

CHAPTER 1

INTRODUCTION TO HEALTHCARE FINANCE

THEME SET-UP

CAREERS IN HEALTHCARE MANAGEMENT

If you are using this book, you either are working or interested in a career in healthcare. A broad range of career opportunities are available in clinical fields, including medicine, dentistry, nursing, and occupational and physical therapy, which some of you are already practicing or will enter upon graduation. Whether you are considering a career in healthcare management or are a clinician finding yourself balancing both clinical and administrative roles, a solid foundation in healthcare management knowledge is a key to success.

According to the US Census Bureau, the United States healthcare and social assistance sector is the nation's largest employer, with more than 20 million employees, representing an annual payroll of more than \$1 trillion. Healthcare manager and executive positions represent more than 420,000 healthcare jobs and are predicted to grow faster than average—by 39 percent between 2019 and 2029 (Bureau of Labor Statistics 2021). Individuals in these positions have the opportunity to make a significant contribution to improving the health of the population and to work in one of tens of thousands of healthcare organizations throughout the United States and the world.

An education in healthcare management can take you in many different directions. Career options for healthcare managers have never been more diverse or exciting. The kinds of entry-level jobs offered to a college graduate vary in terms of the individual's interests, skills, and experience. Today, healthcare management positions can range from entry level to middle management to leadership, serving in organizations of all sizes, from a practice with several people to a major corporation that employs thousands. After gaining the requisite experience, many healthcare management graduates are in a position to shape the future of healthcare in the United States and around the globe.

All that probably sounds good, but what types of organizations might be interested in hiring a healthcare management graduate? By the end of the chapter, you will have an idea of the settings available. See if any of them appeal to you.

LEARNING OBJECTIVES

After studying this chapter, you will be able to do the following:

- Define the term *healthcare finance* as it is used in this book.
- Discuss the structure of the finance department, the role of finance in healthcare organizations, and how this role has changed over time.
- Describe the major players in the healthcare sector.
- List the key issues currently facing healthcare managers.

1.1 INTRODUCTION

In today's healthcare environment, where financial realities play an important role in many, if not most, decisions, healthcare managers at all levels must understand the fundamentals of finance and how that knowledge is used to enhance the financial well-being of the institution. In this chapter, we introduce you to the rationale that underlies this book. Furthermore, we present background information about healthcare finance and the types of healthcare organizations. We sincerely hope that this book provides significant help in your quest to increase your professional competency in the critical area of healthcare finance.

1.2 DEFINING HEALTHCARE FINANCE

What is healthcare finance? It can be surprising to find that there is no single response because the definition of the term depends, for the most part, on the context in which it is used. Thus, your understanding should begin with learning the scope and meaning of the term *healthcare finance* as it is used in this book.

To start, recognize that healthcare finance is not about financing the healthcare system. **Healthcare financing** is a separate topic that involves how society pays for the healthcare services it consumes. This issue is complex and politically charged, and we do not tackle it directly in this book. That said, the manner of financing healthcare affects how hospitals and physicians are reimbursed for services and inevitably has a significant influence on healthcare finance.

Most users of this book will become (or already are) managers at healthcare organizations, such as medical group practices, hospitals, home health agencies, or long-term care facilities. Thus, to create a book that provides the most value to its primary users, we focused on finance as it applies in **health services organizations**. Of course, the principles and practices of finance cannot be studied in a vacuum but must be based on the realities of the current healthcare environment, including how healthcare services are financed.

In health services organizations, *healthcare finance* consists of both the accounting and financial management functions (see “Critical Concept: Healthcare Finance”). **Accounting**, as its name implies, concerns the recording, in financial terms, of economic events that reflect the operations,

healthcare financing
The system that a society uses to pay for healthcare services.

health services organizations
Organizations that provide patient care services. Examples include hospitals, medical practices, clinics, and nursing homes. Also called *providers*.

accounting
The measurement and recording of events that reflect the operations, assets, and financing of an organization.



CRITICAL CONCEPT

Healthcare Finance

Healthcare finance can have diverse definitions, depending on the setting. For our purposes, healthcare finance encompasses the accounting and financial management functions of healthcare organizations. Accounting involves the measurement, in financial terms, of a business's operations and financial status, while financial management (corporate finance) involves the application of theory and concepts developed to help managers make better decisions. In practice, the two functions blend, with accounting generating the data needed to make sound decisions and financial management providing the framework for those decisions.

financial management

The use of theory, principles, and concepts developed to help managers make better financial decisions.

assets, and financing of an organization. In general, the purpose of accounting is to create and provide to interested parties—both internal (managers) and external (investors)—useful information about an organization’s financial status and operations.

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

? SELF-TEST QUESTIONS

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

1.3 THE ROLE OF FINANCE IN HEALTH SERVICES ORGANIZATIONS

chief financial officer (CFO)

The senior manager (or top finance dog) in a large organization’s finance department. Also called *vice president of finance*.

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 enterprise (see “Critical Concept: Role of Finance”). As discussed in section 1.4 of this chapter, the two broad areas of finance—accounting and financial management—are separate functions at larger organizations, although the accounting function usually is carried out under the direction of the organization’s **chief financial officer (CFO)** and hence falls under the overall category of finance.

! CRITICAL CONCEPT

Role of Finance

The primary role of finance in health services organizations is to plan for, acquire, and use resources to maximize the efficiency of the organization. This role is implemented through specific activities such as planning and budgeting.

FINANCE ACTIVITIES

Chapters 1 through 3 of this book provide foundational information that is helpful for understanding finance activities. The specific finance activities explored in the remaining chapters of this book include the following:

- ◆ *Costs and profitability, 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. Chapters 4 through 6 cover these functions.

- ◆ *Financial operations.* Healthcare organizations spend a lot of time managing cash and supply inventories as well as collecting money owed for services rendered. Proper management of these functions is necessary to ensure operational effectiveness and to reduce costs. Typically, managers at all levels are involved, to a greater or lesser extent, in these processes, which are discussed in chapter 7.
- ◆ *Financing decisions.* All organizations must raise funds to buy the assets necessary to support operations. Such decisions involve many issues, such as the choice between long-term and short-term debt and the use of leases versus conventional financing. Senior managers and the financial staff typically make the financing decisions, but these decisions have ramifications for managers at all levels. Business financing is the subject of chapter 8.
- ◆ *Capital investment decisions.* One of the most critical decisions managers make is the selection of new facilities and land, along with other capital investments such as purchases of new equipment. These decisions are the primary means by which businesses implement strategic plans; hence, they play a key role in a business's future financial success and stability. Chapters 9 and 10 describe these decisions, which affect everyone in the organization.
- ◆ *Financial reporting.* For a variety of reasons, businesses must record and report to outsiders the results of operations and current financial status. This task is typically accomplished with a set of financial statements, which are explained in chapters 11 and 12. Chapter 14 examines internal control over financial reporting and effective board governance.
- ◆ *Financial and operational analysis.* To achieve and maintain a high level of organizational performance, businesses must constantly monitor both financial and operational conditions to make informed decisions as needed to ensure that goals are met. Chapters 7 and 13 address these topics.

In addition to those finance activities that involve operational managers, the following activities are accomplished primarily by the finance staff:

- ◆ *Contract management.* In today's healthcare environment, health services organizations must negotiate, sign, and monitor contracts with managed care organizations and health insurers. The finance staff typically has primary responsibility for these tasks, though operational managers clearly are

affected by external contracts and must be involved in their negotiation and management.

- ◆ *Financial risk management.* Many financial transactions that take place to support the operations of a business can, in themselves, increase a business's risk. Thus, an important finance staff activity is to manage financial risk.

THE FOUR CS

The finance activities at health services organizations may be summarized by the four Cs: costs, cash, capital, and control (see “Critical Concept: The Four Cs”).



CRITICAL CONCEPT

The Four Cs

The finance activities in healthcare organizations can be summarized by the four Cs: (1) *cost* measurement and minimization, (2) *cash* management, (3) *capital* acquisition, and (4) *control* of resources.

The measurement and minimization of costs are vital activities to the financial success of all healthcare organizations. Rampant costs, compared to revenues, usually spell doom for any business.

A business might be profitable but still face a crisis because of a shortage of cash. Cash is the lubricant that makes the wheels of a business run smoothly; without it, the business grinds to a halt. In essence, businesses must have sufficient cash on hand (or the ability to raise it quickly) to meet cash obligations as they occur. In health-

care, a critical part of managing cash is collecting money from insurers for patient services provided. (This element is so important that some healthcare finance professors include *collections* as a fifth C.)

Capital represents the funds (money) used to acquire land, buildings, and equipment. Without capital, healthcare businesses would not have the physical resources needed to provide patient services. Thus, capital allows healthcare organizations to meet the healthcare needs of the communities they serve.

Finally, a business must control its financial and physical resources to ensure that they are being wisely employed and protected for future use. In addition to meeting current mission requirements, healthcare organizations must plan to meet society's future healthcare needs.

IMPORTANCE OF FINANCE OVER TIME

In times of high profitability and abundant financial resources, the finance function tends to decline in significance. For example, when most health services organizations were reimbursed on the basis of the actual costs they incurred, the role of finance was minimal.

At that time, the most critical finance function was cost accounting because it was more important to account for costs than it was to control them. In response to payer (primarily Medicare) requirements, health services organizations (primarily hospitals) churned out a multitude of reports 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.

In recent years, however, providers have redesigned their finance functions to recognize the changes that have occurred in the health services field. Billing and collections remain important, but to be of maximum value to the enterprise, the finance function must support cost-containment efforts, population health, accountable care organization strategy, managed care and other payer contract negotiations, joint venture decisions, and integrated delivery system participation. In essence, finance must help lead organizations into the future rather than merely record and report what has happened in the past.

Although in this book our emphasis is on finance, we must stress that all organizational functions are important. In addition to finance, managers must understand some elements of many other business functions, such as marketing, facilities management, and human resource management. All business decisions have financial implications, placing a special responsibility on all managers (whether in operations, marketing, personnel, or facilities) to know and understand enough about finance to incorporate critical financial



FOR YOUR CONSIDERATION

Do Nonfinancial Managers Need to Know Finance?

A much-debated topic at the water cooler is whether nonfinancial managers, including clinical managers, need to know much about finance. As outlined in the American College of Healthcare Executives (ACHE) 2020 Competencies Assessment Tool, healthcare managers should over time attain competencies in 24 areas of financial management (ACHE 2020). Among the areas listed are basic accounting principles, reimbursement principles, budgeting, revenue generation, performance monitoring, and applying financial planning to organizational objectives. Of course, financial management competencies represent only a small proportion of the complete list of management competencies assessed by the tool. Still, by including financial management in the assessment tool, ACHE considers it a key skill set for healthcare managers regardless of work setting or years of experience.

What do you think? Do nonfinancial general managers need financial management skills? What about clinical managers? Justify your answers.

considerations into the plans and decisions in their specialized areas (see “For Your Consideration: Do Nonfinancial Managers Need to Know Finance?”).

SELF-TEST QUESTIONS

1. What is the role of finance in today’s healthcare organizations?
2. What are the four Cs?
3. How has the role of finance changed over time?

1.4 THE STRUCTURE OF THE FINANCE DEPARTMENT

The structure of the finance department depends on the type (e.g., hospital, medical practice) and size of the healthcare organization. Large organizations generally structure their finance departments in the following way.

The head of the finance department holds the title of CFO. (The title of vice president–finance is also used.) This individual typically reports directly to the organization’s chief executive officer (CEO) and is responsible for all finance activities in the organization. With continuous disruption in the healthcare sector, CFOs are also taking on more strategic roles and responsibilities to help guide organizations successfully through change and capitalize on new opportunities. The CFO directs two senior managers who help manage finance activities: the comptroller and the treasurer.

The **comptroller** (pronounced, and sometimes spelled, “controller”) is responsible for accounting and reporting activities, such as routine budgeting, preparation of financial statements, and patient accounts management. For the most part, the comptroller is involved in activities covered in chapters 4 through 7 and 11 through 14 of this text. The **treasurer** is responsible for the acquisition and management of capital (funds). In other words, the treasurer must raise the funds needed by the organization and ensure that those funds are effectively used. Specific activities include the acquisition of capital, cash and debt management, lease financing, financial risk management, and endowment fund management (in not-for-profits). In general, the treasurer is involved in those activities discussed in chapters 8 through 10 and chapter 13 of this book.

In large organizations, the comptroller and treasurer have managers under them who are responsible 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 businesses, many of the finance responsibilities are combined and assigned to one individual. For example, in a small group practice, the finance function is managed by one person, often called the **business manager** or *practice manager*, who typically is supported by one or more clerks.

The organization’s financial statements will undergo review by an external, independent auditor to ensure that financial reports are prepared in accordance with generally

comptroller

The finance department manager who handles accounting, budgeting, and reporting activities. Pronounced as and sometimes spelled as *controller*.

treasurer

The finance department manager who handles capital acquisition, investment management, and risk management activities.

business manager

The manager responsible for the finance function in a small healthcare organization, such as a medical practice with one or a few clinicians. Also called *practice manager*.

accepted accounting principles. In addition, the organization's board of directors and management are responsible for developing internal controls—that is, policies, process, and systems that provide reasonable assurance regarding the objectives related to financial reporting, compliance with laws and regulations, and operational effectiveness and efficiency. We discuss internal controls in greater detail in chapter 14.

? SELF-TEST QUESTIONS

1. How would you briefly describe the typical structure of the finance department in a large healthcare organization?
2. How does the size of the organization affect the finance department structure?

1.5 HEALTHCARE SETTINGS

Healthcare services are provided in numerous settings, including hospitals, ambulatory care offices and clinics, long-term care facilities, and integrated delivery systems. Before the 1980s, most healthcare organizations were freestanding and not formally linked with other organizations. Those that were linked tended to be part of a **horizontal system**, which controls a single type of healthcare facility, such as a group of hospitals or nursing homes. Recently, however, many healthcare organizations have created a **vertical system**, which controls two or more related types of providers, such as medical practices, hospitals, and nursing homes.

HOSPITALS

Hospitals provide diagnostic and therapeutic services to individuals who require more than several hours of care, although most hospitals are actively engaged in ambulatory (walk-in) services as well. To ensure a minimum standard of safety and quality, hospitals must be licensed by the state and undergo inspections for compliance with state regulations. In addition, most hospitals are accredited by **The Joint Commission** (previously called the Joint Commission on Accreditation of Healthcare Organizations). Joint Commission accreditation is a voluntary process intended to promote high standards of care. Although the cost to achieve and maintain compliance with standards can be substantial, accreditation provides eligibility for participation in the Medicare and Medicaid programs, and hence most hospitals seek accreditation (chapter 3 discusses Medicare and Medicaid).

Recent environmental and operational changes have created significant challenges for hospital managers. For example, prior to the COVID-19 pandemic, many hospitals were experiencing decreasing admission rates and shorter lengths of stay, resulting in reduced

horizontal system

A single business entity that owns a group of similar providers, such as hospitals.

vertical system

A single business entity that owns a group of related, but not identical, providers, such as hospitals, medical practices, and nursing homes.

The Joint Commission

The main accreditation body for hospitals and other health services organizations.

revenues and excess capacity. On the other hand, hospitals in fast-growing areas were hard-pressed to keep ahead of patient demand. In addition, all hospitals were being pressured to reduce costs by reimbursement rates that fail to keep up with inflation while also assuming greater risk in their contracts with payers.

Hospitals differ in function, length of patient stay, size, and ownership. These factors affect the type and quantity of assets, services offered, and management requirements and often determine the type and level of reimbursement. Hospitals are classified as either general acute care facilities or specialty facilities.

A **general acute care hospital** provides general medical and surgical services and selected acute specialty services. Such hospitals, which account for the majority of hospitals, have relatively short lengths of stay, typically a week or less. A **specialty hospital**, such as a psychiatric, children's, women's, rehabilitation, or cancer facility, limits the admission of patients to those of a specific age, sex, illness, or condition. The number of specialty hospitals has grown significantly since the 1980s because of the belief that such hospitals can provide better patient services than can hospitals that treat all conditions. In addition, specialty hospitals often experience lower costs than general hospitals do because they do not require the overhead associated with providing multiple types of services.

Hospitals vary in size from fewer than 25 beds to more than 1,000 beds; general acute care hospitals tend to be larger than specialty hospitals. Although economists do not all agree, the general belief is that the optimal hospital size is about 400-500 beds. Smaller hospitals do not benefit from economies of scale, while larger hospitals are too big to manage efficiently (have diseconomies of scale). Small hospitals, those with fewer than 100 beds, tend to be located in rural areas. Many rural hospitals have experienced financial difficulties in recent years because they have less flexibility than large hospitals, limiting their ability to lower costs in response to tightening reimbursement rates or adjust to unprecedented financial pressures. Most of the largest hospitals are academic health centers or teaching hospitals. These hospitals offer a wide range of services, including *tertiary care*, which consists of specialized services for patients with unusually severe, complex, or uncommon problems.

Hospitals are classified by ownership as governmental, private not-for-profit, or investor owned. The category of **government hospital**, makes up about 19 percent of all hospitals, is broken down into federal and public (nonfederal) entities (American Hospital Association [AHA] 2021). Federal hospitals, such as those operated by the uniformed services or the US Department of Veterans Affairs, serve special purposes. Public hospitals are funded wholly or in part by a city, county, tax district, or state. In general, federal and public hospitals provide substantial services to indigent patients. In recent years, many public hospitals have converted to other ownership categories (primarily private not-for-profit) because local governments have found it increasingly difficult to fund healthcare services and at the same time provide other necessary public services.

A **private not-for-profit hospital** is a nongovernmental entity organized for the sole purpose of providing inpatient healthcare services. Because of the charitable origins

general acute care hospital

A hospital that treats all conditions that require a relatively short hospitalization (e.g., fewer than 30 days).

specialty hospital

A hospital that treats patients with a common characteristic or condition, such as a children's or a cancer hospital.

government hospital

A hospital owned by a government entity. Federal hospitals are owned by the federal government, while public hospitals are owned (or funded) by state or local governments.

private not-for-profit hospital

A hospital that is not governmental but is operated for the exclusive benefit of the community.

of US hospitals and a tradition of community service, roughly 70 percent of all private hospitals (57 percent of all community hospitals) are not-for-profit entities (AHA 2021). In return for serving a charitable purpose, these hospitals receive numerous benefits, including exemption from federal and state income taxes, exemption from property and sales taxes, eligibility to receive tax-deductible charitable contributions, favorable postal rates, favorable tax-exempt financing, and tax-favored annuities for employees.

The remaining 30 percent of private hospitals (24 percent of all community hospitals) are in the category of the **investor-owned hospital**, also known as the *for-profit hospital*, whose owners (typically shareholders) benefit directly from the profits generated by the business (AHA 2021). Historically, most investor-owned hospitals were owned by physicians, but now most are owned by large corporations, such as HCA Healthcare (formerly Hospital Corporation of America), which owns or operates 186 hospitals in the United States and the United Kingdom; Community Health Systems (CHS), which owns 84 hospitals in 16 states; and Tenet Healthcare, which owns 65 acute care hospitals in 31 states (CHS 2021; HCA Healthcare 2021; Tenet Health 2021). Unlike not-for-profit hospitals, investor-owned hospitals pay taxes and forgo the other benefits of not-for-profit status.

Despite the expressed differences in mission between investor-owned and not-for-profit hospitals, not-for-profit hospitals are being forced to place greater emphasis on the financial implications of operating decisions than in the past. This trend has raised concerns in some quarters that many not-for-profit hospitals are failing to meet their charitable mission. As this perception grows, some people argue that these hospitals should lose some, if not all, of the benefits associated with their not-for-profit status. (Chapter 2 discusses the differences between investor-owned and not-for-profit hospitals in detail.)

Hospitals are labor intensive because they provide around-the-clock care, including nursing supervision to patients and services provided by other clinical, professional, and semiprofessional staff members. Physicians petition for privileges to practice in hospitals. While they admit and provide care to hospitalized patients, until recently the majority of physicians were not hospital employees and hence were not directly accountable to hospital management. However, nonemployee physicians retain a major responsibility for determining which hospital services are provided to patients and how long patients are hospitalized. Thus, physicians play a critical role in determining a hospital's costs and revenues and hence its financial condition.

As a result of mergers and consolidation in the health care sector, including acquisitions of private practices by healthcare systems, more physicians are becoming employees of hospitals and health systems as they relinquish ownership of their practices. In 2008 approximately 61 percent of physicians owned their practices (Singleton and Miller 2015). But in 2018 and for the first time, more physicians were employed (47.4 percent) than owned their own practice (45.9 percent), as reported by the American Medical Association (Henry 2019). This trend is predicted to continue given that, according to a 2019 survey, nine out of ten final-year medical residents stated they would prefer employment

investor-owned hospital

A hospital that is owned by investors who benefit financially from its operation. Also called a *for-profit hospital*.

(Merritt Hawkins 2019). Traditionally, hospitals and health systems have been the primary employers of physicians, but increasingly nontraditional employers have emerged. These physician employers include health plans, large employers, private equity firms, and venture capitalists (AHA 2020).

AMBULATORY (OUTPATIENT) CARE

Ambulatory (outpatient) care encompasses services provided to patients who are not admitted to a hospital or nursing home. Traditional outpatient settings include clinics, medical practices, hospital outpatient departments, and emergency departments. Nontraditional settings, such as home health care, ambulatory surgery centers, urgent care centers, diagnostic imaging centers, rehabilitation and sports medicine centers, and clinical laboratories, have emerged and are seeing substantial growth. The latest innovation in ambulatory care is the retail clinic, a small clinic operated in a retail store (such as Walmart) or pharmacy (such as CVS or Walgreens) and staffed by a physician assistant or nurse practitioner.

Technology has also changed how outpatient care is delivered. For example, the use of telemedicine to deliver care grew exponentially during the COVID-19 pandemic, and it is likely to continue to be an important modality to provide care going forward.

Compared with hospital-based services, these innovative settings offer patients more amenities and convenience and, in many situations, lower prices. For example, urgent care and ambulatory surgery centers are typically less expensive than their hospital counterparts because hospitals have higher overhead costs. (The same lower-cost logic applies to urgent care centers and retail clinics compared with medical practices.)

Many factors have contributed to the expansion of ambulatory services, with technology leading the way. Often, patients who once required hospitalization because of the complexity, intensity, invasiveness, or risk associated with certain procedures can now be treated in outpatient settings. In addition, health insurers have encouraged providers to expand their outpatient services by requiring authorization for inpatient services and instituting payment mechanisms that provide incentives to perform services on an outpatient basis.

Finally, starting a business that provides outpatient care is easier than starting a new hospital. Ordinarily, ambulatory facilities are less costly to operate and less frequently subject to licensure and certificate-of-need (CON) regulations (exceptions are hospital outpatient units and ambulatory surgery centers) than are hospitals, and they generally are not accredited. (Section 1.6 of this chapter discusses licensure and CON regulation in detail.)

As outpatient care consumes an increasing portion of the healthcare dollar and as efforts to control outpatient spending are enhanced, the traditional role of the ambulatory care manager is changing. Historically, ambulatory care managers have handled routine management tasks such as billing, collections, staffing, scheduling, and patient relations, while the owners, often physicians, have tended to the important business decisions. However, a more complex healthcare environment, coupled with growing competition, is forcing

ambulatory

(outpatient) care

Care that is provided to patients who are not institutionalized.

Typical settings include physicians' offices, outpatient surgery centers, and walk-in clinics.

managers of ambulatory care facilities to become more sophisticated in making business decisions, including finance decisions.

LONG-TERM CARE

Long-term care consists of healthcare (and some personal care) services provided to individuals who lack all or some functional ability, specifically in the activities of daily living such as eating, bathing, and locomotion. This type of care usually covers an extended period and may be given as an inpatient or outpatient service. Although the most common users of long-term care are the elderly, the services are available to individuals of all ages.

Individuals become candidates for long-term care when they become too mentally or physically incapacitated to perform daily living tasks and when their family members are unable to provide the help needed. Long-term care is a hybrid of healthcare and social services. Nursing homes are a major provider of such care.

Nursing home care is offered at three levels: (1) skilled nursing, (2) nursing, and (3) residential care. Skilled nursing facilities (SNFs) provide the level of care closest to hospital care. Services must be provided under the supervision of a physician and must include 24-hour daily nursing care. Nursing facilities (NFs) are intended for individuals who do not require hospital or SNF care but whose mental or physical conditions require daily continuity of one or more medical services. Residential care facilities are sheltered environments that do not provide professional healthcare services. Thus, most health insurance programs do not provide coverage for residential care.

Long-term care facilities are more abundant than hospitals. However, SNFs and NFs are smaller than hospitals, with an average of about 100 beds, compared with about 160 beds for hospitals. Traditionally, nursing homes were mom-and-pop operations. Increasingly nursing homes are owned by for-profit chains. For example, Brookdale Senior Living (2021) operates about 700 facilities across the United States. In 2016, 58 percent of nursing homes were chain-affiliated, and 60 percent were for-profit (Harrington et al. 2018). Nursing homes are licensed and inspected by states, which also license nursing home administrators. Although The Joint Commission accredits nursing homes, only a small percentage of these facilities obtain accreditation because it is not required for reimbursement and the standards to achieve accreditation are much higher than licensure requirements.

The long-term care field has experienced tremendous growth in recent decades. In 1960, long-term care accounted for only 3 percent of US healthcare expenditures, but by 2018 it accounted for nearly 5 percent, according to the Centers for Medicare & Medicaid Services (CMS 2020b). Demand increases are anticipated, as the percentage of the US population aged 65 or older is expected to grow from 16.5 percent in 2019 to 22 percent in 2050 (Statista 2021c). The elderly are disproportionately high users of healthcare services in general and are major users of long-term care in particular.

Although long-term care is often perceived as nursing home care, many new services are less institutional, such as adult day care, life care centers, and hospice programs. These

long-term care

Care that is provided in either an institutional or outpatient setting that covers an extended period.

services tend to offer a higher quality of life, although they are not necessarily less expensive than institutional care. Home health care, provided for an extended period, is an alternative to nursing home care but is not as readily available in many rural areas. Furthermore, many payers have sent mixed signals about adequately paying for home health care (Medicare.gov 2021; Van Houvten and Dawson 2020). In fact, many nursing homes and home health care businesses have been forced to close in recent years, while others consolidate and adopt cost-effective technologies (such as remote patient monitoring), as a result of a changes in payment policies (Medicare Payment Advisory Commission 2021).

Finally, many Americans suffer from a long-lasting, or *chronic*, illness (from the Greek word *chronos*, meaning time). Some chronic diseases, such as cancer, can be life-threatening. Other chronic illnesses, such as asthma and diabetes, while often incurable, can be managed by the patient for many years with proper care.

In the traditional system, the treatment of chronic illnesses was fragmented, with primary care physicians, specialists, hospitals, and other providers separately contributing their services without much planning or coordination with the other parties. Today, payers and providers have finally recognized that the most effective way to provide chronic care is using a long-term integrated approach, wherein a single case manager is responsible for the patient's care, regardless of the setting.

INTEGRATED DELIVERY SYSTEMS

Many healthcare experts have extolled the benefits of providing hospital care, ambulatory care, long-term care, and business support services through a single integrated delivery system (see “Critical Concept: Integrated Delivery System”). The potential benefits of such a system include the following:

- ◆ Patients are kept in the corporate network of services (a concept known as **patient capture**).
- ◆ Providers have access to managerial and functional specialists, such as reimbursement and marketing professionals.
- ◆ Information systems that track all aspects of patient care, as well as insurance and other data, can be developed more easily than under a disjointed care model, and the costs to develop them can be shared.
- ◆ Larger, multipurpose organizations have better access to capital.
- ◆ The ability to recruit and retain management and professional staff is enhanced.
- ◆ Healthcare insurers can be offered a complete package of services (one-stop shopping).

patient capture

The concept that once a patient enters the system (e.g., a doctor's office), all services needed by that patient should be provided in the system.

- ◆ A full range of healthcare services, including chronic disease management and health-status improvement programs, can be better planned and delivered to meet the needs of a defined population, develop patient-centered communication, integrate the continuum of care, and improve care management. Many of these population-based efforts typically are not offered by stand-alone providers.
- ◆ Incentives that encourage all providers in the system to work together for the common good of the system can be created, which has the potential to improve quality and control costs.

**CRITICAL CONCEPT**

Integrated Delivery System

An integrated delivery system consists of multiple types of healthcare organizations, such as hospitals, clinics, and nursing homes, owned and operated as a single entity. Although integrated delivery systems offer the opportunity to coordinate all aspects of patient care under a single umbrella, their complexity makes the overall management process much more difficult than in smaller organizations that focus on one type of service.

Although integrated delivery systems can be structured in many ways, the defining characteristic of such systems is that the organization has the ability to assume full clinical responsibility for the healthcare needs of a defined population. Because state laws typically mandate that the insurance function can be assumed only by licensed insurers, integrated delivery systems typically contract with insurers rather than directly with employers. Sometimes the insurer, often a managed care plan, is owned by the integrated delivery system itself, but generally it is separately owned. In contracts with some insurers, the integrated delivery system receives a fixed payment per plan-covered life and hence assumes both the financial and clinical risks associated with providing healthcare services.

To be an effective competitor, integrated delivery systems must minimize the provision of unnecessary services because additional services create added costs but do not necessarily result in additional revenues. Thus, the objective of integrated delivery systems is to provide all needed services to its member population in the lowest-cost setting (see “Healthcare in Practice: What We Spend on Healthcare”). To achieve this goal, integrated delivery systems invest heavily in primary care services, especially prevention, early intervention, and wellness programs. Thus, clinical integration among the various providers and components of care is essential to achieving quality, cost efficiency, and patient satisfaction.

In spite of the benefits of integration, health system executives have found that managing large, diverse enterprises is difficult. In many cases, the financial and patient care gains predicted were not realized, and some integrated delivery systems formed in the 1990s have broken up. However, healthcare reform legislation has created additional incentives that have fostered the rise of the accountable care organization. We discuss this new provider form, along with other features of reform, in chapter 3.



HEALTHCARE IN PRACTICE

What We Spend on Healthcare

Most people think that healthcare spending in the United States is out of control. For example, in 2019, almost 18 percent of the nation's total value of goods and services—that is, its gross domestic product (GDP)—was spent on healthcare, double the proportion of 9 percent of GDP spent in 1980 (CMS 2021). The proportion of GDP devoted to healthcare is expected to rise to nearly 20 percent by 2028, an amount greater than the anticipated expenditure for housing and food combined (CMS 2020a). In effect, rapidly rising healthcare costs are squeezing out the spending on other goods and services. By comparison, most other industrialized nations, such as Germany, England, and Canada, currently spend about 9 to 11 percent of their GDP on healthcare (Statista 2021b).

Where does all this money go? Data from 2018 indicate that Americans spend health-care dollars in the following way (CMS 2020b):

Hospital care	32.7%
Physician and other clinical services	22.7%
Prescription drugs	9.2%
Public health, research, and facilities	7.3%
Administrative costs	8.4%
Other health and personal care	5.3%
Long-term care	4.6%
Dental care	3.7%
Durable and nondurable medical equipment	3.3%
Home health care	2.8%
Total	<u>100.0%</u>

As you can see, the largest area of healthcare expenditure is hospital care; the second largest, physician and other clinical services, includes diagnostic imaging, outpatient surgeries, physical therapy, and chiropractic care. Combined, hospitals and ambulatory care providers consume more than half of each healthcare dollar.

The next biggest healthcare expense, at 9.2 percent, is prescription drugs. The proportion spent on prescription drugs is expected to increase over time as more and more individuals gain access to insurance programs that cover prescription drugs. However, commentators expect the increase in spending on prescription drugs to be mitigated by the increasing use of lower-cost generics and the potential for large insurers to negotiate lower prices.

(continued)

This is an unedited proof.

Copying and distribution of this PDF is prohibited without written permission. For permission, please contact Copyright Clearance Center at www.copyright.com



HEALTHCARE IN PRACTICE

What We Spend on Healthcare (*continued*)

Just over 8 cents of each healthcare dollar is spent on administrative costs. In 2018, almost \$3.6 trillion was spent on healthcare, and about \$302 billion of that money paid for government and insurance company administrative costs (CMS 2019; Hartman et al. 2019). Administrative costs can be defined and measured in numerous ways, but regardless of how they are measured, these costs eat up a great deal of money. Estimates vary, with some reaching more than 30 percent when all administrative costs, including those at provider organizations, are considered. One persuasive argument for establishing a universal or national healthcare system is that it can dramatically reduce administrative costs and hence make more money available for patient services.

Will we ever get healthcare spending under control? While there are current efforts aimed at reducing costs, predicting the long-term outcome of this problem is impossible. What we do know is that it cannot continue to grow at the current rate without causing financial damage to other parts of the economy. Thus, sooner or later, additional action will have to be taken.

1.6 REGULATORY AND LEGAL ISSUES

Healthcare services are subject to many regulations. For example, pharmacy services are regulated by state and federal laws, and radiology services are highly regulated because of the handling and disposal of radioactive materials. Entry into the healthcare sector is also heavily regulated. Examples of such regulation include licensure, CON, and rate-setting and review programs.

States require **licensure** of certain healthcare providers in an effort to protect the health, safety, and welfare of the public. Licensure regulations establish minimum standards that must be met to provide a service. Many types of providers are licensed, including entire facilities (e.g., hospitals, nursing homes) and individuals (e.g., physicians, dentists, nurses, even some managers).

Licensed facilities must submit to periodic inspections and review activities. Such reviews focus more on physical features and safety than on patient care and outcomes, although progress is being made to change this practice. Thus, licensure has not necessarily ensured that the public will receive high-quality services (see “For Your Consideration: Medical Malpractice”).

Critics of licensure contend that it is designed to protect providers, not consumers. For example, licensed paramedical professionals (e.g., physician assistants, dental hygienists)

licensure

The process of granting “permission” for healthcare (and other) professionals to practice. Most professional licenses are granted by states with the goal of protecting the public from incompetent practitioners.

This is an unedited proof.

Copying and distribution of this PDF is prohibited without written permission. For permission, please contact Copyright Clearance Center at www.copyright.com



FOR YOUR CONSIDERATION

Medical Malpractice

Many people have criticized the medical malpractice system in the United States for being expensive, adversarial, unpredictable, and inefficient. An estimated 59 percent of malpractice claims are dropped, withdrawn, or dismissed without payment, and only a small percentage of malpractice suits result in monetary awards (Golann 2011). Yet, the direct cost of these suits, along with the incentive for providers to practice *defensive* medicine, contributes to the cost of patient care. In total, an estimated 2.4 percent of annual healthcare costs are a result of the current malpractice system (Mello et al. 2010). Proponents of the current system say that it encourages providers to be more aware of patients' medical needs, creates incentives for the development of improved equipment and procedures, and provides a means for patients who have been wronged to seek compensation for damages.

What do you think? Should the current system be changed? If so, what are some potential changes? (Some observers have put forth such ideas as limiting lawyers' fees, capping awards for noneconomic damages, and decreasing the statute of limitations.)

usually are required to work under the supervision of a physician or dentist, making it impossible for paramedical professionals to compete with physicians or dentists. Despite the limitations of licensure, it is undoubtedly here to stay.

Certificate-of-need regulation was enacted by Congress in 1974 in an effort to control growing healthcare costs (see "Critical Concept: Certificate of Need"). CON legislation

required providers to obtain state approval on the basis of community need for construction and renovation projects that either relate to specific services or exceed a defined cost threshold. This attempt to control capital expenditures by controlling expansion and preventing duplication of services lasted less than a decade before the Reagan administration began to downplay CON regulation and promote cost controls through competition. However, CON regulation, in one form or another, still exists in roughly 35 states.

Critics of CON regulation argue that it does not provide as much control over capital expenditures as originally envisioned and that it



CRITICAL CONCEPT

Certificate of Need

A certificate of need (CON) is the approval required by many states before a new healthcare facility can be constructed. CON proponents claim the system helps control costs by preventing excess capacity. Critics, however, contend that CON regulation impedes competition and the spread of new technologies while protecting established providers, even those that do not operate efficiently.

This is an unedited proof.

Copying and distribution of this PDF is prohibited without written permission. For permission, please contact Copyright Clearance Center at www.copyright.com

increases costs by requiring additional administrative expenditures when new facilities are needed. Perhaps the biggest criticism of CON is that it creates a territorial franchise for the services it covers; that is, it creates barriers for new entities entering markets, even though the new businesses may be more cost efficient and offer better patient care than the existing ones.

In addition to CON, many states enacted **cost-containment programs** at the time when most healthcare reimbursement was based on costs. By the late 1970s, nine states had mandatory cost-containment programs, and many other states had voluntary programs (those that did not mandate compliance). The primary tool for cost-containment programs is the *rate-review system*.

Three types of rate-review systems have been used: (1) detailed budget reviews with approval or setting of rates; (2) formula methods, which use inflation formulas to set target rates; and (3) negotiated rates, which involve joint decision making between the provider and the rate setter. Some states that use rate-review systems have reduced the rate of cost increase to below the national average, while others have failed to do so. However, rate review, as a sole means of cost containment, has been criticized because it does not address the issue of demand for healthcare services.

The primary legal concern of healthcare providers is **professional liability**. Malpractice suits are the oldest form of quality assurance in the US healthcare system, and today such suits are used to an extreme extent. Many people believe that the United States is in the midst of a malpractice insurance crisis. Total malpractice premiums, which have remained stable or decreased over the period from 2008 to 2017, have been passed on to healthcare purchasers (Guardado 2018). On average, physicians pay between \$30,000 and \$50,000 on malpractice premiums, although some physicians in higher risk specialties pay malpractice premiums of more than \$100,000 per year (Guardado 2018). However, the total number of paid medical claims and the amount paid for malpractice claims has been steadily decreasing over the past decade.

Although providers in some states have achieved tort reforms, malpractice litigation continues to be perceived as inefficient because it diverts resources to lawyers and courts and creates disincentives for physicians to practice in high-risk specialties and for hospitals to offer high-risk services. In addition, such litigation encourages the practice of defensive medicine, whereby physicians overuse diagnostic services in an effort to protect themselves from liability.

Professional liability is the most visible legal concern in healthcare, but the sector is subject to many other legal issues, including the typical general liability and antitrust claims. In addition, healthcare providers are confronted with unique ethical issues, such as the right to die or to prolong life, that are often resolved through the legal system.

cost-containment programs

State programs that require providers (primarily hospitals) to submit budgets each year for approval.

professional liability

The responsibility of organizations and individuals who provide professional services, such as hospitals and physicians, for losses that result from malpractice.

SELF-TEST QUESTION

1. What are some forms of regulation in the healthcare sector?
2. What is the most pressing legal issue facing healthcare providers today?

This is an unedited proof.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.copyright.com

1.7 CURRENT CHALLENGES

In recent years, the American College of Healthcare Executives (ACHE) has conducted an annual survey of hospital CEOs regarding the most critical concerns of healthcare managers. Financial concerns have headed the list of challenges in every year since the survey began in 2002. When asked to rank their specific financial concerns in 2019, CEOs listed the increasing costs for staff and supplies as their primary challenge, with adequate reimbursement from Medicaid and bad debt also near the top of the list (ACHE 2021). (Reimbursement is discussed in chapter 3.)

Just as ACHE surveys its CEO members, the Healthcare Financial Management Association surveyed CFOs in 2017 regarding their concerns for the future (Wilk 2017). Their most pressing issue was the need for increased investments in technology to improve revenue cycle management. Aside from increased budgets, CFOs cited the need to leverage technology better to link clinical and financial opportunities in order to optimize performance. Another top concern among the CFOs was the increase in uncompensated care as patients assume more responsibility for payments through high-deductible health plans.

Taken together, these surveys confirm the fact 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.

? SELF-TEST QUESTIONS

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

THEME WRAP-UP CAREERS IN HEALTHCARE MANAGEMENT

What are some settings that require healthcare management graduates? The largest employers of healthcare managers are hospitals. In the United States, about 5,100 community hospitals, as well as Veterans Affairs, military, and public health facilities, are in operation (AHA 2021). In hospitals, healthcare managers are needed in a multitude of functional areas, such as operations, marketing, human resources (personnel), facilities, information technology, and finance. About 40 percent of all healthcare management graduates initially take positions at hospitals. Most start their careers in operations, while some find they are better suited for one of the other functional areas and move quickly into specialized staff positions.

Another career opportunity is in medical practice management. Almost 1 million physicians practice in the United States in settings that range from one-physician (solo)

practices to large group practices, such as Mayo Clinic, which has more than 3,800 physicians (Statista 2021a). Physicians practice within specialties, the largest of which is internal medicine. Other specialties include cardiology (heart), dermatology (skin), pediatrics (children), and surgery. Some group practices consist of only one specialty, while other practices include physicians from several specialties (multispecialty practices). Obviously, the larger the group practice, the greater the need for management expertise.

The structure of the management staff at large group practices is similar to that at hospitals, while small practices may have only a practice manager and a few clerks. In addition to physician practices, other healthcare professionals, such as physical therapists and psychologists, may own stand-alone medical practices that require managerial skills beyond those possessed by the clinicians. The bottom line is that healthcare organizations need managers, and the larger the organization, the greater the need.

As the population ages and life expectancy increases, the requirement for long-term care will continue to grow at a rapid rate. According to the Centers for Disease Control and Prevention (CDC 2021), as of 2016, about 15,600 nursing homes operated in the United States. These facilities require significant managerial expertise to prosper in an era of financial constraints, as do other institutional providers.

Many career opportunities are also available in insurance, health services research, consulting, public health, and even homeland security.

Regardless of your specific healthcare management goals, knowledge of the fundamentals of healthcare finance is a critical skill. This book will help you obtain this professional competency.

KEY CONCEPTS

This chapter provides an introduction to healthcare finance. Here are the key concepts:

- The term *healthcare finance*, as it is used in this book, refers to the accounting and financial management principles and practices used in healthcare organizations to ensure the financial well-being of the enterprise.
- The primary role of finance in healthcare organizations, as in all businesses, is to plan for, acquire, and use resources to maximize the efficiency and value of the enterprise.
- Finance activities generally include the following: (1) *estimating costs and profitability, planning, and budgeting*; (2) *financial operations management*; (3) *financing decisions*; (4) *capital investment decisions*; (5) *financial reporting*; (6) *financial and operational analysis*; (7) *contract management*; and (8) *financial risk management*.
- Finance activities can be summarized by the *four Cs*: costs, cash, capital, and control.

- The size and structure of the finance department in healthcare organizations depend on the type and size of the provider entity.
- The finance department in large provider organizations is generally led by the *chief financial officer* (CFO), who typically reports directly to the chief executive officer (CEO) and is responsible for all finance activities in the organization. Under the CFO are the *comptroller* (pronounced as and sometimes spelled as *controller*), who is responsible for accounting and reporting activities, and the *treasurer*, who is responsible for the acquisition and management of capital (funds).
- In large organizations, the comptroller and treasurer direct 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 small healthcare businesses, the finance responsibilities are combined and assigned to one individual, often called the *business manager* or *practice manager*.
- All business decisions have financial implications, so all managers (whether clinical or in operations, marketing, personnel, or facilities) must know enough about finance to incorporate its implications into their specialized decision processes.
- Healthcare services are provided in numerous settings, including hospitals, ambulatory care facilities, long-term care facilities, and even the home.
- Hospitals differ in function (general acute care vs. specialty), length of stay, size, and ownership (government vs. private; for-profit vs. not-for-profit).
- Ambulatory care, also known as *outpatient care*, encompasses services provided to noninstitutionalized patients. Outpatient settings include medical practices, hospital outpatient departments, ambulatory surgery centers, urgent care centers, diagnostic imaging centers, rehabilitation and sports medicine centers, and clinical laboratories.
- *Long-term care* entails healthcare services provided for an extended period, including inpatient, outpatient, and home health care, often with a focus on mental health, rehabilitation, or nursing home care.
- *Home health care* brings many of the same services provided in ambulatory care settings into the patient's home.
- The defining characteristic of an *integrated delivery system* is that it has the capability of providing all healthcare services needed by a defined population.
- Entry into the healthcare sector is heavily regulated. Examples of regulations include licensure, certificate of need (CON), and rate setting and review programs.
- Legal issues, such as malpractice, are prominent in discussions about controlling healthcare costs.

- Two recent surveys of healthcare executives confirm that healthcare managers view financial concerns as their most important current issue.

In chapter 2, we continue our discussion of foundation concepts and move on to finance-related topics, such as business basics, forms of organization, and taxes.

END-OF-CHAPTER QUESTIONS

1. a. What does the term *healthcare finance* mean, as it is used in this book?
b. What are the two broad areas of healthcare finance?
c. Why is it necessary to have a book on healthcare finance as opposed to a generic finance book?
2. a. What is the role of finance in the healthcare field?
b. Has this role increased or decreased in importance in recent years?
3. a. Briefly describe the following healthcare settings:
 - Hospitals
 - Ambulatory care
 - Home health care
 - Long-term care
 - Integrated delivery systemsb. What benefits are attributed to integrated delivery systems?
4. What role does regulation play in the healthcare sector?
5. What is the structure of the finance function in healthcare organizations?
6. What is the primary legal issue facing providers today?

REFERENCES

American College of Healthcare Executives (ACHE). 2021. "Top Issues Confronting Hospitals in 2019." Accessed July 26. www.ache.org/learning-center/research/about-the-field/top-issues-confronting-hospitals/top-issues-confronting-hospitals-in-2019.

———. 2020. *ACHE Healthcare Executive 2020 Competencies Assessment Tool*. Chicago: ACHE.

American Hospital Association (AHA). 2021. "Fast Facts on U.S. Hospitals, 2021." Updated January. www.aha.org/statistics/fast-facts-us-hospitals.

———. 2020. *Evolving Physician-Practice Ownership Models*. Published February. www.aha.org/system/files/media/file/2020/02/Market_Insights_MD_Ownership_Models.pdf.

Brookdale Senior Living. 2021. “Over 695 Senior Living Communities in 42 States.” Accessed July 28. www.brookdale.com/en/locations.html.

Bureau of Labor Statistics. 2021. “Medical Health and Services Managers.” *Occupational Outlook Handbook*. Modified June 2. www.bls.gov/ooh/management/medical-and-health-services-managers.htm.

Centers for Disease Control and Prevention (CDC). 2021. “Fast Stats: Nursing Home Care.” National Center for Health Statistics. Updated March 1. www.cdc.gov/nchs/fastats/nursing-home-care.htm.

Centers for Medicare & Medicaid Services (CMS). 2021. *National Health Expenditures 2019 Highlights*. Accessed July 28. www.cms.gov/files/document/highlights.pdf.

———. 2020a. “NHE Fact Sheet.” Modified December 16. www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.

———. 2020b. *Trend Tables: Health, United States, 2019; Table 45*. Modified December 16. www.cdc.gov/nchs/data/hus/2019/045-508.pdf.

———. 2019. “National Health Expenditure Data.” Modified December 17. www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData.

Community Health Systems (CHS). 2021. “Locations: 84 Hospitals, 16 States.” Accessed July 26. www.chs.net/serving-communities/locations/.

Golann, D. 2011. “Dropped Medical Malpractice Claims: Their Surprising Frequency, Apparent Causes, and Potential Remedies.” *Health Affairs* 30 (7). Published July 1. <https://doi.org/10.1377/hlthaff.2010.1132>.

- Guardado, J. R. 2018. "Medical Professional Liability Insurance Premiums: An Overview of the Market from 2008 to 2017." *AMA Economic and Health Policy Research*. Published January. www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/government/advocacy/policy-research-perspective-liability-insurance-premiums.pdf.
- Harrington, C., H. Carrillo, R. Garfield, and E. Squires. 2018. "Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 2009 Through 2016." Kaiser Family Foundation (KFF). Published April 3. www.kff.org/medicaid/report/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016/.
- Hartman, M., A. B. Martin, J. Benson, and A. Caitlin. 2019. "National Health Care Spending in 2018: Growth Driven by Accelerations in Medicare and Private Insurance Spending." *Health Affairs* 39 (1). Published December 5. <https://doi.org/10.1377/hlthaff.2019.01451>.
- HCA Healthcare. 2021. *HCA Healthcare: Fact Sheet*. Published June. <https://hcahealthcare.com/util/documents/2021/2021-Jun-HCA-Healthcare-Fact-Sheet-a.pdf>.
- Henry, T. A. 2019. "Employed Physicians Now Exceed Those Who Own Their Own Practices." American Medical Association. Published May 10. www.ama-assn.org/about/research/employed-physicians-now-exceed-those-who-own-their-practices.
- Medicare.gov. 2021. "Long-Term Care." Accessed July 28. www.medicare.gov/coverage/long-term-care.
- Medicare Payment Advisory Commission (MedPAC). 2021. *Report to the Congress: Medicare Payment Policy*. Published March. www.medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf?sfvrsn=0.
- Mello, M. M., A. Chandra, A. A. Gawande, and D. M. Studdert. 2010. "National Costs of the Medical Liability System." *Health Affairs* 29 (9). Published September 1. <https://doi.org/10.1377/hlthaff.2009.0807>.
- Merritt Hawkins. 2019. *2019 Survey: Final-Year Medical Residents*. Dallas, TX: Merritt Hawkins.

Powell, E. K. P. 2020. "Health Care Still Largest U.S. Employer." United States Census Bureau. Published October 14. www.census.gov/library/stories/2020/10/health-care-still-largest-united-states-employer.html.

Singleton, T., and P. Miller. 2015. "The Physician Employment Trend: What You Need to Know." *Family Practice Management* 22 (4): 11–15.

Statista. 2021a. "Distribution of Medical Practices by Size in 2018." Accessed August 17, 2021. www.statista.com/statistics/415971/size-of-medical-practices-in-the-us/.

———. 2021b. "Health Expenditure as a Percentage of Gross Domestic Product in Selected Countries in 2018." Accessed August 17, 2021. www.statista.com/statistics/268826/health-expenditure-as-gdp-percentage-in-oecd-countries/.

———. 2021c. "Share of Old Age Population (65 Years and Older) in the Total U.S. Population from 1950 to 2050." Accessed July 28. www.statista.com/statistics/457822/share-of-old-age-population-in-the-total-us-population/.

Tenet Health. 2021. "Locations." Accessed July 26. www.tenethealth.com/locations.

Van Houtven, C. H., and W. Dawson. 2020. "Medicare and Home Health: Taking Stock in the COVID-19 Era." Commonwealth Fund. Published October 21. www.commonwealthfund.org/publications/issue-briefs/2020/oct/medicare-home-health-taking-stock-covid-19-era#2.

Wilk, J. 2017. "Revenue Cycle Challenges and Recommendations for 2017." Healthcare Financial Management Association. Published February 3. www.hfma.org/topics/article/52398.html.