Texas Healthcare Trustees

TRUSTEE GUIDEBOOK

INSPIRING EXCELLENCE IN HEALTH CARE GOVERNANCE™

HEALTH CARE FINANCE AND REIMBURSEMENT

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Inspiring Excellence in Health Care Governance

Health Care Finance and Reimbursement

Ninth Edition

THT provides education, resources and leadership development to inspire excellence in health care governance. For more information visit www.tht.org.

The views expressed are not necessarily those of Texas Healthcare Trustees. Members of the review panel lent their expertise and provided review of the Trustee Guidebook and may have diverging views and opinions from what is expressed in this manual.

A special thank you is owed to those who helped create the newest edition of the *Trustee Guidebook*. It is with their knowledge and expertise that this exhaustive compendium was produced to help hospital governance leaders effectively carry out their fiduciary duties and provide better care for the public.

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Texas Healthcare Trustees

Texas Healthcare Trustees is a statewide association whose members are Texas hospitals, health systems and health-related organizations. THT provides education and resources to board members of these organizations to help ensure they are equipped with the tools and knowledge needed to navigate the health care industry and lead their hospital or health system to success. Membership includes more than 450 governing boards and represents nearly 4,000 trustees. THT is the oldest trustee organization in the country, founded in 1961.

BKD
CPAs & Advisors

Texas Healthcare Trustees is proud to partner with BKD on the development of this resource. BKD, a national CPA and advisory firm, provides consulting, tax, assurance and accounting outsourcing solutions to health care organizations throughout Texas and nationwide. BKD is nationally ranked as a top 15 health care management consulting firm, serves more than 1,000 hospitals and health systems, and has niche expertise serving providers across the continuum of care including physician groups, long-term care and senior living organizations, and home care agencies creating holistic insights for health systems. Health care leaders balance the need for assurance service, tax advice and regulatory compliance against the pressure to prepare for emerging payment models, improve processes and growth goals. When the challenges are steep, leaders turn to BKD advisors for foresight and an integrated service approach.

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Finance and Reimbursement

Financial oversight of the hospital or health system often is viewed as the main function of the organization's governing board. The fiduciary duty is one of the core responsibilities of trustees and can be one of the most challenging given the complexity of the health care industry and hospital reimbursement. Health care is highly regulated by both the federal and state government. The health care industry is often under scrutiny for rising costs with a spotlight often being on hospitals by those looking at cost-containment. Hospitals are very capital intensive, and they operate on low margins compared to many other industries. Hospital governing boards face the dual challenges of meeting community needs while remaining financially viable.

When it comes to the hospital's/health system's financial status, its success or failure rests upon the policies and direction set by the board. In addition, the board must review and monitor financial performance on a regular basis to ensure that policies are being followed and that the hospital/system is in compliance with all applicable laws and regulations.

Governance of hospitals and health systems in general has taken on new significance in the past decade, and scrutiny of financial decisions and actions has intensified. Research has documented that good governance has a direct impact on the overall performance of the organization. Simultaneously, hospital/health system governance has become more complex, due to factors such as:

- More stringent federal and state requirements in response to breakdowns in corporate management, governance and business conduct.
- Enhanced oversight of nonprofit organizations by the Internal Revenue Service (IRS) and state attorneys general to ensure that tax exemptions are warranted and that board members are meeting their fiduciary responsibilities.
- Greater accountability requirements from investors as well as philanthropic donors/underwriters.
- Increased reliance on complex supplemental Medicaid programs.
- More transparency regarding patient outcomes, quality metrics and financial performance.

- Advances in health care delivery fueled by technology, science and changing business models that have increased costs to payers, extended life expectancy and consumed more of the nation's Gross Domestic Product at the expense of other sectors of the economy.

With all of these factors in play, it is crucial that the hospital board has a solid understanding of the finances of their organization, outside factors that may contribute to reimbursement and changing payment models. All of these can greatly impact the success of an organization

The Governing Board

The individuals who are elected or appointed to serve on a hospital's board of trustees (or managers or directors) have the legal responsibility for the operation of the hospital as well as overall patient safety and satisfaction. The board is responsible for establishing policy, overseeing quality and patient safety, providing for institutional management and planning, and determining how the organization's financial and other resources are managed and used. Organizational values should drive policy decisions, and board members should establish operational parameters and ensure effective interaction with hospital and medical staff leadership. While the governing board delegates day-to-day management to the chief executive officer and patient care to members of the medical staff, board members oversee these activities.

The board of a health system oversees and coordinates the boards of other entities in the organization. The system board focuses on strategy for the system as a whole and oversees the system's various businesses. System board members should work to achieve the integrated mission and vision of the system, oversee the appropriate use of the system's financial and other resources, and ensure that individual hospitals and any other business units are fulfilling their purpose, operating legally and ethically, and continuously monitoring and adjusting the strategic direction in response to changes in the operating environment.

Ultimately, the board must protect the financial well-being of the hospital/ health system.

Board Responsibilities

Ultimately, the board must protect the financial well-being of the hospital/health system. Financial and strategic planning must be integrated and should be based on the organization's mission and the needs of the community it serves. The board establishes financial goals that will impact key areas such as growth, capital purchases, debt capacity and annual financial results. Board members approve the annual operating and capital budgets, monitor and review the budget through ongoing reporting, and establish and monitor investment policies and goals.

Board members set the criteria for measuring return-on-investment (ROI) and for evaluating proposed new business ventures or significant technology or capital investments. Boards also determine policies on uncompensated care, provision of needed community services and development of alternative revenue sources, all in conjunction with applicable regulations and laws.

From developing the annual budget and reviewing monthly financial reports to evaluating ROI and receiving the annual audit report, individual board members directly impact the organization's financial status. It is critical that each board member has the knowledge and expertise to fulfill these duties and to ask the right questions at the right time.

Fiduciary Role

Governing board members have a fiduciary responsibility to the hospital/health system, based on the common law duties of care, loyalty and obedience. They have a legal obligation to become thoroughly informed before making any business decision; they must put the hospital/system mission first (remembering that the ability to execute a mission requires a financially viable organization). They must abide by applicable laws, regulations and standards of hospital/system operations. The board holds the organization "in trust" for the community, taxpayers, or other stakeholders.

To fulfill these fiduciary obligations, governing board members have a number of tasks they undertake, including:

- Determining policy on the provision of needed community services.
- Approving the budget and monitoring actual financial results.
- Overseeing proper investment of assets.

- Ensuring sufficient capital to deal with any future problems related to the hospital/system's financial stability.
- Determining fiscal policy relating to insurance coverage, discount policies and third-party reimbursement.
- Being alert to and creating philanthropic opportunities for the hospital or system, if appropriate.

Finance Committees

Most boards have finance, audit and investment committees, and many have a separate compensation committee that reviews executive and employee pay levels. The use of committees allows for a deeper look into an area of importance for the organization. Committee responsibilities are often included in the organization's bylaws; however, organizations should also have a charter, or rules, to establish parameters for the work of this group and a method to evaluate the performance of the committee. Among the several responsibilities a finance committee may have, often its role includes oversight of financial planning and the annual budget, review of financial reports, drafting fiscal policies and monitoring investment performance. However, if investments are significant there may be a separate committee for this.

Often, the audit and finance committees are combined, though typically larger health care systems have separate audit committees. The board (or the audit or finance committee if authority is delegated) should employ an independent certified public accounting firm to perform an annual financial statement audit. It is important that the engaged firm understand the health care environment, including state specific-matters, so that risk areas in the audit can be properly assessed.

Exposure to Legal Risks

Boards are responsible for making sure their organizations comply with relevant laws and regulations. The health care field is under scrutiny by

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regulatory authorities, including the U.S. Department of Justice (DOJ), the Center for Medicare & Medicaid Services (CMS), Office of Inspector General (OIG), the IRS and state agencies. A board's financial fiduciary responsibility includes the organization's compliance with the overall intent of laws and regulations.

Compliance and Fraud

Detecting and punishing health care fraud and abuse have become a high priority for the federal government and many states. The DOJ has targeted hospitals nationwide in investigations of inappropriate Medicare billing or contractual relationships. With fiduciary responsibility for the hospital, trustees have a significant stake in these investigations and in implementing compliance activities. As policy makers for their institutions, trustees have the responsibility for creating and maintaining an ethical business climate. Federal and state agencies routinely audit hospital billing to identify and correct errors. If billing errors are discovered in the audit samples, the errors are often extrapolated to the audited population and estimated overpayments, plus interest, are recouped.

Health care fraud has become a national problem, with high exposure in the news media and before Congress. According to the National Heath Care Anti-Fraud Association, health care fraud costs the nation approximately $68 billion annually, while the DOJ puts that figure closer to $100 billion. With little information available on provider practices and with weaknesses inherent in the health insurance system, fighting health care fraud and controlling costs have become popular, high profile issues. As part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Congress mandated the creation of a fraud and abuse control program. HIPAA strengthened the civil and criminal penalties for health care fraud and abuse.

More recently, the Patient Protection and Affordable Care Act, more commonly known as the Affordable Care Act (ACA), also provided tools to prevent and detect fraud. Among other provisions including data sharing and new deterrent penalties, the ACA provided $350 million to support the addition of resources to prevent and detect fraud.

Compliance Plans

The settlement agreement for a hospital that has been the target of a federal

billing investigation likely requires the establishment of a compliance plan. Even if a hospital has not been investigated, establishing a compliance plan is essential. Such a plan is more than a broad policy stating the hospital's intent to follow the law and urge employees to engage in legal and ethical conduct. A compliance plan is a comprehensive strategy to ensure that the hospital consistently complies with all state and federal laws relating to its activities and the delivery of health care. A compliance plan reduces the chances that the hospital will violate laws, and it provides internal reporting and follow-up procedures.

In addition to understanding the regulatory environment in which it operates, the hospital must ensure that all employees understand how the applicable law affects their job functions and know which practices are prohibited. Additionally, employees must be aware of their obligation to be active participants in the hospital's effort to comply with the law and to identify non-compliance.

When an organization has a mechanism that encourages employees to report concerns internally, the risk of government investigation is reduced. This is often achieved through a compliance hotline that is monitored by the hospital's compliance department or a third-party. Identifying and correcting non-compliant conduct quickly reduces the risk of government intervention. Discovering and reporting offenses voluntarily is evidence of the hospital's good faith efforts to comply with the law.

Corporate entities may be held liable for the criminal conduct of employees who acted with an intent to benefit the corporation, even if the action is contrary to corporate policy or instructions. However, an effective plan to prevent and detect violations of the law can be a mitigating factor.

Hospitals operate within a broad framework of laws and regulations. Although the content of a compliance plan varies by the size and services of the hospital,

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some areas that may be appropriate for inclusion include billing and claims for payment, payments and illegal remuneration, patient referrals, physician recruitment, patient transfers, fundraising, controlled substances and mental health services.

The OIG has developed model compliance programs for hospitals, Medicare managed care organizations (MCOs), clinical laboratories, home health agencies, hospices, durable medical equipment suppliers, third-party billing companies, nursing facilities, physician practices, ambulance suppliers and pharmaceutical manufacturers. There is some variation in these programs but all contain seven requirements that must be included in any effective compliance plan. These requirements are:

1. Development and distribution of written standards of conduct, as well as written policies and procedures that promote the hospital's commitment to compliance and that address specific areas of potential fraud, such as claims development and submission processes, and financial relationships with physicians and other health care professionals.
2. Designation of a chief compliance officer and other appropriate bodies, e.g., a corporate compliance committee, charged with the responsibility of operating and monitoring the compliance program and who report directly to the CEO and the governing body.
3. Development and implementation of regular annual update for all employees and effective education and training programs for all affected employees.
4. Maintenance of effective lines of communication, such as a hotline, to receive complaints, and the adoption of procedures to protect the anonymity of complaints and to protect whistleblowers from retaliation.
5. Enforcement of standards and development of a system to respond to allegations of improper/illegal activities. This includes the administration of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or federal health care program requirements.
6. Use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas.
7. Responsiveness and remediation of identified systemic problems, which may include the development of policies addressing the non-employment or retention of sanctioned individuals.

Additionally, each year the OIG releases its work plan, detailing projects including OIG audits and evaluations that are currently underway or being planned. Boards should encourage management to summarize and review the OIG work plan with the board as it highlights areas of government focus and can often be a tool for internal audit and/or compliance teams to know where to focus their attention.

Poor Quality Can Be Fraud

Federal courts have ruled that the governing board is responsible if the hospital is not delivering quality care. If the board knew or should have known about substandard care while the hospital continued to submit claims to Medicare (and other payers), then the hospital's leadership (including its board members) can be considered to have committed "quality fraud."

Both the federal OIG and DOJ have increased their interest in and surveillance of quality and patient safety. Because quality is linked to reimbursement for Medicare and Medicaid, governments want to be sure that patients are receiving the quality of care for which they are paying. Payment for poor quality may be viewed as a "false claim," and inaccurate reporting of quality data potentially is fraud. Both the OIG and the DOJ hold the board responsible for the quality of care delivered by the hospital.

CMS can and has withdrawn a hospital's credentialing for violations of various Medicare Conditions of Participation related to quality, including government body oversight. Such severe action has a catastrophic impact on the hospital's operations.

Anti-kickback Law

Federal and state laws prohibit a hospital and an individual from offering,

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paying, soliciting or receiving remuneration directly or indirectly – in cash or in kind – for referral of an individual, for furnishing/arranging for a good or service and for obtaining or awarding favorable treatment in conjunction with a government contract. The law is broadly worded and creates both criminal and civil liability.

Hospital acquisition of physician practices, rentals of space and equipment, loans, payment for "good-will," payment for value of an ongoing business unit, payment for covenants not to compete, payment for exclusive dealing agreements and payment for patient lists/patient records are among the areas that require careful scrutiny. In general, "fair market value" is allowed, and "fair market value" should be determined through an independent appraisal. HHS has identified "safe harbors," payment practices that will not be subject to criminal prosecution under the anti-kickback laws. They are complex, and legal counsel should be involved in determining if a situation meets the requirements of a "safe harbor."

A violation of the anti-kickback law is a felony, punishable by a $25,000 fine or imprisonment for up to five years, or both. Violators also may be excluded from participation in the Medicare and Medicaid programs for up to five years.

Stark Law

Similar to the anti-kickback law, the Stark law is often referred to as prohibiting "self-referral." The law prohibits a physician from referring a patient to an entity in which the physician – or an immediate family member – has an ownership interest. Originally applicable only to clinical laboratories, the law was expanded to cover a broad range of health care services, including hospitals, durable medical equipment, home health, outpatient pharmacy, radiation therapy, physical and occupational therapy, radiology, etc. The prohibition also applies to financial investment relationships, such as compensation for administrative or management services, income guarantees, certain loans and free or subsidized administrative services. The law applies to physician investments in a health care facility or a piece of equipment.

Exceptions under the Stark law are complex, and legal counsel should be consulted in all physician-related agreements.

While the anti-kickback law carries criminal sanctions, the Stark law has only civil penalties. Both the physician and the entity to which the referral was

made may be fined up to $15,000 for each service referral, plus additional fines based on the amounts billed. Civil monetary penalties of up to $100,000 plus other assessments may be made against entities, such as hospitals. Both physicians and covered health care service providers may be excluded from the Medicare and Medicaid programs.

Internal Revenue Service

The IRS may audit the activities of tax-exempt organizations, including hospitals, and if cause is found, the IRS may revoke a hospital's tax-exempt status. For example, if the hospital's payments to acquire physicians' group practices are deemed "excessive," the tax-exempt status could be revoked. Legal counsel should be involved in negotiations, which should reflect fair market value as determined by an outside independent review.

Other areas of potential concern include below-market rents for office space, compensation linked to hospital or department revenues, income guarantees, below-market loans and loan guarantees. Compensation of health professionals for recruitment, retention, employment and personal services must be reasonable, in the context of the service provided and the need for it.

The ACA resulted in the addition of Section 501(r) to the IRS code, which imposed new requirements on non-profit hospitals to maintain their 501(c)(3) status. Among other requirements, 501(r) requires hospitals to establish written financial assistance and emergency care policies, limit amounts charged for services rendered to individuals eligible for financial assistance under the hospital's policy and make reasonable efforts to determine eligibility for financial assistance before taking extraordinary collection actions.

Financial Planning and Policies

In addition to compliance, one of the key responsibilities of the board is to guide the organization into the future. Financial planning functions develop as a result of the hospital's long-range strategic planning. When a board is reviewing its hospital's mission statement and the health care needs of its community, several key questions should be posed regarding the addition or elimination of services. The first question the board must answer is: Is there a need for this service? The second question is always: Is this a financially feasible program? Often, there is a tremendous need for the new program, but it is not financially feasible. If the program is important but apparently not financially viable, then

the third question to be addressed is: What can we do to make it work?

It is important to perform studies of the financial feasibility of new programs or capital acquisitions. Questions that need to be thoroughly researched include:

- How much financing is necessary?
- What type of financing is available?
- What about fund raising?
- Do we lease or purchase?
- How long before we break even or recover our costs?
- Which factors/variables will affect success? Which are beyond our control?
- What are the regulatory/compliance risks?

To supplement long-range financial planning, the board should develop and follow policies related to operations as well as investments. Among the types of policies the board should develop and review periodically are the following

Billing and Collection Policies

The hospital should address billing and collection issues in a comprehensive policy. For hospitals with 501(c)(3) status, the requirements of 501(r) should be considered when developing billing and collection policies. To comply with federal law, hospitals must bill all patients the same amount for the same service. However, some patients may pay less than the billed charges because the amount of discount provided to payers varies based on their contractual obligations. Other payers (Medicare/Medicaid) generally pay using a prospective payment system with payment rates that vary according to a patient classification system that is based on clinical, diagnostic and other factors.

The policy should authorize the hospital to offer contractual discounts to third-party payers, including Medicare, Medicaid and private insurers. The

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policy should address discounts that the hospital may offer, such as a discount for cash payments in advance, or courtesy discounts for individuals, such as employees, physicians, board members and their families.

The policy also should address how the hospital will discount its services to uninsured or under-insured individuals with some ability to pay and should determine how time-payment arrangements will be used. The hospital's financial assistance/charity care policy should address payment for care delivered to indigent patients.

The collection policy is especially important. Most hospitals usually bill and attempt collection for a certain period of time, perhaps 120 days. Then, many hospitals turn their accounts receivable over to a collection agency. In recent years, overly aggressive actions and harassing tactics of some collection agencies have created public relations issues for hospitals. The hospital should specify the types of collection activities permissible in its contract with the collection agency, and the policy should establish the parameters in which collections may occur. Some states may allow a lien to be placed on the property of an individual unable to pay for his hospital care. If permissible, the hospital's policy should detail whether this is an acceptable practice or not.

The policy also should state the consequences if the collection agency violates it contract. One issue that the hospital must decide is if it will turn bad debt information over to credit rating bureaus. In some states, medical debt is not reported to credit rating bureaus.

Non-profit hospitals, in compliance with 501(r), must develop a financial assistance policy that outlines who will be given free and discounted care at the hospital. Qualifying patients cannot be billed any more than the amount generally billed to Medicare and commercial insurance patients. Additionally, certain collection activities cannot occur until a patient is determined to not be eligible under the financial assistance policy.

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Capital Asset Planning Policy

Access to capital is a key determinant of long-term success for a hospital, and accessing capital has become increasingly difficult for all but those with the strongest credit. Ratings distributions show that larger systems continue to have greater access to capital than their smaller competitors.

Variable rate debt, on average, is significantly cheaper than fixed rate. However, it carries unique risks that have put hospitals in a bind when they cannot refinance this debt. Since 2008, the use of variable rate debt has decreased in health care.

The hospital's capital asset planning policy should address:

- Appropriate mix of fixed versus variable rate debt.
- Credit requirements for underlying issuer.
- Parameters on liquidity position.
- Criteria for the appropriate use of derivatives.

Many hospitals use a financial advisor and underwriter to help determine their debt strategy. It is important that boards understand the covenants included in a bond issue, and that they also ask what exposure the hospital has if significant adverse economic events occur. In addition to understanding what covenants exist, boards should also monitor compliance with covenants. A significant event may limit the hospital's ability to refinance variable rate debt, may result in default interest rates that are very high, or may result in operating limitations that are untenable for achieving the strategic goals of the hospital.

Charity Care Policy (Financial Assistance)

Having a well-developed charity care/financial assistance policy and following it consistently are critical to demonstrating community benefit and qualifying

Having a well-developed charity care/financial assistance policy and following it consistently are critical to demonstrating community benefit and qualifying for continued tax-exempt status.

for continued tax-exempt status. The hospital should have a policy regarding establishing eligibility for charity care. When developing this policy the board should have a clear understanding of charity care and financial assistance versus bad debt. Charity care and financial assistance is the unreimbursed cost to a hospital for providing, funding or otherwise financially supporting health care services on an inpatient or outpatient basis to a person classified by the hospital as financially or medically indigent. Bad debt is debt that is unlikely to be paid or that is not collectible. In general, this determination should be made prospectively, based on the patient's assets, income and other factors. Partial payment may be expected for an individual who qualifies for financial assistance. No payment is expected for an individual who qualifies for charity care.

Nonprofit hospitals provide charity care and community benefits to maintain their tax-exempt status. The IRS requires nonprofits to submit reports annually to demonstrate that they continue to operate in the public's interest and meet the qualifications for tax-exemption.

Having a well-developed charity care/financial assistance policy and following it consistently are critical to demonstrating community benefit and qualifying for continued tax-exempt status. In Texas nonprofit hospitals must maintain a level of charity care, government-sponsored indigent health care, community benefits and incorporate the hospital's mission into their operations and charity care policy to maintain their charitable status.

Conflict of Interest Policy

The board should have a strong conflict of interest policy to provide clear expectations for board member conduct and require immediate and full disclosure of any potential conflicts of interest. If a board member potentially could benefit personally from a decision, he or she should acknowledge the conflict to the board and refrain from participating in the discussion and

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decision-making process. Most boards require members to sign statements that document the board's policy on conflict of interest and privacy, and allow the board member to list any potential conflicts.

Investment Policy

The board should have an investment policy that defines its cash management and investment goals. Most states have laws that address the investments of public funds, and public hospitals should comply with their applicable state laws. The investment policy should address the following:

- Who has authority to make investments.
- The distribution between long- and short-term investments.
- The use of outside consultants.
- Acceptable risk parameters.
- Investment restrictions.
- Expected objectives.
- How the risks taken and rates of return will be maintained and evaluated.

The board should review investment performance routinely, and should consider modifying the investment policy on an annual basis to address changes in the operating environment. Governmental hospitals in Texas must follow the Texas Public Funds Investment Act which includes various restrictions on investment strategy, including the types of investments the hospital can hold.

The Budget

The annual budget is the primary way in which the governing board and the hospital executive team set financial goals for the organization over a short-term basis; monthly reports allow the board and CEO to monitor ongoing operations to ensure that the goals are met, and if not, to implement corrective action.

Types of Budgets

Hospitals typically have three types of budgets: operating budget, cash flow budget and capital budget.

Operating Budget

The operating budget generally covers a one-year period and reflects projected income and operating expenses. The board monitors performance through monthly reports that reflect actual income and expenses, allowing month-to-month and year-to-date comparisons. In some cases, budgets are modified midyear when the operating environment changes so significantly that the original budget is no longer meaningful. The board should understand the primary assumptions that drive budget results. From a global perspective, the board should know the key assumptions made by management related to patient volume, changes in payer mix and staffing. Boards in Texas should also understand what assumptions management has made regarding the net benefit of Medicaid supplemental funding programs and how those assumptions align with the program changes that occur each year.

Cash Flow Budget

The cash flow budget supplements the operating budget, and it projects cash collections, investment activities, borrowing, and operating and capital expenditures. The cash flow budget is vital, because it documents if the organization will be able to pay for planned operating results and capital spending with available resources. Cash flow budgets help determine short-term borrowing needs, as well as identify potential problems with billing and collection activities. The board should examine if the cash flow budget aligns with the net income or loss in the operating budget.

Capital Budget

The capital budget generally covers a longer period of time, often a three-year period. The first-year capital budget should be fairly detailed, as capital needs over the next 12 months should be predictable. Longer-term needs are more subjective and may vary due to technological or operating

The board should understand the primary assumptions that drive budget results. From a global perspective, the board should know the key assumptions made by management related to patient volume, changes in payer mix and staffing.

changes. The long-range capital budget allows the hospital to plan to accumulate cash or borrowing capacity to finance high-dollar equipment or physical plant renovations/expansion. When reviewing the capital budget, board members should look to see if the capital expenditures align with the strategic plan and if the capital expenditures align with other goals of the organization.

The board should challenge management to be sure that very expensive projects are being considered years in advance to allow time to plan for cash needs. Additionally, the board should help management distinguish between vital items that must be updated versus lower-priority spending needs.

The Budget Process

Developing the budget requires involvement of hospital administration, department heads, the medical staff and the governing board. The budget should reflect the organization's strategic plan, and provide the necessary capital and financial resources needed to achieve the organization's goals. For example, if the strategic plan targets expansion of a specific service line – such as maternal/child health – then the budget should direct resources to its growth, both in capital investment and operating resources, such as staffing.

The organization's chief financial officer usually is the driver of the budgeting process, which often is quite lengthy. Typically, department directors each review the current year's volume, revenue and expenses, as well as volume projections, rate increases and inflation factors for the coming year. Using these figures as guidelines, in conjunction with the hospital's strategic and financial plans, initial budget projections are made. Department-level budgeting may show projected volumes of services provided by each department along with estimated staffing figures, expenses (salaries, materials, supplies, continuing education, etc.) and needed equipment, either replacement/ upgrading or new to support a larger volume.

The board's role in understanding and approving the budget is very important, and board members should exercise their responsibilities carefully.

Departments/service lines also should project patient population statistics, such as number of inpatient days or number of discharges, outpatient visits, surgical procedures, acuity index and payer percentages. These statistics produce information that the accounting/budget department needs to complete the initial revenue and expense budget. It is important that these volume projections take into account significant changes in the medical staff, competition or economic changes such as changes in a community's employer base.

With the advent of the prospective payment system, many hospitals create budgets based on the expected mix of patients. This number is based on payer mix and may include variables such as changes in case mix. Case mix is defined as the various types of patients categorized by disease related groups, severity of illness or other indicators. Depending on the sophistication of the hospital's information management technology, computer programs may be used to model the results of various third-party payer contracts and expected payment changes in Medicare and Medicaid on the hospital's revenues. This type of information can help the hospital more accurately project net revenue.

The Board's Role

The board's role in understanding and approving the budget is very important, and board members should exercise their responsibilities carefully. First, the assumptions on which the budget is based should be well documented, and they should describe how the budgets fit into the board's financial and strategic plans. Board members should be satisfied with the reasonableness of budget assumptions and projections.

Throughout the budget review process, board members should remember the mission, goals, and financial and strategic plans of the hospital and should ensure that the budgets provide the necessary financial resources for the hospital to reach its goals.

Too often, a board focuses solely on current financial results and not on long-range trends and the future. A good financial plan starts with looking back, not forward.

The board should provide guidance and insight on long-range goals of the organization as part of the budget process. Management can provide volumes of data and detailed information in this effort, but the board is charged with making sure the long-range plan meets the needs of the community and mission of the organization.

Review Trends

Too often, a board focuses solely on current financial results and not on long-range trends and the future. A good financial plan starts with looking back, not forward. By looking at financials for the last three to five years, you can get a sense of what factors are driving change each year — the general trend of the organization for revenues, expenses, volume, etc. and whether or not financial health is improving over time. Historical perspective provides good context in which to review key budget assumptions made by management. For example, a 3 percent increase in revenue over the next two years with no strategic change in the long-range plan may not be a reasonable assumption when the last five years have shown a 5 percent annual decline.

Strategic Financial Planning

Once the board has a good grip on the history of the organization, then it should look at strategic planning on both a short-term and long-term basis. Most hospitals do a good job on the short-term. Hospitals are adept at developing detailed annual budgets that project the next year's operations. These are usually pretty accurate, because many budget inputs (salary increases, revenue impacts, the competitive landscape, etc.) generally are known or can be controlled by management over the short-term. When assessing the annual budget, the board should challenge any significant changes from the prior year. Note this should not occur at the detail level but should be at a macro-level on the financial statements. Management should work things out at the department level, but the board should serve as a "gut check" for reality.

Hospitals that truly are effective strategic planners take the annual budget and capital budget one step further, using them as a baseline for a three- or five-year long-range financial plan.

A common problem with the budgeting process in many hospitals is that it only focuses on the income statement and not necessarily on the balance sheet, cash position, etc. Another problem is that the budget is typically only a one-year view. As previously noted, a cash flow budget is imperative to understand if the hospital can afford its plans. And, as discussed below, a long-range financial plan can help keep you on track. The board should make sure these items are in place.

The Long-Range Financial Plan

Hospitals that truly are effective strategic planners take the annual budget and capital budget one step further, using them as a baseline for a three- or five-year long-range financial plan. Understanding the history of the hospital's financial results is key to developing an effective annual budget. Preparing a three- or five-year long-range plan is important for making sure that decisions made in the annual budgeting process will result in a financial picture that meets the board's objectives in the long run.

Long-Range Goals

As part of the initial preparation of the long-range plan, the board must decide what those long-term objectives are. Several items that should be considered when setting long-range goals include the following:

- What level of capital spending is a "must" versus "desired" over the next five years? The long-range plan should include the level of spending necessary to meet these objectives.
- What key changes in operations will occur over the next five years? For example, will the hospital need to acquire any other entities, expand physician recruitment efforts or start any new programs?
- Significant items in this category should be included in required cash expenditures in the budget.
- Will the hospital close any programs over the same period?
- How does the hospital plan to pay for these investments? Will the hospital issue debt, use cash reserves or pay for items out of annual operating cash flows?
- What key environmental changes will occur that will result in additional spending, significant differences in revenue, etc.? For example, payment models continue to evolve impacting hospital reimbursement.

Developing a Long-Range Financial Model

Once high-level strategic issues are identified, the long-range financial model can be developed. Key inputs for this model may include items such as projected volume changes by year, forecasts for staffing levels and employee pay rates, changes to reimbursement rates, and expense inflation assumptions.

These inputs can be used to project operations on a yearly basis. Strategic expenditures also should be included in the model. It is critical that a five-year plan include a full set of financial statements. Without a forecast balance sheet and cash flow statement, it is difficult to know if the hospital will have the cash necessary to fund the long-range plan, if the level of anticipated debt can be serviced and if the assumptions will result in the level of financial health the board desires. Once the initial long-range financial model is complete, the board (or its strategic planning committee) and management should review key items such as:

- Are projected annual operating results in line with the hospital's goals?
- Does the projection result in key measures like days cash-on-hand, debt service coverage, debt-to-capitalization, etc., that will allow the hospital to maintain its bond rating (if applicable) and keep the hospital solvent for the long-term?
    - — Is the long-range picture what the board wants the hospital to look like in five years?
    - — Taken as a whole, do the assumptions used make sense? Are the assumptions internally consistent and do the board and management believe that they are really achievable? For example, projected staffing reductions and a volume increase may not be consistent.

At this stage, the board can either accept the plan or direct management to

By updating the long-range plan each year, the board and management can gain a better understanding of the hospital's financial future and the key strategic decisions that are necessary to achieve the board's desired outcomes.

tweak certain assumptions. For example, the long-range plan may show a large capital purchase is not feasible, and management will need to go back to the drawing board on how to meet that need. The board should ask management to prepare a sensitivity analysis of what changes in assumptions do to the long-range financial picture of the hospital. For example, what happens if annual volume increase projections do not occur? How would a 1 percent compounded difference in the rate of increase in revenue affect the bottom line five years from now? How much better would the bottom line be if annual raises were 2.5 percent per year instead of 3 percent, or what would it look like if the hospital could increase staffing efficiency 5 percent over the next five years? These types of questions can be very enlightening and help guide decisions in the annual budget process. Remember, while the long-range plan looks at high-level assumptions over a longer period, at some point they must be implemented by management and incorporated into each year's annual budget process.

Once the first long-range plan is completed, it should be updated each year to incorporate the inevitable differences that will occur in projected versus actual results. Remember that the long-range plan is really an educated guess about the future, and that many items are outside of management's control and must be adapted to as they occur. These matters may include changes in technology and medical practice, changes in regulations, significant factors affecting the local economy, competitors, etc. By updating the long-range plan each year, the board and management can gain a better understanding of the hospital's financial future and the key strategic decisions that are necessary to achieve the board's desired outcomes.

Annual Audit

The governing board is responsible for engaging external auditors to perform an independent audit of the hospital's financial records each year. It is important that the board select auditors who understand the health care

It is important to note that the hospital auditors report to the board, not to management.

industry and can provide an objective analysis of the hospital's financial position, including how your results relate to peers.

The audit determines if the hospital's financial position and its financial operations are presented accurately and fairly in accordance with generally accepted accounting principles (GAAP). Governmental entities like public hospital districts and authorities use Government Accounting Standards Board (GASB) principles, while non-profit and investor-owned hospitals follow standards issued by the Financial Accounting Standards Board (FASB).

In addition to auditing the hospital's accounting records, reviewing existing internal controls and providing an opinion as to the fairness of the financial statements, the outside accounting firm may present the board with a management letter commenting on the hospital's management and accounting practices. It is important to note that the hospital auditors report to the board, not to management. Boards should ensure that this relationship is understood by both management and the auditors. Some put it this way – auditors work with management but for the board. All of the auditor's reports, including the initial reports, should be sent to the board and hospital management for review. The hospital's auditors also may assist with preparation of annual tax returns, the Medicare and Medicaid cost reports or various consulting matters.

Just as the annual budget permits the board to express specific financial goals for the hospital, the annual audited financial statements and management letter provide the board with added information to measure the attainment of those goals. Board members should use the audited statements to determine if the hospital is reaching the financial and operational goals they set, and if not, the hospital's current operations and long-range strategic plan should be modified so that the goals are more realistic.

The board also should look for significant differences in the internal and audited financial statements. If there are significant adjustments required during the audit, the board may not have received accurate information throughout the year on which to base key decisions. Continual adjustments may indicate changes are needed in the hospital's internal controls over financial reporting.

Should the auditing firm make recommendations for changes in procedures or practices, the board should monitor management's response and make sure that appropriate changes are made in a timely manner.

Revenue and Reimbursement

While many board members have a general understanding of accounting processes and financial reports, hospital finance may be challenging. A hospital's accounting and reimbursement systems are unique. The acronyms, the volume of payers, the complicated reimbursement formulas and the involvement of government and third parties in paying for hospital services can lead to confusion and frustration.

Hospitals earn revenue off their primary operations – delivering health care – and from other sources, such as joint ventures, investments and contributions. Board members may have questions about how the hospital gets paid, why the payment amount is so different from the charged amount, and how much "profit" the hospital should make.

Bad debt, uncompensated care and charity care further complicate the situation. Both federal and state tax exemption may be dependent on the level of charity care provided by non-profit hospitals, and boards should understand the level of uncompensated care their hospital provides as compared to other organizations. While the IRS has requirements for nonprofit organizations, it does not offer specifics in terms of the value of community benefits/charity care to earn and maintain tax-exempt status. Some states have minimum levels of community benefits that a non-profit hospital must provide, and other states have revoked state-level exempt status when amounts were deemed insufficient as compared to the value of the tax benefits received.

Operating Revenue

Although each hospital's mix of payers differs slightly, for most hospitals Medicare and Medicaid pay a large portion of revenue. Medicaid and various Medicaid managed care programs are the largest payers for children's hospitals. For many hospitals, Medicare and Medicaid account for nearly half of patient volume, and in rural hospitals, may represent 60 percent to 75 percent of patient revenue. Private insurance covers a significant percentage of patients, with others having no insurance.

Some hospitals are owned by local governmental units – such as counties, cities or hospital districts – and they receive local tax revenue to help offset the costs of uncompensated care.

Medicare, Medicaid and CHIP

On July 30, 1965, President Lyndon B. Johnson signed legislation that has shaped the delivery of and financing for health care for more than five decades. The Medicare program has provided health insurance for the nation's elderly since its implementation in 1966. This program provides people age 65 and older who are covered by the Social Security program with hospital (Medicare Part A) and physician (Medicare Part B) care.

Since it was signed into law with Medicare, Medicaid has evolved from a program to provide health care coverage for welfare recipients into a public health insurance program for low-income individuals and the main long-term care program for the elderly and disabled. According to a 2016 Kaiser Family Foundation study, Medicaid paid for about 50 percent of births in half of the states in the United States.

Both programs are administered by the Centers for Medicare & Medicaid Services. While the federal government pays for Medicare, Medicaid is financed jointly by the federal government and states. Over the decades, both programs have evolved to try to rein in health care costs and expand coverage. This includes payment adjustments based on quality measures and a transition to Medicaid managed care which provides for the delivery of Medicaid benefits through contracted arrangements between state Medicaid agencies and managed care organizations that accept a set per member per month payment for these services.

Historically, Medicare has reimbursed hospitals on a fee-for-service basis, directly paying them for each service they provide. The issue with this model is that it rewards volume, regardless of patient outcomes. Over the past few years, both private and public payers have begun shifting the way they reimburse

Over the past few years, both private and public payers have begun shifting the way they reimburse hospitals toward value-based programs that link payments to better and/or less-costly care, rather than to the volume of services provided.

hospitals toward value-based programs that link payments to better and less-costly care, rather than to the volume of services provided.

One emerging model in the shift from volume to value is pay-for-performance (PFP), which strives to positively impact health care quality by financially rewarding hospitals that achieve or exceed specified quality benchmarks and targets. Characteristics of PFP programs include mandatory reporting, public access to performance data, cost containment, and the use of evidence-based performance measures relating to clinical process of care, patient experience of care, and outcome and efficiency.

There are five primary programs implemented by using a pay-for-performance approach to the purchasing system that represents the largest share of Medicare spending, they are;

- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)/
- Value Modifier (VM) Program (also called the Physician Value-Based Modifier or PVBM).
- Hospital Acquired Conditions (HAC) Reduction Program.
- Hospital Value-Based Purchasing (VBP) Program.
- Hospital Readmission Reduction (HRR) Program.

The last three of the list above are primarily focused on hospitals. Based on a defined set of measures, these programs adjusts a portion of payments to hospitals based on either (a) how well they perform on each measure, compared with all other hospitals, or (b) how much they improve their own performance on each measure, compared with their performance on the same measure during a previous baseline period. The VBP program is designed to promote better clinical outcomes for hospitalized patients and improve their care experience during hospital stays. The VBP program is the only quality program where hospitals can receive more funds than they put in.

Payers, including Medicare, are also experimenting with bundled payment programs. Under these programs, various providers are paid a single payment for all of the various services a patient receives during an episode of care. These programs are designed to improve coordination among the hospital, physician and post-acute providers that may be involved in a particular care episode.

Critical-Access and Specialty Hospitals

The VBP program excludes critical access hospitals (CAH) and specialty hospitals such as psychiatric rehabilitation, long-term care, children's hospitals and cancer hospitals. CMS could implement special requirements for these hospitals in future regulations. However, most CAHs and rural hospitals do not have the volume of patients to accurately calculate a reliable performance, which is why measurement in current CMS programs presents a challenge. Currently, those that do not meet the minimal volume requirements will not be rewarded or penalized financially.

Children's Health Insurance Program

The Balanced Budget Act of 1997 established the State Children's Health Insurance Program (CHIP), allowing states to cover uninsured children in families with incomes below 200 percent of poverty who were ineligible for Medicaid.

Administered by state health departments/commissions, CHIP coverage is offered by private health plans and provides a full range of services, including immunizations. In CHIP, most families pay an enrollment fee, depending on the family's income level, and many states require co-payments, based on the family's income.

Medicaid Value-Based Purchasing

Medicaid and CHIP are also moving away from reimbursing providers based on volume to a system where payments are based on quality and efficiency. Texas' Medicaid and CHIP programs make value-based payments to managed care organizations (MCO) and health care providers, including hospitals.
In Texas, Medicaid and CHIP payments to hospitals are adjusted based on the facility's performance on two distinct measures: potentially preventable readmissions (PPR) and potentially preventable complications (PPC), both fall under the broader category of potentially preventable events (PPE). A PPR is a return hospital admission within a set time period that may have resulted from problems in care during a previous hospitalization or follow-up. A PPC is a harmful event or negative outcome, such as an infection or a surgical complication that occurs after a hospital admission and might have resulted from care or lack of care or treatment during the admission.

Medicaid and CHIP payments for inpatient hospitalizations may be reduced

for hospitals with high PPR and PPC rates. Alternatively, safety net hospitals – which care for Medicaid and low-income, uninsured patients – may receive incentive payments from Medicaid or CHIP for achieving low PPR and low PPC rates.

Medicaid and CHIP services are delivered primarily through MCOs. The Texas Health and Human Services Commission (HHSC) contracts with state-licensed MCOs and pays them a monthly amount to coordinate health services for the Medicaid or CHIP members enrolled in their health plan. The MCO health plans contract directly with hospitals and other health care providers to create provider networks. They are required to provide all covered medically necessary services to MCO members.

HHSC promotes VBP through its contracts with Medicaid and CHIP MCOs. Moving forward, MCOs can lose part of their premium payments or receive additional payments based on their performance on quality measures. MCOs must also implement VBP with contracting health care providers to advance quality care.

Other Funding Mechanisms

For almost 50 years, states have used Section 1115 Medicaid waivers to use federal funds in ways that do not conform to federal standards, such as changing eligibility, benefits or cost-sharing. States increasingly have used Section 1115 waivers as a way to relieve state fiscal pressures. In Texas' waiver funding is provided through uncompensated care payment and Delivery System Reform Incentive Payments (DSRIP). In order to receive DSRIP funds, Texas hospitals are incentivized to collaborate and implement locally-driven project to improve health care delivery though increased access, innovations in care and infrastructure development. In 2018, the waiver provided an estimated $6.2 billion in payments to Texas hospitals. The state and federal governments share responsibility for financing payments. In Texas, local tax dollars that are levied

The percentage of employers that offer health care coverage has declined over the last decade and many employers have shifted to high-deductible plans as a way to share costs.

by hospital districts and local municipalities provide the non-federal share. In 2017, CMS approved a Section 1115 Medicaid waiver extension for Texas through September 30, 2022. DSRIP funding will be phased out over the term of the extension and beginning in federal fiscal year 2020, total uncompensated care payment funding will be limited to the cost of providing charity care.

Along with the Medicaid 1115 Transformation Waiver, hospitals receive funds through the Disproportionate Share Hospital (DSH) payments, which allowsstates to make additional payments to hospitals serving a disproportionate share of Medicaid and low-income patients. In 2017 $1.79 billion in DSH payments were made to Texas hospitals. Starting in 2019 The federal share of DSH payments is scheduled to decrease as part of DSH cuts in the Affordable Care Act in response to expected decreases in the number of uninsured.

Private Payers and Individual Coverage

Although the percentage is shrinking, the majority of insured Americans receive health coverage through private group policies – usually employer-sponsored. According to the U.S. Census Bureau, in 2016 157 million Americans had employer-sponsored coverage.

Some organizations and associations also offer group policies. The percentage of employers that offer health care coverage has declined over the last decade and many employers have shifted to high-deductible plans as a way to share costs.

Many employers have established new types of employee accounts, such as health reimbursement arrangements and health savings accounts, which allow employees to accumulate funds to pay for health care services and cover deductible and coinsurance amounts.

Many payers do not base their payment on charges, but rather on the diagnosis of the patient or the procedure performed, regardless of the drugs, supplies or other items used in the procedure.

Individual Coverage

Self-employed individuals and employees who are not offered employer-sponsored coverage may obtain health benefits from a health insurer or health maintenance organization. A small percentage of Americans have individual policies. Premiums for individual coverage generally are more expensive and may have higher deductibles. To reduce premium costs, individuals often will sign-up for health plans that have higher annual deductibles, co-payments and co-insurance amounts.

Charges/Reimbursement

Charges describe the amount a hospital bills for providing care to a patient. Federal law requires hospitals to use standard charges, regardless of the type of health coverage the individual has.

The charge is supposed to include all the hospital's direct and indirect costs in providing a service or treatment. For example, the room charge includes direct costs for nursing care, dietary/food service, housekeeping, laundry and utilities as well as indirect costs such as compliance with regulatory requirements for the physical plant, purchasing supplies for the room, insurance for the hospital building, etc.

Hospitals keep a master price lists called a chargemaster. Gross charges represent a hospital's "full" charge and are based on data in the chargemaster. This list should be reviewed and updated on a regular basis.

An often-heard question is, "Why does an aspirin cost $6 in the hospital? Everyone knows you can buy a bottle of aspirin for less than that." Of course, the aspirin itself doesn't cost $6. But it does when you pay someone to dispense it in a secure medication box, record the dispensing and deliver it to the patient unit, and someone else delivers it to the patient's room, checks to make sure it is the right medication for the right patient, brings water, makes sure the aspirin is taken and records the action and that this process is available 24 hours a day, seven days a week. Also, keep in mind that the hospital is usually not paid $6 for this. Many payers do not base their payment on charges, but rather on the diagnosis of the patient or the procedure performed, regardless of the drugs, supplies or other items used in the procedure, except for CAHs, which are reimbursed based on Medicare usage and costs. While a hospital

has a single charge for each service, the amount of reimbursement accepted as payment in full varies widely.

Common Payment Rates

Most government programs reimburse using a prospective payment system based on services being provided. Commercial payers may also use a prospective payment system or reimburse a percentage of billed charges. Hospitals negotiate payment amounts with each commercial insurers. Typical payment methods include:

- Per diem rates – a flat amount paid per day for categories of patients, such as medical or surgical.
- Case rates or prospective rates – episode-based rates, such as a flat rate for a hip surgery replacement patient from planning and pre-op through six months post-op.
- Discounts from gross charges – a negotiated percentage off the gross or full charges.
- Capitation – a bundled payment in which the provider is paid a fixed amount on a per patient/enrollee basis to meet whatever care needs surface during the year. Capitation agreements are not widely used in Texas.

Contractual Adjustments and Bad Debts

Contractual adjustments are the difference in the gross charge and the amount a provider contractually has agreed to accept from Medicare, Medicaid and managed care/commercial insurance payers. Providers cannot attempt to collect this difference.

The hospital-specific discount of charges is calculated based on the anticipated volume of patients from the payer, with assumptions about the types of services that will be delivered. These assumptions usually are based on historical patterns and an analysis of hospital statistics—for example, top 10 diagnoses and top 20 outpatient procedures. These estimates should be as accurate as possible since they impact the hospital's revenue for the life of the contract. The contractual allowance is shown as a reduction from gross charges on most hospitals' internal financial statements. On external financial statements, contractual adjustments generally are not shown separately, but are netted against gross charges, resulting in "net patient service revenue."

One of the most challenging aspects of budgeting is determining contractual allowances/bad debt. With government and commercial payers, hospitals can make fairly accurate projections, although policy changes may affect reimbursement. Hospitals tend to have good trend data and can make well-grounded assumptions.

It is more difficult to project how many patients will not pay. Some patients are uninsured or under-insured (e.g. patients may not be able to pay their co-payment or deductible amounts, even if they have insurance or a job). A hospital's level of bad debt expense is highly dependent on its payer mix and the level of uninsured and low-income individuals in the hospital's service area.

The national average for bad debt is approximately 2-3 percent, but in some states and some communities, bad debt may be as high as 10 to 25 percent of net patient revenue.

Claim denials by any third-party payers as well as unexpected financial class changes can impact projections. Hospital board members should understand that contractual allowances and projections on revenue and shortfalls are educated estimates and never are 100 percent correct.

Other Revenue

Non-operating income for hospitals often includes: interest and dividend income, unrealized gains and losses on investments, and other income or expenses not directly related to operations. Governmental hospitals also included interest expense and property tax revenues as part of non-operating income. Some hospitals qualify to participate in the federal 340b program. This program can bring additional revenue to non-profit hospitals to help offset the costs of the uninsured.

Hospitals have other sources of revenue, including joint-ventures, investment income and contributions/donations. Some governmental hospitals also receive property taxes, sales taxes or county appropriations that are usually included in other income. The percentage of total revenue that these non-operating income sources contribute varies widely among hospitals.

Some hospitals operate a variety of joint ventures or non-patient care revenue centers. These may include small revenue producers such as the cafeteria, gift

shop and vending machines. Others leverage their expertise in a specific area, selling services to others in the community or area. For example, hospitals may sell laundry, food service, housekeeping or maintenance services.

Hospitals often own adjacent/nearby office buildings that they lease to physicians or other health care providers. Some hospitals also own and operate related activities, like long-term care facilities, fitness facilities, wellness centers that provide education, day care centers, extended stay accommodations for families of hospitalized patients, ambulance services, etc.

Investment Income

Most governmental and non-profit hospitals attempt to build a large investment portfolio to give them flexibility when significant changes occur. For example, cash reserves can be used to offset losses when significant reimbursement changes are implemented, giving the hospital time to implement cost-saving measures. Cash and investment reserves are also necessary to allow the hospital to adapt quickly to market changes, such as the ability to purchase a line of business or recruit a new physician to the market.

The complexity of hospital investment portfolios varies widely based on the board's risk tolerance levels. Most hospitals invest in some type of fixed income securities, which generate interest income. Hospitals with more diversified portfolios often invest in mutual funds, equity securities, alternative investments like hedge funds and real estate funds.

Hospitals generally carry all investments at market value. As such, it is not uncommon for hospitals to have investment income comprised of realized and unrealized gains and losses, as well as dividends income. State law limits the types of investments most governmental hospitals may purchase. Most state laws do not allow these entities to invest in equity securities and alternative investments or many mutual funds. These laws also may restrict the average maturity level of investments and sometimes limit the amount of any single investment a hospital can own.

Contributions and Grant Income

Many non-profit and governmental hospitals have a robust philanthropy program. Hospitals may have specific capital campaigns, usually for a major building program or significant expansions. Others have ongoing fund-raising

programs, accepting memorial donations and honorariums.

Hospitals also may apply for and receive grants from a variety of sources, including government initiatives, private nonprofit foundations and local charities or civic organizations. Hospital volunteers/auxiliaries often make donations to their hospitals to purchase equipment or support specific services.

If a hospital receives grants from government programs or private foundations, performance metrics usually are established, and periodic reports on program implementation as well as use of financial resources are required. Hospitals receiving federal and state grants often have very specific audit requirements that must be completed to document compliance with the applicable grant document.

Expenses and Operations

The income statement also reflects expenses and operating costs. Because they are open 24/7 and contain many moving parts, hospitals are expensive places to operate. From food service and security to nursing care and emergency room availability, hospitals must be staffed and delivering services around the clock.

Expenses in hospital accounting are fairly straightforward. The two broad categories of expenses are "operating expenses" and "capital expenses." Operating expenses consist of salary and benefit costs, and non-salary expenses (supplies and materials, purchased services, professional fees, etc.). Capital expenses represent the depreciation, amortization and interest expense associated with capital purchases or leases.

Salary and Benefit Expenses

Hospitals are labor-intensive businesses, and often more than 50 percent of expenses are for salaries, wages and benefits. Industry averages for salaries as a

The governing board should be aware of how the hospital purchases supplies and materials and monitor compliance with applicable policies and legal requirements.

percent of net revenue vary, but depending on the source of data, range from 50 to 60 percent of operating revenues. However, this ratio can vary widely depending on a hospital's structure. For example, a hospital that operates the ambulance service, that employs a large number of physicians or that is a teaching hospital generally has higher salary percentages as a percent of revenue. Employee benefits are generally 20 to 25 percent of salary costs. Shortages of nurses, allied health professionals and technicians tend to drive up wages. A key to profitability is limiting the amount of expenses that fall in salary. Hospitals can reduce their salaries by not only limiting staff but also changing the mix of the staff that is used.

Additionally, hospital management may want to look at their use of contract labor. Hospitals can limit the number of employees and can supplement with contract/agency nurses. However, contract positions are typically more expensive than an employee.

Because quality increasingly is linked to a hospital's financial health, adverse outcomes related to inadequate staffing are having a growing impact on a hospital's bottom line. The most direct example of the quality-finance link can be seen in CMS' rules that reduce Medicare reimbursement for any patient care needed as a result of a hospital-acquired condition or "never event." A contributor to these errors can be inadequate nursing levels, so having an adequate supply of nurses is essential. Hospital management teams face a delicate battle of striving for efficiency and quality patient outcomes.

Non-Salary Expenses

Hospitals purchase a wide variety of supplies and materials. From food and cleaning products to medications and surgical sutures, hospitals have many needs. Materials management is the process of procuring, transporting and managing inventory of the actual products from the manufacturer or distributor. Materials management also plays an important role in controlling costs as well as inventory.

For hospitals, critical stocks must be available in the right place at the right time. Inventory practices should be consistent among departments. For example, pharmacy inventory management practices should look almost identical to operating room inventory management practices. Following standard policies and procedures reduces maverick spending and helps ensure consistent stock quality.

Beyond purchasing, materials management analyzes how products are used and where the products are at any given time. Understanding these dimensions leads to efficient utilization and inventory control, which are essential to managing expenses. With an understanding of how supplies are used, materials personnel can help clinicians better manage supplies and finances and get the best prices.

Efforts to standardize product purchases to one or two brands have been going on for decades; increased volume for one or two brands leads to better pricing and lower inventory levels. With changes in health care delivery and more shared financial risk, physicians are working with hospitals to get the best product values possible. Many management teams work closely with physicians to limit "physician preference" items to keep supply costs down. For example, hospitals often work with medical staff to develop a formulary, a list of prescription drugs covered by prescription drug plan or other insurance plan, and require physicians to order from the formulary to limit the number of options and help to contain costs.

Almost all hospitals in the U.S. use one or more group purchasing organizations (GPOs) to secure discounts on their supplies and materials. A GPO helps hospitals realize savings and efficiencies by aggregating purchasing volume and using that leverage to negotiate discounts with manufacturers, distributors and other vendors. GPOs do not purchase or buy any products for hospitals. They negotiate contracts that hospitals can use when making their own purchases. The hospital must decide which product is most appropriate in each circumstance and make its own purchases.

Some GPOs are owned by hospitals, but others are independent organizations. Some GPOs only serve not-for-profit hospitals, while others serve just proprietary facilities, and some serve both. Some GPOs offer hospitals the

In looking at the myriad of reporting and compliance requirements, the board should consider things like infrastructure and staffing to ensure compliance and the major payment or community implications that could occur if an organization isn't found to be in compliance.

ability to purchase nearly every conceivable type of product, while others focus on specific product categories. In addition, some GPOs specialize in certain types of health care, such as long-term care.

The governing board should be aware of how the hospital purchases supplies and materials and monitor compliance with applicable policies and legal requirements.

The Cost of Regulatory Compliance

Hospitals operate in one of the most highly regulated fields in the nation. More than 20 federal agencies as well as dozens of state agencies oversee some aspect of health care delivery. Regulations exist for almost everything in the hospital, from its physical structure and equipment to the way services are delivered and the individuals who provide them.

Fire/safety requirements, elevators, oxygen and other gases, hall and door widths, non-slip flooring and security systems are among the areas of the physical plant that must meet requirements.

Periodically, hospital equipment must be tested and meet specific requirements, such as radiation levels, calibration, weight/temperature levels and presence of infectious agents. A number of entities establish standards of care that must be met to achieve certification or accreditation. For example, the American College of Surgeons establishes standards for trauma designation, and the Medicare Conditions of Participation establish service delivery expectations, including policy and process requirements.

Hospitals also are required to collect and report data about everything from infection rates and deaths to patient population demographics and causes of traumatic injuries.

Hospitals must comply with a wide range of financial requirements. For example, nonprofit hospitals must submit reports to the IRS regarding charity care and community benefits provided. Medicare and Medicaid have extensive financial reporting requirements to obtain reimbursement. Some investor-owned hospitals must meet Securities and Exchange Commission requirements for publicly traded companies.

In looking at the myriad of reporting and compliance requirements, the board

should consider things like infrastructure and staffing to ensure compliance and the major payment or community implications that could occur if an organization isn't found to be in compliance.

Capital Expenses

Capital expenses include depreciation, interest and amortization.

Capital assets purchased by hospitals are recorded on the balance sheet, and then a portion of the cost is charged to expense based on the estimated useful life of the asset. Useful lives vary based on the type of asset. Buildings often are depreciated over 40 years, equipment ranges from three to 10 years and software costs are spread out over three to five years. In recent years, hospitals have made significant investments in electronic health record and patient accounting systems which may have a service life greater than five years. Land is not depreciated, but any improvements (parking lots, landscaping, etc.) are.

Repairs and maintenance costs generally are charged to routine operating expenses, unless the repair outlay is so significant that it extends the useful life of the assets. These types of repairs are capitalized and depreciated.

A policy should be established for the minimum amount that can be capitalized. The policy should include the maximum dollar amount that can be approved by the CEO, with larger purchases approved by the board. This should be reported to the board monthly.

Interest expense is charged to expense each month based on the interest rates on revenue bonds, capital leases and other notes payable. During periods of construction, interest charges related to debt used to build an asset are capitalized as part of the asset's cost. Once the construction project is complete, interest is charged to expense.

While board members should anticipate variances from budget and prior year actual results on a month-to-month basis, they should focus more on trends that might be occurring.

Amortization is similar to depreciation, except it generally relates to intangible assets like bond issuance costs.

Each year a hospital is required to determine if any of its assets are impaired. Impairments occur when the expected use of an asset changes significantly due to technological obsolescence, property damage or regulatory changes. If an asset is impaired, a significant portion of un-depreciated cost is charged to expense in the year the impairment occurs.

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. There is no "bright line" that directs how much a hospital should spend on capital equipment each year. This is something that must be viewed over time and reflect the hospital's long-range strategic plan. According to Moody's, the average hospital spending ranged from 1.1 to 1.5 times annual depreciation expense over the last several years. Hospitals with a physical plant more than 10 years old may need to spend higher amounts within a few years.

Non-Operating Expenses

Some hospitals include expenses in operating and non-operating categories. For governmental hospitals, the GASB requires that expenses like interest be shown as a non-operating expense, while FASB hospitals recognize interest as an operating expense. Other expenses that are classified as non-operating are those not directly related to patient care, and this categorization can be very subjective. It is important for boards to know what types of expenses are excluded from operations, because operating income is often a metric used in management's incentive compensation arrangements. Investor-owned hospitals will show the provision for income taxes as other expense.

Financial Reports

The board should monitor the hospital's financial condition by reviewing various monthly reports, focusing on results from operations, overall financial

performance and the overall financial health of the organization. While board members should anticipate variances from budget and prior year actual results on a month-to-month basis, they should focus more on trends that might be occurring. Boards should determine what their key metrics are and focus on those each month. Key financial ratios like operating margin, debt service coverage and days cash on hand are examples of important metrics to monitor over time.

The hospital's financial staff is responsible for providing board members with accurate financial statements on a timely basis. Experts caution against falling into the "information overload" trap. Your board packet may only need summary financial statements and a couple of other reports:

- Balance sheet.
- Income statement.
- Cash flow statement.
- "Readable" statistics or a dashboard report is desirable.
- A one-page summary of variations from expected performance.

These reports should compare the current month's financial situation to that of the same month in the previous year and the budgeted amount. The accounting staff also should prepare monthly reports tracking key operating and utilization statistics. These include accounts receivable analyses, physician utilization, outpatient visits, full-time equivalent personnel numbers, days or discharges, payer percentages and acuity index. For a monthly report to be useful to the board, it should not be overly complex or voluminous. Comparisons of key ratios to industry averages is also helpful to put the financial results and financial position into context.

The Balance Sheet

The balance sheet represents a snapshot in time of a hospital's assets and liabilities. Timing differences can impact the initial interpretation. Experts recommend that the balance sheet in the monthly board packet have a comparison to the same period for the prior year and the year-end audited amounts. Board members should look for major changes since last year, especially in working capital.

Assets are usually classified as "current," "property, plant, equipment,"

"designated" or "other." "Current" assets have an expected life of one year or less, or represent assets immediately available for use. These include cash, accounts receivable, prepaid expenses and supplies. "Property, plant and equipment" assets have a life of more than one year. For example, equipment might have a useful life of 10 years before it is fully depreciated. "Designated" assets may be either board-designated accounts – such as fund depreciation, self-insurance reserves or other reserve accounts – or trustee-designated accounts that include interest and sinking funds as required by bond trustees. "Other" assets include general investments, goodwill or other intangible assets.

Liabilities are the monies a hospital owes to other parties or revenue that the hospital has accrued but not yet earned. Liabilities are recorded in two categories – current liabilities and long-term liabilities. Current liabilities are those that are expected to be paid by the hospital within one year. For example, vendors for hospital supplies are listed under "Accounts Payable." Long-term liabilities are not required to be paid within one year. Long-term debt is the most common long-term liability.

Hospitals often need to issue debt to modernize the facility or to build cash reserves. However, high debt levels create high fixed costs or can limit operating choices due to covenant restrictions. Most hospital debt agreements include restrictive financial covenants, including the following:

- Minimum days cash on hand.
- Minimum debt service coverage ratio.
- Maximum debt to capital ratios.
- Limitations on distribution of assets.
- Limitations on additional borrowing.

Hospitals borrow money using:

- Tax-exempt debt via revenue bonds.
- Direct or enhanced borrowing via the federal government (USDA, HUD).
- Leases.
- Bank loans.

The net assets or retained earnings are the difference between total assets and

total liabilities and represent the equity of the hospital. It is an accumulation of all the prior years' earnings and contributed capital such as stock or donations. Governmental hospitals refer to net assets as net position.

Management should provide benchmarks to measure balance sheet status compared to aggregate numbers. Typical performance measures include:

- Days cash on hand.
- Days in accounts receivable.
- Days in accounts payable.

Cash on Hand

Hospitals' cash and investments are reported in various areas on the balance sheet and for many, these are the hospital's most important assets. 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 of cash on hand (that is, how many days of operating expenses are represented by cash and investments owned by the hospital?).

Moody's reports an average of approximately 200 days cash on hand for hospitals it rates. Many hospitals, especially those without bond ratings, are below this amount.

The days of cash on hand has an impact on the hospital's investment portfolio. Hospitals with a higher number of days of cash on hand tend to have more diversified investment portfolios. Hospitals with a lower number of days of cash on hand often have very conservative portfolios.

Accounts Receivable

Accounts receivable represent amounts owed by patients and third-party payers like Medicare and insurance companies. It is a very difficult amount to estimate because payment rates vary greatly by payer and even patient. The number of days of revenue uncollected is the metric on which accounts receivable is measured. The number of days in gross receivables indicates how fast accounts are cleared from the books. Days in net receivables show how conservative

or aggressive the hospital's allowances are. Board members should compare these measures to a benchmark each month and look for trend changes and differences compared to peers.

These measures can help identify potential problems with billing or collections as well as the accuracy of estimating the amounts collectible from patients. It is important to note that most significant audit adjustments occur because management's internal estimate does not accurately represent the amounts truly collectible. If accounts receivable is overstated, net income will also be overstated.

The national average for days in net accounts receivable is approximately 45 days, but many hospitals have days between 30 and 35 days. Days in gross accounts receivable usually run a little higher than net days, but the difference should be minimal. Days in accounts receivables can be impacted by a variety of factors including payer mix and the effectiveness of a hospital's billing and collection practices. Boards should challenge management if uncollected net days are significantly different than industry averages. Variances that are significant may indicate:

- Valuation errors.
- Overly conservative estimates.
- Collection process problems.

One key way for assessing how accurate management's estimate was is through look-back reports. From time to time, boards should ask management to assess how much was collected from patients since a particular point in time, and how did that compare to the estimate at that time. For example, if management estimated that accounts receivable was worth $20,000,000 in Year 1, but in Year 2 only $15,000,000 was collected, there is likely a valuation problem that needs to be analyzed. In general, a minimum of 90 percent of

Key rating agencies report average operating margins of 1.5 percent to 3 percent, although investor-owned hospitals strive for a higher margin in order to provide a dividend to their investors.

accounts receivable should be collected within one year of a balance sheet date.

Accounts Payable

One of the first signs of trouble is increasing accounts payable not caused by revenue or activity growth. Rapidly growing accounts payable could indicate trouble paying invoices.

Accounts payable usually are analyzed by measuring the days it takes to pay bills and should generally be somewhere around 45 days.

Income Statement

The income statement often is called the "profit-and-loss statement" or a "statement of revenue and expenses." This monthly report demonstrates the hospital's financial performance by summarizing its sources of revenue and expenses from both operating and non-operating activities. It also shows the net profit or loss incurred over a specific accounting period.

Sometimes board members question if the hospital – particularly a nonprofit – should make a profit. The answer is "of course," because the hospital must have the financial resources to invest in equipment and the physical plant to fulfill the hospital's mission. The hospital also must recruit and retain a qualified medical staff. And, the hospital must have financial resources to use in special circumstances, such as implementing electronic health records or expanding or creating a new service line, such as cancer research or a transplant program.

Board members also may wonder how much the profit margin should be. Key rating agencies report average operating margins of 1.5 percent to 3 percent, although investor-owned hospitals strive for a higher margin in order to provide a dividend to their investors. For many hospitals, the total margin (which includes investment income) is usually 2 percent to 3 percent higher than the operating margin. In many years, almost 50 percent of hospitals lose money from operations, and as the payment system transitions to pay-for-performance and requires hospitals to absorb more risk, the percentage of hospitals losing money on operations is likely to increase.

Cash Flow Statement

This financial report provides aggregate data regarding all cash inflows from both operating and non-operating sources, as well as all cash outflows that pay

for business activities and investments during a specific time period, usually quarterly. This report helps the board see how cash is being managed. While accounts receivable may reflect a positive increase, the actual payment has not been received, which affects the hospital's cash flow. Cash collections generally should match net patient revenue (after bad debts). Cash and investment balances are important because they show that income is being turned into cash.

Dashboards

Dashboards provide a visual snapshot of figures and statistics which is helpful in identifying trends. For example, the board should be provided updates on hospital operating statistics, such as:

- Number of staffed and available beds.
- Number of inpatient admissions and discharges.
- Average inpatient daily census.
- Number of outpatient visits.
- Number of ER visits.
- Adjusted patient days which modifies inpatient days for outpatient volume.
- Case mix index that measures patient acuity, and a higher case mix indicates sicker patients.
- Average length of stay.

It is important to monitor these statistics and how they relate to payment. Boards should be given dashboards that reflect an organization's key metrics and progress on strategic goals.

Summary of Variations

Board members may find it helpful to have a one-page summary of why performance varied from expectations, either positively or negatively. For example, a flu epidemic may cause admissions to rise in a specific month. A delay in payment due to the audit of a large claim by an insurance company may impact cash flow, or temporarily increase days in accounts receivable. The explanation need not be lengthy but should concisely explain the situation, and what further action, if any, is being taken.

Ratio Analysis

Numerous ratios measure every aspect of the financial statement. Trustees should be familiar with the following terms and what each means to their own hospital.

Liquidity

Is the hospital able to pay its debts that are coming due in the next few months? Cash and accounts receivable should be compared to accounts payable and accrued expenses. The more cash or current assets that the hospital has to pay its debts, the more "liquid" it is said to be.

Total Current Assets (excluding restricted funds)
Total Current Liabilities (from unrestricted funds) = the current ratio.

This ratio provides a generally reliable indication of a hospital's liquidity. Board members should track liquidity over time. Has the ratio changed significantly since the prior year-end? Remember that liquidity is not an absolute measuring stick. There are many reasons this relationship may not work, including third-party payer reserves, liquid assets in the "assets limited as to use" or "noncurrent cash" section, and contingent reserves.

Accounts Receivable Position

"Days in accounts receivable" is the term used to indicate the length of the cycle from the date of the patient bill to the date payment is received. Days in accounts receivable generally should be approximately 45 days or less. When hospital assets are tied up in accounts receivable, cash flow problems can result.

Net Patient Accounts Receivable
(Net Patient Service Revenue ÷ 365) = days of revenue in patient accounts receivable.

Board members may find it helpful to have a one-page summary of why performance varied from expectations, either positively or negatively.

Debt Service Coverage Ratio

This ratio measures the capacity of the hospital to make debt service payments (i.e., interest expense plus principal) from operations. The ratio should be at least 1.5 and also should be increasing over time. The calculation is as follows:

Net Income + Interest + Depreciation
Principal Payment + Interest Expense = the debt service coverage ratio.

This ratio should be measured on at least a quarterly basis. There may be a debt service coverage bond covenant requirement and the ratio is indicative of the hospital's ability to borrow new money.

Cash to Debt Ratio

Another key measure is the ratio of a hospital's unrestricted cash and investments to total long-term debt. Highly rated hospitals have cash and investments that exceed the balance of long-term debt. Hospitals that have just completed an expansion project or that are highly leveraged often have less cash than long-term debt. Low cash-to-debt ratios are viewed as a risk factor by many rating agencies. This is another measure of liquidity and should be considered when borrowing new funds.

Profitability Ratios

Profit per adjusted discharge is the overall measure of the amount of profit or net income earned per adjusted discharge. The ratio is directly related to the pattern of price and cost increases in health care.

Net Patient Revenue

The estimated amount of patient revenue that remains after contractual allowances and bad debt are subtracted from charges (or gross revenue). Hospitals also often calculate the NPR plus other operating revenue to get the total net revenue.

Contractual Allowance Percentage

The contractual allowance percentage defines the percentage of gross patient revenue that is discounted to third-party payers. The average contractual allowance range is dependent on the level of a hospital's gross charges. While many hospitals' contractual allowances range between 60 percent and 80 percent, boards should look at changes in this rate over time compared to

industry averages. The contractual allowance ratio is calculated as follows:

Deduction from Patient Service Revenues
Gross Revenue = Contractual Allowance Percentage

Benchmarking with Other Hospitals

Financial statements cannot be reviewed in a vacuum. Hospitals need to know how they compare to peers in the market and nationally. Choose a peer group carefully. An organization should compare themselves to similar sizes and types of hospitals. For example, a teaching hospital should choose other teaching hospitals of approximately the same size.

The board should decide whether to use the median benchmark or not. If the board chooses several peers to benchmark against, then one of them might be a high performer. While it's important to perform at the standard of care, improvement requires taking performance to a higher level.

The board should limit the number of items measured and compared to benchmarks to keep it reasonable. Focusing on a few items makes it easier to monitor performance. The board should set goals based on meeting the benchmarks.

Conclusion

The hospital governing board is responsible for the financial condition and stability of the hospital/health system. Board members have a duty to understand the hospital's revenues and expenses, and thoroughly understand the potential impact of financial decisions they make. This is especially important as the health care landscape, and payment models, continue to evolve.

The board should monitor financial performance, watch for trends on a routine basis, and have a long-range financial plan. While it is important for board members to monitor financial performance and watch for trends on a routine basis, the board also should have a long-range financial plan that provides the financial resources needed to achieve the organization's strategic goals and objectives. This will help to ensure the sustainability of the hospital and the community it serves.

Key Take-Aways

- Hospital reimbursement is unusual in that third-parties pay for most health care, including government programs like Medicare and Medicaid and private payers, like health plans and insurance companies. Payers have moved away from charged-based payments to fee-for-service, prospective payments and risk-sharing arrangements. Today, payment is moving rapidly toward value-based purchasing, pay-for-performance and bundled and capitated payment arrangements.
- The board influences the hospital's financial condition by the policies it adopts.
- Decisions about discounts, contractual allowances, charity care and investments impact the bottom line.
- The board must comply with numerous federal laws related to decision-making in the financial realm. Inappropriate financial incentives must be avoided in recruitment/retention activities, particularly related to the medical staff.
- The board must ensure that the hospital is in compliance with Medicare and Medicaid billing and reporting requirements. False claims can result in serious civil and criminal penalties.
- Nonprofit hospitals must ensure compliance with IRS requirements. The board also must oversee an annual independent audit and take action on any recommendations.
- Board members should try to focus on big-picture items; small problems in departments will show up in the financials over time. However, governing board members should review monthly financial reports and comparisons to budget and the previous year, and ask appropriate questions. While board members should not become involved in the details, management should be held accountable for performance, which might require delving into details on specific issues.
- The hospital is a business and needs to be managed as one. The board is responsible for overseeing management's performance on financial matters, asking the right questions at the right time, and making informed decisions based on the best information available.

Discussion Questions

1. How sound is the hospital's financial position? How could it be strengthened?

2. How does the hospital's return-on-investment compare to benchmark organizations/facilities? How can the hospital increase non-operating revenue to offset losses on government programs?
3. What is the hospital's cash position? Will the hospital be solvent in six months, 12 months, two years from now? What could be done to improve the cash position?
4. What is the hospital's debt capacity? Does the hospital have the financial resources or the borrowing capacity to achieve its long-term strategic goals? Do plans or strategies need to be adjusted based on the myriad of changes occurring in health care delivery?
5. Does each board member understand the changes occurring in hospital reimbursement, and the potential impact of a pay-for-performance world? Is appropriate emphasis being placed on quality metrics and patient satisfaction?
6. How could the audit process be improved? Are board members asking the right questions of management and the auditors? What are the biggest "estimates" on the balance sheet? How were they tested?
7. How effective is the hospital's compliance plan? Are concerns being reported and investigated? If questions are not being raised, why not? Are employees, etc., afraid to speak up?
8. What is the hospital doing to ensure accurate coding and billing? How is the hospital's billing accuracy validated?
9. Are the monthly financial reports provided to the board sufficient to evaluate performance and financial condition? Is there additional information that would be helpful? Is there anything received now that isn't needed?
10. What additional training/education would help the board fulfill its fiduciary duties in this rapidly evolving/changing business climate?

Commonly Used Finance Terms

Accrual Accounting – Accounting method that recognizes a revenue or expense at the time services are rendered, regardless of when cash is actually handed over.

Affordable Care Act (ACA) – Formally known as the Patient Protection and Affordable Care Act, or informally as Obamacare, this federal legislation was

signed into law in 2010. The ACA refers to two separate pieces of legislation, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. Key provisions of the ACA are to increase access to quality, affordable health insurance, lower the uninsured rate, increase industry efficiency and lower health care costs.

All Patient Refined Diagnosis Related Groups (APR-DRG) – The DRG system classifies patients into clinically consistent groups with similar length-of-stay patterns and utilization of hospital resources. Payment for an acute hospital stay is based on these groups which are comprised of diagnosis codes and procedure codes reported by the provider. All acute hospital stays within a particular DRG are paid the same base DRG rate.

Allowable Costs – The maximum amount covered for a service under health insurance benefits. The contracted allowable amount may not cover the full amount charged by a health care provider in which case the patient/consumer may have to pay the difference.

Allowable Expenses – Necessary and reasonable expenses that an insurer will cover. Also referred to as eligible expenses.

Annual Payment Update – Annual adjustment to Medicare reimbursement rates for hospitals and other health care providers based on inflation. Hospitals can receive their full annual payment update by meeting the requirements of the Reporting Hospital Quality for Annual Payment Update initiative.

Bad Debt – Debt that is unlikely to be paid or that is not collectible.

Balance Billing – The practice of a health care provider billing a patient for the difference between what the patient's health insurance reimburses and what the provider charges.

Block Grant – A set amount of federal funds awarded to a state or local government with minimal requirements on how the funds should be used.

Bundled Payment – A single payment to providers or health care facilities (or jointly to both) for all services to treat a given condition or provide a given treatment. Payments are made to the provider on the basis of expected costs for clinically defined episodes that may involve several practitioner types, settings of care and services or procedures over time.

Capital Asset – Tangible or intangible property with a life of over one year that contributes to the functioning of a business and is not intended for sale during

the normal course of business.

Capital Expense – Expenditure that is spent to acquire or improve a long-term asset.

Capitation – Method of payment for health services in which a hospital, physician or provider is paid a fixed amount for each patient regardless of the services provided.

Case Mix – Various types of patients categorized by disease-related groups, severity of illness or other indicators; used as a tool for managing and planning health care services.

Center for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare and Medicaid programs.

Chargemaster – The gross billed amount or retail price for specific services delivered by a care provider. Typically this incorporates all services, space, and supplies that can be charged on a patient account.

Charges – The amount charged for services rendered to a patient in a hospital. Patient charges are derived from the hospital's chargemaster.

Charity Care – The unreimbursed cost to a hospital for providing, funding or otherwise financially supporting health care services on an inpatient or outpatient basis to a person classified by the hospital as financially or medically indigent. Medically indigent means someone has the means to pay but medical is so high the patient is unable to pay their medical bills. Financially indigent are those who meet the hospital's charity care guidelines, who don't have the ability to pay.

Children's Health Insurance Program (CHIP) – A joint state-federal insurance program under Title XXI of the Social Security Act that provides low-cost health coverage to children from birth through age 18. CHIP is for families who earn too much money to qualify for Medicaid but cannot afford private health insurance. In Texas, CHIP covers children in families with incomes above Medicaid eligibility levels up to 200 percent of the federal poverty level.

Claims – A formal request submitted to a health insurer requesting payment for health care services provided to a patient by a health care facility or provider.

Co-Insurance/Co-Payment – A cost-sharing arrangement in which an insured

person pays a fixed amount for a specified service. The insured typically is responsible for payment at the time the health care service is rendered.

Contractual Allowance – The difference between the amount charged for a service and the amount that is contractually allowed for the service.

Deductible – The amount that the patient must pay before the insurance company will pay.

Denial – Billed amounts that are denied payment by a third-party payer.

Disproportionate Share (DSH) Adjustment – Provides a percentage increase in Medicare payment to hospitals that care for a disproportionate share of Medicaid patients and low-income, uninsured individuals.

Federal Poverty Level (FPL) – A measure of income determined annually by the U.S. Department of Health and Human Services. The FPL is used to determine eligibility for certain programs and benefits (i.e., Medicaid). In 2018 the federal poverty level was calculated at an annual income of $12,140 for an individual and an income of $25,100 for a family of four.

Full-time equivalent employee (FTE) – Calculated by taking the total number of hours worked divided by the maximum number of compensable hours in a period. FTEs are units, equivalent to employees, i.e. one FTE is equal to one employee working full-time, having worked 2,080 hours.

Gross Revenue – The total amount charged for hospital services during a specified period.

Managed Care Organization (MCO) – A provider or organization that uses the principles of managed care as a business model by combining the managed care health plans with the delivery of care from specific providers. Examples are PPOs, HMOs and Point-of-Service Plans.

Medicaid – A joint state-federal insurance program under Title XIX of the Social Security Act for low-income individuals. The program provides health care to qualifying individuals based on their citizenship status, income and assets. The federal government has established minimum eligibility levels and required covered populations, but states determine covered benefits and reimbursement rates and whether to expand coverage to optional populations.

Medicare – Federal program under Title XVIII of the Social Security Act that provides hospital and medical coverage to people 65 and over and to certain disabled individuals regardless of age. It has four parts: Part A covers inpatient

costs (hospital insurance); Part B covers outpatient costs (medical insurance); Part C is the Medicare Advantage Program that provides managed care benefits for Part A and Part B; and Part D covers prescription drugs.

Net Patient Revenue – The estimated amount of patient revenue that remains after contractual allowances and bad debt are subtracted from charges (or gross revenue).

Office of Inspector General (OIG) – Division of the U.S. Department of Health and Human Services responsible for fighting waste, fraud and abuse in Medicare, Medicaid and more than 100 other HHS programs.

Payer – Agency, insurer or health plan that pays for health care services and is responsible for the costs of those services.

Payer Mix – Refers to the percentage of patient volume, usually based on charges, that comes from each of the different payer types (e.g., Managed Care, Medicare, Self-Pay).

Prospective Payment System (PPS) – Method of reimbursement in which Medicare payment is made based on a predetermined, set rate based on the classification system of that service, regardless of the length of stay or time it takes to provide care.

Revenue Cycle – The administrative and clinical processes that contribute to the management and collection of patient service revenue, from the beginning of a patient interaction to the end.

Third-Party Payer – An entity, public or private, that pays or reimburses for health and medical expenses on behalf of beneficiaries or recipients.

Value-Based Purchasing – A CMS initiative that rewards acute-care hospitals with incentive payments for the quality of care they provide to Medicare beneficiaries.

References

"1115 Waiver Is Critical for Texas Hospitals and Patients." Texas Hospital Association, 2018. Web. 2018. Andrews, John. "Scope of Materials Management Function Widens." Healthcare Finance News. Jan./Feb. 2013. Web. 1 Feb. 2013.

A Patchwork of Payers and Priorities. Health Care Finance in Texas. Austin: Texas Hospital Association, 2013. Print.

Barnett, Jessica C., and Edward r. Berchick. "Health Insurance Coverage in the United States: 2016." Census.gov, United States Census Bureau, 12 Sept. 2017. Web. 2018.

Beith, Carsten, and Tim Schier. "Finding the Money." 2011 Texas Healthcare Trustee Annual Conference. Fort Worth. 29 July 2011. Lecture.

"Births Financed by Medicaid." The Henry J. Kaiser Family Foundation, 3 Mar. 2017. Web. 2018.

"The Challenge of Health Care Fraud." The National Healthcare Antifraud Association, n.d. Web. 2018.

Department of Health and Human Services. "Compliance Guidance." Medicare Fraud Strike Force, Office of Inspector General. n.d. Web. 2018.

Desjardins, Jeff. "How Americans Get Their Health Insurance." Business Insider, Business Insider, 1 Aug. 2017. Web. 2018.

"Finance Committee Fundamentals." BoardSource, 9 Mar. 2017. Web. 2018.

Guidebook for Healthcare Trustees. 7th ed. Austin: Texas Healthcare Trustees, 2006. Print.

"Health Care Fraud Unit." The United States Department of Justice, 5 Sept. 2017. Web. 2018.

"Healthcare Supply Chain Association (HSCA)." Supplychainassociation.org. HSCA, n.d. Web. Feb. 2013.

"Individual Mandate of the Healthcare Law - NFIB Research Cribsheet." Nfib.com. National Federation of Independent Business, 15 Feb. 2012. Web. 2013.

"Materials Management's Five Critical Processes and People." Purchasing & Procurement Center, n.d. Web. Mar. 2013.

"Medicaid: A Timeline of Key Developments." KFF.org. The Henry J. Kaiser Family Foundation, n.d. Web. Feb. 2013.

"Medicare: A Timeline of Key Developments." KFF.org. The Henry J. Kaiser Family Foundation, n.d. Web. Feb. 2013.

Monahan, Brad. "Healthcare Finances – What a Board Member Needs to Know." 2010 Texas Healthcare Trustee Annual Conference. San Antonio. 29 July 2010. Lecture.

Morse, Susan. "Half of States Report 50% or More of Births Financed by Medicaid." Healthcare Finance News, 30 Mar. 2017, Web. 2018.

"Percent of Private Sector Establishments That Offer Health Insurance to Employees." The Henry J. Kaiser Family Foundation, The Henry J. Kaiser Family Foundation, n.d. Web. 2018

Thomas, M.D., K. "Quality and Patient Safety: The Unique Hospital Board Responsibility." Huntsville Memorial Hospital Board Retreat. Huntsville. 14-15 Oct. 2011. Lecture.

Trustee Guidebook: Governance. 8th ed. Austin: Healthcare Governance Academy, 2012. Print.

Trustee Guidebook: Quality and Patient Safety. 9th ed. Austin: Healthcare Governance Academy, 2018. Print.

"Value Based Programs." CMS.gov Centers for Medicare & Medicaid Services, 25 July 2018, Web. 2018.

Whitley, Deborah. "Understanding Hospital Finances." 2018 Texas Healthcare Trustee Healthcare Governance Conference. Grapevine. 26 July 2018. Lecture.

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