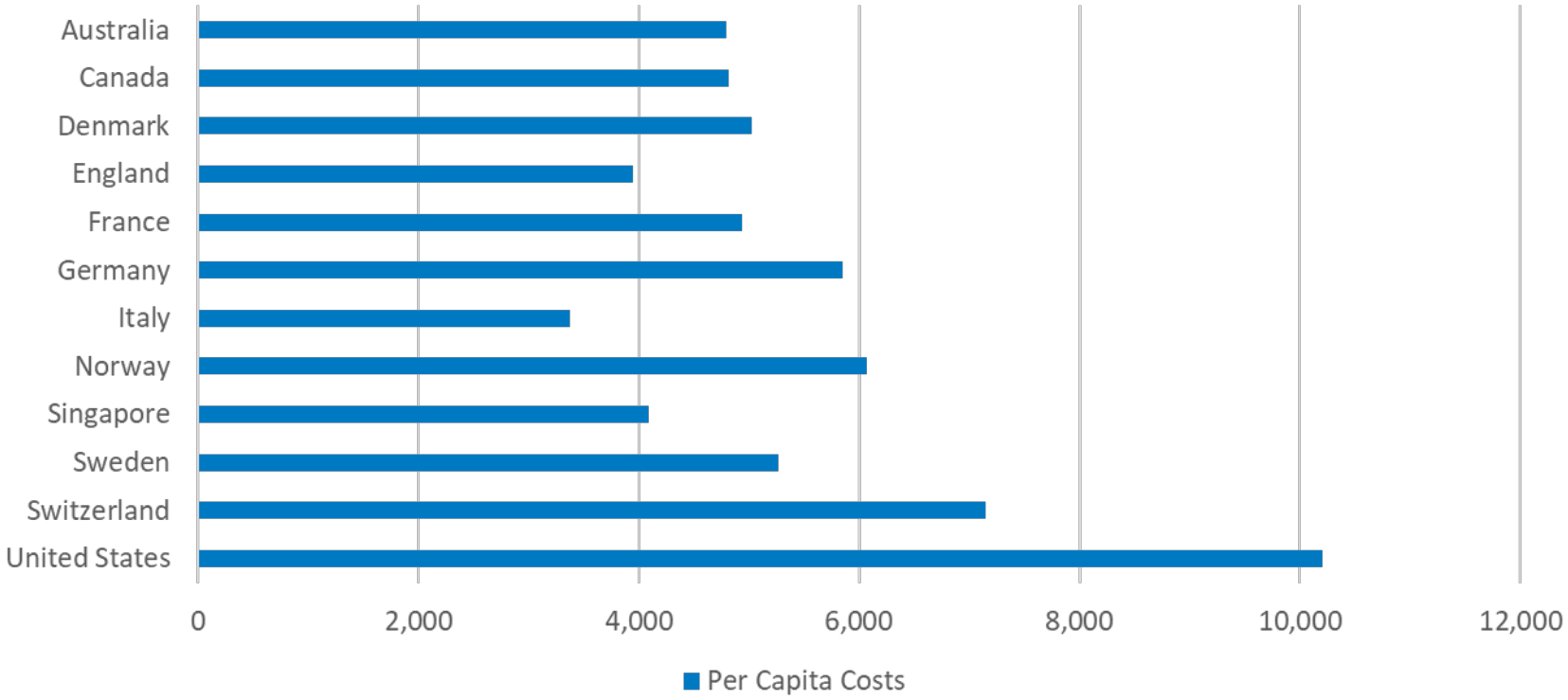
Medicare History

- Medicare was started in 1965 and provides insurance primarily to U.S. residents over age 65
  - ❖Provides coverage to over 60 million beneficiaries
- Medicare initially covered inpatient hospital/long-term care benefits (Part A) and outpatient and physician services (Part B). In recent years, a drug benefit was added (Part D).
  - ❖Medicare Advantage plans fall under Part C of the Medicare program
- Medicare is administered by CMS from Baltimore, Maryland. CMS hires "Medicare Administrative Contractors" to pay claims to providers, audit cost reports and enroll new providers
- Medicare requires patients to pay as much as 20% of the amounts due to providers as coinsurance and/or deductibles

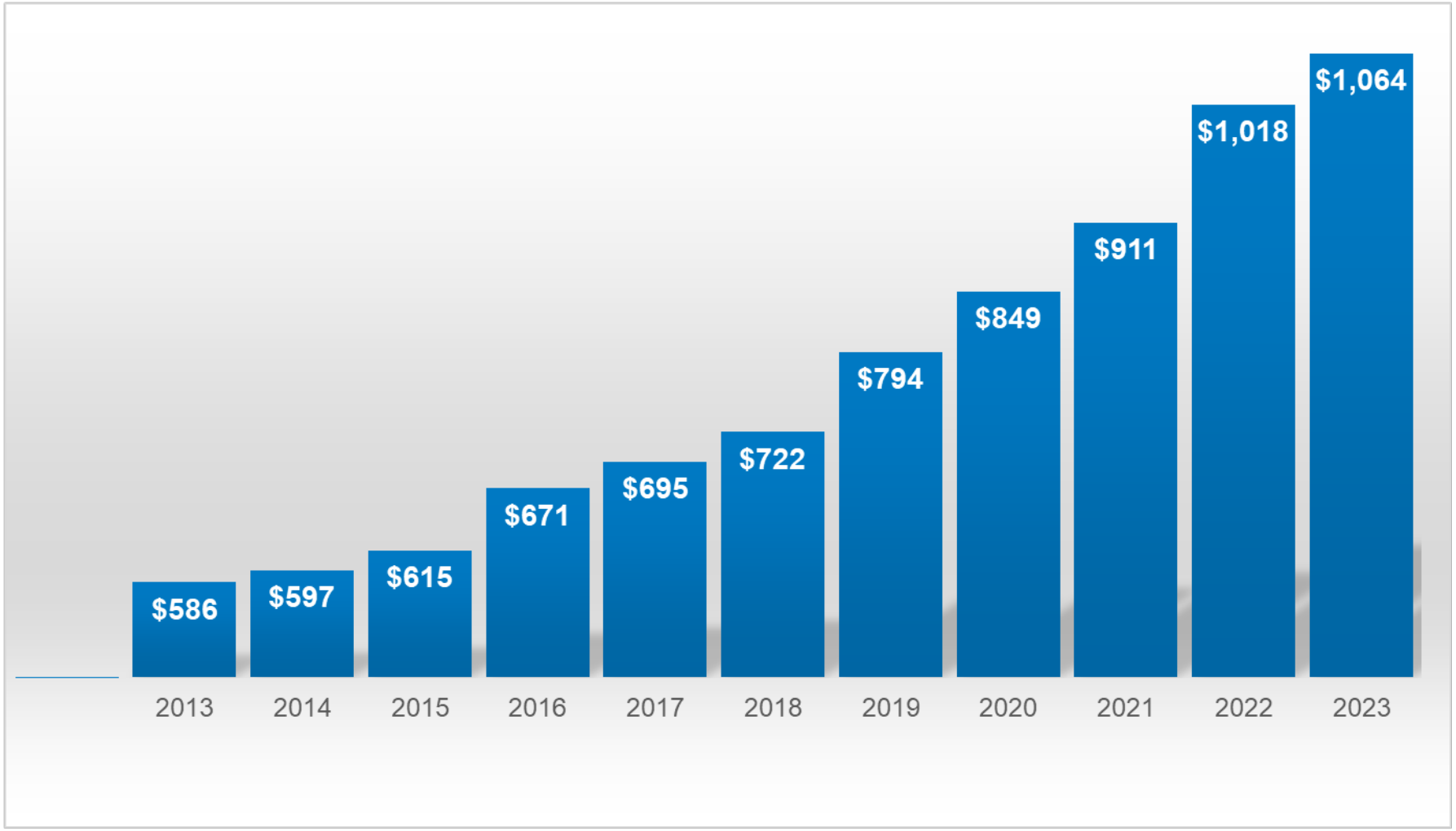
Transition of health care payment methods over time



Historical Per Capita Total Health Care Expenditures

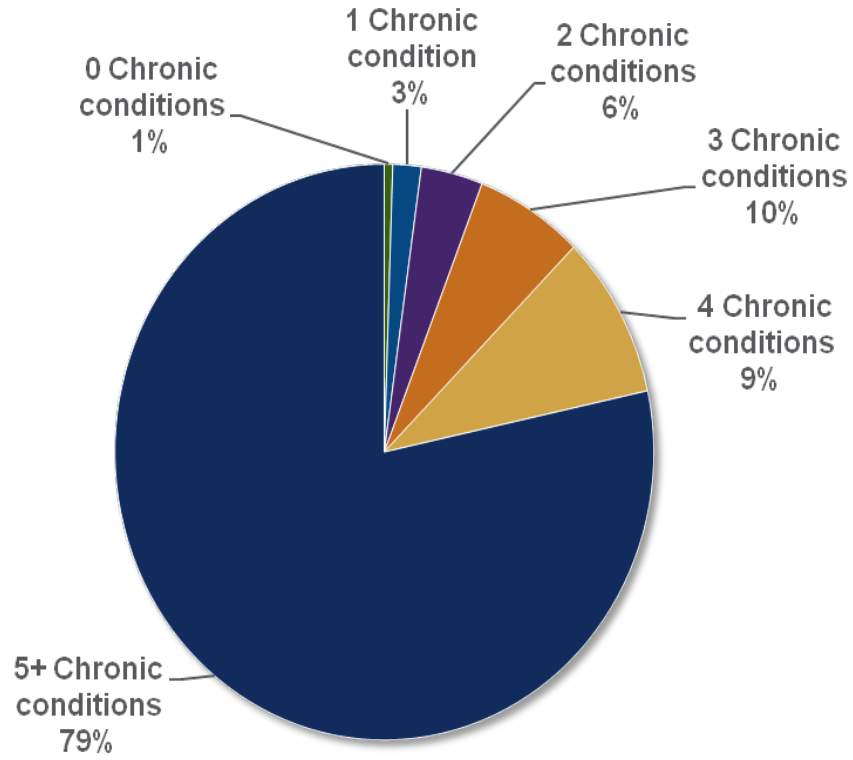


Historical Projected Medicare Spending- (in Billions)

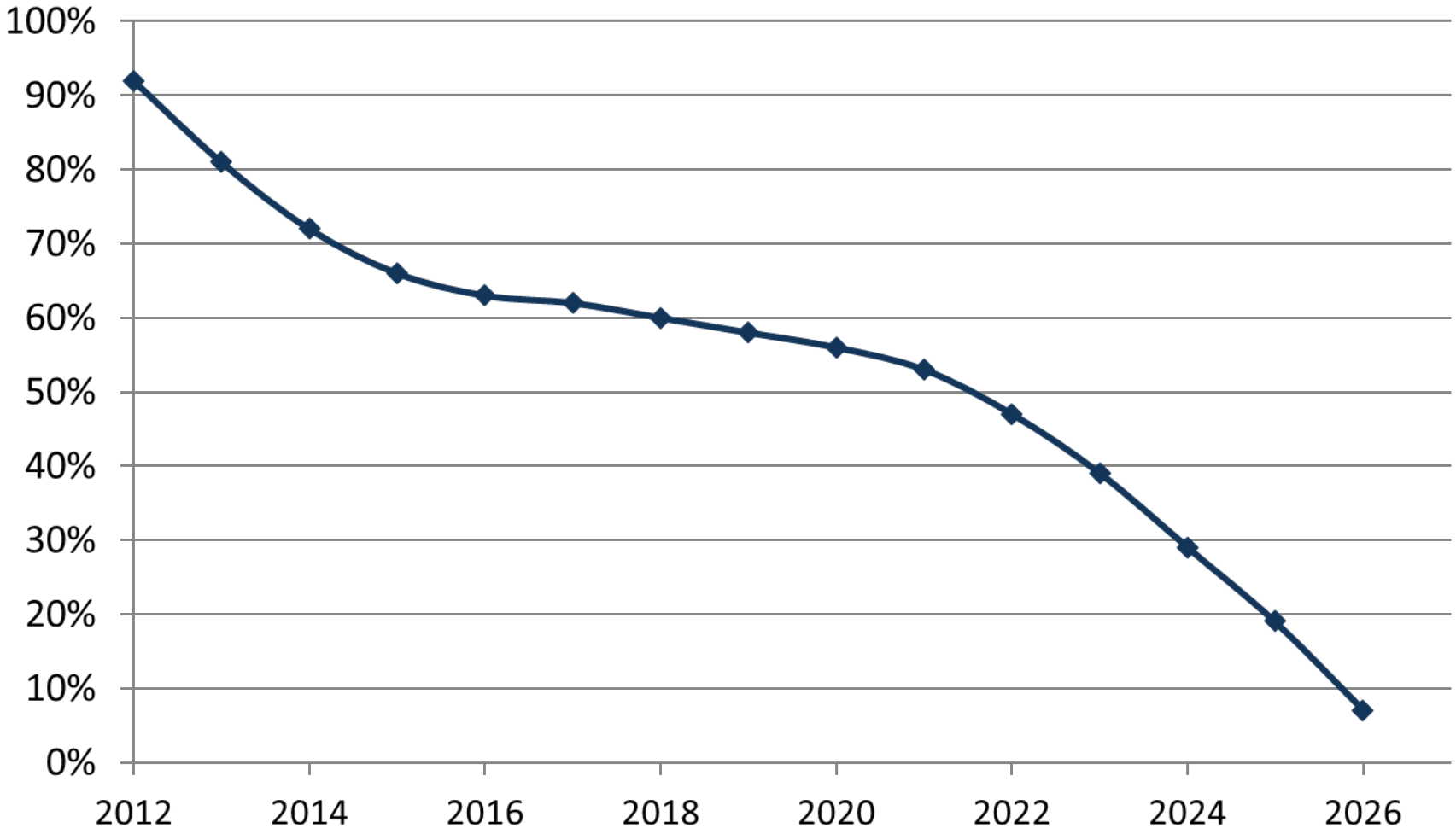


2/3 of Medicare spending is for people with 5 or more chronic conditions

- Three percent of Medicare expenditures involve individuals with one or less chronic conditions.
- Ninety-seven percent of Medicare expenditures involve individuals with two or more chronic conditions.



Historical Medicare Part A trust fund (In billions)



Medicare Payment Methods

- **Prospective Payment System**
  - Predetermined payments based on patient acuity or groups of services provided
  - Most common payment method for providers like hospitals, nursing homes and home health agencies
- **Cost based reimbursement**
  - Payment based on Medicare's share of cost of providing care
  - Medicare only pays for allowable costs
  - Mostly limited to rural facilities that are Critical Access Hospitals
- **Fee schedule**
  - Much like prospective payment, but based on individual non-packaged services
  - Covers most physician, therapist and mid-level provider payments

Acute Care Hospital
Part A-Medicare Inpatient PPS (DRGs)
Part B-Medicare Outpatient PPS (APCs)

- Payments are based on a prospectively determined amount per discharge rate or procedure
- Varies based on the acuity (or case mix) of each patient
- About 2/3 of the payment is based on the geographic area where a hospital is located
- The DRG payment generally does not change based on the patient's length of stay or the amount of charges
- Case mix adjustment impacts payment

Critical Access Hospital

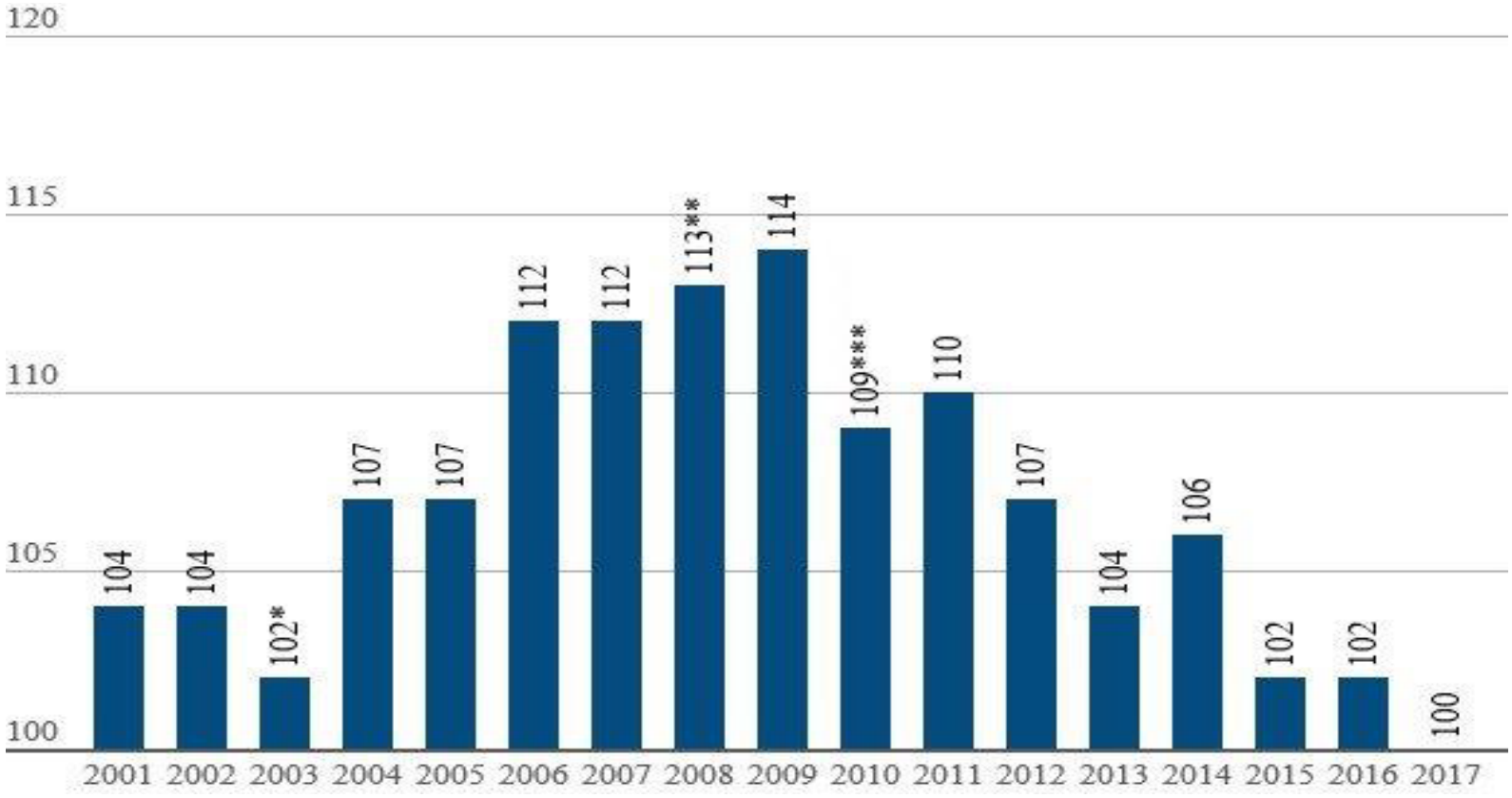
Designation began in 1997
Necessary Provider Provision sunsets in 2006
Mileage Criteria to 2023

- Receive cost-based payments for Medicare services
  - ❖Inpatient payments are based on average cost per inpatient day
  - ❖Outpatient payments are based on the ratio of costs to charges in each department multiplied by Medicare charges
- Potential for large cost report settlements

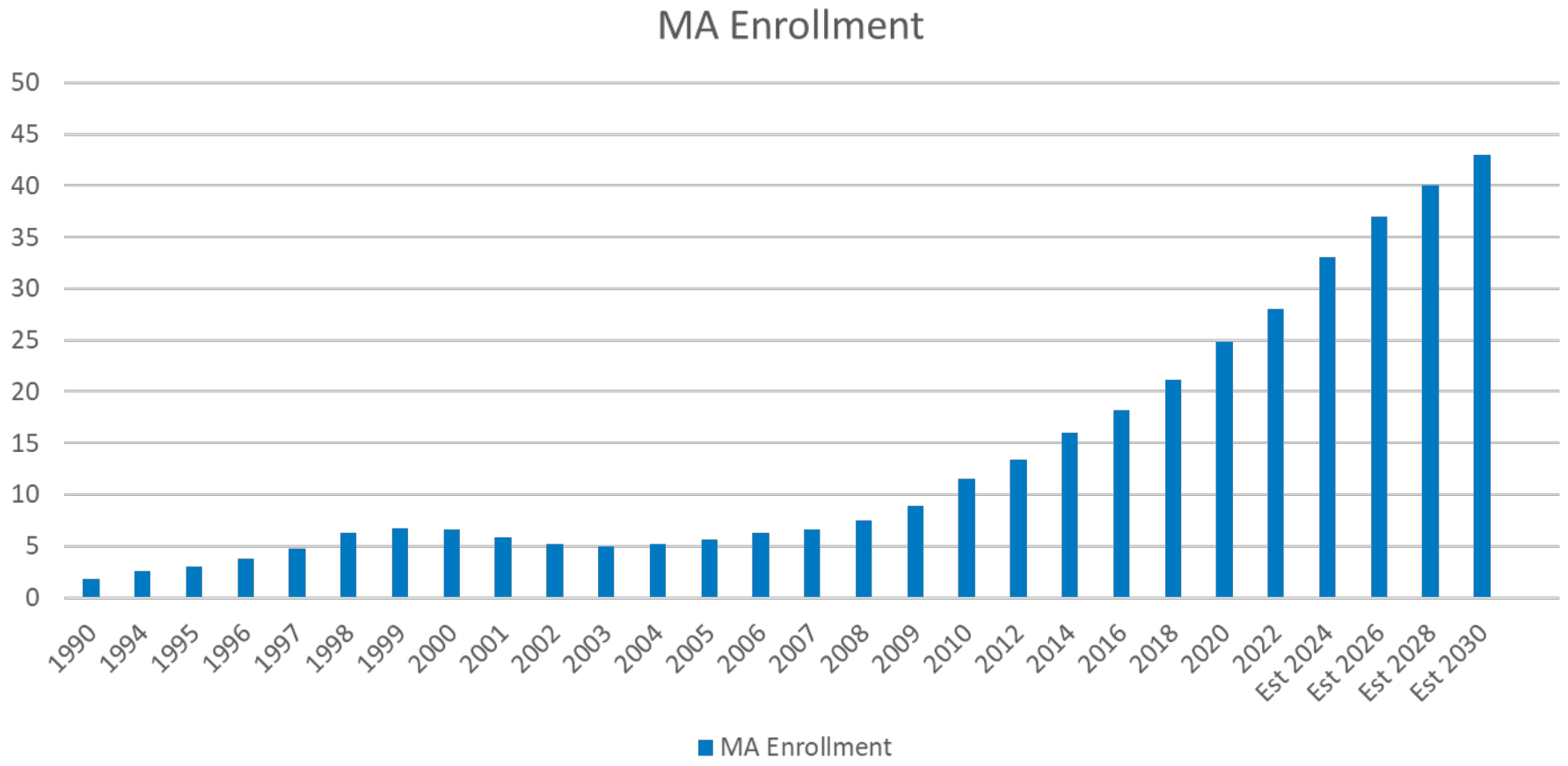
Impact of Medicare Advantage to all Hospitals

- **Dilution of Medicare** – Increasing pressure/campaigns to lure Medicare eligible participants away from traditional Medicare to managed care plans.

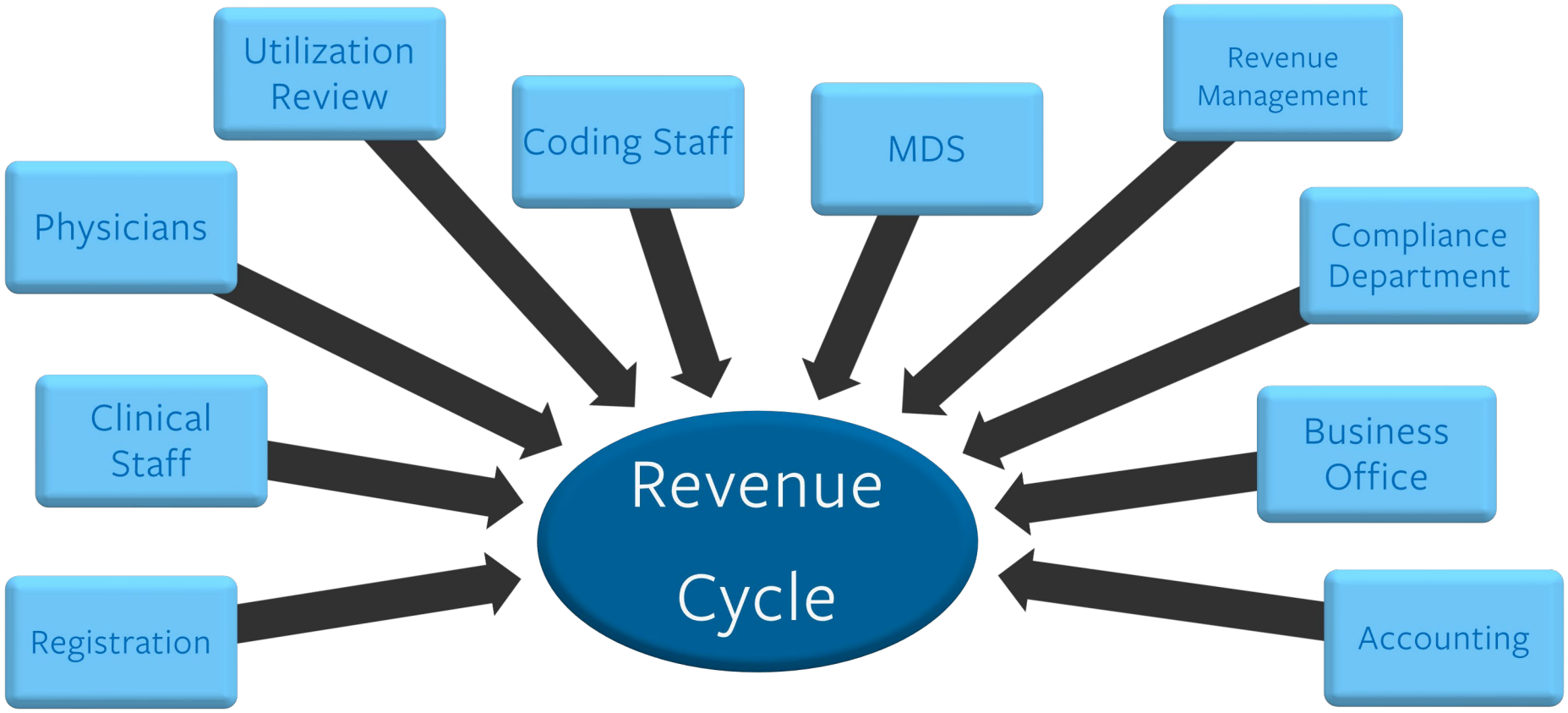
Medicare Private Plan Payments Relative to Traditional Medicare Spending



Medicare Private Plan Penetration in Millions



Who's Responsible for Revenue Cycle Process? is a combination of processes whose end result is cash (net revenue)



Key Revenue Cycle Management Indicators

Key Performance Indicator	KPI	Example Hospital
Days from Discharge to Bill	3-5 days	12 days
Clean Claim Rate	95%	75%
Rebill % of Total Primary Claims Billed	<5%	No Report
Registration Accuracy Rate	97%	75%

General Expenses Breakdown

- Salaries and Benefits 54%
- Professional Fees 12%
- Other Products- Food and Medical Equipment 11%
- Non Labor Admin Costs-Insurance/ Utilities/Phones 9%
- All Other 12%

- <u>Typical Hospital Expense Categories</u>
- Nursing Services
- Other Professional Services
- General Services
- Fiscal Services
- Administrative Services
- Other Services

Average Salary Expense

- Staffing during the Great Resignation, Great Realignment and Great Recession affected numerous industries including the healthcare industry.
- Rising Salary Expenses and Costs for Contracted Labor especially made an impact on hospitals and their financial spreadsheets

- A hospital's structure will impact this
  - ❖For example, hospitals that operate the ambulance service generally have a higher salary %
  - ❖Hospitals with a very high percent may need collection improvements

How Do You Use a Balance Sheet?

- The balance sheet represents a snapshot of a hospital's assets and liabilities at a particular date
- Timing differences can impact initial interpretation
  - ❖ Look for major changes since last year, especially in working capital
  - ❖ Use benchmarks to measure balance sheet status vs. aggregate numbers
    - ✓ Days cash on hand
    - ✓ Days in accounts receivable
    - ✓ Days in accounts payable
- One best practice is to show a comparison of the monthly balance sheet to the last year-end audit

Cash and Investments

- Hospitals cash and investments are reported in various areas on the balance sheet
  - ❖ Unrestricted amounts are shown as “Cash and cash equivalents” and “Investments”
  - ❖ Restricted amounts (including board designated investments) may be shown as “Assets limited as to use”
- Cash and Investment restrictions often relate to malpractice funds, donor restricted funds and funds restricted under debt agreements
- Cash is generally measured by the number of days cash on hand (that is, how many days of operating expenses are in the bank)

Accounts Receivable

- Accounts Receivable - the second most important asset on the books
- Measured based on days
  - ❖ Days in Gross Receivables
    - ✓ How fast are accounts cleared from the books?
  - ❖ Days in Net Receivables
    - ✓ How conservative or aggressive are our allowances?
- Compare these measures to a benchmark each month; look for trend changes and differences compared to your peers.

Property and Equipment

- The largest asset for many hospitals is its investment in property and equipment
- Assets are added to the balance sheet based on their cost, and then depreciation is expensed over time based on the assets' estimated useful life
- Health care technology changes rapidly, often requiring significant investments in new facilities, equipment or information technology systems

Long-term Debt and Leverage

- Long-term debt is measured using:
  - ❖ Debt-to-capitalization ratio – Measures total debt as a % of total capital. Hospitals with higher debt must manage it carefully. Higher debt as a % of total capital means there is a higher financial risk of insolvency. (Lower number is better)
  - ❖ Cash-and-investments to debt ratio- A high cash flow to debt ratio indicates a strong financial position and is able to accelerate its debt repayment if necessary. (Higher is better)
  - ❖ Debt Service Coverage- A measurement of available cash flow to pay current debt obligations (Higher is better)
- Debt pros and cons
  - ❖ Debt is often a necessity to modernize the facility and maintain liquidity
  - ❖ High debt levels can create high fixed costs, limiting operating options

Finance Perspective as a Board Member

Roles/Responsibilities of Board of Directors

1. Establish Vision, Mission and Values- guide and set the pace for its current operations and future development
2. Set Strategy and Structure- determine the business strategies and plans and ensure the company's organizational structure is appropriate to implement the strategies
3. Delegate to Management- delegate, monitor and evaluate implementation of strategies by management

Financial Obligations of the Board

- Oversee Financial Results
  - Evaluate results vs. Budget
  - Evaluate results vs. Prior Year to Date
  - Understand Variances

- Short and Long term financial plan
  - What is considered short term?
  - What is considered long term?
  - Why long term? Important for capital planning?

Summary

- Various revenue sources surrounding NPSR and how you get paid
- Balance Sheet highlights
- Board Member Responsibilities

Questions and Answers

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