

Introduction to Healthcare Accounting, Governance, and Financial Statements



Case 1.1: Blue Sky

Key concept: The role of accounting in healthcare

Jessica Nelson has an undergraduate degree in psychology from a fine university where the sky is always blue. Because of her interest in doing good deeds and helping society, she is considering a career as a hospital administrator and has been exploring the possibility of obtaining a master in health administration degree from a prestigious university near the beach. While studying the degree requirements, which were posted online, she noticed that one of the required courses was “Healthcare Accounting.”

Jessica has never had any business courses, does not know any accounting, and cannot quite understand why a hospital administrator would need to know accounting. She thinks a hospital administrator’s efforts should be focused on patient care.

You can help Jessica by explaining a number of concepts to her.

Questions

1. What parties are responsible for hiring the top management (e.g., CEO, CFO) of a hospital?
2. What is a major, regular source of financial information that the parties responsible for hiring a hospital’s top management receive at their periodic meetings?

3. What types of information are contained in financial statements prepared under generally accepted accounting principles (GAAP)?

4. Who are some other individuals who might want to use the information in the financial statements?

5. What specific decisions might the individuals you identified in the previous question make based at least partly on GAAP-based financial statements?

6. How would external reporting of GAAP-based financial statements differ for a nonprofit hospital compared to a for-profit hospital?

7. Name at least two government regulators who could demand financial information from a hospital, either nonprofit or for-profit.
8. A famous quote in healthcare circles is, “No Margin, No Mission.” What does this statement mean, and how does it connect to healthcare accounting?

Case 1.2: Health Diagnostic Laboratory Inc.

Note: Although most cases in this book are based on fictitious organizations and individuals, this case is based on a real healthcare entity.

Key concept: Regulation in healthcare—Anti-Kickback Statute, Stark Law, and corporate integrity agreements

Healthcare providers must comply with both the Anti-Kickback Statute (42 USC § 1320a-7b(b)) and the Stark Law (42 USC § 1395nn).

The Anti-Kickback Statute prohibits offering, paying, or receiving anything of value (“remuneration”) to induce or reward referrals from anyone or to generate federal healthcare program business. Penalties for knowing and willful violations (intent must be proven) can include prison time or civil penalty assessments. However, a number of “safe harbors” protect certain payments and other business practices that could otherwise fall under this statute.

The Stark Law prohibits physicians from referring Medicare patients for health services to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies. It also prohibits the health services entity from submitting claims to Medicare for services resulting from a prohibited referral. Proof of intent to violate the law is not necessary.

Payment of kickbacks or referral fees in healthcare can lead to undesirable outcomes such as

- unfair competition,
- overutilization of services,
- impairment of medical decision making, and
- steering of patients to particular providers.

Health Diagnostic Laboratory Inc. (HDL) was incorporated as a startup company in late 2008 by individuals who had formerly worked for Berkeley HeartLab Inc. It built a business selling blood tests that measure “biomarkers” to help doctors predict heart disease and diabetes (Carreyrou and McGinty 2014).

HDL grew rapidly, collecting \$139 million from Medicare in 2012 and \$157 million from Medicare in 2013. The company dominated the market for certain types of blood tests. For example, in 2012 it received \$11.9 million from Medicare for a lab procedure to separate blood particles based on their electric charge—accounting for 93 percent of Medicare’s payments for the procedure. The rest of the lab industry received only \$0.85 million (7 percent of payments) for the blood particle electric charge test (Carreyrou 2014).

HDL was financially successful, as evidenced by the fact that its 16 stockholders received a total of \$119 million between 2011 and 2013, with about \$50 million of that going to the three cofounders. Because HDL is a Subchapter S corporation under US tax laws, the tax liability is paid by the shareholders and amounted to about \$71 million of the \$119 million (Carreyrou 2015).

Until June 2014, HDL paid \$20 per blood sample to doctors ordering its lab tests. The company stopped these payments after a June 25, 2014, special fraud alert from the US Department of Health and Human Services. The department warned that the payments represented “a substantial risk of fraud and abuse under the Anti-Kickback Statute” (Carreyrou and McGinty 2014).

HDL argued that its \$20 fee fairly compensated doctors for the labor cost involved in drawing and handling blood. However, Medicare only pays \$3 for each blood draw; the \$20 fee was \$17 more than the Medicare reimbursement.

The legality of the \$20 fee revolves around the following “safe harbor” exception to the federal Anti-Kickback Statute (§ 1001.952 (d)(5)):

The aggregate compensation paid to the agent over the terms of the agreement is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid, or other Federal health care programs.

The key phrase is “fair market value” for the compensation paid. What is fair market value for drawing a blood sample? What is fair market value for processing and handling of the blood sample (e.g., vial labeling, cooling, shipment coordination) to ship it off to the lab? An HDL spokesperson cited a time and motion study conducted by HDL that valued the processing and handling tasks at \$17.

Apparently, as part of a widespread industry practice, other labs in the industry also paid fees to doctors for blood samples drawn (Carreyrou and McGinty 2014):

- Berkeley HeartLab \$7.50 to \$11.50 (including \$3 fee)
- Singulex Inc. \$10 (excluding \$3 fee)
- Boston Heart Diagnostics \$15 (excluding \$3 fee)
- Atherotech Diagnostics Lab \$10 (\$3 fee status not disclosed)

To the extent that the reimbursements were above actual cost, the fees could give physicians a financial incentive to order unnecessary tests. It was alleged that “some physician practices send HDL more than 5,000 blood samples a year for testing, which would have earned them more than \$100,000 in annual sample fees” (Husten 2015).

In March 2015, HDL denied any wrongdoing but entered into a five-year corporate integrity agreement (CIA) with the Department of Health and Human Services (HHS) Office of Inspector General.

According to the Office of Inspector General (2015), “A comprehensive CIA typically lasts five years and includes requirements to:

- hire a compliance officer/appoint a compliance committee;
- develop written standards and policies;
- implement a comprehensive employee training program;
- retain an independent review organization to conduct annual reviews;
- establish a confidential disclosure program;
- restrict employment of ineligible persons;
- report overpayments, reportable events, and ongoing investigations/legal proceedings; and
- provide an implementation report and annual reports to OIG on the status of the entity’s compliance activities.”

References

- Carreyrou, J. 2015. “Lab Reaches Tentative Deal with Government over Doctor Payments.” *Wall Street Journal*. Published March 23. www.wsj.com/articles/lab-reaches-tentative-deal-with-government-over-doctor-payments-1427144514.
- . 2014. “Health Diagnostic Laboratory CEO Resigns.” *Wall Street Journal*. Published September 23. www.wsj.com/articles/health-diagnostic-laboratory-ceo-to-step-down-1411500521.
- Carreyrou, J., and T. McGinty. 2014. “Medicare Unmasked: A Fast-Growing Medical Lab Tests Anti-Kickback Law.” *Wall Street Journal*. Published September 8. www.wsj.com/articles/a-fast-growing-medical-lab-tests-anti-kickback-law-1410143403.
- Husten, L. 2015. “More Turmoil for Troubled Medical Laboratory Company.” *Forbes*. Published January 12. www.forbes.com/sites/larryhusten/2015/01/12/more-turmoil-for-troubled-medical-laboratory-company/.
- Office of Inspector General, US Department of Health and Human Services. 2015. “Corporate Integrity Agreements.” Accessed March 24. <http://oig.hhs.gov/compliance/corporate-integrity-agreements/index.asp>.

Questions

1. Is the Medicare \$3 reimbursement for a blood draw the “fair market value”? Why or why not?
2. Is a time and motion study a reasonable way to determine the cost of processing and handling blood samples?
3. What are other ways to determine “fair market value”?
4. Do you think a \$20 reimbursement for drawing, processing, and handling blood samples is a “kickback” that does not meet the “safe harbor” provisions of the Anti-Kickback Statute? Why or why not?

5. What are some possible factors that may have influenced HDL in agreeing to an HHS “corporate integrity agreement”?

6. Locate the March 31, 2015, HDL “corporate integrity agreement” at the HHS website (<https://oig.hhs.gov/compliance/corporate-integrity-agreements/cia-documents.asp>). What are the most restrictive provisions?

Case 1.3: High Coastal Hospital Post-Acute Care

Key concept: Transitioning patients from acute care and healthcare regulation by CMS

You are an MHA (Master of Health Administration) fellow working in the CEO's office at High Coastal Hospital, a 500-bed acute-care not-for-profit hospital in a large, southeastern coastal city. Three other competing hospitals are in the immediate region. Two of these hospitals are not-for-profit, and one is a for-profit subsidiary of a large national corporation. High Coastal Hospital operates a wide range of physician practices outside the hospital in the local community. The hospital has had a positive yearly operating surplus for the last several years, but the amount has been steadily declining as the government continues to cut reimbursements.

Dr. Richard Thomas, CEO of High Coastal Hospital, previously hired a national consulting firm to study the hospital's current status and to recommend a methodology for improving post-acute care transitions. His interest in this area was heightened by recent changes in the Centers for Medicare & Medicaid Services' (CMS) Hospital Readmissions Reduction Program, which penalizes hospitals that have patients return, unplanned, within 30 days of discharge for certain conditions. Many readmissions are the result of hospital-acquired infections, medical errors, or inadequate care. Because readmissions are a substantial revenue stream for some hospitals, CMS wanted to remove any financial incentives for substandard care. The CMS changes increased the Medicare payment penalty to as much as 3 percent and expanded the number of conditions included in the program to the following five:

- Heart failure
- Heart attack
- Pneumonia
- Chronic lung problems such as emphysema and bronchitis
- Elective hip and knee replacements

Dr. Thomas was concerned about the post-acute care area because the penalty will be applied prospectively and hospitals will not know the exact amount of lost dollars until the end of the federal fiscal year. He was also concerned that CMS will likely add other conditions to the program in the future.

The post-acute care technology and benefits in this area are summarized in the following table:

Goals	Technologies	Benefits
<ul style="list-style-type: none"> • Medication adherence • Medication reconciliation • Remote patient monitoring • Personal health information • Social support • Remote training and supervision 	<ul style="list-style-type: none"> • Medication reminders and dispensers • Medication list software • In-home diagnostic devices • Problem-detection algorithm • Videoconferencing • Social networks 	<ul style="list-style-type: none"> • Reduced hospitalizations • Increased patient satisfaction • Reduced costs • Improved health • Increased quality of life

Source: Center for Technology and Aging (2010).

The consulting firm recommended that High Coastal Hospital implement either a Care Transition Intervention (commonly called CTI, or the “Coleman model”), lasting one month, or the Transitional Care Model (commonly called TCM, or the “Naylor model”), lasting from one to three months. The estimated cost of the first intervention was \$200 per patient, and the estimated cost of the second intervention was \$1,000 per patient (Center for Technology and Aging 2010). The consulting firm stated that personnel implementing either model would benefit from having videoconferencing capability with patients after discharge, and the firm recommended that the hospital add videoconferencing capability to their discharge follow-up under either model.

The Care Transition Intervention involves the use of a transition coach to help patients and families learn transition-specific self-management skills. It consists of a hospital visit, a home visit one to three days after discharge, and at least three follow-up phone calls to reinforce coaching previously offered. The transition coach receives only one day of training.

The Transitional Care Model involves an advanced-practice nurse who visits the patient in the hospital, conducts a home visit within 24 hours of discharge, accompanies the patient on her first postdischarge visit with the physician, conducts weekly home visits for the first month, provides active engagement, and facilitates communication with the patient, family caregivers, and healthcare providers.

A large-scale study by the Veterans Administration found that a home telehealth program led to a 20 percent reduction in number of readmissions. The Veterans Administration telehealth program cost \$1,600 per patient per year.

Dr. Thomas is aware that High Coastal Hospital faces significant financial risk due to poor post-acute care processes. For example, the hospital currently has an average 16.6 percent rate of readmission within 30 days for the five conditions on which CMS is focusing. The conditions are broken down as follows:

Condition	ICD-9-CM Code	Number of Eligible Patient Discharges	Number of 30-Day Readmissions	Risk-Adjusted Predicted Readmission Percentage	Expected Readmission Percentage (hospital actual case mix applied to national hospital data readmission rates)	Excess Readmission Ratio	Average Hospital Charge	National Crude Readmission Rate
Heart failure (HF)	428	915	215	23.5%	21.5%	1.0744	\$28,120	22.6%
Heart attack (acute myocardial infarction) (AMI)	410	749	163	21.8%	16.3%	1.3435	\$29,168	17.4%
Pneumonia (PN)	486	296	155	52.4%	15.0%	3.4533	\$17,199	17.4%
Chronic obstructive pulmonary disease (COPD)	490	330	33	10.0%	19.7%	0.5178	\$26,266	20.7%
Total hip and/or total knee arthroplasty (THA/TKA)	436	400	15	3.8%	8.2%	0.4268	\$36,121	5.4%

Dr. Thomas is also aware that the hospital's postdischarge follow-up is currently fragmented and uncoordinated, with approximately 50 percent of patients receiving no significant follow-up. Dr. Thomas wants a major improvement in this area so the hospital will stay in line with the national trend of decreased readmissions (see www.medicare.gov/hospitalcompare/readmission-reduction-program.html).

Dr. Thomas likes the idea of either the transition coach or advanced-practice nurse having videoconferencing capability with the patient, and he wants to pursue costing out this concept, along with the two recommended approaches, for the next board of directors meeting. He thinks that loaning patients an iPhone 6 for 30 days after discharge would be an innovative and cost-effective way to accomplish this objective. You check out this possibility and discover that the hospital could lease the iPhones with a 5-gigabyte data plan for \$150 per month.

At Dr. Thomas's request, you have researched the CMS methodology for computing the Readmissions Reduction Program penalty. You found that the methodology for estimating the penalty works as follows (Centers for Medicare & Medicaid Services 2016):

Excess readmission ratio = risk-adjusted predicted readmissions / risk-adjusted expected readmissions

Aggregate payments for excess readmissions = [sum of base operating DRG payments for AMI × (excess readmission ratio for AMI – 1)] + [sum of base operating DRG payments for HF × (excess readmission ratio for HF – 1)] + [sum of base operating DRG payments for PN × (excess readmission ratio for PN – 1)] + [sum of base operating DRG payments for COPD × (excess readmission ratio for COPD – 1)] + [sum of base operating payments for THA/TKA × (excess readmission ratio for THA/TKA – 1)]

Note: If a hospital's excess readmission ratio for a condition is less than / equal to 1, then there are no aggregate payments for excess readmissions for that condition included in this calculation.

Aggregate payments for all discharges = sum of base operating DRG payments for all discharges

Ratio = 1 – (aggregate payments for excess readmissions / aggregate payments for all discharges)

Readmissions Adjustment Factor = for FY 2013, the higher of the Ratio or 0.99 (1% reduction); for FY 2014, the higher of the Ratio or 0.98 (2% reduction); for FY 2015, the higher of the Ratio or 0.97 (3% reduction)

Note: AMI = acute myocardial infarction; COPD = chronic obstructive pulmonary disease; DRG = diagnosis-related group; HF = heart failure; PN = pneumonia; THA = total hip arthroplasty; TKA = total knee arthroplasty.

References

- Centers for Medicare & Medicaid Services. 2016. "Readmissions Reduction Program." Revised January 15. www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html.
- Center for Technology and Aging. 2010. "Technologies for Improving Post-Acute Care Transitions." September 2010 discussion draft. www.techandaging.org/PACTdraftPositionPaper.pdf.

Assignments

1. Assume the CMS reimbursement is 40 percent of the average High Coastal Hospital charge, and compute the estimated CMS Hospital Readmissions Reduction Program penalty that High Coastal Hospital faces. Consult the CMS website or other sources as necessary to help you with this computation.

2. Compute the cost of implementing either the Care Transition Intervention or the Transitional Care Model, assuming that all discharges in the five categories will participate in a transition program. Assume an iPhone 6 with "FaceTime" features will be issued to each CTI patient for a 30-day period after discharge and to each TCM patient for a 90-day period after discharge.

