

Financial Management Overview

Health Services & Applications to Neurodevelopmental Disabilities & Related Disorders in Children

The health care sector of our economy is growing rapidly in both size and complexity. Understanding the financial and economic implications of decision making has become one of the most critical areas encountered by health care decision makers. Knowledge paired with successful decision making can lead to a viable operation capable of providing needed health care services. Unsuccessful decision making often leads to financial failure. The role of financial information in rounding out the professional's perspective cannot be overstated.

Compared with most businesses, health care organizations are financially complex. Not only do they provide a large number of specific services, but also their individual services often have different effective prices structures. Services may be bundled in different ways to determine prices, according to extant agreements with specific payers. One customer [patient] may pay on a cost basis while another may pay based on self pay criteria. Prices may be determined prospectively or may be **capitated** for broad scopes of care. This variation in payment patterns or reimbursement creates problems in the establishment of prices for products and services. Indeed, the revenue function of a typical health care entity is usually much more complex than that of a comparably sized non-health care business. Further, organizations within different segments of the health care industry are affected by changes in payment arrangements in different ways.

Health care entities also depend heavily on a very limited number of key clients for most of their **operating costs**. The largest client is often the federal or the state government. Doing business with these governmental agencies involve a significant amount of reporting to ensure compliance and adherence to government regulations. Moreover, since the federal government is such a large purchaser of services, a thorough understanding of the nature and implications of the Medicare and Medicaid payment system's rules and regulations is a must for effective management practices.

Health care organizations can have vastly different **revenue structures** depending on which segments of the health care industry in which they are active. Government commands enormous influence as a purchaser of health care services and maintains complex payment systems. The **Managed Care** arena is an evolving payment mechanism that also must be critically analyzed and understood. Health plans have historically paid providers, doctors and hospitals on a **fee-for-service** basis. The health plan then assumed the risk for all **utilization variances**, whereas, the provider assumed the risk for production, being able to provide services at cost less than negotiated prices. **HMOs** and other managed care organizations are also trying to shift utilization risk to providers by capitating payment to them.

Capitation payment systems require the providers to know much more about the populations that they are obligated to provide services to and to do a much better job of

forecasting. Pricing under a capitated payment system is easy to conceptualize but difficult to implement because most providers have little experience with utilization variation in a covered population.

Regardless of whether a health care service is for profit or not-for-profit, both types of health care organizations must be able to cover their costs or the services will not survive. Generating more revenue, or income, than what it costs to provide those services is also a worthy goal, regardless of non-profit status. If a not-for-profit health care service generates a “profit” (i.e., takes in more revenues than it expends), the organization can put those resources back into the program for improvements or to meet increasing costs. The costs of doing business, whether it is health care or something else, usually involves a combination of **fixed costs** which are independent of volume of goods and services produced, such as salary for employees or equipment, and **variable costs**, which are goods or materials whose consumption is related to the volume or number of goods and services produced. The components are typically referred to as the “**cost structure**” of an organization. In the case of health care, the services or products of this sector are typically referred to as volume, visits, or utilization. Because the ability to survive as a health care provider organization is dependent upon an organization’s capacity to balance costs and revenues, it is critically important for not only managers and budget analysts to understand the basic tools of financial management, but also for clinicians to understand these concepts and their role in the cost structure and revenue generation processes. It is a fundamental requirement of leaders within an organization to assure the fiscal “health” of a company or organization, and thus, leaders of clinical programs must also have a command of financial management tools to assure good financial health.

Analyzing cost structures typically involves identifying **fixed costs** of salary and benefits of health care providers, facilities, debt service, and equipment. Fixed costs for the most part do not change within a fiscal year, and the organization is committed to paying out those costs whether one or 1000 patients are seen. Thus, to meet fixed costs there is an incentive to generate volume. **Variable costs** will vary, or change, as a function of patient volume. For example, laundry and food service charges in a hospital will vary depending on number of admissions and length of admissions. Both fixed and variable are referred to as direct costs. **Indirect costs** include the cost of administrative and overhead types of services that may be shared by a number of other clinical program areas or units, such as payroll, information services, billing, and housekeeping, but some portion of those costs must be borne equitably by each of the service units who make use of those shared services.

Generating revenue involves not only offering services that are attractive and responsive to customer needs, but also assuring adequate patient mix to secure reimbursement, managing timely billing, raising non-patient revenue based income, and effectively managing to maximize efficiencies that save the organization and the consumer money. **Analyzing utilization, revenues, and cost recovery** can also help a health care organization identify strengths and weaknesses and gaps in revenue generation, and can also contribute to **pricing** of services. Many health care organizations function as “price takers,” meaning that they take the reimbursement

provided by third party payers for particular services. Analysis of utilization and revenues based on prices set by the insurers is often all that is needed to project revenues under different volume scenarios. However, when new services are offered, establishing prices (i.e., becoming a “price setter” instead of “price taker”) may require the use of other types of analytic tools which may be based upon the actual costs of providing the service (based on the “cost structure”) and the presence or absence of discounts or a profit targets. A **cost-volume-profit analysis** and **break-even analysis** are two financial management tools that allow managers to explore the impact of alternative assumptions about costs, prices, and volume on its capacity to provide a particular service. This type of information can help managers “evaluate future courses of action regarding prices and the introduction of new services.” (Source: Louis Gapenski, *Health Care Finance*. Foundation of the American College of Health Care Executives, 2005).

Budgeting is also an important management tool that enables administrators to establish operational goals to keep costs in balance. Oftentimes a budget is set based upon previous year’s experience, and significant variations can occur in the current year from the previous year’s experience. If, for example, volume of visits is significantly lower than projected for a given period, there can be cost savings in variable costs, but fixed costs must be met regardless. Using c-v-p analysis in the budgeting process can allow administrators to develop a range of cost estimates based on volume and set volume targets to keep costs manageable. Use of the **balance sheet** (which provides a real time summary of costs/expenditures and cash flow) to monitor costs and revenues on an ongoing basis throughout the year is also an excellent tool to support the fiscal health of a health care organization and enables timely responses revenue or expense problems that might emerge.

Internal fiscal controls are employed in health care settings to assure accountability of the funds being generated (revenues) and being expended (payouts for salary, supplies, equipment, debt service, etc). Internal fiscal controls, such as payroll analysis and accounting audits, help managers identify any unusual outflows of cash or other inappropriate use of funds, and help avoid billing errors that could lead to costly and embarrassing fraud investigations.

Beyond using financial tools to effectively manage a health care service, financial analysis is a necessary component to any **business plan**. Analysis of market conditions is essential to predicting the potential of a new or expanded service, product, or line of business to cover its costs and/or make a profit, but this analysis cannot be complete until there is a full understanding of costs under various market scenarios, or projected volume of sales or services. Thus, all of the tools of financial management described above would prove useful when incorporated in business planning for new services. This type of analyses can gain the confidence of potential investors, whether they are financial investors, grant makers, academic administrators, or chief financial officers of health care organizations, all of whom will evaluate the merits of various proposals based on not just the need for the service, but is fiscal soundness as well.

The ability to manage financial decision-making requires an understanding of various terms. Below are listed common finance and budgeting terms and definitions of health services that will be invaluable in the professional's consideration of financial issues in care delivery for children with special health care needs.

Third-party payers-insurers from which a large proportion of the health service industry receives its revenues. Third-party payers are classified as private insurers (Blue Cross/Blue Shield, commercial, and self insurers) and public insurers (Medicare and Medicaid).

Revenues-monies collected or expected to be collected by an organization from the provision of patient services.

Expenses- economic costs associated with the provision of services.

Reimbursement-payment methods used to reimburse providers. Payment methods fall into two major classifications: **fee-for-service** and **capitation**.

Fee-for-Service-a payment method of which many variations exist and is based on the greater the amount of services provided, the higher the amount of reimbursement.

Capitation-a payment method in which a fixed payment is made to providers for each enrollee regardless of the amount of services provided. Providers receive a specific amount in advance to care for specific health care needs of a defined population over a specific period. Providers are usually paid on a "per-member-per-month" basis (PMPM).

A **capitated provider** assumes the risk of caring for the covered population for the PMPM amount. The capitation dollars are derived from premiums paid by enrollees.

Prospective Payment System-The rates paid by the payers are determined by the payer before the service is provided. For example, per procedure, per diagnosis, or per diem. This system is used by Medicare to reimburse providers a set amount based on the patient's DRG (Diagnosis-related group).

Managed Care- various arrangements made that are designed to control health care costs through monitoring, prescribing, or proscribing the provision of healthcare to a patient population, for example, an **HMO**. Managed care plans provide both the insurance function and the provision of healthcare services.

Health Maintenance Organization (HMO)-Entities that receive premium payments from enrollees with the understanding that the HMO is financially responsible for all predefined health care required by its enrollees for a specified period of time. The healthcare is provided through the HMO's provider network.

Preferred provider organization (PPO)- An independent provider or provider network pre-selected by the payer to provide a specific service or range of services at predetermined (usually discounted) rates to the payer's covered members.

Utilization review-used to ensure that services rendered are appropriate and needed.

Usage Variance-the dollar amount caused by excess utilization.

Negotiated charges-allow for discounts for billed charges. Some HMO's and PPO's can negotiate discounts ranging from 20 to 30 percent or more of charges billed to them because of the large number of patients that they bring to a provider.