

## HEALTHCARE FINANCE BASICS

### Learning Objectives

After studying this chapter, readers will be able to

- Describe the organization of this book and the learning aids contained in each chapter.
- Define the term *healthcare finance* as it is used in this book.
- Describe the key characteristics of a business.
- Discuss the structure of the finance department, the role of finance in health services organizations, and how this role has changed over time.
- Describe the major players in the health services sector.
- List the key operational issues currently faced by healthcare managers.
- Describe the forms of business organization and corporate ownership and their organizational goals.
- Discuss the key elements of healthcare reform and its expected effect on the provision of health services.

### Introduction

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

## Before You Begin

Before you begin the study of healthcare finance, here are a few tips about the book that will make the process easier.

### *Purpose of the Book*

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

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

Second, because this book is introductory, it contains a broad overview of healthcare finance. The good news is that the book presents virtually all the important healthcare finance principles used by managers in health services organizations. The bad news is that the large number of topics covered prevents us from covering principles in great depth or from including a wide variety of illustrations. Thus, students who use this book are not expected to fully understand every nuance of every finance principle and practice that pertains to every type of health services organization. Nevertheless, this book provides sufficient coverage of healthcare finance concepts so that readers will be better able to function as managers, judge the quality of financial analyses performed by others, and incorporate sound principles and practices into their own personal finance decisions.

Naturally, an introductory finance book cannot contain everything that healthcare financial managers must know to competently perform their jobs. Nevertheless, the book is useful even for those working in finance positions within health services organizations because it presents an overview of

the finance function. Often, when working in a specific area of finance, it is easy to lose sight of the context of the work. This book will help provide that context.

### ***Organization of the Book***

To ensure that this book meets its goals, the destination has been carefully charted: to provide an introduction to healthcare finance. The book is organized into the following parts to pave the road to this destination.

Part I, *The Healthcare Environment*, contains fundamental background material that is essential to the practice of healthcare finance. Part I introduces the book, provides insights into the unique nature of the health services field, and provides additional information on how healthcare providers obtain their revenues. Healthcare finance cannot be studied in a vacuum because the practice of finance is profoundly influenced by the economic and social environment of the field, including the different types of ownership and reimbursement methods.

Part II, *Financial Accounting*, begins the actual discussion of healthcare finance principles and practices. Financial accounting, which involves the creation of statements that summarize a business's financial status, is most useful for outsiders and for long-term planning and management. In this part, we discuss the format and interpretation of the four primary financial statements and provide an overview of the double-entry accounting system used to record financial accounting transactions.

Part III, *Managerial Accounting*, which consists of four chapters, focuses on the creation of data used in the day-to-day management and control of a business. Here, the emphasis is on the overall organization, before shifting to the subunit (department) level and then to the individual service level. The key topics in part III include costing methods and behavior, profit planning, cost allocation, pricing decisions, and financial planning and budgeting.

In part IV, *Basic Financial Management Concepts*, the focus moves from accounting to financial management. In the first of two chapters, we cover time value analysis, which provides techniques for valuing future cash flows. In the second chapter, we discuss financial risk and required return. Taken together, these chapters provide readers with knowledge of two of the most important concepts used in financial decision-making.

Part V, *Long-Term Financing*, turns to the capital acquisition process. Businesses need capital, or funds, to purchase assets, and this part examines the two primary types of financing—long-term debt and equity. In addition, the final chapter of part V provides the framework for analyzing a business's appropriate financing mix and assessing its cost.

Part VI, Capital Investment Decisions, considers the vital topic of how businesses analyze new capital investment opportunities (capital budgeting). Because major capital projects take years to plan and execute, and because these decisions generally are not easily reversed and will affect operations for many years, their impact on the future of an organization is profound. The two chapters in this part first focus on basic capital investment analysis concepts and then turn to project risk assessment and incorporation.

Part VII, Other Topics, covers two diverse topics. The first chapter in this part discusses the revenue cycle and the management of short-term assets, such as cash and inventories, as well as how such assets are financed. The techniques used to analyze a business's financial and operating condition are discussed in the book's final chapter. These topics are presented last because students may benefit from an overview of the other concepts in the book before embarking on these chapters. However, instructors may also choose to combine these chapters with other parts of the book. For example, chapter 16, Revenue Cycle and Current Accounts Management, may be taught near the chapters in part V as this would present students with a picture of the management of short-term versus long-term accounts. Chapter 17, Financial Condition Analysis, may be taught with the financial accounting chapters in part II since much of the chapter involves the analysis of financial accounting data.

Health services managers must be able to assess the current financial condition of their organizations. Even more important, managers must be able to monitor and control current operations and assess ways in which alternative courses of action will affect the organization's future financial condition.

### ***How to Use This Book***

As mentioned earlier, this book is designed to introduce students to healthcare finance. It contains several features designed to make the process as easy as possible.

First, pay particular attention to the *Learning Objectives* listed at the beginning of each chapter. These objectives highlight the most important topics in each chapter and identify readers' learning goals for the chapter.

Following each major section in a chapter (except the chapter's introduction), one or more *Self-Test Questions* are included. As you finish reading each major section, try to answer these questions. Your responses do not have to be perfect, but if you are not satisfied with your answer, reread the section before proceeding. Answers are not provided for the self-test questions, so a review of the section is necessary if you are not sure whether your answers are satisfactory.

It is useful for readers to have important equations both embedded in the text to illustrate their use and broken out separately for easy identification and review. The *Key Equation* boxes can be used for both section and chapter review and as an aid to solving the end-of-chapter problems. The book contains several additional types of boxes, such as *For Your Consideration* and *Healthcare in Practice* boxes. Each of these boxes presents an important issue that is relevant to the text discussion and allows readers to pause to think about the issue presented, generate opinions, and draw conclusions. Many instructors use these boxes to stimulate in-class discussions.

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

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

Some chapters conclude with a set of *Selected Cases* from *Gapenski's Cases in Healthcare Finance*, sixth edition, that illustrate practical applications of healthcare finance. Additionally, each chapter includes a set of *Resources*. The books and articles cited can provide a more in-depth understanding of the material covered in the chapter. Finally, some chapters contain a *Chapter Supplement*, whose purpose is to present additional information pertaining to topics in the chapter that is useful but not essential.

Taken together, the pedagogic structure of the book is designed to make learning healthcare finance as easy and enjoyable as possible.

1. Why is it necessary to have a book dedicated to healthcare finance?
2. What is the purpose of this book?
3. Briefly describe the organization of this book.
4. What features of this book are designed to make learning easier?

## SELF-TEST QUESTIONS

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## Defining Healthcare Finance

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

We began by examining the *healthcare sector* of the economy, which consists of a diverse collection of subsectors that involve, either directly or indirectly, the healthcare of the population. The major subsectors of healthcare include the following:

### provider

An organization that provides healthcare services (treats patients).

- **Health services.** The health services subsector consists of **providers** of health services, including medical practices, hospitals, nursing homes, home health care agencies, and hospice providers.
- **Health insurance.** The health insurance subsector, which makes most of the payments to health services providers, includes government programs, commercial insurers, and self-insurers. Also included here are managed care companies, such as health maintenance organizations (HMOs), which incorporate both insurance and health services (provider) functions.
- **Medical equipment and supplies.** These subsectors include the makers of diagnostic equipment, such as X-ray machines; durable medical equipment, such as wheelchairs; and expendable medical supplies, such as disposable surgical instruments and hypodermic syringes.
- **Pharmaceuticals and biotechnology.** These subsectors develop and market drugs and other therapeutic products.
- **Other.** This broad category includes organizations such as consulting firms that advise hospitals on strategy and operations, educational institutions that train providers and healthcare managers, government agencies that regulate various health services subsectors, and private agencies that provide a wide variety of services.

Most users of this book will become (or already are) managers at health services organizations or at companies such as insurance and consulting firms that deal directly with health services organizations. Thus, to give this book the most value to its primary users, we focus on finance as it applies within the health services subsector.

Now that we have defined the healthcare focus of this book, the term *finance* must be defined. Finance, as the term is used within health services organizations and as it is used in this book, consists of both the accounting and financial management functions. (In many settings, accounting and financial management are separate disciplines.) **Accounting**, as the term

### accounting

The field of finance that involves the measuring and recording of events, in dollar terms, that reflect an organization's operational and financial status.

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implies, is concerned with the recording, in financial terms, of economic events that reflect the operations, resources, and financing of an organization. In general, the purpose of accounting is to create and provide to interested parties, both internal and external, useful information about an organization's operations and financial status.

Whereas accounting provides a rational means by which to measure a business's financial performance and assess operations, **financial management** provides the theory, concepts, and tools necessary to help managers make better financial decisions. Of course, the boundary between accounting and financial management is blurry; certain aspects of accounting involve decision-making, and much of the application of financial management theory and concepts requires accounting data.

**financial management**  
The field of finance that provides the theory, concepts, and tools used by healthcare managers to make financial decisions.

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

### SELF-TEST QUESTIONS

## The Concept of a Business

This book focuses on finance as it is practiced within health services businesses, so it is reasonable to ask, What is a *business*?

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

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

### For Your Consideration

#### Businesses, Pure Charities, and Government Entities

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

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

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

Businesses are also different from *government agencies* such as local public health departments. In general, government agencies do not receive revenues by selling services or soliciting contributions. Rather, their revenues are derived from taxing the populations that benefit from the government services, so providing additional services typically uses resources without generating additional income. Thus, like a pure charity, a government agency has a budget that is fixed, but by appropriations rather than by contributions.

### SELF-TEST QUESTIONS

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

## The Role of Finance in Health Services Organizations

The primary role of finance in health services organizations, as in all businesses, is to plan for, acquire, and use resources to maximize the efficiency and value of the organization. As we discuss in the next section, the two broad areas of finance—accounting and financial management—are separate functions in larger organizations, although the accounting function usually

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is carried out under the direction of the organization's chief financial officer and hence falls under the overall category of finance.

In general, finance activities include the following:

- **Planning and budgeting.** First and foremost, healthcare finance involves evaluating the financial effectiveness of current operations and planning for the future. **Budgets** play an important role in this process.
- **Financial reporting.** For a variety of reasons, it is important for businesses to record and report to outsiders the results of operations and current financial status. This is typically accomplished by a set of **financial statements**.
- **Capital investment decisions.** Although capital investment is typically handled by senior management, managers at all levels must be concerned with the capital investment decision-making process. Decisions that result from this process, which are called **capital budgeting** decisions, focus on the acquisition of land, buildings, and equipment. They are the primary means by which businesses implement strategic plans, and hence they play a key role in an organization's financial future.
- **Financing decisions.** All organizations must raise **capital** to buy the assets necessary to support operations. Such decisions involve the choice between internal and external funds, the use of debt versus equity capital, the use of long-term versus short-term debt, and the use of lease versus conventional financing. Although senior managers typically make financing decisions, these decisions have ramifications for managers at all levels.
- **Revenue cycle and current accounts management.** Revenue cycle management includes the billing and collections function, while current accounts management involves the organization's short-term assets, such as cash and inventories, and short-term liabilities, such as accounts payable and debt. Such functions and accounts must be properly managed both to ensure operational effectiveness and to reduce costs. Generally, managers at all levels are involved to some extent in revenue cycle and current accounts management.
- **Contract management.** In today's healthcare environment, health services organizations must negotiate, sign, and monitor contracts with managed care organizations and third-party payers. The financial staff typically has primary responsibility for these tasks, but managers at all levels are involved in these activities and must be aware of their effects on operating decisions.
- **Financial risk management.** Many financial transactions that take place to support the operations of a business can themselves increase

### **budget**

A detailed plan, in dollar terms, of how a business and its subunits will acquire and use resources during a specified period of time.

### **financial statements**

Statements prepared by accountants that convey the financial status of an organization. The four primary statements are the income statement, balance sheet, statement of changes in equity, and statement of cash flows.

### **capital budgeting**

The process of analyzing and choosing new long-term assets such as land, buildings, and equipment.

### **capital**

The funds raised by a business that will be invested in assets, such as land, buildings, and equipment that support the organizational mission.

the business's risk. Thus, an important finance activity is to control financial risk.

#### four Cs

A mnemonic for the four basic finance activities: costs, cash, capital, and control.

#### cost

A resource use associated with providing or supporting a specific service.

These specific finance activities can be summarized by the **four Cs**: costs, cash, capital, and control. The measurement and minimization of **costs** is vital to the financial success of any business. *Cash* is the “lubricant” that makes the wheels of a business run smoothly—without it, the business grinds to a halt. *Capital* represents the funds used to acquire land, buildings, and equipment. Without capital, businesses would not have the physical resources needed to provide goods and services. Finally, a business must have adequate *control* mechanisms to ensure that its capital is being wisely employed and its physical resources are protected for future use.

In times of high profitability and abundant financial resources, the finance function tends to decline in importance. Thus, at the time when most healthcare providers were reimbursed on the basis of costs incurred, the role of finance was minimal. The most critical finance function was cost identification because it was more important to account for costs than it was to control them. In response to payer (primarily Medicare) requirements, providers (primarily hospitals) churned out a multitude of reports both to comply with regulations and to maximize revenues. The complexities of cost reimbursement meant that a large amount of time had to be spent on cumbersome accounting, billing, and collection procedures. Thus, instead of focusing on value-adding activities, most finance work focused on bureaucratic functions.

Now, finance functions are typically much more strategic and sophisticated in recognition of the changes that have occurred in the health services sector. Although billing and collections remain important, to be of maximum value to the enterprise today, the finance function must support a much broader array of activities, including strategy development, cost containment efforts, third-party payer contract negotiations, joint venture decisions, risk management, and clinical integration. In essence, finance must help lead organizations into the future rather than merely record what has happened in the past.

In this book, the emphasis is on the finance function, but there are no unimportant functions in healthcare organizations. Senior executives must understand a multitude of other functions, such as operations, marketing, facilities management, quality improvement, and human resource management, in addition to finance. Still, all business decisions have financial implications, so all managers—whether they are in finance or not—must know enough about finance to properly incorporate any financial implications into decisions made within their own specialized areas.

SELF-TEST  
QUESTIONS

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

## The Structure of the Finance Department

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

The head of the finance department holds the title *chief financial officer (CFO)* or sometimes *vice president of finance*. This individual typically reports directly to the organization's *chief executive officer (CEO)* and is responsible for all finance activities within the organization.

The CFO directs two senior managers who help manage finance activities. First is the *comptroller* (pronounced, and sometimes spelled, "controller"), who is responsible for accounting and reporting activities such as routine budgeting, preparation of financial statements, payables management, and patient accounts management. For the most part, the comptroller is involved in the activities covered in chapters 3–8 of this text. Second is the *treasurer*, who is responsible for the acquisition and management of capital (funds). The treasurer's activities include the acquisition and employment of capital, cash and debt management, lease financing, financial risk management, and endowment fund management (within not-for-profits). In general, the treasurer is involved in the activities discussed in chapters 11–17 of this text.

Of course, in larger organizations, the comptroller and treasurer have managers with responsibility for specific functions, such as the *patient accounts manager*, who reports to the comptroller, and the *cash manager*, who reports to the treasurer.

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

**SELF-TEST  
QUESTIONS**

1. Briefly describe the typical structure of the finance department within a health services organization.
2. How does the structure of the finance department differ between small and large health services organizations?

## Health Services Settings

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

Most readers of this text are familiar with health services settings either through previous courses or work in the field. For readers who have not had exposure to health services settings, the chapter 1 supplement, available online at [ache.org/books/HCFinance7](http://ache.org/books/HCFinance7), provides additional information.

**SELF-TEST  
QUESTIONS**

1. Name a few settings in which health services are provided.
2. Briefly describe horizontal and vertical integration.

## Current Managerial Challenges

In recent years, the American College of Healthcare Executives has surveyed CEOs regarding the most critical concerns of healthcare managers. Financial concerns have headed the list of challenges every year since the survey began in 2002. When asked to rank their specific financial concerns, in 2018, CEOs put costs for staff, supplies, and other expenses; Medicaid reimbursement; and operating costs at the forefront.<sup>1</sup> (Reimbursement is discussed in chapter 2.)

In a survey of senior healthcare executives conducted by the Advisory Board in 2019, respondents reported that their most pressing issues were revenue growth, population health, and accountable care organization strategy and cost containment.<sup>2</sup> Finally, a survey conducted by the Healthcare

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Financial Management Association identified improving the accuracy of clinical documentation as a key revenue cycle (billing and collecting on a timely basis) concern.<sup>3</sup>

Taken together, the results of these surveys confirm that finance is of primary importance to today's healthcare managers. The remainder of this book is dedicated to helping you confront and solve these issues.

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

## SELF-TEST QUESTION

## Legal Forms of Businesses

Throughout this book, the focus is on business finance—that is, the practice of accounting and financial management within business organizations. There are three primary legal forms of *business organization*: proprietorship, partnership, and corporation. In addition, there are several hybrid forms. Because most health services managers work for corporations, and because not-for-profit businesses are organized as corporations, this form of organization is emphasized. However, some medical practices are organized as proprietorships, and partnerships and hybrid forms are common in group practices and joint ventures, so health services managers must be familiar with all forms of business organization.

### Proprietorships

A **proprietorship**, sometimes called a *sole proprietorship*, is a business owned by one individual. Going into business as a proprietor is easy—the owner simply begins business operations. However, most cities require even the smallest businesses to be licensed, and state licensure is required for most healthcare professionals.

**proprietorship**  
A simple form of business owned by a single individual; also called *sole proprietorship*.

### Partnerships

A **partnership** is formed when two or more people associate to conduct a business that is not incorporated. Partnerships may operate under different degrees of formality, ranging from informal oral understandings to formal agreements filed with the state in which the partnership does business. Both the proprietorship and partnership forms of organization are easily and inexpensively formed, are subject to few government regulations, and pay no corporate income taxes. All earnings of the business, whether reinvested in the business or withdrawn by the owner(s), are taxed as personal income to the proprietor or partner.

**partnership**  
A nonincorporated business entity that is created by two or more individuals.

Proprietorships and partnerships have several disadvantages, including the following:

- Selling their interest in the business is difficult for the owners.
- The owners have unlimited personal liability for the debts of the business, which can result in losses greater than the amount invested in the business. In a proprietorship, unlimited liability means that the owner is personally responsible for the debts of the business. In a partnership, it means that if any partner is unable to meet his or her obligation in the event of bankruptcy, the remaining partners are responsible for the unsatisfied claims and must draw on their personal assets if necessary.
- The life of the business is limited to the life of the owners.
- It is difficult for proprietorships and partnerships to raise large amounts of capital. This is generally not a problem when the business is very small or when the owners are very wealthy; however, the difficulty of attracting capital becomes a real handicap if the business needs to grow substantially to take advantage of market opportunities.

### **Corporations**

A **corporation** is a legal entity that is separate and distinct from its owners and managers. The creation of a separate business entity gives these primary advantages:

- A corporation has an unlimited life and can continue in existence after its original owners and managers have died or left the company.
- It is easy to transfer ownership in a corporation because ownership is divided into shares of stock that can be sold.
- The owners of a corporation have limited liability.

To illustrate limited liability, suppose that an individual made an investment of \$10,000 in a partnership that subsequently went bankrupt, owing \$100,000. Because the partners are liable for the debts of the partnership, that partner could be assessed for a share of the partnership's debt in addition to the loss of his or her initial \$10,000 contribution. In fact, if the other partners were unable to pay their shares of the indebtedness, one partner would be held liable for the entire \$100,000. However, if the \$10,000 had been invested in a corporation that went bankrupt, the potential loss for the investor would be limited to the \$10,000 initial investment. (However, in the case of small, financially weak corporations, the limited liability feature

#### **corporation**

A legal business entity that is separate and distinct from its owners (or community) and managers.

of ownership is often fictitious because bankers and other lenders will require personal guarantees from the stockholders.) Because of these three factors—unlimited life, ease of ownership transfer, and limited liability—corporations can more easily raise money in the financial markets than can sole proprietorships or partnerships.

The corporate form of organization has two primary disadvantages. First, corporate earnings of taxable entities are subject to double taxation—once at the corporate level and then again at the personal level. Second, setting up a corporation, and then filing the required periodic state and federal reports, is more costly and time-consuming than what is required to establish a proprietorship or partnership.

Setting up a corporation requires that the founders, or their attorney, prepare a charter and a set of bylaws. Today, attorneys have standard templates for charters and bylaws, so they can set up a “no-frills” corporation with modest effort. In addition, several companies offer online services that help with the incorporation process. Still, setting up a corporation remains relatively difficult compared with a proprietorship or partnership, and it is even more difficult if the corporation has nonstandard features, such as multiple classes of stock.

### **Hybrid Forms of Organization**

Although the three basic forms of organization—proprietorship, partnership, and corporation—historically have dominated the business scene, several hybrid forms of organization have become quite popular in recent years.

In general, the hybrid forms are designed to limit owners’ liability without having to fully incorporate. For example, in a **limited liability partnership (LLP)**, the partners have joint liability for all actions of the partnership, including personal injuries and indebtedness. However, all partners enjoy limited liability regarding professional malpractice because partners are only liable for their own individual malpractice actions, not those of the other partners. In spite of limited malpractice liability, the partners are jointly liable for the partnership’s debts. Other hybrid forms of organization include limited liability companies (LLCs), professional corporations (PCs), and professional associations (PAs).

**limited liability partnership (LLP)**  
A partnership form of organization that limits the professional (malpractice) liability of its partners.

1. What are the three primary forms of business organization, and how do they differ?
2. What is the purpose of hybrid forms of business organization?

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## Corporate Ownership

In the previous section, we discussed the different legal forms of businesses. Now, we turn our attention to the two ownership forms of corporations: for-profit and not-for-profit. Unlike other sectors in the economy, not-for-profit corporations play a major role in the healthcare sector, especially among providers. For example, about 56 percent of the community hospitals in the United States are private, not-for-profit hospitals. Only 25 percent of all community hospitals are investor owned; the remaining 19 percent are government hospitals.<sup>4</sup> Furthermore, not-for-profit ownership is common in the nursing home, home health care, hospice, and health insurance industries.

### Investor-Owned Corporations

When you think of a corporation, an **investor-owned**, or **for-profit, corporation** likely comes to mind. For example, Ford ([www.ford.com](http://www.ford.com)), IBM ([www.ibm.com](http://www.ibm.com)), and Microsoft ([www.microsoft.com](http://www.microsoft.com)) are investor-owned corporations. In health services, corporations such as HCA Healthcare (<https://hcahealthcare.com>) and Community Health Systems ([www.chs.net](http://www.chs.net)) are examples of large for-profit hospital systems; Kindred Healthcare ([www.kindredhealthcare.com](http://www.kindredhealthcare.com)) and Brookdale Senior Living ([www.brookdale.com](http://www.brookdale.com)) are examples of long-term care providers; Select Medical ([www.selectmedical.com](http://www.selectmedical.com)) and Encompass Health ([www.encompasshealth.com](http://www.encompasshealth.com)) offer rehabilitation services; and MEDNAX ([www.mednax.com](http://www.mednax.com)) offers pediatric services. Individuals become owners of for-profit corporations by buying shares of *common stock* in the company. The *stockholders* (also called *shareholders*) are the owners of investor-owned corporations. As owners, they have two basic rights:

#### investor-owned (for-profit) corporation

A corporation that is owned by shareholders who furnish capital and expect to earn a return on their investment.

- **The right of control.** Common stockholders have the right to vote for the corporation's *board of directors*, which oversees the management of the company. Each year, a company's stockholders receive a *proxy* ballot, which they use to vote for directors and to vote on other issues that are proposed by management or stockholders. In this way, stockholders exercise control over the corporation. In the voting process, stockholders cast one vote for each common share held.
- **A claim on the residual earnings of the firm.** A corporation sells products or services and realizes revenues from the sales. To produce these revenues, the corporation must incur expenses for materials, labor, insurance, debt capital, and so on. Any excess of revenues over expenses—the *residual earnings*—belongs to the shareholders of the business. Often, a portion of these earnings is paid out in the form of *dividends*, which are cash payments to stockholders, or

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*stock repurchases*, in which the company buys back shares held by stockholders. However, management typically elects to reinvest some (or all) of the residual earnings in the business, which presumably will produce even higher payouts to stockholders in the future.

Compared with not-for-profit corporations (discussed next), three key features make investor-owned corporations different. First, the owners (stockholders) of the corporation are well defined and exercise control of the business by voting for directors. Second, the residual earnings of the business belong to the owners, so management is responsible only to the stockholders for the profitability of the firm. Finally, investor-owned corporations are subject to various forms of taxation at the local, state, and federal levels.

### **Not-for-Profit Corporations**

If an organization meets a set of stringent requirements, it can qualify for incorporation as a **tax-exempt**, or **not-for-profit, corporation**. Tax-exempt corporations are sometimes called *nonprofit corporations*. Because nonprofit businesses (as opposed to pure charities such as United Way) need profits to sustain operations, and because it is hard to explain why nonprofit corporations should earn profits, the term *not-for-profit* better describes such health services corporations. Examples of not-for-profit health services corporations include Kaiser Permanente (<https://healthy.kaiserpermanente.org>), Catholic Health Initiatives ([www.catholichealthinitiatives.org](http://www.catholichealthinitiatives.org)), and the Mayo Clinic Health System ([www.mayoclinic.org](http://www.mayoclinic.org)).

**tax-exempt (not-for-profit) corporation**  
A corporation that has a charitable purpose, is tax exempt, and has no owners; also called *nonprofit corporation*.

Tax-exempt status is granted to corporations that meet the tax definition of a charitable organization as defined by Internal Revenue Service (IRS) tax code section 501(c)(3) or 501(c)(4). Hence, such corporations are also known as *501(c)(3)* or *501(c)(4) corporations*. The tax code defines a charitable organization as “any corporation, community chest, fund, or foundation that is organized and operated exclusively for religious, charitable, scientific, public safety, literary, or educational purposes.” Because the promotion of health is commonly considered a charitable activity, a corporation that provides healthcare services can qualify for tax-exempt status, provided that it meets other requirements.

In addition to the charitable purpose, a not-for-profit corporation must be organized and run so that it operates exclusively for the public, rather than private, interest. Thus, no profits can be used for private gain, and no direct political activity can be conducted. Also, if the corporation is liquidated or sold to an investor-owned business, the proceeds from the liquidation or sale must be used for charitable purposes. Because individuals cannot benefit from the profits of not-for-profit corporations, such organizations cannot pay dividends. However, the prohibition of private gain from profits

does not prevent parties, such as managers and physicians, from benefiting through salaries, perquisites, contracts, and so on.

Not-for-profit corporations differ significantly from investor-owned corporations. Because not-for-profit firms have no shareholders, no single body of individuals has ownership rights to the firm's residual earnings or exercises control of the firm. Rather, control is exercised by a *board of trustees* that is not constrained by outside oversight, as is the board of directors of a for-profit corporation, which must answer to stockholders. Also, not-for-profit corporations are generally exempt from taxation, including both property and income taxes, and have the right to issue tax-exempt debt (municipal bonds). Finally, individual contributions to not-for-profit organizations can be deducted from taxable income by the donor, so not-for-profit firms have access to tax-subsidized contribution capital.

For-profit corporations must file annual income tax returns with the IRS. The equivalent filing for not-for-profit corporations is IRS **Form 990**, titled "Return of Organization Exempt from Income Tax." Its purpose is to provide both the IRS and the public with financial information about not-for-profit organizations, and it is often the only source of such information. It is also used by government agencies to prevent organizations from abusing their tax-exempt status. Form 990 requires significant disclosures related to governance and boards of trustees. In addition, hospitals are required to file **Schedule H** to Form 990, which includes financial information on the amount and type of community benefit (primarily charity care) provided, bad debt losses, Medicaid patients, and collection practices. IRS regulations require not-for-profit organizations to provide copies of their three most recent Form 990s to anyone who requests them, whether in person or by mail, fax, or email. Form 990s are also available to the public through several online services.

The financial problems facing most federal, state, and local governments have prompted politicians to take a closer look at the tax subsidies provided to not-for-profit hospitals. The Patient Protection and Affordable Care Act (ACA) of 2010 added four requirements that must be met for hospitals to maintain their tax-exempt status: (1) conducting a community health needs assessment every three years and developing plans for implementation; (2) establishing a written financial assistance policy; (3) charging patients who qualify for financial assistance amounts similar to what insured patients are charged; and (4) not engaging in aggressive collection efforts before making an effort to determine whether a patient is eligible for financial assistance.<sup>5</sup>

Likewise, officials in several states have proposed or enacted legislation mandating the minimum amount of charity care to be provided by not-for-profit hospitals and the types of billing and collections procedures

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#### **Form 990**

A form filed by not-for-profit organizations with the Internal Revenue Service that reports on governance and charitable activities.

#### **Schedule H**

An attachment to Form 990 filed by not-for-profit hospitals that gives additional information on charitable activities.

that can be applied to the uninsured.<sup>6</sup> For example, Texas has established minimum requirements for charity care that hold not-for-profit hospitals accountable to the public for the tax exemptions they receive. The Texas law specifies four tests, and each hospital must meet at least one of them. The test that most hospitals use to comply with the law requires that at least 4 percent of net patient service revenue be spent on charity care.

Finally, municipalities in several states have attacked the property tax exemptions of not-for-profit hospitals that have “neglected” their charitable missions. For example, in 2015, a tax court in New Jersey canceled a not-for-profit hospital’s property tax exemption because it was found to have substantial “for-profit” elements and characteristics that made it ineligible for the exemption.<sup>7</sup> According to one estimate, if all not-for-profit hospitals had to pay taxes comparable to their investor-owned counterparts, local, state, and federal governments would receive an additional \$17.9 billion in tax revenues.<sup>8</sup> This estimate explains why tax authorities in many jurisdictions are pursuing not-for-profit hospitals as a source of revenue.

The inherent differences between investor-owned and not-for-profit organizations have profound implications for many elements of healthcare financial management, including organizational goals, financing decisions (i.e., the choice between debt and equity financing and the types of securities issued), and capital investment decisions. Ownership’s effect on the application of healthcare financial management theory and concepts is addressed throughout the text.

## For Your Consideration

### Making Not-for-Profit Hospitals Do Good

Many people have criticized not-for-profit hospitals for not “earning” their charitable exemptions. In a 2010 court ruling, the Illinois Supreme Court concluded that Provena Covenant hospital, located in Urbana, Illinois, was not a charitable institution for property tax purposes. The court’s opinion reasoned that the primary use of the hospital property was to provide medical services for a fee, whereas *charity* means providing a gift to the community. The opinion further pointed out that (1) the charity care being provided was subsidized by payments from other patients; (2) many patients granted partial charity care still paid enough to cover costs; and (3) the hospital’s community benefit activities, such as a residency program and an education program for emergency responders, also benefited the hospital and thus were not truly gifts to the community. Thus, the hospital property was not in charitable use.

Most not-for-profit hospitals today are primarily supported by payments for services rather than by charitable contributions. Under the opinion’s reasoning, the property tax exemption may well be hard to maintain. However, a partial dissent by two justices suggests that this case is not the end of the story. The dissent argues that the plurality opinion impinges on the legislative function of setting specific standards for tax exemption, and the issue should be settled by legislative action rather than by courts.

What do you think? Should not-for-profit hospitals lose their property tax or income tax exemptions? Should legislatures set standards that hospitals must meet to maintain their tax-exempt status? If so, how might such standards be specified?

**SELF-TEST  
QUESTIONS**

1. What are the major differences between investor-owned and not-for-profit corporations?
2. What types of requirements have been placed on not-for-profit hospitals to ensure that they meet their charitable mission?
3. What are the purpose and content of IRS Form 990?

## Organizational Goals

Healthcare finance is not practiced in a vacuum; it is practiced with some objective in mind. Finance goals within an organization clearly must be consistent with, as well as supportive of, the overall goals of the business. Thus, by discussing organizational goals, a framework for financial decision-making within health services organizations can be established.

### *Small Businesses*

In a small business, regardless of its legal form, the owners generally are also its managers. In theory, the business can be operated for the exclusive benefit of the owners. If the owners want to work very hard to get rich, they can. On the other hand, if every Wednesday is devoted to golf, no outside owner is hurt by such actions. (Of course, the business still has to satisfy its customers or it will not survive.) It is in large, publicly held corporations, in which owners and managers are separate parties, that organizational goals become important to the practice of finance.

### *Publicly Held Corporations*

From a finance perspective, the primary goal of large investor-owned corporations is generally assumed to be *shareholder wealth maximization*, which translates to stock price maximization. Investor-owned corporations do, of course, have other goals. Managers, who make the actual decisions, are interested in their own personal welfare, in their employees' welfare, and in the good of the community and society at large. Still, the goal of stock price maximization is a reasonable operating objective on which to build financial decision-making rules.

### *Not-for-Profit Corporations*

Corporations consist of a number of classes of *stakeholders*, which include all parties that have an interest, usually of a financial nature, in the organization. For example, a not-for-profit hospital's stakeholders include the board of trustees, managers, employees, physician staff, creditors, suppliers, patients,

and even potential patients, which may include the entire community. An investor-owned hospital has the same set of stakeholders, plus stockholders, who dictate the goal of shareholder wealth maximization. While managers of investor-owned companies have to please primarily one class of stakeholders—the shareholders—to keep their jobs, managers of not-for-profit firms face a different situation. They have to try to please all of the organization’s stakeholders because no single well-defined group exercises control.

Many people argue that managers of not-for-profit corporations do not have to please anyone at all because they tend to lead the boards of trustees that are supposed to exercise oversight. Others argue that managers of not-for-profit corporations have to please all of the business’s stakeholders to a greater or lesser extent because all are necessary to the successful performance of the business. Of course, even managers of investor-owned corporations should not attempt to enhance shareholder wealth by treating other stakeholders unfairly, because such actions ultimately will be detrimental to shareholders.

Typically, not-for-profit corporations state their goals in terms of a mission statement. For example, here is the current mission statement of Riverside Hospital, a 450-bed, not-for-profit acute care hospital:

To care for others as we would care for those we love—to enhance their well-being and improve their health.

Although this mission statement provides Riverside’s managers and employees with a framework for developing specific goals and objectives, it does not provide much insight into the goal of the hospital’s finance function. For Riverside to accomplish its mission, its managers have identified the following five financial goals:

### For Your Consideration

#### Does the Finance Function Differ Among Providers?

Readers of this book understand the difference between for-profit and not-for-profit providers. Not-for-profit providers have a charitable mission, whereas for-profits are in business to make money for owners. Furthermore, all not-for-profit earnings must be reinvested in the enterprise, while some (or all) profits of for-profit health services businesses may be returned to owners in the form of dividends or stock repurchases. Although many studies have tried to assess which type of ownership is better for patients, no consensus has been reached.

But what about the finance function? That is, what about the day-to-day activities of operational managers and the finance staff? Are these appreciably different at not-for-profit providers than at for-profit providers? What about different types of providers—say, medical group practices versus hospitals?

What do you think? Is the finance function at not-for-profit providers appreciably different from that at for-profit providers, or is there an appreciable difference between types of providers? If there are differences, what are they?

1. The hospital must maintain its financial viability.
2. The hospital must generate sufficient profits to continue to provide the current range of healthcare services to the community. This means that current buildings and equipment must be replaced as they become obsolete.
3. The hospital must generate sufficient profits to invest in new medical technologies and services as they are developed and needed.
4. Although the hospital has an aggressive philanthropy program in place, it does not want to rely on this program or government grants to fund its operations.
5. The hospital will strive to provide high-quality services to the community as inexpensively as possible, given the financial requirements.

In effect, Riverside's managers are saying that to achieve the hospital's commitment to excellence as stated in its mission, it must remain financially strong and profitable. Financially weak organizations cannot continue to accomplish their stated missions over the long run.

Riverside's five financial goals are probably not much different from the financial goals of Jeffersonville Health System (JHS), a for-profit competitor. Of course, JHS has to worry about providing a return to its shareholders, and it receives only a very small amount of contributions and grants. However, to maximize shareholder wealth, JHS also must maintain its financial viability and have the financial resources necessary to offer new services and technologies. Furthermore, competition in the market for hospital services does not permit JHS to charge appreciably more for services than its not-for-profit competitors.

### SELF-TEST QUESTIONS

1. What is the difference in goals between investor-owned and not-for-profit businesses?
2. Briefly describe the differences in key stakeholders between investor-owned and not-for-profit businesses.

## Healthcare Reform and Finance

The Affordable Care Act has been called the most significant healthcare legislation since Medicare and Medicaid were enacted in 1965. The ACA, which became law on March 23, 2010, was designed to provide all US citizens and

legal residents with access to affordable health insurance, reduce healthcare costs, and improve care and quality. The legislation put in place comprehensive health insurance exchanges to expand coverage, enacted provisions to hold insurance companies accountable for product cost and quality, required that everyone buy insurance through an individual mandate (this provision was repealed in 2017 as part of the Tax Cuts and Jobs Act), and offered subsidies to low-income individuals. All of these components of the ACA were intended to transform the US healthcare system and make it more affordable and sustainable.

The ACA had numerous aims. However, the central goal was to expand healthcare coverage through shared responsibility among government, individuals, and employers.

Since the ACA's passage, several congressional efforts have been made to repeal and replace the law; however, none has been passed. While the future of healthcare reform is uncertain, major provisions of the ACA remained in effect in 2020. The major implications of healthcare reform for health insurance and provider payments are addressed in chapters 2 and 3, respectively. The major implications of healthcare reform for the institutional setting and the delivery of healthcare services are discussed in the next section of this chapter.

## Key Trends Following the Affordable Care Act

### *Sector Consolidation*

Since its passage, the ACA has driven the consolidation of healthcare organizations. It has accelerated health systems' acquisition of hospitals and hospitals' acquisition of physician practices—a trend that is likely to continue for many years. As a result of their greater focus on clinical integration, quality of care, and changing reimbursement methodologies, healthcare organizations are now seeking to restructure healthcare delivery to operate more efficiently and to improve coordination between patients and providers. Healthcare organizations are also looking to gain a competitive advantage by combining assets, staff, and resources.

Consolidation not only provides organizations with access to capital, economies of scale, negotiating power with payers, and market share, but also it may lead to improvements in patient care by making it easier to share patient information, adhere to clinical practice guidelines (thus reducing variations in care), and access high-quality specialist physicians. There is, however, a notable downside to consolidation: increases in prices as healthcare organizations gain greater market share and negotiating power.

**population health management**

The concept that the health of all individuals is improved when the health of the entire population is improved.

**social determinants of health**

Social, economic, and environmental conditions in the places where people are born, live, grow, learn, work, and play that affect health.

### ***Population Health***

The ACA is moving providers toward the **population health management** approach to care provision. The goal of population health management is to shift the focus of healthcare from treating illness to maintaining or improving health. The idea is to prevent costly illnesses when possible and hence avoid unnecessary care. This approach is supported by reimbursement models such as capitation, payment bundling, and shared savings (discussed in chapter 2). Instead of providing only preventive and chronic care when patients seek out healthcare for acute problems, healthcare practices that adopt the population health management approach track and monitor the health status of their entire patient population. Doing so requires greater use of health information technology (IT). Key to the success of population health management are greater awareness of the health status of the population and proactive intervention to reduce the use of provider resources and achieve the best population outcomes.

### ***Social Determinants of Health***

In response to increasing incentives to manage healthcare utilization and costs, health systems, government payers, and insurers are taking steps to address the **social determinants of health**. Scholars and healthcare providers increasingly are recognizing that social, economic, and environmental factors such as housing, education, income, and food security have a powerful influence on health outside the healthcare system. Examples of initiatives to address the social determinants of health include screening patients or populations for social needs (e.g., healthy food, housing) and then connecting individuals with resources (e.g., food pantries, information and referral services) in sectors outside healthcare. This goal is consistent with the population health management approach, which focuses on preventing costly illnesses, improving health, and reducing health inequities.

### ***Clinical Integration***

A fundamental component of achieving the goals of healthcare reform is clinical integration. Clinical integration aims to coordinate patient care across conditions, providers, settings, and time to achieve care that is safe, timely, effective, efficient, and patient focused. New payment models and advances in health IT systems are used to facilitate the transition to the clinical integration model and to manage the continuum of care for patients. Provider payments are tied to results for quality, access, and efficiency with the objective of better coordination between hospitals and physicians.

Health IT supports clinical integration by capturing patient information and making it accessible to authorized providers at the point of care. Complete patient information facilitates optimal treatment strategies and



reduces the chance of medication errors and conflicting treatment plans. However, the sharing of patient data requires that policies and procedures be in place to protect patient privacy and to guarantee the security of data transferred among patients, caregivers, and organizations.

### **Technology**

Technology has a major impact on the delivery and financial management of healthcare, as shown by the adoption of electronic health record systems starting in the 2000s; however, healthcare as a sector has been slow to adopt new technology because of privacy and safety concerns. A new technology, *blockchain*, has the potential to drastically change the way healthcare providers protect their data and communicate with each other. Blockchain is a system of securing data by linking pieces of data together in chains; thus, a change to one piece of data will update the rest of the chain. While this technology has the potential to revolutionize the sharing of electronic health data, there are still some concerns about ensuring the patient privacy.

Electronic health data are still hard to share among providers. However, the increasing emphases on collaboration among clinicians and on quality patient care are spurring healthcare organizations to invest in integrated health IT systems to collect large quantities of patient and provider data (so-called *big data*). Data analytic systems are capable of analyzing large amounts of patient data to better understand clinical processes and to identify problems and opportunities for improvement in the provision of healthcare services. New, complex IT systems and applications of artificial intelligence will facilitate the analysis of care coordination, patient safety, and healthcare utilization.

### **Staffing Shortages**

Healthcare reform has increased the number of patients who can access the healthcare system. As a result, healthcare organizations are seeing an influx of formerly uninsured patients who are now seeking care because they have insurance or better coverage. As a result, the demand for healthcare professionals—especially primary care physicians, nurse practitioners, and physician assistants—has increased.

Healthcare reform is also driving changes in hospital staffing by emphasizing prevention and value-based care, creating demand for primary care providers, emergency physicians, clinical pharmacists, social workers and care coordinators, and health IT and data specialists. Several strategies may increase the supply and distribution of health professionals (including primary care physicians): scholarships, flexible loan repayment programs, and debt forgiveness have been identified as ways to increase the number of providers and attract them to underserved areas. However, many healthcare organizations likely will face great competition for some healthcare staff.

## Key Programs of the Affordable Care Act

### *Accountable Care Organizations*

#### **accountable care organization (ACO)**

A network of healthcare providers joined together for the purpose of increasing patient service quality and reducing costs.

**Accountable care organizations (ACOs)**, a cornerstone of healthcare reform, integrate local physicians with other members of the healthcare community and reward them for controlling costs and improving quality. While ACOs are not radically different from other attempts to improve the delivery of healthcare services, they are unique in the flexibility of their structures and payment methodologies and in their ability to assume risk while meeting quality targets. Similar to some managed care organizations and integrated healthcare systems such as the Mayo Clinic, ACOs are responsible for the health outcomes of a specific population and tasked with collaboratively improving care to reach cost and quality targets set by Medicare. To help achieve cost control and quality goals, ACOs can distribute bonuses when targets are met and impose penalties when targets are missed.

One feature of healthcare reform is a shared savings program in which Medicare pays a fixed (global) payment to ACOs that covers the full cost of care for an entire population. This program establishes cost and quality targets. Any cost savings (i.e., costs that are below the target) are shared between Medicare and the ACO, as long as the ACO also meets its quality targets. If an ACO is unable to save money, it could be liable for the costs of the investments made to improve care; it also may have to pay a penalty if it does not meet performance and savings benchmarks.

To be effective, an ACO should include, at a minimum, primary care physicians, specialists, and a hospital, although some ACOs are being established solely by physician groups.

An ACO can take many forms, such as the following:

- An integrated delivery system that has common ownership of hospitals and physician practices and has electronic health records, team-based care, and resources to support cost-effective care
- A multispecialty group practice that has strong affiliations with hospitals and contracts with multiple health plans
- A physician–hospital organization that is a subset of a hospital's medical staff and functions, such as a multispecialty group practice
- An independent practice association comprising individual physician practices that come together to contract with health plans
- A virtual physician organization that sometimes includes physicians in rural areas

ACOs should have managerial systems in place to administer payments, set benchmarks, measure performance, and distribute shared savings.

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A variety of federal, regional, state, and academic hospital initiatives are investigating how best to implement ACOs. Although the concept shows potential, many legal and managerial hurdles must be overcome for ACOs to live up to their promise.

### **Medical Homes**

A **medical home** (or *patient-centered medical home*) is a team-based model of care that is led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime with the goal of maximizing health outcomes. The medical home is responsible for meeting all of a patient's healthcare needs or appropriately arranging care with other qualified professionals. This includes the provision of preventive services, treatment of acute and chronic illnesses, and assistance with end-of-life care. It is a model of practice in which a team of healthcare professionals, coordinated by a personal physician, works collaboratively to ensure coordinated and integrated care, patient access and communication, quality, and safety. The medical home model is independent of the ACO concept, but most ACOs provide an organizational setting that facilitates implementation of the model.

Supporters of the medical home model argue that it allows better access to healthcare, increases patient satisfaction, and improves health. The Agency for Healthcare Research and Quality defines a medical home as a model of primary care that encompasses the following functions and attributes:<sup>9</sup>

- **Comprehensive care.** The medical home includes a team of providers that are responsible for meeting a majority of the patients' physical and mental healthcare needs.
- **Patient-centered.** The medical home partners with patients and families to help patients actively engage in care decisions and manage their care.
- **Coordinated care.** The medical home coordinates care across specialists, hospitals, home health agencies, nursing homes, hospices, and community services.
- **Accessible services.** Medical care and information are available at all times through open scheduling, expanded hours of service, and new and innovative communications technologies.
- **Quality and safety.** Quality and patient safety are ensured by a care planning process, evidence-based medicine, clinical decision support tools, performance measurement, active participation of patients in decision-making, use of IT, and quality improvement activities.
- **Payment-for-value methodologies.** Payment methodologies must recognize the added value provided to patients. Payments should reflect

**medical home**  
A team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime with a goal of maximizing health outcomes; also called *patient-centered medical home*.

the value of work that falls outside of face-to-face visits, support the adoption and use of health IT for quality improvement, and recognize differences among the patient populations treated within the practice.

## SELF-TEST QUESTIONS

1. What is the primary purpose of healthcare reform?
2. What is an accountable care organization (ACO), and what is it designed to accomplish?
3. What is the medical home model, and what is its purpose?

## Key Concepts

This chapter provides an introduction to healthcare finance. The key concepts of this chapter are as follows:

- The term *healthcare finance*, as it is used in this book, refers to the accounting and financial management principles and practices used within health services organizations to ensure the financial well-being of the enterprise.
- A *business* maintains its financial viability by selling goods or services, whereas a *pure charity* relies solely on contributions.
- The *primary role of finance* in health services organizations, as in all businesses, is to plan for, acquire, and use resources to maximize the efficiency and value of the organization.
- Finance activities generally include (1) *planning* and *budgeting*, (2) *financial reporting*, (3) *capital investment decisions*, (4) *financing decisions*, (5) *revenue cycle* and *current accounts management*, (6) *contract management*, and (7) *financial risk management*. These activities can be summarized by the *four Cs*: *costs*, *cash*, *capital*, and *control*.
- The size and structure of the finance department within a health services organization depend on the type of provider and its size. The finance department within a larger provider organization generally consists of a *chief financial officer (CFO)*, who typically reports directly to the *chief executive officer (CEO)* and is responsible for all finance activities within the organization. Reporting to the CFO are the *comptroller*, who is responsible

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for accounting and reporting activities, and the *treasurer*, who is responsible for the acquisition and management of capital (funds).

- In larger organizations, the comptroller and treasurer direct managers who have responsibility for specific functions, such as the *patient accounts manager*, who reports to the comptroller, and the *cash manager*, who reports to the treasurer.
- In small health services organizations, the finance responsibilities are combined and assigned to one individual, often called the *business (practice) manager*.
- All business decisions have *financial implications*, so all managers—whether they are in finance or not—must know enough about finance to incorporate those implications into their own specialized decision-making processes.
- Recent surveys of health services executives confirm that healthcare managers regard financial concerns as the most important issue they face.
- The three main forms of business organization are *proprietorship*, *partnership*, and *corporation*. Although each form of organization has its own unique advantages and disadvantages, most large organizations, and all not-for-profit entities, are organized as *corporations*.
- *Investor-owned corporations* have *stockholders* who are the owners of the corporation. As owners, stockholders have claim on the *residual earnings* of the corporation. Investor-owned corporations are fully taxable.
- Charitable organizations that meet certain criteria can be organized as *not-for-profit corporations*. Rather than having a well-defined set of owners, such organizations have a large number of *stakeholders* who have an interest in the organization. Not-for-profit corporations do not pay taxes, they can accept tax-deductible contributions, and they can issue tax-exempt debt.
- In lieu of tax filings, not-for-profit corporations must file IRS *Form 990*, which reports on an organization's governance structure and community benefit services, with the Internal Revenue Service.
- From a financial management perspective, the primary goal of investor-owned corporations is *shareholder wealth maximization*,

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which translates into stock price maximization. For not-for-profit corporations, a reasonable goal for financial management is to ensure that the organization can fulfill its mission, which translates to *maintaining financial viability*.

- *Healthcare reform*—such as the *Affordable Care Act (ACA)*, federal legislation that was signed into law in 2010—is having a significant impact on health insurers and providers.
- *Accountable care organizations (ACOs)* integrate local physicians with other members of the healthcare community and reward them for controlling costs and improving quality.
- A *medical home* (or *patient-centered medical home*) is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.

In chapter 2, we continue the discussion of the healthcare environment, with an emphasis on health insurance and reimbursement methodologies.

## Questions

- 1.1. Briefly describe the purpose and organization of this book and the learning tools embedded in each chapter.
- 1.2.
  - a. What are some of the subsectors that make up the healthcare sector?
  - b. What is meant by the term *healthcare finance* as it is used in this book?
  - c. What are the two broad areas of healthcare finance?
  - d. Why is it necessary to have a book on healthcare finance as opposed to a generic finance book?
- 1.3. What is the difference between a business and a pure charity?
- 1.4.
  - a. Briefly discuss the role of finance in the health services sector.
  - b. Has this role increased or decreased in importance in recent years?
- 1.5. What is the structure of the finance department within health services organizations?

- 1.6. a. (Hint: The material reviewed in this question is covered in the chapter 1 supplement online.) Briefly describe the following health services settings:
- Hospitals
  - Ambulatory care
  - Home health care
  - Long-term care
  - Integrated delivery systems
- b. What are the benefits attributed to integrated delivery systems?
- 1.7. What are the major current concerns of healthcare managers?
- 1.8. What are the three primary forms of business organization? Describe their advantages and disadvantages.
- 1.9. What are the primary differences between investor-owned and not-for-profit corporations?
- 1.10. a. What is the primary goal of investor-owned corporations?
- b. What is the primary goal of most not-for-profit healthcare corporations?
- c. Are there substantial differences between the finance goals of investor-owned and not-for-profit corporations? Explain.
- 1.11. Briefly describe the main provisions of the Affordable Care Act and its implications for the practice of healthcare finance.
- 1.12. Describe the primary features of accountable care organizations and medical homes. What benefits are attributed to them?

## Notes

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## Resources

*For a general introduction to the healthcare system in the United States, see* Barton, P. L. 2010. *Understanding the U.S. Health Services System*. Chicago: Health Administration Press.

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*For the latest information on events that affect health services organizations, see* Modern Healthcare, *published weekly by Crain Communications Inc.*: [www.crain.com/brands/modern-healthcare/](http://www.crain.com/brands/modern-healthcare/)

*For current information about the Affordable Care Act, see the Kaiser Family Foundation*: [www.kff.org/](http://www.kff.org/)

*For information about the patient-centered medical home model of care, see the Agency for Healthcare Research and Quality's Patient-Centered Medical Home Resource Center*: <https://pcmh.ahrq.gov/page/defining-pcmh>



*For discussion of the future of healthcare in the United States and other information pertinent to this chapter, see*

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*For current information on how the internet affects health and the provision of health services, see the Journal of Medical Internet Research: [www.jmir.org](http://www.jmir.org)*