INTRODUCTION TO HEALTHCARE ACCOUNTING
FEBRUARY 23, 2015
10:15 – 11:15

AGENDA

• Audit & Finance Committee Responsibilities
• Revenue Recognition
  - Definitions
  - Calculating net revenue
• Industry Trends
• Expense Management
• Affordable Care Act (“Obamacare”)
  - Past, present and future
  - Accounting/finance implications
• Closing Comments, Q & A
AUDIT & FINANCE COMMITTEE HAS RESPONSIBILITY FOR FINANCIAL OVERSIGHT

AUDIT & FINANCE COMMITTEE
FINANCIAL RESPONSIBILITY

- Annual audit
- Financial reporting and review
- Internal control
- Budgeting - operating and capital
  - Business plan
- Debt financing
  - Bond covenant compliance
- Investment policy
- Risk management and insurance
AUDITOR’S REPORT

Unqualified Opinion

- Reasonable assurance F/S free from material misstatement
- Assessing the accounting principles used and significant estimates by management
- F/S present fairly, in all material respects on a comparative basis
  - Balance sheet
  - Results of operations
  - Changes in cash flows

Required Communications

- Auditor’s responsibilities under professional standards
- Accounting practices used
- Managements’ judgments and accounting estimates
- Financial statement disclosures
- Audit adjustments
- Waived adjustments
- Letter communicating significant deficiencies, material weaknesses
“NO MARGIN, NO MISSION”

“The way to do it is to run institutions that are financially solid.”

Sister Irene Kraus
Past President
Daughters of Charity National Health System

Past Chairman
AHA Board of Trustees

Revenue Recognition - Definitions

Gross charge - list price for service or item

Deductions from revenue
  • Contractual allowance - agreed upon rate of payment
    - Gross charge less payment = contractual allowance
  • Discount - discretionary reduction to self-pay patients
    - A percentage of charges
  • Charity care - patient unable to pay, can’t qualify for Medicaid
    - 100% write-off of gross charges
  • Bad debt expense - expected, but may not receive payment

Admission - inpatient stay
Revenue Recognition - Definitions (cont’d)

Adjusted admissions (or equivalent admissions) - measure of volume of business including outpatient activity

\[
admissions \times O/P\ \text{adjustment factor} \left( \frac{\text{total charges}}{I/P\ \text{charges}} \right) = \text{adjusted admissions}
\]

A/R days - number of days revenue in accounts receivable
Deductibles - balance after insurance, due by patient
Capitation - fixed payment per patient, per month regardless of the level of services used
Per diem - fixed daily payment regardless of level of services used
Case rate - fixed payment based on diagnosis or procedure, regardless of length of stay or services used
Medicare Part A - covers hospital, SNF, hospice, home health
Medicare Part B - covers doctors, O/P care, PT and OT

Revenue Recognition - Definitions (cont’d)

Medicare Advantage - plan purchased from insurance company
Supplemental coverage - pays for gaps not covered
Revenue per adjusted admission - NR ÷ adjusted admission
Cost per adjusted admission - operating costs ÷ adjusted admission
Utilization - breakdown of usage of hospital payor: by revenue or volume
Length of stay (LOS) - total patient days ÷ admissions
Revenue Recognition - Definitions (cont’d)

DRG – Medicare inpatient payment (DRG - Diagnostic Related Group)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor rated (adjusted by wage index factor)</td>
<td>$ 3,500</td>
</tr>
<tr>
<td>+ Non-labor related (geographic)</td>
<td>+ 1,500</td>
</tr>
<tr>
<td>Hospital adjusted base rate</td>
<td>5,000</td>
</tr>
<tr>
<td>x Individual DRG case weight</td>
<td>x 1.25</td>
</tr>
<tr>
<td>Hospital payment before add-ons</td>
<td>6,250</td>
</tr>
<tr>
<td>Add: DSH (disproportionate share)</td>
<td>x 1.20</td>
</tr>
<tr>
<td>Total hospital DRG payment</td>
<td>$ 7,500</td>
</tr>
</tbody>
</table>

Revenue Recognition - Utilization

<table>
<thead>
<tr>
<th>Payor</th>
<th>Based On</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Payments (Net Revenue)</td>
</tr>
<tr>
<td>Managed Care (Blue Cross, United, Cigna, etc)</td>
<td>±45%</td>
</tr>
<tr>
<td>Medicare</td>
<td>±35%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>±10%</td>
</tr>
<tr>
<td>Self Pay</td>
<td>±10%</td>
</tr>
<tr>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>
### Revenue Recognition - Utilization (cont’d)

#### Methods of Payment

<table>
<thead>
<tr>
<th>Payor</th>
<th>Inpatient</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% of Charges</td>
<td>Per Diem</td>
</tr>
<tr>
<td>Managed Care</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Medicare</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Medicaid</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Self-Pay</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Revenue Recognition- Bad Debt Expense

Prior to 1980- Deduction from revenue

1980- Hospital Audit Guide: operating expense

2011- FASB ASU (Accounting Standards Update):
- Deduction from revenue
- Footnote disclosure
Revenue Recognition - Bad Debt Expense

Hospital Accounting for Bad Debt Expense

Month of Service

• Charge $100
• Uninsured discount (hospital policy) $<65>
  Revenue before bad debt expense $35
• Bad debt expense (65% reserve, so 65% x $35) $<23>
  Net revenue $12

Subsequent Months

• Increase reserve monthly from 65% to 100% (unless collected or written off)

FOCUS: Accounting policy to estimate bad debt reserve
Methodology to validate policy - lookback analysis

Revenue Recognition - Net Revenue/ Operating Cost Overview

<table>
<thead>
<tr>
<th></th>
<th>Managed Care</th>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Charge</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Contractual Allowance</td>
<td>$&lt;50&gt;</td>
<td>$&lt;68&gt;</td>
<td>$&lt;84&gt;</td>
</tr>
<tr>
<td>Discount</td>
<td></td>
<td></td>
<td>$&lt;60&gt;</td>
</tr>
<tr>
<td>Bad Debt Expense</td>
<td></td>
<td>$&lt;30&gt;</td>
<td></td>
</tr>
<tr>
<td>Net Revenue</td>
<td>$50</td>
<td>$32</td>
<td>$16</td>
</tr>
</tbody>
</table>

Cost to charge ratio = \( \frac{\text{total operating expenses}}{\text{total gross charges}} \)

If ratio > 32%, generally loss on Medicare business
If ratio < 32%, generally profit on Medicare business
Revenue Recognition - Managing Margin

How does the finance department manage reimbursement?

- Net revenue/adjusted admission ≥ operating cost/ adjusted admission

Assume expected increase of 3% in operating cost/adjusted admission, need weighted average revenue increase of same 3%

<table>
<thead>
<tr>
<th>Payor</th>
<th>%age of net revenue</th>
<th>Rate increase</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care</td>
<td>50%</td>
<td>5.5%</td>
<td>2.77</td>
</tr>
<tr>
<td>Medicare</td>
<td>30%</td>
<td>0.5%</td>
<td>0.15</td>
</tr>
<tr>
<td>Medicaid</td>
<td>10%</td>
<td>0.5%</td>
<td>0.08</td>
</tr>
<tr>
<td>Self-pay</td>
<td>10%</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>3.00</td>
<td>Weighted avg. rev. incr.</td>
</tr>
</tbody>
</table>

Expected operating cost increase
No impact on operating margin 0%

Revenue Recognition- Troubleshooting High A/R Days

Inaudit File

- Are physicians required to sign off on medical record 1-3 days after discharge?
- Average # of days in file before dropped (billed)?
- Coders – critically important. Certified?
- After bill drops, are edits resolved timely?

Billing Process

- Does hospital bill or use a contractor?
- Contractor advantage: run their own edits. Are edits resolved timely?
- Clinics – physician credentialing delays prevent billing
Revenue Recognition- Troubleshooting High A/R Days

**Billed A/R**
- Are rejected bills worked timely?
- Are accounts turned over to collection agency timely per policy?

**ICD - 10**
- Is billing system ready for ICD - 10 effective 10/1/2015?
- Education and training
- Tested and validated with carriers?

**Industry Trends – New Business Model**

- Hospital
- Diagnostic Centers
- Urgent Care
- Surgery Centers
- Home Health Services
- Physician Offices

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**2015 ICD-10-CM Manual**

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2/11/2015
Industry Trends – Inpatient/Outpatient Utilization

Distribution of Outpatient vs. Inpatient Revenues, 1990 – 2010

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2010, for community hospitals.

Industry Trends – Hospital Medicare Margins

Medicare Payment Shortfall Causes Negative Hospital Medicare Margins

Hospital Overall Medicare Margins

Industry Trends – Pressure on Net Revenue

- Continual movement from I/P to O/P, and away from hospital
- Increase in patient deductibles
- Competition- other hospitals, physicians
- Reduced rate increases
  - Medicare: market basket reductions (productivity, DRG creep, sequester)
  - Employer/managed care pushback
  - Legislation
- Intense scrutiny on admissions
  - Inpatient vs observation
- Readmission penalties
- Recovery Audit Contractor (RAC) program

Industry Trends – Special Items

- Meaningful Use Incentive Payments for EHR (Electronic Health Record)
  - Phase I, II, and III criteria
- Value Based Purchasing/Pay for Performance
  - Quality of care, patient satisfaction
- ICD-9 to ICD-10 Conversion
  - Effective date 10/1/2013 – 10/1/2014 – now 10/1/2015
  - ICD-9: 17,000 codes; ICD-10: over 140,000 codes
  - Software, education, and training
  - Test and validate billing with carriers
  - Noncompliance results in significant increase in A/R
- Movement Away from Fee for Service
  - ACO’s (Accountable Care Organizations)
  - Bundled payments
  - Capitation, disease management
Expense Management- Labor and Supplies

Two largest expense areas

Labor
- Compliance with all regulations
- Consistent application of pay practices (OT, shift diff, etc.)
- Work comp program (claims mgmt., back to work philosophy)

Supply Expense
<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>Medical - surgical</td>
</tr>
<tr>
<td>30%</td>
<td>Implants</td>
</tr>
<tr>
<td>15%</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>5%</td>
<td>Other</td>
</tr>
<tr>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Savings Opportunities
- GPO compliance
- Vendor agreements, physician preference
- Pharmacist interaction w/ physicians

Expense Management- Physicians

- Standard agreements – recruitment, employment, professional fees, rented space
- CEO’s most important job
- Primary care network and specialists
- Hospitalists – reduction in LOS?
- Evaluate quality and profitability of each physician
  - Peer group metrics, payor mix, LOS, supplies, drugs
Affordable Care Act (“Obamacare”)

- Signed into law March 2010
- Provisions
  - Insurance reform
    - Young adults stay or parent’s plan until age 26
    - Minimum benefits
    - No denial (pre-existing condition) or dropping coverage
    - No overcharging based upon health status
    - No lifetime or annual dollar limits
  - Insurance mandate - employer and individual
  - Coverage of uninsured
    - Expansion of Medicaid (up to 138% of federal poverty level)
    - Establishment of exchanges: federal and state
      - Healthcare.gov
      - Policy subsidies (138% to 400% of federal poverty level)
  - Hundreds of sections not detailed – the Secretary (of HHS) shall promulgate…

Affordable Care Act (“Obamacare”)

Financial Considerations

- Cover 25-30 million uninsured and costs go down?
- Costs will only accelerate
  - Administrative infrastructure cost
  - Actuarial issues
    - Community rating can’t exceed 3:1
    - Enrollment targets for young and healthy not achieved
  - Exchanges
    - Up to 85% of enrolled receive a subsidy
    - Initial premiums are artificially low for 3 years
      - By individual insurers to attract initial year enrollment
      - “corridor” payments – make insurers whole for 2013-2015
    - Significant premium increases in 2016
- Hospital DSH payments generally aggregate 2%-3% of net revenue
  - Significant reductions scheduled
  - Will increase revenue from uninsured offset DSH reductions?
Closing Comments

- No margin, no mission philosophy
  - Business plan – SWOT analysis
  - Service line and physician evaluation
  - If it’s not being measured, you can’t improve upon it
- Quality team and finance work together
- Continually evaluate management team
- Meeting agendas
  - Reserves review
  - Key performance ratios: bond covenants, A/R days
  - Periodic 15-20 minute presentations from front-line management
    - Compliance, legal, nursing, quality, physician management, A/R, supplies/pharmacy, ERM, work comp, insurances
- ICD - 10 effective 10/1/2015
- Fee for service → capitation
- Involvement in governmental process

Q & A