Health Care Finance 101

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CFO PeaceHealth Ketchikan Medical Center

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Common Financial Terminology

Gross Charges (Revenue) – Total Patient Revenue generated (price x quantity)

Deductions from Revenue – Amount of gross charges not collected due to
- uncompensated care – charity and bad debt
- contractual allowances – difference between charges and payments for all payers

Net Patient Service Revenue – Total amount of cash collected from gross charges

Income From Operations - Total Operating Revenue less Total Operating Expense (operations bottom line)

Non Operating Revenue - Income from Non Operating Activities – such as investments, gains/losses on disposal of assets, etc.

Net Income (Excess of Revenue over Expense) - Income from Operations plus Non Operating Revenue

Days of Cash – Cash and Investments/ Average daily cash expenses

Price/Payment/Cost – Different Definition for provider vs payer vs patient
Hospitals register with American Hospital Association as one of these 4 types:

(1) **General** - Provides both diagnostic and therapeutic patient services for a variety of medical conditions

(2) **Specialty** - A specialty hospital is generally defined as a type of hospital that restricts its admissions to a particular group of persons or class of services (Surgical Centers e.g.)

(3) **Rehab and Chronic Diseases*** - Provides diagnostic and treatment services to disabled individuals requiring restorative and adjustive services

(4) **Psychiatric*** - Provides diagnostic and treatment services for patients who require psychiatric –related services

*Can be set up as sub units within hospitals
• **Public** - 2 types
  - Federal - run by the Military or VA
  - Non-Federal - funded in part by a city, county, tax district or State
  * 21% in US  ** 5% in Alaska

• **Not-for-Profit** - Tax exemption in exchange for providing charitable services
  * 58% in US  ** 86.5% in Alaska

• **For Profit (Investor-Owned)** - Have shareholders, pay income tax, still provide charitable services
  * 21% in US  **8.5% in Alaska

* AHA Annual Survey 2011
** ASHNHA June 2013
All different types of Affiliations are possible
- Ownership
- Joint venture
- Independent
Health Care Revenue
Total Patient Service Revenue: $107,101
(000’s Omitted)

Inpatient: 38,187 (36%)
Outpatient: 45,371 (42%)
Medical Group: 23,543 (22%)

Transitional Care Revenue makes up 18% of Inpatient Revenue
Gross Charges = 107,101
Deductions = 42,619
Payments = 64,482

Deduction % = 40%
Payment % = 60%

Gross Revenue
Payer Mix

Commercial 38,510 36%
Medicaid 20,666 19%
Other 14,776 14%

Payments

Commercial 36,278 56%
Medicaid 8,508 13%
Other 4,883 8%

Commercial makes up 36% of Gross Revenue yet accounts for 56% of Payments
Most health care providers use a hybrid approach incorporating aspects of both resource based and market based methodologies in setting prices.

**Resource Based**
- RVU’s - Diagnostics
  Medicare RVU weights multiplied by a conversion factor
  
<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>RVU’s</th>
<th>Conversion Factor</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>73100</td>
<td>X-RAY EXAM OF WRIST</td>
<td>.92</td>
<td>215</td>
<td>197.8</td>
</tr>
</tbody>
</table>

- Cost - Room Charge
- Mark Up - Supplies and Drugs
- Time Studies - OR Minute Charges

**Market Based Adjustments**
- Competition
- Payer Mix/Payer Contracts
- Loss Leaders

Conversion Factor – must cover both costs and margin requirements (deductions from revenue and profit)

Theoretical – each procedure unique CF
Practical – overall CF applied, or hospital/Medical Group
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Colonoscopy Alone</th>
<th>Total Charges For Colonoscopy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy W Or Wo Bx</td>
<td>1,020</td>
<td>4,717</td>
</tr>
<tr>
<td>Colonoscopy With Polypectomy</td>
<td>1,190</td>
<td>7,106</td>
</tr>
</tbody>
</table>

Ancillary Charges include: Recovery room, pharmacy, etc.
Cost Shifting in simple terms is the practice of raising overall prices to improve payment from a group of payers (Commercial) to offset payment shortfalls from other payers (Medicare/Medicaid, Self Pay).

Medicare Pays:
Cost + 1%

50/50 Payer Mix

Commercial Pays:
Cost +3%

Commercial Pays 3 times Medicare to achieve margin of 2%
Negative Margins
- Medical Group
- Transitional Care Unit
- Home Health
- Intensive Care Unit
- Emergency Department
- Therapies

Positive Margins
+ Imaging
+ Surgery
+ Pharmacy
+ Women’s Health
+ Lab
+ Pathology

Positive Margin Service Lines subsidize Negative Margin Service Lines
Traditionally, Surgery and Imaging Service Lines most profitable
Payment Mechanisms
## Medicare Payment Methodologies

### Quick Overview

Medicare Hospital PPS

<table>
<thead>
<tr>
<th></th>
<th>Reimbursement Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>DRG Prospective Payment System</td>
</tr>
<tr>
<td></td>
<td>Relative Weight of DRG x Base Rate</td>
</tr>
<tr>
<td>Outpatient</td>
<td>APC Prospective Payment System</td>
</tr>
</tbody>
</table>

**Critical Access Hospital**

<table>
<thead>
<tr>
<th></th>
<th>Calculation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>Cost Calculated from Medicare Cost Report</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Cost Calculated from Medicare Cost Report</td>
</tr>
</tbody>
</table>

**Sole Community Hospital**

<table>
<thead>
<tr>
<th></th>
<th>Calculation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>Cost Calculated from Base year cost per discharge inflated forward</td>
</tr>
<tr>
<td>Outpatient</td>
<td>APC Prospective Payment System</td>
</tr>
</tbody>
</table>

**Skilled Nursing Facility**

<table>
<thead>
<tr>
<th></th>
<th>Calculation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUGS</td>
<td>Prospective Payment System</td>
</tr>
</tbody>
</table>

**Physician Clinics**

<table>
<thead>
<tr>
<th>Clinic Type</th>
<th>Calculation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Based Clinics</td>
<td>Hospital Outpatient Departments Fee Schedule</td>
</tr>
<tr>
<td>Freestanding Clinics</td>
<td>Follow methodology for Hospital Outpatient Type</td>
</tr>
</tbody>
</table>
The DRG payment for a Medicare patient is determined by multiplying the relative weight for the DRG by the hospital’s blended rate:

\[
\text{DRG PAYMENT} = \text{WEIGHT} \times \text{RATE}
\]

- The weight indicates the relative costs for treating patients
- The Base Rate is defined by Federal regulations and includes Operating and Capital Payments with local adjustments for: Wage Index, Geographic Factor, Disproportionate share of financially indigent patients

### Sample Case:

**DRG 194**  SIMPLE PNEUMONIA & PLEURISY W CC  
**Weight** = 0.9996  
**Total Charges** = $16,082.00

### CAH Reimbursement:

<table>
<thead>
<tr>
<th>Department</th>
<th>Charges</th>
<th>Per Diem</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Charges</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room Charge (LOS 3)</td>
<td>6,066.00</td>
<td>1,898</td>
<td>5,694.00</td>
</tr>
<tr>
<td>Ancillary Charges</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RCC Lab</td>
<td>660.10</td>
<td>48%</td>
<td>316.85</td>
</tr>
<tr>
<td>CT</td>
<td>2,585.20</td>
<td>48%</td>
<td>1,240.90</td>
</tr>
<tr>
<td>Radiology</td>
<td>354.40</td>
<td>48%</td>
<td>170.11</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>1,866.40</td>
<td>48%</td>
<td>895.87</td>
</tr>
<tr>
<td>Respiratory</td>
<td>4,549.90</td>
<td>48%</td>
<td>2,183.95</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16,082.00</strong></td>
<td><strong>48%</strong></td>
<td><strong>10,501.68</strong></td>
</tr>
</tbody>
</table>

Contractual Adjustment = $5,580.32

### SCH Reimbursement:

\[
\begin{align*}
\text{DRG Weight} \times \text{Base Rate} &= 0.9996 \times 7,478.14 \\
&= 7,475.15 \\
\text{Contractual Adjustment} &= 8,606.85
\end{align*}
\]

### PPS Reimbursement:

\[
\begin{align*}
\text{DRG Weight} \times \text{Base Rate} &= 0.9996 \times 7,040.99 \\
&= 7,038.17 \\
\text{Contractual Adjustment} &= 9,043.83
\end{align*}
\]
The APC payment for a Medicare patient is determined by multiplying the relative weight for the APC by the adjusted conversion factor:

\[
\text{APC PAYMENT} = \text{WEIGHT} \times \text{CONVERSION FACTOR}
\]

Outpatient services are grouped into ambulatory payment classifications (APCs) on the basis of clinical and cost similarity.

The relative weight for an APC measures the resource requirements of the service and is based on the median cost of services in that APC.

The conversion factor is adjusted for geographic differences and the hospital wage index.
Medicare pays for Clinic Charges Based on each billed CPT Code

Clinic charges are reimbursed 3 different ways:

1. Free Standing Clinic
2. OPPS Provider Based Entity
3. CAH with Method II

CPT Based Payment:

1. FSC - Physician Fee Schedule Global Payment = Facility + Professional
2. OPPS PBE - Facility Portion paid based on APC and Professional Portion paid based on Physician Fee Schedule
3. CAH with Method II – Facility Portion paid based on Cost and Professional Portion paid based on Physician Fee Schedule plus 15%
Medicaid Payment Methodologies

**Medicaid**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Reimbursement Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>Cost Based from Base year Medicare Cost Report</td>
</tr>
<tr>
<td>Outpatient</td>
<td>% of Charges Medicare Cost Report</td>
</tr>
</tbody>
</table>

**Skilled Nursing Facility**

| SNF | Cost Based from Base year Medicare Cost Report | Rebased every four years 2011---> 2013-2016 |

**Physician Clinics**

<table>
<thead>
<tr>
<th>Provider Based Clinics</th>
<th>Fee Schedule</th>
</tr>
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<tr>
<td>Freestanding Clinics</td>
<td>Fee Schedule</td>
</tr>
</tbody>
</table>

**Clinic:**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Modifier</th>
<th>Alaska Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>73100</td>
<td>Pro 26</td>
<td>$15.33</td>
</tr>
<tr>
<td>73100</td>
<td>Fac TC</td>
<td>$32.51</td>
</tr>
</tbody>
</table>

**Inpatient:**

Medicaid Days x Per Diem = IP Medicaid Payment

**Outpatient:**

Charges x RCC = OP Medicaid Payment
Commercial Payers Pay Based on:

- Percentage of Charges
- Case Rate
- Fee Schedule
- Per Diem
- Capitated
Health Care Costs
Labor Costs (Salaries, Benefits, and Contract Labor) = 59%
Wage Observations

- Two thirds of labor costs are clinical
- Physicians – Starting point MGMA Median plus 15%
## Healthcare Salaries

What a difference an education can make!

<table>
<thead>
<tr>
<th>Career</th>
<th>Years Post HS</th>
<th>Median Gross $ at the 50th percentile of the market</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>2-4 Years</td>
<td>$80,000</td>
</tr>
<tr>
<td>Rad Tech</td>
<td>2 years</td>
<td>$62,000</td>
</tr>
<tr>
<td>Ultrasound Tech</td>
<td>2 years</td>
<td>$82,000</td>
</tr>
<tr>
<td>Med Tech (Lab)</td>
<td>4 - 5 years</td>
<td>$68,000</td>
</tr>
<tr>
<td>Nurse Practitioner/Physician Assistant/CNM/CRNA</td>
<td>6 -8 years</td>
<td>$110,000 - $192,000</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>6 - 8 years</td>
<td>$82,000</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>6 - 8 years</td>
<td>$120,000</td>
</tr>
<tr>
<td>Physician</td>
<td>10+ years</td>
<td>$250,000 - $600,000+</td>
</tr>
</tbody>
</table>

What a difference an education can make!
Alaska Providers face different challenges:

• **Contract Labor** - Essential staff (Providers, nursing, clinical, etc.) terminate, requiring coverage through agency staffing at a premium (35-100%)

• **Recruitment /Retention** - Costs to recruit high, long duration, limited labor pool

• **Cost of Living** - Higher in Alaska, requires higher wages and moving allowances

• **Lower volumes** - Lower volumes restrict efficiency resulting in lower productivity

• **Supply costs** - Barged or flown in to all Alaskan communities

• **Construction Costs** - 25% higher in Alaska than lower 48 ($300/sq ft vs $240/sq ft)
Other Information
What is a Charge Description Master?
The Charge Description Master (CDM) is *primarily* a list of services/procedures, room accommodations, supplies, drugs/biologics, and/or radiopharmaceuticals that may be billed to a patient registered as an inpatient or outpatient on a claim.

The CDM may also contain/be used for the following:
- Statistical tracking line items
  - Used to capture labor for budgetary purposes
  - No dollars, CPT/HCPCS or revenue code attached
- Payment and adjustment codes
The core group of data elements that typically resides within a CDM are:

- CDM numbers
  Example: 30000612
- Charge Descriptions
  XR WRIST RIGHT 2 VIEWS
- Charge amounts
  $186.10
- Revenue codes
  320
- Department numbers
  41400
- CPT/HCPCS codes
  73100
- Modifiers
  RT
- Relative Value Units (Statistical measures)
  0.71

5600 charge items on KMC’s charge master
Medicare Cost Reports - An annual report required of all institutions participating in the Medicare program, which records each institution's total costs and charges associated with providing services, the portion of those costs and charges allocated to Medicare patients, and the Medicare payments received.

The cost report contains provider information such as:
• Facility characteristics
• Utilization data
• The cost and charges by cost center (in total and for Medicare)
• Medicare settlement data
• Financial statement data.

Primary reimbursement determined via the cost report for:

**CAH**
Calculate Cost Based Reimbursement

**PPS/SCH**
• Bad Debt
• Disproportionate Share
• Medical Education
Cost Report Flow Chart

Total Expenses
- Adjustments
- Reclasses

Total Revenue
- Physician Rev
- Non-Allowable

Allowable Expenses

Adjusted Revenue

Overhead Allocations

Fully Loaded Cost by Department

Inputs from entity financial statements

Adjustments based on cost report parameters

Cost Per Diem

Medicare Program Days

Routine Medicare Program Cost

Medicare Program Cost

Ancillary Medicare Program Charges

Ancillary Medicare Cost

Total Medicare Program Cost

Ratio of Cost to Charges
<table>
<thead>
<tr>
<th>Trend</th>
<th>Penalty</th>
<th>Hospitals Impacted</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10</td>
<td>Requirement 10/1/14</td>
<td>All</td>
<td>10/1/14</td>
</tr>
<tr>
<td>Inpatient Quality Reporting</td>
<td>2%</td>
<td>IPPS</td>
<td>FY12</td>
</tr>
<tr>
<td>OP Quality Reporting</td>
<td>2%</td>
<td>OPPS</td>
<td>FY12</td>
</tr>
<tr>
<td>Value Based Purchasing</td>
<td>2%</td>
<td>IPPS</td>
<td>1% FY13→2%FY17</td>
</tr>
<tr>
<td>Hospital Acquired Conditions /Present on Admission</td>
<td>1%</td>
<td>IPPS</td>
<td>1% FY15</td>
</tr>
<tr>
<td>Readmissions</td>
<td>3%</td>
<td>IPPS</td>
<td>FY13, 3 Year Phase-In</td>
</tr>
<tr>
<td>Meaningful Use</td>
<td>Loss of Incentive</td>
<td>All</td>
<td>10/1/12</td>
</tr>
<tr>
<td>HIPAA 5010</td>
<td>Denied Claims</td>
<td>All</td>
<td>10/1/12</td>
</tr>
<tr>
<td>ACA</td>
<td>All Must Comply</td>
<td>All</td>
<td></td>
</tr>
</tbody>
</table>
Health Care Finance is complicated due to:

- Each input is unique, therefore care delivery must be flexible (variable)
- Physician orders drive provision of care adding to that variability
- Payment is also variable depending on:
  - Insurance coverage
  - Negotiated Rates
  - Payer Mix
- Regulation is high
- Technology changes rapidly requiring intensive capital investment
- Many players in Health Care, from capital equipment vendors to Pharmaceutical companies to agency staffing making it difficult to control all aspects of Costs