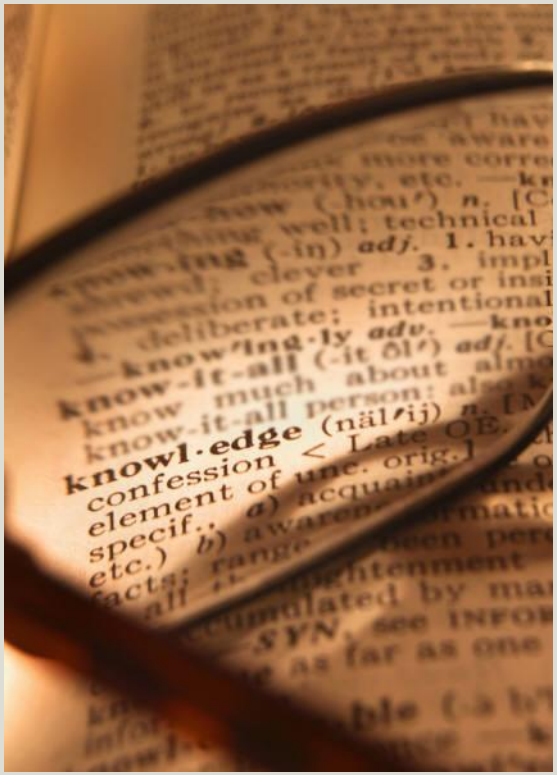
Health Care Finance 101



Ken Tonjes
CFO PeaceHealth Ketchikan Medical Center

June 20, 2013

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

Hospital Types

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**

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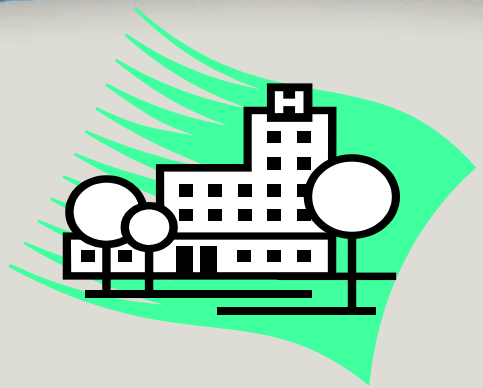
Hospital Organization Structures



- **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**

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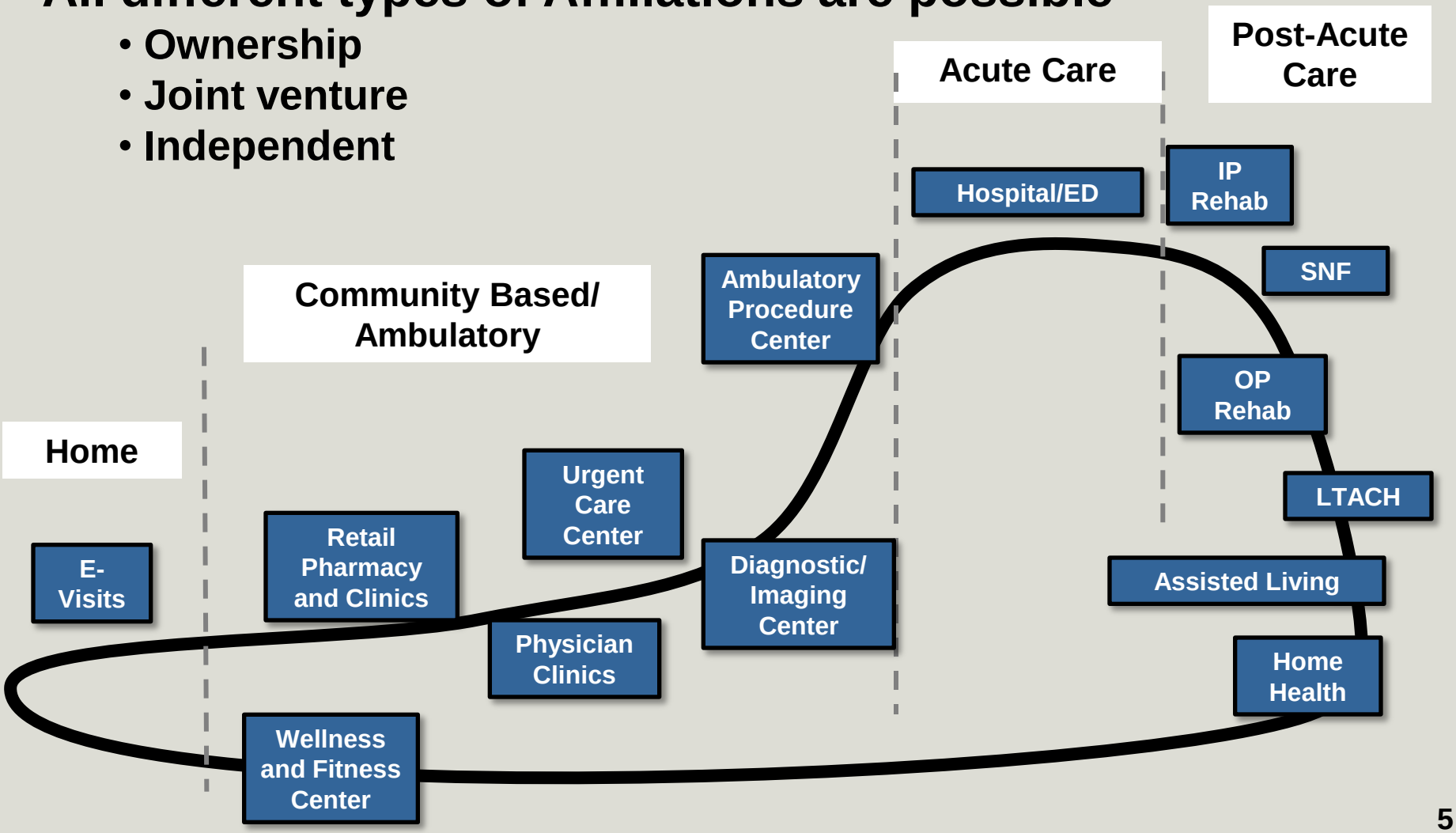
Health Care Providers

All different types of Affiliations are possible

- Ownership
- Joint venture
- Independent



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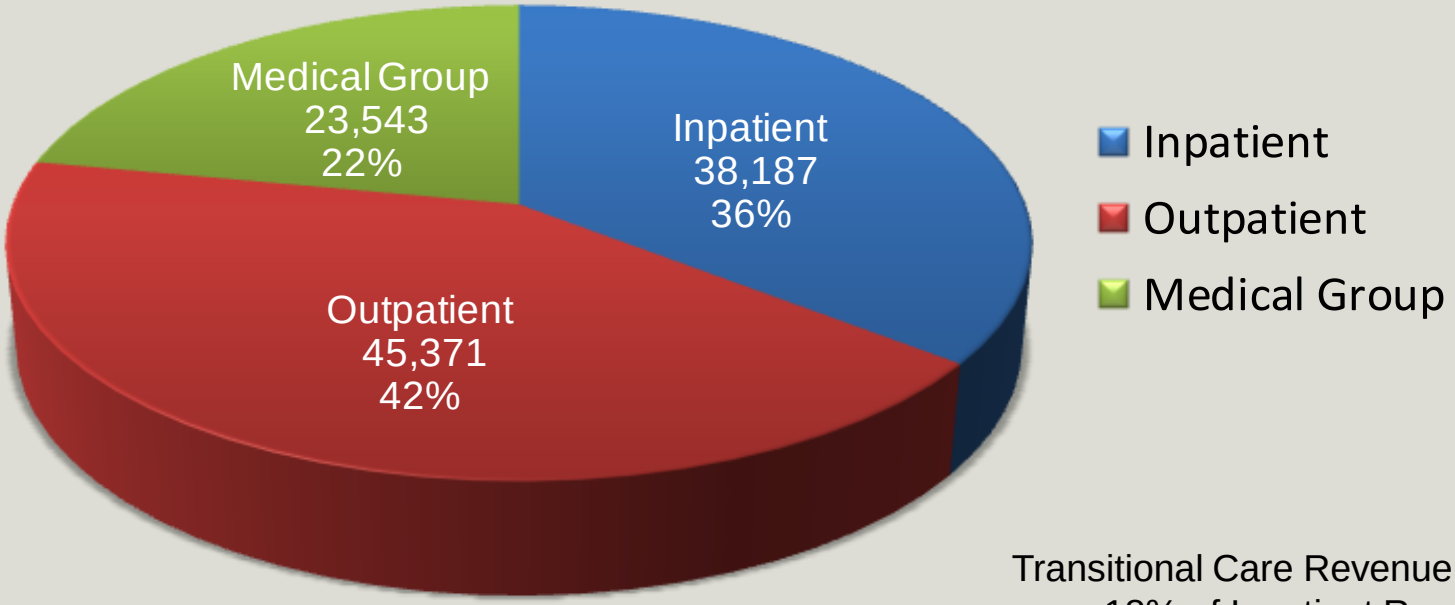
Health Care Revenue

Revenue Mix

Total Patient Service Revenue: $107,101
(000's Omitted)



Transitional Care Revenue makes up 18% of Inpatient Revenue

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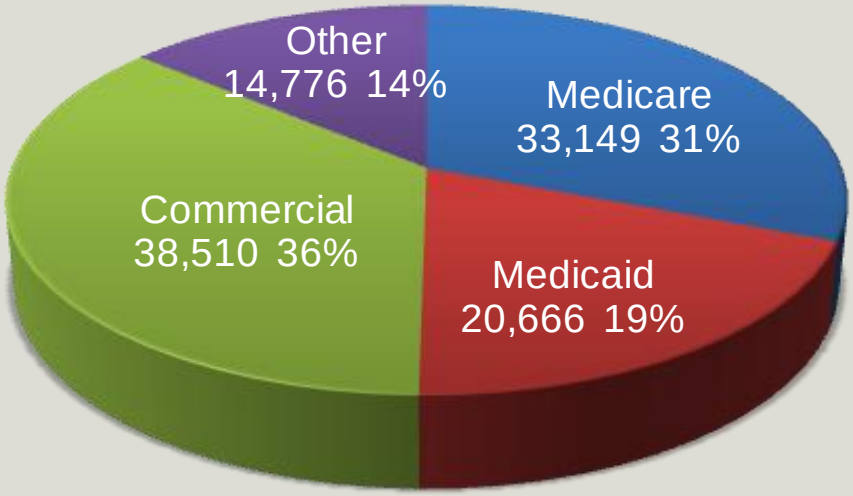
KMC Payer Mix and Payments

Gross Charges	=	107,101
Deductions	=	42,619
Payments	=	64,482

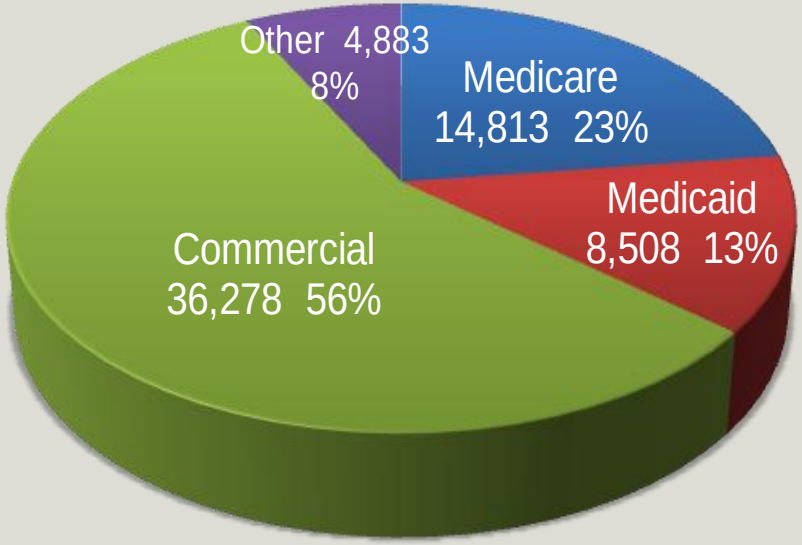
(000's omitted)

Deduction %	=	40%
Payment %	=	60%

Gross Revenue Payer Mix



Payments



Commercial makes up 36% of Gross Revenue yet accounts for 56% of Payments

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Hospital Price Setting

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

CPT	Description	RVU's		Conversion Factor		Price
73100	X-RAY EXAM OF WRIST	.92	✖	215	=	197.8

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

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

Market Based Adjustments

- Competition
- Payer Mix/Payer Contracts
- Loss Leaders

Theoretical – each procedure unique CF
Practical – overall CF applied, or hospital/Medical Group

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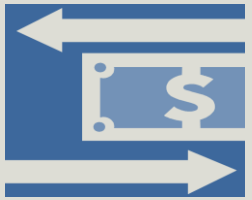
Colonoscopy

Procedure	Colonoscopy Alone	Total Charges For Colonoscopy
Colonoscopy W Or Wo Bx	1,020	4,717
Colonoscopy With Polypectomy	1,190	7,106

Procedure	Colonoscopy Alone	Ancillary Charges	Physician Fees	Anesthesia	Pathology
Colonoscopy W Or Wo Bx	1,020	1,879	395	1,198	225
Colonoscopy With Polypectomy	1,190	2,506	1,987	1,198	225

Ancillary Charges include: Recovery room, pharmacy, etc.

Cost Shifting



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)

Commercial Pays 3 times Medicare
to achieve margin of 2%

Service Mix

Negative Margins

- Medical Group
- Transitional Care Unit
- Home Health
- Intensive Care Unit
- Emergency Department
- Therapies

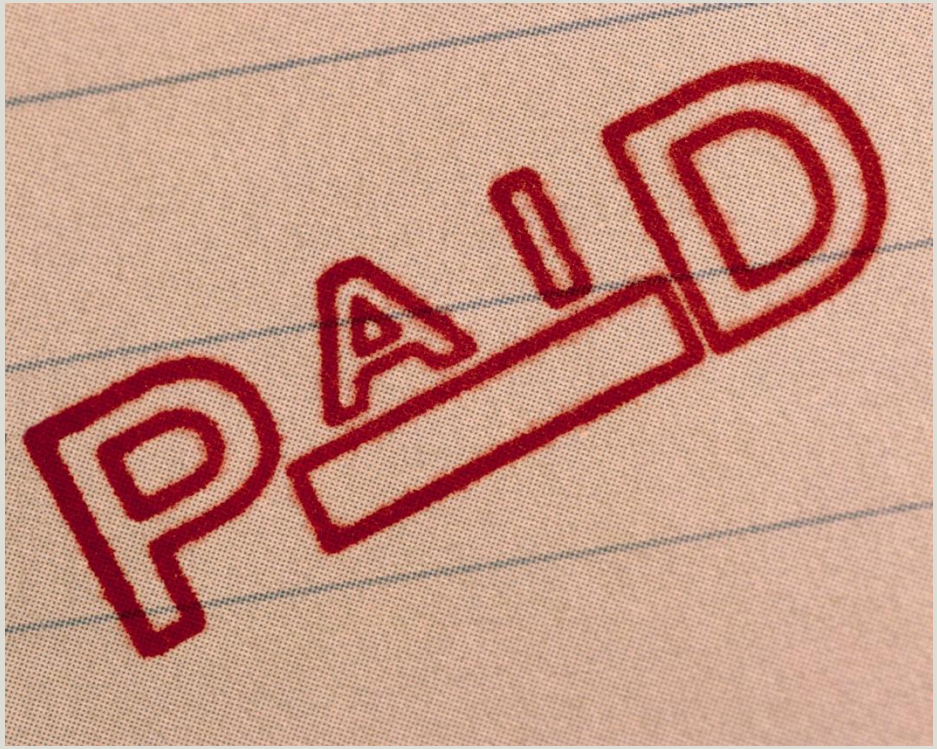
Positive Margins

+ 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



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Medicare Payment Methodologies
Quick Overview

Medicare
Hospital PPS

	Reimbursement Methodology		
Inpatient	DRG	Prospective Payment System	Relative Weight of DRG x Base Rate
Outpatient	APC	Prospective Payment System	

Critical Access Hospital

Inpatient	Cost	Calculated from Medicare Cost Report	
Outpatient	Cost	Calculated from Medicare Cost Report	

Sole Community Hospital

Inpatient	Cost	Calculated from Base year cost per discharge inflated forward	
Outpatient	APC	Prospective Payment System	

Skilled Nursing Facility	RUGS	Prospective Payment System	Per Discharge

Physician Clinics

Provider Based Clinics	Hospital Outpatient Departments	Follow methodology for Hospital Outpatient Type
Freestanding Clinics	Fee Schedule	

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Medicare - IP

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

CAH Reimbursement:

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

Contractual Adjustment = $5,580.32

SCH Reimbursement:

DRG Weight .9996
X
Hospital Specific Base Rate $7,478.14
=
$7,475.15

Contractual Adjustment = $8,606.85

PPS Reimbursement:

DRG Weight .9996
X
Base Rate $7,040.99
=
$7,038.17

Contractual Adjustment = $9,043.83

The DRG payment for a Medicare patient is determined by multiplying the relative weight for the DRG by the hospital's blended rate: DRG PAYMENT = WEIGHT x 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

Medicare - OP

CPT Based Payment: Outpatient Services (Imaging, PT, ED, etc)

CPT	Description	Charge Amount	PPS/SCH Payment	CAH Payment
93017	CARDIAC STRESS W/O INTERP	$ 375.70	$178.58	$ 180.34
A9579	NM MYO PERF W SPECT/WALL/EF	$2,186.10	$686.45	$1,049.33
TOTAL		**$2,561.80**	**$865.03**	**$1,229.67**
			APC Payment	Cost Reimbursement: Charge x RCC

The APC payment for a Medicare patient is determined by multiplying the relative weight for the APC by the adjusted conversion factor:

APC PAYMENT = WEIGHT x 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

HNPRDS13 ALASKA - MEDICARE CARRIER 02102 PAGE 145
FSY13 LOCALITY FEE SCHEDULE FOR AREA 01 DATE 01/09/13

NOTE	PROCEDURE	MOD	PAR AMOUNT	NON-PAR AMOUNT	LIMITING CHARGE	eRX LIMITING CHARGE***
	73100		37.38	35.51	40.84	40.23
	73100	TC	25.64	24.36	28.01	27.59
	73100	26	11.74	11.15	12.82	12.63

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%

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Medicaid Payment Methodologies

Medicaid

Hospital	Reimbursement Methodology		
Inpatient	Per Diem	Cost Based from Base year Medicare Cost Report	Rebased every four years 2011--> 2013-2016
Outpatient	% of Charges	Cost Based from Base year Medicare Cost Report	Rebased every four years 2011--> 2013-2016

Skilled Nursing Facility			
SNF	Per Diem	Cost Based from Base year Medicare Cost Report	Rebased every four years 2011--> 2013-2016

Physician Clinics	
Provider Based Clinics	Fee Schedule
Freestanding Clinics	Fee Schedule

Inpatient:

Medicaid Days
x
Per Diem
=
IP Medicaid Payment

Outpatient:

Charges
x
RCC
=
OP Medicaid Payment

Clinic:

Table I.(a) CPT [1] Fee Schedule

Procedure		Modifier	Alaska Fee
73100	**Global**		$47.84
73100	**Pro**	26	$15.33
73100	**Fac**	TC	$32.51

Commercial Payment Methodologies

Commercial Payers Pay Based on:

- Percentage of Charges
- Case Rate
- Fee Schedule
- Per Diem
- Capitated

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Health Care Costs

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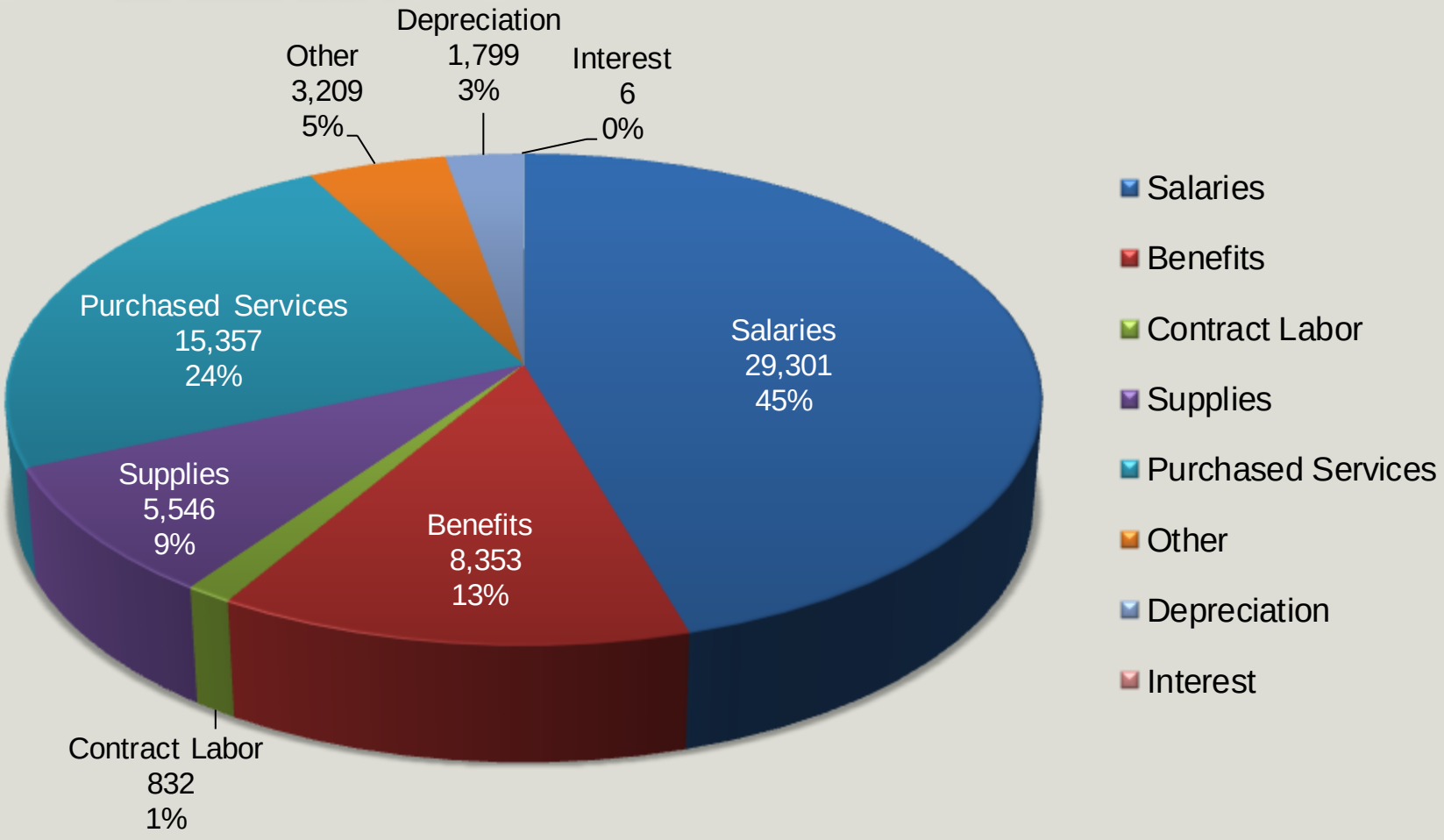
Operating Costs

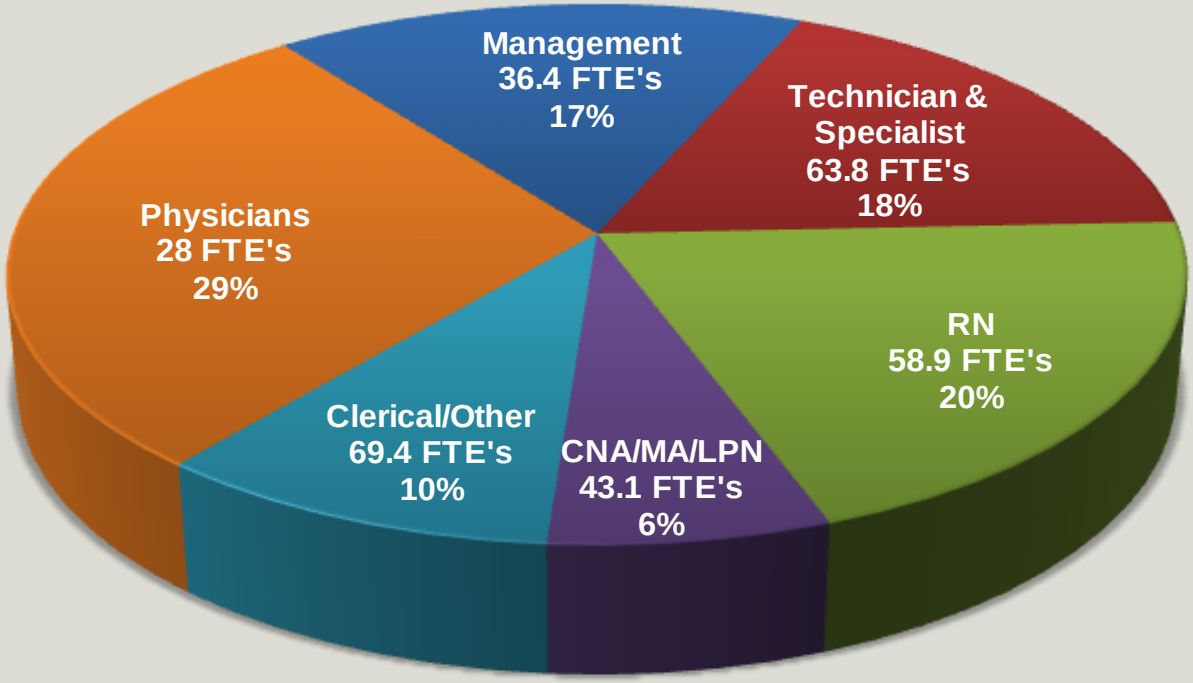


Labor Costs (Salaries, Benefits, and Contract Labor) = 59%

Labor Costs

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!

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

Cost Pressures

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)

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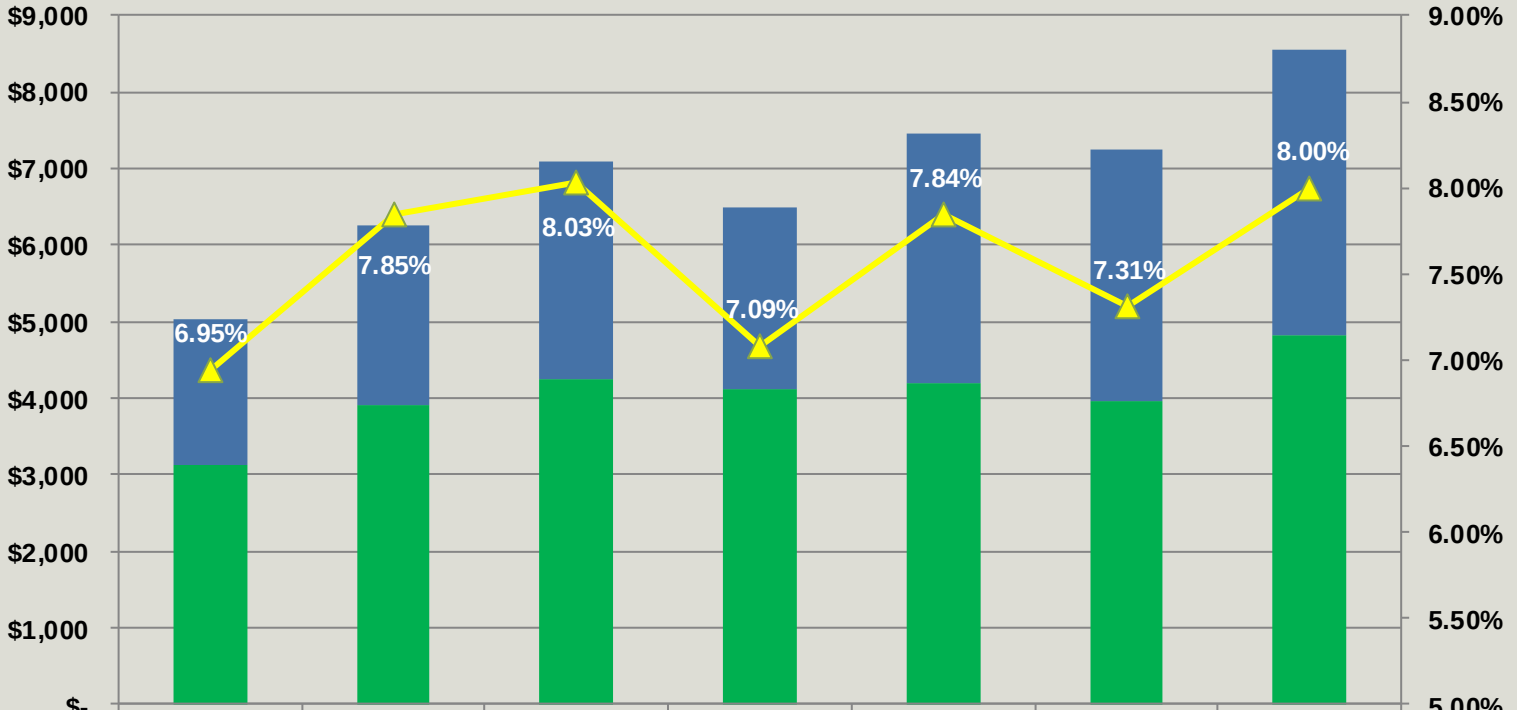
Bad Debt and Charity Trend



(000's omitted)	2008 Actual	2009 Actual	2010 Actual	2011 Actual	2012 Actual	2013 Projected	2014 Budget
Charity	$1,916	$2,350	$2,856	$2,360	$3,243	$3,280	$3,749
Bad Debt	$3,122	$3,914	$4,241	$4,129	$4,205	$3,964	$4,820
Total Uncomp Care	$5,038	$6,264	$7,097	$6,489	$7,449	$7,245	$8,568
% of Gross Charges	6.95%	7.85%	8.03%	7.09%	7.84%	7.31%	8.00%

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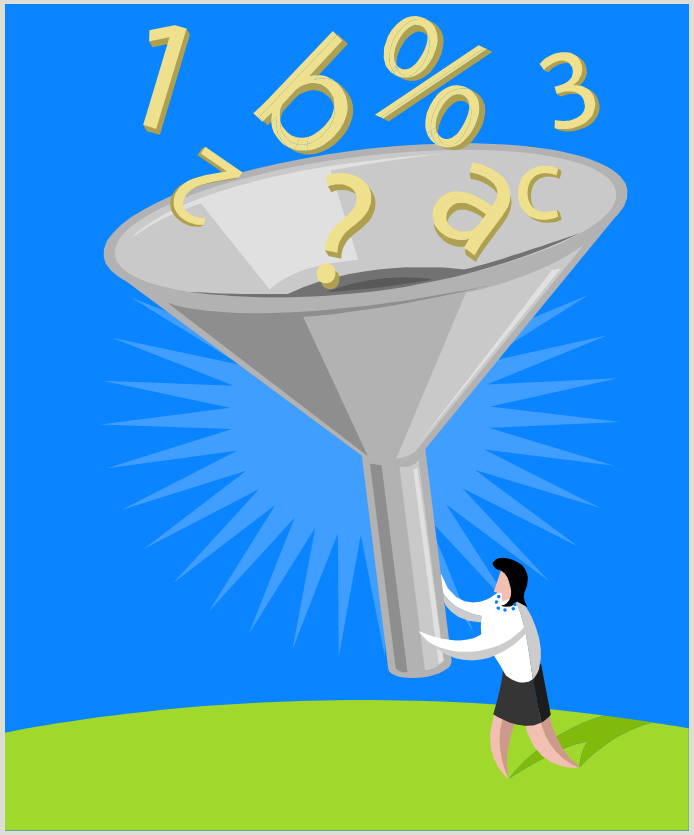
Other Information



Charge Master - What it is and What it Does

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

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Charge Master Common Elements

The core group of data elements that typically resides within a CDM are:

	Example:
• CDM numbers	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

Cost Report

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	**PPS/SCH**
Calculate Cost Based Reimbursement	• Bad Debt • Disproportionate Share • Medical Education

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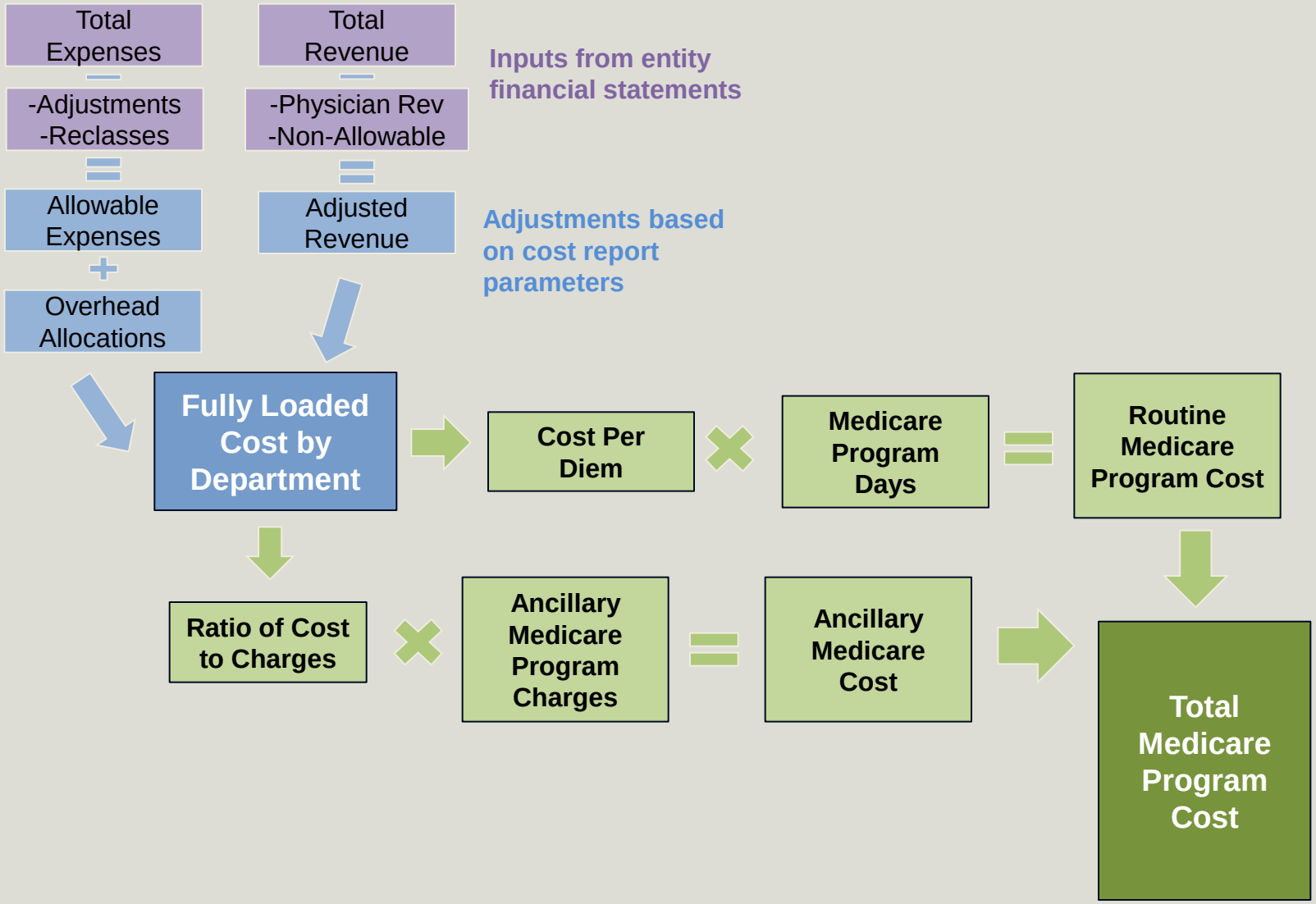
Cost Report Flow Chart



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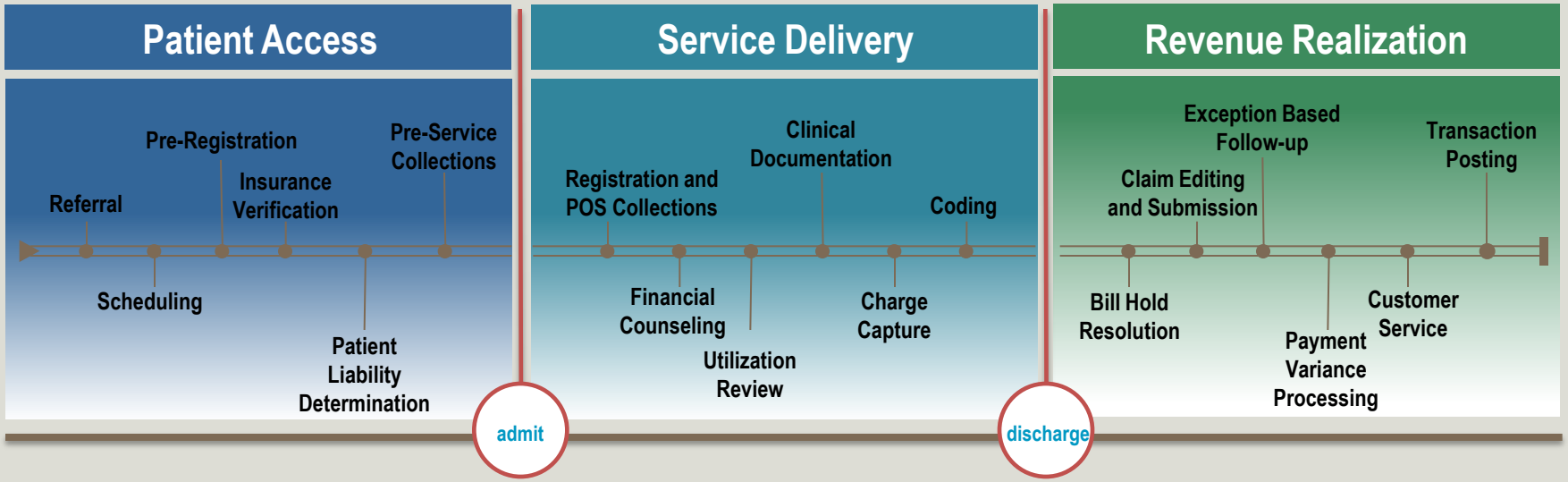
Revenue Cycle



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Trends Influencing Health Care

Trend	Penalty	Hospitals Impacted	Date
ICD-10	Requirement 10/1/14	All	10/1/14
Inpatient Quality Reporting	2%	IPPS	FY12
OP Quality Reporting	2%	OPPS	FY12
Value Based Purchasing	2%	IPPS	1% FY13→2%FY17
Hospital Acquired Conditions /Present on Admission	1%	IPPS	1% FY15
Readmissions	3%	IPPS	FY13, 3 Year Phase-In
Meaningful Use	Loss of Incentive	All	10/1/12
HIPAA 5010	Denied Claims	All	10/1/12
ACA	All Must Comply	All	

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Presentation Summary

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