Hospital Finances 101

Learning to speak to a CFO

Paul Hain, MD, FAAP
Section on Hospital Medicine

How It Looks from the C-Suite

"Hospital finance as a CEO isn't all that hard in concept. Hire a really good CFO and make sure that you bring in more money than you spend."

-Jeff Sperring

How Hospitals Get Inpatient Revenue

* Patient Admitted to Hospital
* Care Given
* Patient Discharged
* Bill Sent
* Somebody Pays… or doesn't

Payor Mix

* Medicaid
* Commercial Insurance (Blue Cross, United…)
* Other Governmental Programs
* Self Pay

An Example: How Payor Mix Affects Revenue

* Given a hospital that discharges 10,000 inpatients per year
* And given a hypothetical payment of

  $10,000 per discharge by Commercial Insurance versus
  $5,000 per discharge by Medicaid
* 70% Commercial Mix/ 30% Medicaid = $85 Million in revenue
* 40% Commercial Mix/ 60% Medicaid = $70 Million in revenue

An Aside About Commercial Insurance

* Most of the business of commercial insurance isn't insurance (that is, risk)
* Mostly they transfer money from businesses (self insured plans) to healthcare providers (in our case, hospitals)

Payment Methodologies

Per Diem	Percent of Charges	DRG (Diagnosis Related Groups)
Hospital gets a set fee per day that the patient is in the hospital (different for floor vs ICU)	Hospital gets a negotiated percent of the billed charges (chargemaster)	Hospital gets a bucket of money based on the diagnosis or surgical procedure of each admission
Incentives Admissions: Increase LOS: Increase Costs: Decrease	**Incentives** Admissions: Increase LOS: Increase Costs: Increase	**Incentives** Admissions: Increase LOS: Decrease Costs: Decrease

A Simple Question with a Complicated Answer:

Do you make money on a Medicaid Admission?

A guy walks into a University and asks, "what is one plus one?"

What do you want it to be?

Vocabulary Alert: Contribution Margin

* Defined as the difference between the revenue and variable expense
* It is the "profit" left over from a transaction that is available to be assigned to fixed costs

Our Medicaid Admission Example

* Simple Admission for which we are paid $5,000
* Overhead Allocated Cost (for room cost, cleaning, power, administration, med mal, advertising, etc):$3,000
* Hourly Salaries (nursing, RT, etc): $1,000
* Labs and Radiology: $500
* Drugs: $1,000
* Total Cost = $5,500
* Evaluation: $5,000 paid, $5,500 spent, ($500)

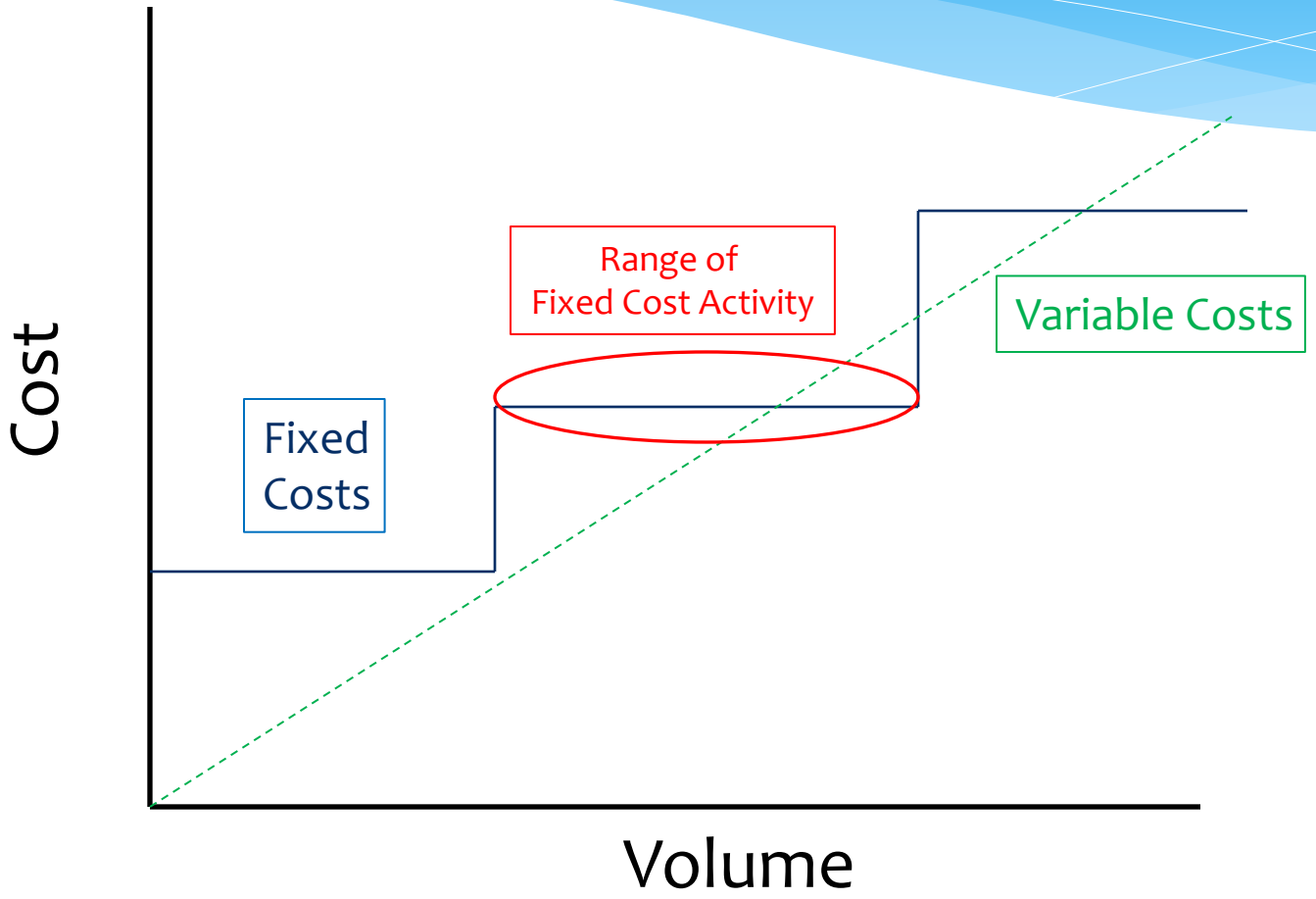
Marginal Analysis

* If this patient didn't exist, then all those allocated costs would be spread out over the rest of the patients. So the only money we really "spent" was:
* Hourly Salaries: $1,000
* Drugs: $1,000
* Actual parts of lab and radiology that cost money (like reagents and electricity): $200
* Total Variable expense = $1,000+$1,000+$200

Marginal Analysis

* Total variable expense = $2,200
* So the contribution margin was $5,000 - $2,200, or $2,800 in profit
* But the “fully loaded cost” was $5,500
* So one could either say we lost $500 or made $2,800 depending on how you wanted to look at it

Expense Types



Overheard CFO

“Our ADC is actually slightly better than we thought, but our CMI is killing us. At this rate, we won’t make budget.”

What did she say?

Vocabulary Alert: Average Daily Census (ADC)

* ADC = # of inpatient days/time period
* Traditionally measured by the sum of the daily census over a time period, divided by that number of days
* Important detail: daily census is traditionally measured at midnight ("heads in beds")
  * So what you see at 2pm as a very full hospital, your CFO may see as not very full

Vocabulary Alert: Case Mix Index (CMI)

* A DRG relative assigned value to each inpatient. Most Children's Hospitals use the APR-DRG system and CMI
* A measure of "how sick on average" the patients in your hospital are.
* CMI can be measured for a single patient, a floor, a service line, or a hospital

Overheard CFO

“Our ADC is actually slightly better than we thought, but our CMI is killing us. At this rate, we won’t make budget.”

What did she say?

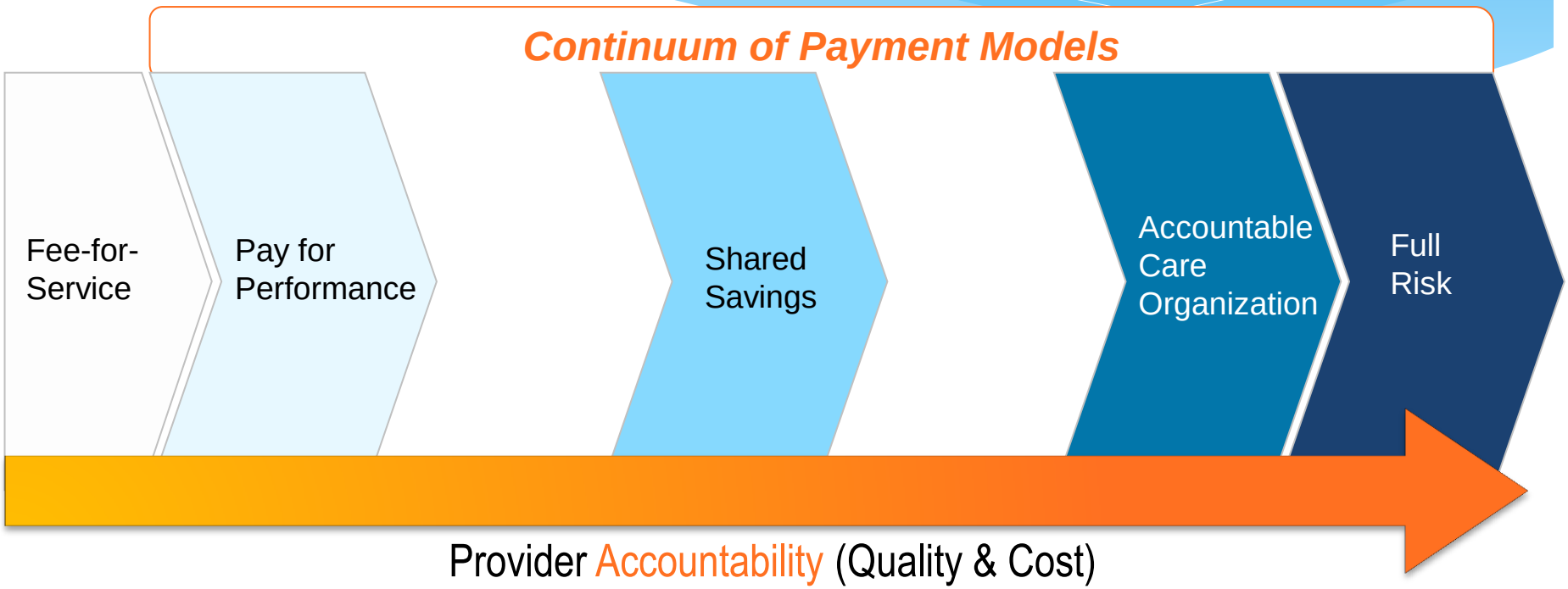
Overheard CFO

“We have admitted slightly more patients than we expected, but the reimbursement per patient is lower than we expected because, on average, our patients aren’t as sick as we thought they would be. The number of patients multiplied by the payments per patient is less than we thought. We may have allocated more money to be spent than we are going to take in.”

What's Keeping Your CFO Awake at Night?

* New payment methodologies
* Transition from old methodologies to new
  * How do you run a hospital if half of your contracts pay you to keep people healthy and at home, and the others pay you more every time you admit somebody?

Payment Structures to Align Incentives:



New Payment Structures

* Pay For Performance (P4P)
  * Negotiate targets for quality, efficiency or both
* Shared Savings
  * Set target goals based on actuarial assessments of populations, group gets a share of the amount of money below the target
* Accountable Care Organization (ACO)
  * Group of physicians/providers/facilities who agree to be responsible for the total care of a population
  * Incentives aligned so that spending less (fewer admissions) results in a gain to the group

Beware of ACOs in Name Only

Hospital A

$2,000 per member per year;
Attracts 500 employees of company XYZ

Total costs = $2,000 x 500 = $1 M

Hospital B

$1,000 per member per year;
Attracts 500 XYZ employees

Total costs = $1,000 x 500 = $0.5 M

New ACO to cut 10% costs

Total Cost
$1.5M

$1.64M

$1,800 per member per year;
Attracts 800 members

Total costs = $1,800 x 800 = $1.44 M

$1,000 per member per year;
Attracts 200 XYZ employees

Total costs = $1,000 x 200 = $0.2 M

How Hospital vs Insurance Company Conflicts Start

* Either side can instigate
  * Issue a termination
* Hospitals looking for increased rates
  * High Overhead
  * Market has shifted
  * Offset other losses (like Medicaid)
* Insurance Companies looking to lower trend
  * Pressure from self insured clients to lower total cost of care
  * May feel that other companies get a better deal

Things that Favor

The Hospital

- Niche Services
  - High End Pediatrics
  - Geographic Isolation
- Halo Effect
  - Great PR Team
  - Academic Medical Center

The Insurance Company

- High Marketshare
- Viable 2nd Option
  - Steerage is easy
  - Halo effect small
- High Hospital Charges
  - "Numbers Don't Lie"

Important Issues in a Conflict

* Communication
  * With Physicians often favors the Insurance Company
  * With Brokers often favors the Hospital
  * With Members is volatile
* At 30 days prior to going Out of Network
  * Members must have a communication
    * Often an impetus to settle
* At the drop dead date, things heat up even more
  * Cash flow issues for hospital
  * Out of Network charges for Insurance Company

Typical Management of High Priced Facilities

* Remove from Network Completely
  * Insurance company decides
  * Or Company decides in a Narrow Network
* Create Tiered Benefits
  * Self Insured corporation decides
* Advance Consumerism
  * Let the patient decide through transparency tool

More on "Steerage"

* Hospitals will often trade price concession for volume
* Carriers, or individual companies may steer patients to certain facilities for price breaks
* Typical ways:
  * Tiering
    * Covered deductible or all covered
    * Increased company co-insurace (90/10 vs 70/30)
  * Narrow Network
* Universal Out of Pocket limits have decreased the ability to steer… Unless you make a system out of network

CFO Job Description

Old Description:

"Maximize prices, Maximize Volume"

New Description:

"Maximize Profit by balancing different types of contracts, incentive payments, volume in the hospital and expense management"

And That Is Why Your CFO Is So Cranky

Questions?