Two factors make the provision of health services different from other services. First, many providers are organized as not-for-profit corporations as opposed to being investor owned. Second, payment for services typically is made by third parties rather than by the patients who receive the services. Part I provides readers with background information that creates the unique framework for the practice of healthcare finance.

Part I contains many introductory topics that are designed to provide readers with the structural framework in which finance is practiced within healthcare organizations. Such topics include the definition of healthcare finance, the organization and role of the finance staff, health services settings, key issues facing healthcare managers, and information on the book itself and its use. In addition, Part I contains information on alternative forms of business organization and ownership, the third-party payer system, alternative reimbursement methodologies, and the impact of healthcare reform.

It is essential that healthcare managers understand the information presented in Part I because the external factors discussed here have a profound influence on the practice of healthcare finance.
INTRODUCTION TO HEALTHCARE FINANCE

Learning Objectives

After studying this chapter, readers will be able to:

• Define the term healthcare finance as it is used in this book.
• Describe the key characteristics of a business.
• Discuss the structure of the finance department, the role of finance in health services organizations, and how this role has changed over time.
• Describe the major players in the health services industry.
• Discuss some of the regulatory and legal issues pertinent to the health services industry.
• List the key operational issues currently facing healthcare managers.
• Describe the organization of this book and the learning aids contained in each chapter.

Introduction

In today’s healthcare environment, where financial realities play an important role in health services decision making, it is vital that managers at all levels understand the basic concepts of healthcare finance and how these concepts are used to enhance the financial well-being of the organization. In this chapter, we introduce readers to the book, including its goals and organization. Furthermore, we present some basic background information about healthcare finance and the health services system. We sincerely hope that this book will be a significant help to you in your quest to increase your professional competency in the important area of healthcare finance.

Defining Healthcare Finance

What is healthcare finance? Surprisingly, there is no single answer to that question because the definition of the term depends, for the most part, on the context in which it is used. Thus, in writing this book, the first step was to establish the definition of “healthcare finance.”

We began by examining the healthcare sector of the economy, which is second in size only to the real estate sector and consists of a diverse collection
of industries that involve, either directly or indirectly, the healthcare of the population. The major industries in the healthcare sector include:

- **Health services.** The health services industry consists of providers of health services, including medical practices, hospitals, clinics, nursing homes, home healthcare agencies, and hospices.
- **Health insurance.** The health insurance industry, which makes most of the payments to health services providers, includes government programs and commercial insurers as well as self-insurers. Also included here are managed care companies, such as health maintenance organizations (HMOs), which incorporate both insurance and health services (provider) functions.
- **Medical equipment and supplies.** These industries include the makers of diagnostic equipment, such as x-ray machines; durable medical equipment, such as wheelchairs; and expendable medical supplies, such as disposable surgical instruments and hypodermic syringes.
- **Pharmaceuticals and biotechnology.** These industries develop and market drugs and other therapeutic products.
- **Other.** This category includes a diverse collection of organizations ranging from consulting firms to educational institutions to government and private research agencies.

Most users of this book will become (or already are) managers at health services organizations, or at companies such as insurance and consulting firms that deal directly with health services organizations. Thus, to create a book that has the most value to its primary users, we focus on finance as it applies within the health services industry. Of course, the principles and practices of finance cannot be applied in a vacuum but must be based on the realities of the current healthcare environment, including how health services are financed. Furthermore, insurance involves payment to healthcare providers; much of managed care involves utilization management of healthcare providers, either directly or through contracts; and most consulting work is done for providers; so the material in this book is also relevant for managers in industries related to health services.

Now that we have defined the healthcare focus of this book, the term finance must be defined. Finance, as the term is used within the health services industry, and as it is used in this book, consists of both the accounting and financial management functions. (In many settings, accounting and financial management are separate disciplines.) Accounting, as its name implies, concerns the recording, in financial terms, of economic events that reflect the operations, resources, and financing of an organization. In general, the purpose of accounting is to create and provide to interested parties, both internal and external, useful information about an organization’s operations and financial status.
Whereas accounting provides a rational means by which to measure a business’s financial performance and assess operations, financial management, or 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 theory and concepts requires accounting data.

1. What is meant by the term healthcare finance?
2. What is the difference between accounting and financial management?

Purpose of the Book

Many books cover the general topics of accounting and financial management, so why is a book needed that focuses on healthcare finance? The reason is that while all industries have certain individual characteristics, the health services industry is truly unique. For example, the provision of healthcare services is dominated by not-for-profit organizations, both private and governmental, and such entities are inherently different from investor-owned businesses. Also, the majority of payments made to healthcare providers are not made by the individuals who use the services but by third-party payers (e.g., an employer, commercial insurance company, or government program). Throughout this book, the ways in which the unique features of the health services industry influence the application of finance principles and practices are emphasized.

This book is designed to introduce students to healthcare finance, which has two important implications. First, the book assumes no prior knowledge of the subject matter; thus, the book is totally self-contained, with each topic explained from the beginning in basic terms. Furthermore, because clarity is so important when concepts are first introduced, the chapters have been written in an easy-to-read fashion. None of the topics is inherently difficult, but new concepts often take some effort to understand. This process is made easier by the writing style used.

Second, because this book is introductory, it contains a broad overview of healthcare finance. The good news here is that the book presents virtually all the important healthcare finance principles that are used by managers in health services organizations. The bad news is that the large number of topics covered prevents us from covering principles in great depth or including a wide variety of illustrations. Thus, students who use this book are not expected to fully understand every nuance of every finance principle and practice that pertains to every type of health services organization. Nevertheless, this

Not-for-profit corporation
A corporation that has a charitable purpose, is tax exempt, and has no owners. Also called nonprofit corporation.

Investor-owned business
A for-profit business whose capital is supplied by owners (stockholders in the case of corporations).

Third-party payer
An entity other than the patient that pays for healthcare services. Examples include commercial insurance companies and government programs such as Medicare.
book provides sufficient knowledge of healthcare finance so that readers will be better able to function as managers, judge the quality of financial analyses performed by others, and incorporate sound principles and practices into their own personal finance decisions.

Naturally, an introductory finance book does not contain everything that a healthcare financial manager must know to competently perform his or her job. Nevertheless, the book is useful even for those working in finance positions within health services organizations because it presents an overview of the finance function. Often, when one is working in a specific area of finance, it is too easy to lose sight of the context of one’s work. This book will help provide that context.

**SELF-TEST QUESTIONS**

1. Why is it necessary to have a book dedicated to healthcare finance?
2. What is the purpose of the book?

### Concept of a Business

This book focuses on finance as practiced within businesses, so it is reasonable to ask this question: What is a business? If this question were asked to a group of accountants, the answer probably would involve financial statements, such as the income statement and balance sheet, which we cover in chapters 3 and 4. However, if the question were posed to a group of lawyers, the answer likely would include legal forms of business, which we describe in Chapter 2.

From a financial (economic) perspective, a business can be thought of as an entity (its legal form does not matter) that (1) obtains financing (capital) from the marketplace; (2) uses those funds to buy land, buildings, and equipment; (3) operates those assets to create goods or services; and then (4) sells those goods or services to create revenue. To be financially viable, a business has to have sufficient revenue to pay all of the costs associated with creating and selling its goods or services.

Although this description of a business is surprisingly simple, it tells a great deal about the basic decisions that business managers must make. One of the first decisions is to choose the best legal form for the business. Then, decide how the business will raise the capital that it needs to get started. Should it borrow the money (use debt financing), raise the money from owners (or from the community if not-for-profit), or use some combination of the two sources? Next, once the start-up capital is raised, what physical assets (facilities and equipment) should be acquired to create the services (in the case of healthcare providers) that will be offered to patients?

Note that businesses are profoundly different from pure charities. A business, such as a hospital or medical practice, sustains itself financially by selling goods or services. Thus, it is in competition with other businesses for
the consumer dollar. A pure charity, such as the American Heart Association, on the other hand, does not sell goods or services. Rather, it obtains funds by soliciting contributions and then uses those funds to supply charitable (free) services. In essence, a pure charity is a budgetary organization in that the amount of contributions fixes its budget for the year. Similarly, a governmental agency has a budget that is fixed by appropriations.

Admittedly, pure charities and governmental agencies must operate in a business-like manner, but they do not operate like businesses because they do not obtain the bulk of their revenues by selling goods or services. Of course, some healthcare providers do solicit contributions, and many provide some charitable care, but healthcare organizations primarily sustain themselves by selling services.

1. From a financial perspective, briefly describe a business.
2. What is the difference between a business and a pure charity?

The Role of Finance in Health Services Organizations

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. As we discuss in the next section, the two broad areas of finance—accounting and financial management—are separate functions in larger organizations, although the accounting function usually is carried out under the direction of the organization’s chief financial officer and hence falls under the overall category of finance.

In general, finance activities include:

- **Planning and budgeting.** First and foremost, healthcare finance involves evaluating the financial effectiveness of current operations and planning for the future. **Budgets** play an important role in this process.
- **Financial reporting.** For a variety of reasons, it is important for businesses to record and report to outsiders the results of operations and current financial status. This is typically accomplished by a set of financial statements.
- **Capital investment decisions.** Although capital investment is more important to senior management, managers at all levels must be concerned with the capital investment decision process. Such decisions, which are called **capital budgeting** decisions, focus on the acquisition of land, buildings, and equipment. They are the primary means by which businesses implement strategic plans, and hence they play a key role in an organization’s financial future.
- **Financing decisions.** All organizations must raise capital to buy the assets necessary to support operations. Such decisions involve the choice...
between internal and external funds, the use of debt versus equity capital, the use of long-term versus short-term debt, and the use of lease versus conventional financing. Although senior managers typically make financing decisions, these decisions have ramifications for managers at all levels.

- **Working capital management.** An organization’s short-term assets, such as cash, marketable securities, receivables, and inventories, must be properly managed both to ensure operational effectiveness and to reduce costs. Generally, managers at all levels are involved to some extent in short-term asset management.

- **Contract management.** In today’s healthcare environment, health services organizations must negotiate, sign, and monitor contracts with managed care organizations and third-party payers. The financial staff typically has primary responsibility for these tasks, but managers at all levels are involved in these activities and must be aware of their effects on operating decisions.

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

These specific finance activities often are summarized by the **four Cs**: costs, cash, capital, and control. The measurement and minimization of costs is vital to the financial success of any business. Rampant costs, as compared to revenues, usually spell doom for any business. A business can be profitable but still face a crisis due to 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. **Capital** represents the funds used to acquire land, buildings, and equipment. Without capital, businesses would not have the physical resources needed to provide goods and services. Finally, a business must have adequate control mechanisms to ensure that its capital is being wisely employed and its physical resources are protected for future use.

In times of high profitability and abundant financial resources, the finance function tends to decline in importance. Thus, when most healthcare providers were reimbursed on the basis of costs incurred, the role of finance was minimal. At that time, the most critical finance function was cost identification because it was more important to account for costs than it was to control them. In response to payer (primarily Medicare) requirements, providers (primarily hospitals) churned out a multitude of reports both 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 been redesigning their finance functions to recognize the changes that have occurred in the health
services industry. Although billing and collections remain important, to be of maximum value to the enterprise today the finance function must support cost-containment efforts, third-party 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.

In this book, the emphasis is on the finance function, but there are no unimportant functions in healthcare organizations. Senior executives must understand a multitude of other functions, such as marketing, facilities management, and human resource management, in addition to finance. Still, all business decisions have financial implications, so all managers—whether in operations, marketing, personnel, or facilities—must know enough about finance to properly incorporate any financial implications into decisions made within their own specialized areas.

1. What is the role of finance in today’s health services organizations?
2. What are the “four Cs”?
3. How has this role changed over time?

For Your Consideration: Businesses, Pure Charities, and Governmental Entities

A healthcare business relies on revenues from sales to create financial sustainability. For example, if a hospital’s revenues exceed its costs, cash is being generated that can be used to provide new and improved patient services, and the hospital can continue to meet community needs. On the other hand, pure charities, such as the American Red Cross, rely on contributions for revenues, so the amount of charitable services provided (which typically are free) is limited by the amount of contributions received. Finally, most governmental units are funded by tax receipts, so, as with charities, the amount of services provided is limited, but in this case by the taxing authority’s ability to raise revenues. Yet, in spite of differences, all three types of organization must operate in a financially prudent manner.

What do you think? From a finance perspective, how different are these types of organizations? How does the day-to-day functioning of the finance departments vary? Is finance more important in one type of organization than another?

The Structure of the Finance Department

The size and structure of the finance department within health services organizations depend on the type of provider and its size. Still, the finance department within larger provider organizations generally follows the model described here.

The head of the finance department holds the title chief financial officer (CFO), or sometimes vice president–finance. This individual typically reports directly to the organization’s chief executive officer (CEO) and is respon-
sible for all finance activities within the organization. The CFO directs two senior managers who help manage finance activities. First is the comptroller (pronounced, and sometimes spelled, “controller”), who is responsible for accounting and reporting activities such as routine budgeting, preparation of financial statements, payables management, and patient accounts management. For the most part, the comptroller is involved in those activities covered in chapters 3 through 8 of this text.

Second is the treasurer, who is responsible for the acquisition and management of capital (funds). Treasurer activities include the acquisition and employment of capital, cash and debt management, lease financing, financial risk management, and endowment fund management (within not-for-profits). In general, the treasurer is involved in those activities discussed in chapters 11 through 18 of this text.

Of course, in larger organizations, the comptroller and treasurer have 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 very small businesses, many of the finance responsibilities are combined and assigned to just a few individuals. In the smallest health services organizations, the entire finance function is managed by one person, often called the business (practice) manager.

Health Services Settings

Health services are provided in numerous settings, including hospitals, ambulatory care facilities, long-term care facilities, and even at home. Before the 1980s, most health services organizations were freestanding and not formally linked with other organizations. Those that were linked tended to be part of horizontally integrated systems that controlled a single type of healthcare facility such as hospitals or nursing homes. Recently, however, many health services organizations have diversified and become vertically integrated either through direct ownership or contractual arrangements.

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*. Joint Commission accreditation is a voluntary process that is 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 program, and hence most hospitals seek accreditation.

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, which results in excess capacity. At the same time, hospitals have been pressured to give discounts to private third-party payers, governmental payments have failed to keep up with the cost of providing services, and indigent care and bad-debt losses have increased. Because of the changing payer environmental and resultant cost-containment pressures, the number of hospitals (and beds) has declined in recent years.

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*, which provide general medical and surgical services and selected acute specialty services, are short-stay facilities and account for the majority of hospitals. *Specialty hospitals*, such as psychiatric, children’s, women’s, rehabilitation, and cancer facilities, limit 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 increased need for such 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. Small hospitals, those with fewer than 100 beds, usually are located in rural areas. Many rural hospitals have experienced financial difficulties in recent years because they have less ability than larger hospitals to lower costs in response to ever-tighter reimbursement rates. Most of the largest hospitals are academic health centers or teaching hospitals, which offer a wide range of services, including tertiary services. (*Tertiary care* is highly specialized and technical in nature, with services for patients with unusually severe, complex, or uncommon problems.)

Hospitals are classified by ownership as private not-for-profit, investor owned, and governmental. *Governmental hospitals*, which make up 25 percent of all hospitals, are broken down into federal and public (nonfederal) entities. *Federal hospitals*, such as those operated by the military services or the Department of Veterans Affairs, serve special populations.

*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 still provide other necessary public services. In addition, the inability of politically
governed organizations to respond quickly to the changing healthcare environment contributed to many conversions as managers tried to create organizations that are more responsive to external change.

**Private not-for-profit hospitals** are nongovernment 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 80 percent of all private hospitals (60 percent of all 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 20 percent of private hospitals (15 percent of all hospitals) are investor owned. This means that they have owners (typically shareholders) that 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, which owns about 165 hospitals; Hospital Management Associates (HMA), which owns about 55 hospitals; and Tenet Healthcare, which owns about 50 hospitals.

Unlike not-for-profit hospitals, investor-owned hospitals pay taxes and forgo the other benefits of not-for-profit status. However, investor-owned hospitals typically do not embrace the charitable mission of not-for-profit hospitals. 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 now 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.

Hospitals are labor-intensive because of their need to provide continuous nursing supervision to patients, in addition to the other services they provide through professional and semiprofessional staffs. Physicians petition for privileges to practice in hospitals. While they admit and provide care to hospitalized patients, physicians, for the most part, are not hospital employees and hence are not directly accountable to hospital management. However, physicians retain a major responsibility for determining which hospital services will be provided to patients and how long patients are hospitalized, so physicians play a critical role in determining a hospital’s costs and revenues and hence its financial condition.

**Ambulatory (Outpatient) Care**

*Ambulatory care*, also known as *outpatient care*, encompasses services provided to noninstitutionalized patients. Traditional outpatient settings include medical practices, hospital outpatient departments, and emergency rooms. In
addition, the 1980s and early 1990s witnessed substantial growth in nontraditional ambulatory care settings such as home healthcare, ambulatory surgery centers, urgent care centers, diagnostic imaging centers, rehabilitation/sports medicine centers, and clinical laboratories. In general, the new settings offer patients increased amenities and convenience compared to hospital-based services and, in many situations, provide services at a lower cost than hospitals. For example, urgent care and ambulatory surgery centers are typically less expensive than their hospital counterparts because hospitals have higher overhead costs.

Many factors have contributed to the expansion of ambulatory services, but technology has been a leading factor. 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, third-party payers have encouraged providers to expand their outpatient services through mandatory authorization for inpatient services and by payment mechanisms that provide incentives to perform services on an outpatient basis. Finally, fewer entry barriers to developing outpatient services relative to institutional care exist. Ordinarily, ambulatory facilities are less costly and less often subject to licensure and certificate-of-need regulations (exceptions are hospital outpatient units and ambulatory surgery centers). (Licensure and certificate-of-need regulation are discussed in detail under Regulatory and Legal Issues, page X.)

As outpatient care consumes an increasing portion of the healthcare dollar, and efforts to control outpatient spending are enhanced, the traditional role of the ambulatory care manager is changing. Ambulatory care managers historically have focused on such routine management tasks as billing, collections, staffing, scheduling, and patient relations, while the owners, often physicians, have tended to make the more important business decisions. However, reimbursement changes and increased affiliations with both insurers and other providers are requiring a higher level of management expertise. This increasing environmental complexity, along with increasing 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_ entails the provision of healthcare services, as well as some personal services, to individuals who lack some degree of functional ability. It usually covers an extended period of time and includes both inpatient and outpatient services, which often focus on mental health, rehabilitation, and nursing home care. Although the greatest use is among the elderly, long-term care services are used by individuals of all ages.

Long-term care is concerned with levels of independent functioning, specifically activities of daily living such as eating, bathing, and locomotion. Individuals become candidates for long-term care when they become too
mentally or physically incapacitated to perform necessary tasks and when their family members are unable to provide needed services. Long-term care is a hybrid of healthcare services and social services; nursing homes are a major source of such care.

Three levels of nursing home care exist: (1) skilled nursing facilities, (2) intermediate care facilities, and (3) residential care facilities. Skilled nursing facilities (SNFs) provide the level of care closest to hospital care. Services must be under the supervision of a physician and must include 24-hour daily nursing care. Intermediate care facilities (ICFs) 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 and thus for which most health insurance programs do not provide coverage.

Nursing homes are more abundant than hospitals and are also smaller, with an average bed size of about 100 beds, compared with about 170 beds for hospitals. Nursing homes are licensed by states, and nursing home administrators are licensed as well. Although The Joint Commission accredits nursing homes, only a small percentage participate because accreditation is not required for reimbursement, and the standards to achieve accreditation are much higher than licensure requirements.

The long-term care industry has experienced tremendous growth in the past 50 years. Long-term care accounted for only 1 percent of healthcare expenditures in 1960, but by 2010 it accounted for about 6 percent of expenditures. Further demand increases are anticipated, as the percentage of the US population age 65 and older increases, from less than 15 percent in 2010 to a forecasted 20 percent in 2030. The elderly are disproportionately high users of healthcare services and are major users of long-term care.

Although long-term care is often perceived as nursing home care, many new services are developing to meet society’s needs in less-institutional surroundings 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 time period, can be an alternative to nursing home care for many patients, but it is not as readily available as nursing home care in many rural areas. Furthermore, third-party payers, especially Medicare, have sent mixed signals about their willingness to adequately pay 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, and less generous, Medicare payment system.

**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 entity called an integrated delivery system. The hypothesized benefits of such systems include the following:
• Patients are kept in the corporate network of services (*patient capture*).
• Providers have access to managerial and functional specialists (for example, 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, and the costs to develop them are shared.
• Linked organizations have better access to capital.
• The ability to recruit and retain management and professional staff is enhanced.
• Integrated delivery systems are able to offer payers a complete package of services (“one-stop shopping”).
• Integrated delivery systems are better able to plan for and deliver a full range of healthcare services to meet the needs of a defined population, including chronic disease management and health improvement programs. Many of these population-based efforts typically are not offered by stand-alone providers.
• Incentives can be created that encourage all providers in the system to work together for the common good of the system, which has the potential to improve quality and control costs.

Although integrated delivery systems can be structured in many different 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 of current state laws, which 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 managed care plans, the integrated delivery system often receives a fixed payment per plan member 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. To achieve this goal, integrated delivery systems invest heavily in primary care services, especially prevention, early intervention, and wellness programs. The primary care gatekeeper concept is frequently used to control utilization and hence costs. While hospitals continue to be centers of technology, integrated delivery systems have the incentive to shift patients toward lower cost settings. 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 hypothesized benefits of integration, executives of healthcare systems have found it more difficult than they originally envisioned to manage large, diverse enterprises. This difficulty has been especially true when hospitals or health systems have acquired physician practices. In many cases, the financial and patient care gains predicted were not realized, and some of the integrated delivery systems that were formed in the 1990s have broken up.

However, healthcare reform legislation has created additional incentives that are expected to foster the creation of a new type of integrated delivery system, the accountable care organization. We will discuss this new form of provider, along with other features of reform, in Chapter 2.

1. What are some different types of hospitals, and what trends are occurring in the hospital industry?
2. What trends are occurring in outpatient and long-term care?
3. What is an integrated delivery system?
4. Do you think that integrated delivery systems will be more or less prevalent in the future? Explain your answer.

Regulatory and Legal Issues

Entry into the health services industry is heavily regulated. Examples of such regulation include licensure, certificate of need, rate setting, and review programs. In addition, legal issues, especially malpractice, are prominent in discussions of healthcare cost control.

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 whole facilities, such as hospitals and nursing homes, as well as individuals, such as physicians, dentists, and nurses. Facilities that are licensed must submit to periodic inspections and review activities. Such reviews have focused more on physical features and safety and less on patient care and outcomes, although some progress is being made in these areas. Thus, licensure has not necessarily ensured that the public will receive quality services. Critics of licensure contend that it is designed more to protect providers than to protect consumers. For example, licensed paramedical professionals are required to work under the supervision of a physician or dentist, and thus it is impossible for the paramedical professions to compete with physicians or dentists. Despite the limitations of licensure, it is probably here to stay.

Certificate of need (CON) legislation was enacted by Congress in 1974 in an effort to control increasing healthcare costs. States were required to
conduct healthcare planning, and a logical extension of this planning was to require providers to obtain approval based on 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 to promote cost controls through competition, although CON regulation still exists in most states.

Critics of CON regulation argue that it does not provide as much control over capital expenditures as originally envisioned and it increases healthcare costs by forcing providers to incur additional administrative costs when new facilities are needed. Perhaps the biggest criticism of CON regulation is that it creates a territorial franchise for services that it covers; that is, it makes it difficult for new entities to enter markets, even though the new businesses may be more cost efficient and offer better patient care than the existing ones.

In addition to CON regulation, cost containment programs were enacted in many states at the time when most health services reimbursement was based on costs. By the late 1970s, nine states had mandatory cost containment programs, and many other states had voluntary programs or programs that did not mandate compliance. The primary tool for cost containment programs is the rate review system. Three types of 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 involving joint decision making between the provider and the rate setter. Some states that use rate review systems have reduced the rate of increase in healthcare costs below the national average, while others have failed. 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.

Healthcare services are subject to many other forms of regulation. 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. The costs of complying with regulation are not trivial. The CEO of a 430-bed hospital estimated that the cost of dealing with regulatory agencies, including third-party payers, is about $8 million annually, requiring a staff of 140 full-time workers to handle the process.

The primary legal concern of health services providers is professional liability. Malpractice suits are the oldest forms of quality assurance in the US healthcare system, and such suits now are used to an extreme extent. Many people believe that the United States is facing a malpractice insurance crisis. Total malpractice premiums, which have doubled in the last ten years, have been passed on to healthcare purchasers. Some specialist physicians pay malpractice premiums of more than $100,000 per year, and each month
US courts manage approximately 20,000 new malpractice suits, with awards averaging $300,000 for cases that go to trial. Although providers have been successful in achieving some 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 in which physicians overuse diagnostic services in an effort to protect themselves.

Although professional liability is the most visible legal concern in health services, the industry is subject to many other legal issues, including those typical of other industries, such as general liability and antitrust issues. Finally, healthcare providers are confronted with unique ethical issues, such as the right to die or to prolong life, which are often resolved through the legal system.

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 increases the cost of patient care. In total, it is estimated that 5 to 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 that 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 ideas that have been put forth include limiting lawyers’ fees, capping awards for noneconomic damages, and decreasing the statute of limitations.)

Current Challenges

In recent years, the American College of Healthcare Executives (ACHE) has surveyed CEOs regarding the most critical concerns of healthcare managers. Financial concerns have headed the list of challenges on every survey conducted since the survey began in 2002. When asked to rank their specific financial concerns, CEOs put reimbursement at the forefront, with Medicaid,
Medicare, and bad debt losses at the top of the list. (Reimbursement will be discussed in Chapter 2.) Clearly, the ability of government payers to adequately reimburse providers leads the list of concerns.

In addition to the ACHE survey, the Healthcare Financial Management Association (HFMA) surveyed CFOs regarding their concerns for the future. Their most pressing issue was balancing clinical and financial issues—in essence, how to improve financial performance without having a negative impact on clinical performance. Other issues of concern included improving the revenue cycle (billing and collecting on a timely basis) and developing different ways to access (raise) capital.

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.

1. What are some important issues facing healthcare managers today?

**Organization of the Book**

In *Alice in Wonderland*, Lewis Carroll wrote: “If you don’t know where you are going, any road will get you there.” Because not just any road will ensure that this book meets its goals, the destination has been carefully charted: to provide an introduction to healthcare finance. Furthermore, the book is organized to pave the road to this destination.

Part I (The Healthcare Environment) contains fundamental background materials essential to the practice of healthcare finance. Chapter 1 introduces the book, while Chapter 2 provides additional insights into the uniqueness of the health services industry. Healthcare finance cannot be studied in a vacuum because the practice of finance is profoundly influenced by the economic and social environment of the industry, including alternative types of ownership, taxes, and reimbursement methods.

Part II (Financial Accounting) begins the actual discussion of healthcare finance principles and practices. Financial accounting, which involves the creation of statements that summarize a business’s financial status, is most useful for managing at the organizational (aggregate) level. In Chapter 3, financial accounting concepts, the income statement, and the statement of changes in equity are discussed; while in Chapter 4, the balance sheet and statement of cash flows are introduced.

Part III (Managerial Accounting), which consists of chapters 5 through 8, focuses on the creation of data used in the day-to-day management and control of a business. Here, the focus changes from the aggregate organization to sub-unit (department) level management. The key topics in Part III
include cost behavior, profit planning, cost allocation, pricing and service decisions, and planning and budgeting.

In Part IV (Basic Financial Management Concepts), the focus moves from accounting to financial management. Chapter 9 covers time value analysis, which provides techniques for valuing future cash flows, and Chapter 10 presents financial risk and required return. These two chapters discuss two of the most important concepts in financial decision making.

Part V (Long-Term Financing) turns to the capital acquisition process. Businesses need capital, or funds, to purchase assets, and chapters 11 and 12 examine the two primary types of financing—long-term debt and equity. These chapters not only provide descriptive information about securities and the markets in which they are traded but also discuss security valuation. Chapter 13 provides the framework for analyzing a business’s appropriate financing mix and assessing its cost.

Part VI (Capital Investment Decisions) considers the vital topic of how businesses analyze new capital investment opportunities (capital budgeting). Because major capital projects take years to plan and execute, and because these decisions generally are not easily reversed and will affect operations for many years, their impact on the future of an organization is profound. Chapter 14 focuses on basic concepts, while Chapter 15 discusses risk assessment and incorporation.

Part VII (Other Topics) contains three chapters. Chapter 16 reviews the management of short-term assets, including cash, receivables, and inventories as well as how such assets are financed. The techniques used to analyze a business’s financial and operating condition are discussed in Chapter 17. Health services managers must be able to assess the current financial condition of their organizations. Even more important, managers must be able to monitor and control current operations and assess ways in which alternative courses of action will affect the organization’s future financial condition. Finally, Chapter 18 covers two unrelated topics: lease financing and business valuation.

In addition to the printed text, there are two chapters available from the publisher’s website for this book. Chapter 19 (Distributions to Owners: Bonuses, Dividends, and Repurchases) discusses how profits in investor-owned businesses are returned to owners, and Chapter 20 (Capitation, Rate Setting, and Risk Sharing) provides the details of capitation reimbursement and how insurers set premium rates. To access these chapters, see ache.org/books/HCFinance5.

SELF-TEST QUESTIONS

1. Briefly, what is the organization of this book?
How to Use this Book

As mentioned earlier, the overriding goal in creating this book is to provide an easy-to-read, content-filled introductory text on healthcare finance. The book contains several features designed to assist in learning the material.

First, pay particular attention to the **LEARNING OBJECTIVES** listed at the beginning of each chapter. These objectives provide a feel for the most important topics in each chapter and what readers should set as learning goals for the chapter.

After each major section, except the Introduction, one or more **SELF-TEST QUESTIONS** are included. As you finish reading each major section, try to provide reasonable answers to these questions. Your responses do not have to be perfect, but if you are not satisfied with your answer, it would be best to reread the section before proceeding. Answers are not provided for the self-test questions, so a review of the section is indicated if you are in doubt about whether your answers are satisfactory.

It is useful for readers to have important equations both embedded in the text to illustrate their use and broken out separately to permit easy identification and review. Thus, this edition contains **KEY EQUATION** boxes that can be used both for section and chapter review and as aid to working end-of-chapter problems. In addition, the book contains **FOR YOUR CONSIDERATION** boxes. These boxes present an important issue relevant to the text discussion and allow readers to pause for a few moments to think about the issue presented, generate opinions, and draw conclusions. Many instructors will use these boxes to stimulate in-class discussions.

Within the book, italics and boldface are used to indicate importance. *Italics* are used whenever a key term is introduced; thus, italics alert readers that a new and important concept is being presented. **Boldface** indicates terms that are defined in each chapter’s running glossary, which complements the glossary at the back of the book.

In addition to in-chapter learning aids, materials designed to help readers learn healthcare finance are included at the end of each chapter. First, each chapter ends with a summary section titled **KEY CONCEPTS**, which very briefly summarizes the most important principles and practices covered in that chapter. If the meaning of a key concept is not apparent, you may find it useful to review the applicable section. Each chapter also contains a series of **QUESTIONS** designed to assess your understanding of the qualitative material in the chapter. The questions are followed by a set of **PROBLEMS** designed to assess your understanding of the quantitative material.

Finally, each chapter ends with a set of **REFERENCES**. The books and articles cited can provide a more in-depth understanding of the material covered in the chapter. Taken together, the pedagogic structure of the book is designed to make learning healthcare finance as easy and enjoyable as possible.
Key Concepts

This chapter provided an introduction to healthcare finance. The key concepts of this chapter are:

- The term *healthcare finance*, as it is used in this book, means the accounting and financial management principles and practices used within health services organizations to ensure the financial well-being of the enterprise.
- A *business* maintains its financial viability by selling goods or services, while a *pure charity* relies solely on contributions.
- 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.
- Finance activities generally include the following: (1) *planning and budgeting*, (2) *financial reporting*, (3) *capital investment decisions*, (4) *financing decisions*, (5) *working capital management*, (6) *contract management*, and (7) *financial risk management*. These activities can be summarized by the *four Cs*: costs, cash, capital, and control.
- The size and structure of the finance department within health services organizations depend on the type of provider and its size. Still, the finance department within larger provider organizations generally consists of a *chief financial officer* (CFO), who typically reports directly to the *chief executive officer* (CEO) and is responsible for all finance activities within the organization. Reporting to the CFO are the *comptroller*, who is responsible for accounting and reporting activities, and the *treasurer*, who is responsible for the acquisition and management of capital (funds).
- In larger organizations, the comptroller and treasurer direct managers who have 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 health services organizations, 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 in operations, marketing, personnel, or facilities—must know enough about finance to incorporate its implications into their own specialized decision processes.
- Healthcare services are provided in numerous settings, including hospitals, ambulatory care facilities, long-term care facilities, and even at home.
- *Hospitals* differ in function (*general acute care* versus *specialty*), patient
length of stay, size, and ownership (governmental versus private and, within the private sector, for-profit versus 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/sports medicine centers, and clinical laboratories.

- **Home health care** brings many of the same services provided in ambulatory care settings into the patient’s home.

- **Long-term care** entails healthcare services that cover an extended period of time, including inpatient, outpatient, home health, and hospice care, often with a focus on mental health, rehabilitation, or nursing home care.

- The defining characteristic of an integrated delivery system is that the organization assumes full clinical, and in certain cases financial, responsibility for the healthcare needs of the covered population.

- Entry into the health services industry has been heavily regulated. Examples of regulation include licensure, certificate of need, and rate setting and review programs.

- Legal issues, such as malpractice, are prominent in discussions about controlling healthcare costs.

- Recent surveys of health services executives confirm the fact that healthcare managers view financial concerns as the most important current issue.

In the next chapter, the discussion of the healthcare environment is continued, moving to more finance-related topics such as forms of organization, reimbursement, and taxes.

**Questions**

1.1  a. What are some of the industries in the healthcare sector?
   b. What is meant by the term healthcare finance as used in this book?
   c. What are the two broad areas of healthcare finance?
   d. Why is it necessary to have a book on healthcare finance as opposed to a generic finance book?

1.2 What is the difference between a business and a pure charity?

1.3  a. Briefly discuss the role of finance in the health services industry.
   b. Has this role increased or decreased in importance in recent years?

1.4  a. Briefly describe the following health services settings:
   - Hospitals
   - Ambulatory care
The Well-Managed Healthcare Organization

- Home health care
- Long-term care
- Integrated delivery systems

b. What are the benefits attributed to integrated delivery systems?

1.5 What role does regulation play in the health services industry?

1.6 What is the structure of the finance function within health services organizations?

1.7 What is the primary legal issue facing providers today?

1.8 What are the major current concerns of healthcare managers?

1.9 Briefly describe the organization of this book and the learning tools embedded in each chapter.

Notes


References

For a general introduction to the healthcare system in the United States, see Barton, P. L. 2009. Understanding the U.S. Health Services System. Chicago: Health Administration Press.


For the latest information on events that affect health services organizations, see Modern Healthcare, published weekly by Crain Communications Inc., Chicago.


*For current information on how the internet affects health and the provision of health services, see The Journal of Medical Internet Research* at www.jmir.org.