Overview of the American Healthcare System

SECTION I

Financial management in health care comes with a unique set of challenges. Section I analyzes the differences between health care and other types of businesses and reviews the varied legal structures and missions of healthcare organizations. The evolution to third-party payers for healthcare services is traced from the start of healthcare insurance to government involvement in financing health care. The issues of rising medical costs and the impacts of the Patient Protection and Affordable Care Act of 2010 (PPACA) bring healthcare financial management to the present day.

The Environment of Healthcare Finance

CHAPTER 1

Key Terms

Capitation
Certificate of Need (CON)
Corporation
Equity
Fee-for-service
Health maintenance organizations (HMOs)
Hospice care
Hospital Survey and Construction Act of 1946
In-patient facilities
Limited liability partnership (LLP)
Long-term-care facilities
Managed care
Outpatient facilities
Palliative care
Partnership
Preferred provider
Professional corporation (PC)
Professional association (PA)
Proprietorship
Spend-down
Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

Chapter Objectives

After completing this chapter, readers should be able to:

- Explain the similarities and differences of health care from other types of businesses.
- Discuss the background of financing health care in the United States.
- Analyze the factors causing the growth of inpatient hospital facilities until the mid-1980s and the decline after that time.
- Identify the variety of services provided in outpatient settings.
- Analyze the growth in outpatient services and home-based services.
- Describe the functions of nursing homes, the rise of life-care facilities, and hospice care as a specialty within health care.
- Describe the legal differences between proprietorships, partnerships, and corporations.
- Explain the use of professional corporations (PCs) and limited liability partnerships (LLPs) to control business liability.
- Discuss the differences in function and mission between for-profit, not-for-profit, and governmental healthcare organizations.

Chapter Glossary

Capitation plans are insurance programs that pay providers a specific amount in advance to provide healthcare services to members. Providers are normally paid on a per-member, per-month (PMPM) basis. Unless otherwise stipulated in the contract, the provider bears the full costs of providing agreed services to members and accepts the monthly payment amounts as the full amount due under the contract.

A **Certificate of Need (CON)** is a legal document required in 36 states and federal jurisdictions issued by healthcare authorities prior to the expansion of an existing hospital or construction of a new facility.

A **corporation** is a business entity where the business is separate and distinct from its ownership, providing limited liability to its stockholders.

Equity is ownership.

Fee-for-service is the reimbursement to a medical service provider for specified services based on a fee schedule established by the third-party payer and agreed to by the provider.

Health maintenance organizations (HMOs) are a form of managed care healthcare insurance. A primary care physician "gatekeeper" coordinates patient care and directs patients to specialists. Plan participants are required to use medical service providers within the HMO network.

Hospice care is designed to meet the needs of dying patients and their families, keeping the patient free of pain and attending to the spiritual and emotional issues faced during this stage of life.

The **Hospital Survey and Construction Act of 1946** required the states to implement plans for hospital construction programs and provided federal grants to finance the construction of community hospitals.

In-patient facilities, most commonly hospitals, provide medical services where the patient resides in the facility for a minimum of one overnight stay.

A **limited liability partnership (LLP)** is a structure authorized under state statutes for a medical services partnership to limit the partners' liability in malpractice.

Long-term-care facilities, such as nursing homes and life-care facilities, meet extended care needs of patients who are no longer able to live independently.

Managed care is a term used to describe efforts to provide quality care at a reasonable cost.

Outpatient facilities provide medical services without overnight stays.

Palliative care is the medical care provided to a patient at the last stages of life, designed to manage the symptoms of the patient's final illness and provide relief from pain.

A **partnership** is a business owned by two or more individuals or entities.

Preferred provider healthcare insurance programs restrict plan participants to an approved list of providers who have contractually agreed to accept established reimbursement schedules for medical services.

A **professional corporation (PC)**, also known as a **professional association (PA)**, is a legal form of business established to allow proprietorships (defined below) to limit the liability of the owner.

A **proprietorship** is a business owned by one individual.

Spend-down is the term used for the process that occurs when an individual's financial resources are exhausted and the individual becomes eligible for Medicaid assistance in meeting nursing home bills.

The **Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)** abolished the former cost-plus Medicare reimbursement system and replaced it with standardized reimbursement tables.

Introduction

Financial management of healthcare facilities is still financial management, but with a few twists. The debits and credits of accounting are the same, and the balance sheet and income statement of a hospital or physician practice will look very similar to those of the neighborhood hardware store or midsized corporation. Healthcare facilities have the same financial management needs as other businesses: developing operating and capital budgets, generating cash flow from providing services to meet the ongoing obligations of the business, financing the acquisition of capital assets needed for the business, and developing banking relationships.

While there are many similarities, there are also major differences in the financial management of healthcare facilities and other businesses. In most businesses, customers make decisions on what vendors to use for goods and services and use their own financial resources to pay the bill. In health care, the majority of the costs of services provided are paid for by a third-party, either an insurance company such as Blue Cross/Blue Shield or a government agency such as Medicare or Medicaid. Instead of the customer (the patient) paying for the services provided, the facility needs to have financial systems in place to manage third-party contracts and bill for services. Under some of these third-party payer systems, the patient continues to have the right to select the provider of healthcare services. Under some types of managed care, the healthcare facility is paid a capitation rate and a fixed monthly amount per patient, and has the responsibility to provide for the medical needs of the patient. In managed care systems, patients lose their freedom of choice in selecting the providers of their medical care.

A second major difference is that health care in the United States is provided by a unique mix of governmental agencies, free-enterprise for-profit businesses, and not-for-profit corporations. Many communities are served by a mix of privately owned physician practices, a government-run health clinic, an investor-owned hospital competing in the marketplace to generate a financial return for stockholders, and a not-for-profit hospital exempt from the taxes that have to be paid by the investor-owned hospital. The goals of each of these types of organizations are different, and the challenge to financial managers is to operate the businesses in a manner that will allow the facility to meet its goals. The goal of the government-run health clinic will be to provide quality care while operating within its authorized budget; the goal of the for-profit hospital will be to provide quality care while still generating a return on investment.

Health care in the United States is also a heavily regulated business. Other types of businesses, for example, manufacturing plants, have the ability to expand capital

investment in order to increase production and profits. In health care, the **certificate of need (CON)** process may limit the ability of a hospital to expand its facility to increase revenues. A certificate of need is a legal document required in 36 states and federal jurisdictions issued by healthcare authorities prior to the expansion of an existing hospital or construction of a new facility. Hospitals must prove that there is a local need for increased capacity. The CON process arose from the concern that excess capacity constructed in a community would lead to overcharging for services to finance hospital overhead costs. The CON program has not been without controversy. Critics are concerned that the CON process is designed to maintain the monopoly status of existing hospitals, increasing costs to patients by eliminating potential competition. Services offered by physicians are limited by state licensing regulations.

Financing Health Care in the United States

Prior to 1900, the medical profession was pure free enterprise. Individuals made the decisions of when to secure medical services and which medical provider to use, paying for the services with their own funds. Workers' compensation insurance had not yet been legally mandated, and private health insurance was in its infancy, limited to reimbursement of lost wages. These early voluntary health insurance policies were closer to the form of a disability policy than to modern health insurance that covers doctor and hospital costs.

Hospitalization insurance started during the Great Depression. Charitable donations, historically the primary funding sources for hospitals, declined with the crash of the stock market in 1929, and hospitals needed to turn to fee-for-service to support their operations. Concern over the costs of a hospital visit resulted in the creation of Blue Cross in 1933, providing the means for individuals to insure against these unexpected costs. Blue Cross was formed as a nonprofit corporation; private for-profit insurance companies saw an opportunity in hospitalization insurance and entered the field in competition with Blue Cross. These plans at that time covered only hospital charges, not physician services.

Blue Shield and its competitors in private insurance developed insurance programs to cover the costs of physician services as a companion program to Blue Cross insurance coverage for hospital charges. Blue Shield, at its inception, was a separate and independent agency from Blue Cross; however, the two programs were often offered together to provide insurance for both hospital and physician services. These combined health insurance programs expanded rapidly during World War II. The federal government imposed wage freezes during the war, and unions began to seek new health insurance benefits through collective bargaining. Health insurance continued to expand as an employer-provided benefit through the favorable economic times of the 1950s and became a standard feature of employer wage and benefit packages. Health insurance plans during this era were **fee-for-service** plans, with physicians and hospitals compensated for medical services provided based on their costs for providing the services.

In 1965, the federal government responded to the impact of the costs of medical services on the aged and lower-income members of the population with approval of the Medicare and Medicaid programs. These two programs were created by amending

the Social Security Act (SSA). SSA dates back to its authorization in 1935, providing retirement income to the elderly and the disabled.

In the original Medicare and Medicaid programs, hospitals were paid based on a retrospective, or cost-based, payment system similar to the fee-for-service health insurance plans in the private sector. Charges were submitted to Medicare and insurance companies by providers, and the providers would be reimbursed, usually at 80% of the charge. There were no incentives for providers to control costs. As healthcare costs continued to rise, Medicare began to investigate prospective payment systems for inpatient services. The **Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)** mandated change to the Medicare program to control costs. In 1983, the Social Security Act was changed to mandate implementation of a prospective payment system for Medicare Part A. The prospective payment method used by Medicare is called the diagnosis-related group (DRG) system. This system takes into account the resources used for each patient by diagnosis and assigns a relative weight that represents the intensity of the diagnosis. This was the first attempt to manage a portion of the cost of health care.

Early models of private sector group healthcare insurance were based on fee-for-service. Plan participants received medical services and the medical facilities billed insurance carriers based on the costs of providing the services. These early plans did not include cost controls over the medical services provided. As healthcare costs continued to rise, insurance carriers responded with premium increases to employers and plan participants.

Concerns over rising costs have resulted in a variety of methods implemented to control costs. The traditional fee-for-service insurance plan is no longer a significant part of the healthcare insurance market. Instead, modern health insurance plans attempt to control costs by changing consumer behavior and reducing reimbursement to the providers of care. **Health maintenance organizations (HMOs)** are a form of **managed care** healthcare insurance. A primary care physician "gatekeeper" coordinates patient care and directs patients to specialists when needed. Plan participants are required to use medical service providers within the HMO network. Managed care plans also take the form of **preferred provider** insurance contracts that limit participants to in-network providers. Providers of medical services who are in these networks have agreed to accept a certain level of payment in return for an expanded client base of plan participants. Managed care also includes **capitation** plans, where the medical services provider takes the risk for the costs of providing medical services to a group of patients and is paid a monthly fee for each patient. Each of these managed care models include wellness programs as a way to control costs. Plans offer smoking-cessation and weight-loss programs in an effort to have healthier employees.

Types of Medical Businesses

Business may be defined as any entity that raises funds to be invested in property, plant, and equipment and uses those assets in the generation of revenue. A physician uses her own money or a bank loan to open a private practice. A large hospital holding company issues bonds to purchase more hospitals or expand facilities. Businesses are dependent on revenues generated from selling goods or providing services to

cover the costs of doing business. The business model, including both for-profit and not-for-profit entities, is different than a government program or a charity. A charity or government-run program raises money either from taxes or contributions and uses those funds to provide goods or services either free of charge to eligible recipients or at subsidized rates. Business growth is only limited by the level of revenues generated, which can grow by selling more goods or providing more services. Government programs must operate within a budget, and charities are limited by contributions received. Organizations providing healthcare services can be categorized as follows:

BOX 1-1 Types of Medical Businesses

1. For-profit healthcare organizations
   - Proprietorships and professional corporations (PCs)
   - Partnerships and limited liability partnerships (LLPs)
   - Small corporations
   - Large publicly-held corporations
2. Not-for-profit business-style organizations
3. Government healthcare facilities
4. Other healthcare organizations

For-Profit Healthcare Organizations: Proprietorships & Professional Corporations (PCs)

A **proprietorship**, also referred to as a *sole proprietorship*, is a business owned by one individual. Proprietorships are easy to form, not requiring the legal documentation of partnership agreements or corporate charters. When a proprietorship business has a profit, evidenced by annual revenues in excess of annual expenses, the profit is taxed as income to the owner whether it is reinvested in the business or withdrawn from the business by the owner in the form of salary.

Example 1-1

Dr. Serena Tompkins attended the University of Michigan Medical School and had her postgraduate training at a major Detroit hospital. In 2000, she started a private practice in her hometown in rural Michigan. She hired an office manager who also served as bookkeeper and two medical assistants to assist in the practice. Dr. Tompkins uses a local accountant to prepare financial statements and tax returns as a sole proprietorship.

Proprietorships have several major disadvantages. The business owner, wishing to recover his or her investment in the business, will not find an organized market that may be easily accessed for selling the business. A physician wishing to retire from private practice may face a lengthy process in attracting a new physician to purchase

the practice and structuring the sale. This is different from an individual holding stock in a hospital corporation listed on a major stock exchange. In that case, the stock may be easily sold and the equity position converted to cash.

A second major disadvantage is that the owner of a proprietorship has unlimited personal liability for any debts or legal settlements against the business. If the business loses money and is closed with debts still outstanding, creditors have the ability to collect funds due them from the personal assets of the owner. To address this issue of unlimited liability, all 50 states have statutes that allow proprietorships to form a **professional corporation (PC)**. In some states, this is referred to as a **professional association (PA)**. While providing protections to the business owner, professional liability for malpractice is not covered and remains the responsibility of the individual physician.

Partnerships and Limited Liability Partnerships (LLPs)

A **partnership** is a business owned by two or more individuals or entities. Partnerships in health care are most commonly two or more individual medical professionals in business together to provide services. As in a proprietorship, profits generated by the business are taxed as income to the partners. Profits are divided by the partners based on the partnership agreement that can range from a simple oral agreement to a complex written document.

Example 1-2

Dr. Tompkins, from Example 1-1, opened her practice in 2000. Over the years, her hometown has grown and her practice with it. In 2008, Dr. Tompkins hired Dr. Samuel Restin to a salaried position with no **equity** *position in the practice. The term equity represents an ownership position in a business. In 2011, Dr. Tompkins contacted a local attorney and had him prepare a partnership agreement for the practice, making Dr. Restin an equal partner. The business is now a legal partnership between the two physicians.*

Partnerships have the same disadvantages as proprietorships, including a limited market for the sale of partnership equity and in the unlimited liability of the partners. This issue of unlimited liability has been addressed by legislation to provide financial protection to partners in a medical business. **Limited liability partnerships (LLPs)** are available under a number of state statutes. These LLPs retain unlimited liability to the partners for most debts, but any debts resulting from malpractice settlements are the responsibility of the individual physician responsible for the malpractice, not the partners. The legal structure of a professional corporation (PC), discussed earlier in the section on proprietorships, is also available to a medical partnership.

Small For-Profit Corporations

Any business can be organized as a **corporation**, requiring only a corporate charter and a set of bylaws. Corporations may be privately held or owned by a single person or a small group of people. In a privately or closely held corporation, the owners

are private investors. Small corporations may function in a fashion very similar to a proprietorship or partnership, with no market for the capital stock and the future of the business dependent on the work of the owner or partners. Small corporations, with stock held by a single individual or just a few stockholders, may be incorporated as *S corporations* under the Internal Revenue Code. In these S corporations, profits of the corporation are passed through to the stockholders and taxed as income.

Large Publicly-Held Corporations

Publicly-held corporations raise funds by issuing stock. Many of these large corporations have thousands of stockholders, and the stock of these companies is actively traded on major stock markets. In the world of business, think of General Electric and Microsoft. In medical services, these large investor-owned businesses include Health Management Associates (HMA) and Tenet Healthcare Corporation in hospital management, Walgreens and CVS in pharmacies, healthcare insurance companies such as United Healthcare, and large corporations doing business in nursing homes and life-care facilities. These large corporations will continue to provide their goods and services indefinitely, surviving the death or departure of key executives and individual stockholders.

Example 1-3

Tenet Healthcare Corporation is an example of a large publicly-held corporation in health care. On Tenet's website (www.Tenethealth.com), they report that they own and operate 49 hospitals in 11 states and 63 outpatient facilities in 12 states. A Standard & Poor's stock report stated in April 2011 that Tenet had 2010 total revenues of $9.2 billion. The corporation had 846 million shares of capital stock outstanding and had a total market value of $3.4 billion.

One of the major advantages of the corporate structure is that the corporation has an unlimited life, not limited to the lifespan of the owner or partners. A second major advantage to the corporation is that the corporation is a separate and distinct legal entity and the liability of the stockholders is limited to the value of the investment made in the stock. Under this concept of limited liability, if the company becomes bankrupt, debts owed by the business are paid up to the limits of the assets held by the corporation and creditors are precluded from making claims against the stockholders.

Example 1-4

To illustrate the concept of limited liability: GenX Biotech is a new research company that has a public stock offering. Tom Adams, an individual investor, purchases $5,000 of GenX Biotech stock at the initial public offering. Capital raised from the stock offering is supplemented with a bank line of credit. The company conducts basic research in hopes of developing marketable products. After three years, the company has exhausted all its resources and fails. The stock purchased by Mr. Adams is now worthless, but he is not personally responsible for any of the debts of the company.

One of the major trends in U.S. medicine over the past several decades has been the rise of for-profit hospital corporations purchasing and managing a number of hospitals. Centralized functions such as administration, corporate accounting, and purchasing can lead to cost-efficiencies and greater profits. Large for-profit systems may own hundreds of hospitals across the country. Public stock offerings and cash generated by operations provide funding for further acquisitions and generating value for stockholders. Management and corporate planning will be centered within corporate headquarters, with the day-to-day operations of individual hospitals handled locally.

The major financial disadvantage for large publicly-held corporations is double taxation. Businesses with a standard corporate structure are referred to as *C corporations* in the federal tax code. These corporations are required to pay taxes on profits made in their business activities. Then when the profits are distributed to stockholders in the form of dividends, they are taxed again as income on individual tax reports.

Not-For-Profit Business Organizations

Many communities are served by not-for-profit hospitals. These hospitals operate in a business style similar to for-profit hospitals, with the revenues received from providing medical services used to cover their costs of operation. Where a for-profit business *may* decide to adopt a corporate structure, not-for-profit businesses (also called nonprofits) *must* be structured as corporations. For-profit businesses are established and operated to make money and share the profits with stockholders in the form of dividends and growth in the value of the stock. Not-for-profits provide for the public good and are not designed to earn profits. Businesses that meet the qualifications as not-for-profit are exempt from both property and income taxes under Internal Revenue Code Section 501(c)(3) as charitable organizations. That section provides the following definition of a charitable organization: "any corporation, community chest, fund, or foundation that is organized and operated exclusively for religious, charitable, scientific, public safety, literary, or educational purposes."

A for-profit business has stockholders who elect a board of directors to oversee the operations of the entity. A not-for-profit corporation has an appointed board, generally comprising community leaders dedicated to the charitable mission of the entity. However, there are no stockholders to whom the board is accountable.

One of the areas of uniqueness in the healthcare industry comes from the competition of a for-profit entity and a not-for-profit entity in the same marketplace. For-profit hospitals are outnumbered by nongovernment, not-for-profit hospitals. In the United States, there are approximately 800 for-profit community hospitals as compared to 3,000 nongovernment, not-for-profit community hospitals. It is not uncommon for a large community to be served by both for-profit hospitals and not-for-profit hospitals. Not-for-profit hospitals have the advantages of not having to generate profits for stockholders and frequently enjoy community donor and volunteer support. For-profit hospitals that are part of multihospital holding companies have available cost savings from the centralization of functions such as purchasing and accounting to hold down operating costs.

Government Healthcare Facilities

Federal, state, and local units of government are heavily involved in directly providing medical services. The U.S. Department of Veterans Affairs (VA) owns and operates medical facilities nationwide, providing services to veterans and their families. In many communities, local governments own hospitals that are operated as a service to the citizens. In low-income areas, these government-run hospitals are able to support operating revenues with local taxes to be able to continue services. County health departments provide services to the communities, supported by local taxes.

Other Healthcare Organizations

A number of healthcare organizations that provide medical services directly to patients and clients do not fit neatly into the previous business categories. These are primarily voluntary health and welfare organizations that rely on public donations for their funding. Examples of these types of organizations would be the American Red Cross, the March of Dimes, and Planned Parenthood.

1. What are the major differences between financial management for healthcare facilities and other types of free-enterprise businesses?

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_____

2. What types of skills do you think are necessary for an effective financial manager in health care?

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3. Dr. Reginald Dustin is a licensed family practice physician. He has hired a staff of five to help him in running the practice. He draws a monthly salary and leaves profits in the business for capital purchases. This type of business is a:
   - **A.** Proprietorship
   - **B.** Partnership
   - **C.** For-profit corporation
   - **D.** Not-for-profit corporation

continues

4. Dr. Susan Towers has an established medical practice and wishes to expand the practice by bringing in another physician. The two physicians agree to a document specifying how much the new physician will pay into the business over time to secure an equity position, their monthly salary draws, and a division of profits. This type of business is a:
   A. Proprietorship
   B. Partnership
   C. For-profit corporation
   D. Not-for-profit corporation
5. American Hospitals owns and operates 18 hospitals in eleven states. It is registered with the Securities & Exchange Commission and has several thousand stockholders. This type of business is a:
   A. Proprietorship
   B. Partnership
   C. For-profit corporation
   D. Not-for-profit corporation
6. What is a professional corporation (PC), and why would this structure be an advantage to a physician?

   _____

   _____

   _____

7. What is a 501(c)(3) corporation?

   _____

   _____

   _____

Medical Facilities: The Evolving Process of Healthcare Delivery

The brick-and-mortar part of health care is the physical facilities used to house medical services. Over the course of the 20th century, services provided by these facilities have changed dramatically. The number of hospital stays increased into the 1980s, replacing home remedies and family members as caregivers. Hospital stays then began a steady decline as cost pressures reduced the duration of hospital stays and medical procedures were transferred to outpatient settings. The business model of nursing homes expanded into life-care centers. Hospice care became a specialty service to meet the needs of those with terminal illnesses.

There are three separate and distinct types of facilities, based on their mission:

- **Inpatient facilities,** most commonly hospitals, provide medical services where the patient resides in the facility for a minimum of one overnight stay.
- **Outpatient facilities** provide medical services without overnight stays.
- **Long-term-care facilities,** such as nursing homes and life-care facilities, meet extended care needs of patients who are no longer able to live independently due to age, disability, illness, or injury.

Inpatient

> "It may seem unnecessary to define a "hospital" since everyone knows the nature of a hospital. The word *hospital* comes from the Latin *hospes,* which refers to either a visitor or the host who receives the visitor. *Hospital* only took on its modern meaning as "an institution where sick or injured are given medical or surgical care" in the 16th century."
>
> (www.MedicineNet.com April 27, 2011)

The major growth in not-for-profit community hospitals began after World War II. Very little hospital construction was done during the Great Depression, and World War II focused capital investment on the war effort. The result of almost two decades without new or expanded hospitals left the country short of hospital beds when soldiers and sailors returned from the war and started to raise families. The **Hospital Survey and Construction Act of 1946** required the states to implement plans for hospital construction programs and provided federal grants to finance the construction of community hospitals. The program was successful in increasing the availability of in-patient hospital services with beds per 1,000 residents increasing from 3.2 in 1940 to 4.5 in 1980. However, the growth of the outpatient sector has reduced the need for inpatient beds.

The number of hospitals as well as the total number of patient beds available began to shrink after 1980. During the 1980s, concern about rising healthcare costs, combined with new technologies and medical treatments, resulted in the shift from inpatient to outpatient medical services. Many of these new outpatient services were provided in medical facilities with medical providers not associated with hospitals, reducing hospital revenues and forcing the closing of many hospital facilities that could no longer cover their costs of operation. According to the American Hospital Association, the number of community hospitals in the United States declined from 5,900 in 1975 to 5,000 in 2009. The total number of hospital beds per 1,000 population declined from 4.5 in 1980 to 2.7 in 2008, the latest figures available.

Compounding the loss of revenues from the increased emphasis on outpatient medical services was a major change in Medicare reimbursements. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) abolished the former cost-plus Medicare reimbursement system and replaced it with standardized reimbursement tables. Under the new rules, hospitals received less reimbursement for identical procedures. Following the lead of Medicare, both Medicaid and private insurance companies tightened their reimbursement formulas and paid the hospitals less for the same services.

The rise of managed care has also had a serious negative impact on hospital revenues. Managed care, focusing on holding down costs and premiums, stresses wellness programs, outpatient medical procedures, and the use of nursing homes and home-based healthcare services in lieu of inpatient hospital stays.

Hospital management is another unique characteristic of health care. Refer to Figure 1-1:

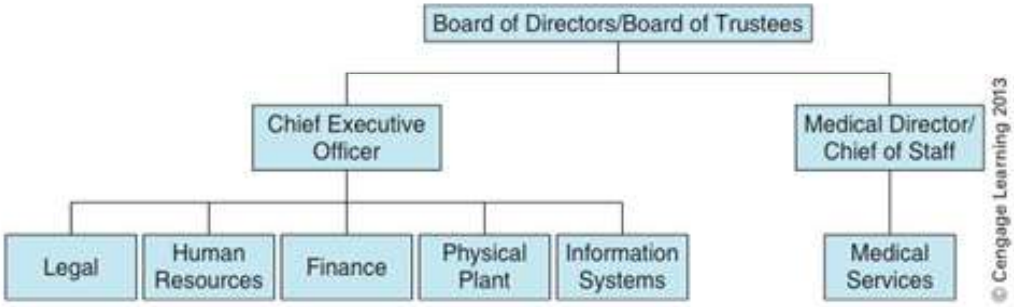

Figure 1-1 An example of a hospital organizational chart.

At the top of the organizational chart for an investor-owned hospital is its board of directors. In a community not-for-profit hospital, there is a board of trustees. Both the board of directors and the board of trustees serve as the governing board of the hospital. The uniqueness in health care comes at the *chief executive officer (CEO)* level. The CEO is the sole authority for the daily operations in a normal business-style corporation and reports directly to the board of directors. In many hospitals, authority is shared between the CEO and the *medical director*, called the chief of staff in many hospitals. The CEO has authority over the administrative functions of the hospital, while the medical director is responsible for the medical services side of the hospital. The smooth functioning of the hospital depends on the ability of these two individuals to interact effectively.

Outpatient

The simple definition of an **outpatient facility** is any medical facility where the services provided do not require an overnight stay. Outpatient care is also referred to as "ambulatory care" or "primary care." Outpatient facilities provide a wide range of medical services and are owned and operated by independent physicians, hospitals, managed care and insurance companies, large employers, home-heath companies, and community health agencies. Medical service facilities providing outpatient care include:

- Doctor, dentist, and optician offices
- Outpatient surgery centers
- Urgent care and walk-in medical centers
- Physical therapy centers
- Wound care facilities

- Imaging centers
- Cancer treatment centers
- Dialysis facilities
- Outpatient psychiatric facilities
- Chiropractic care centers

Example 1-5

Anne Davidson is a 68-year-old retired nurse with failing eyesight. During a routine visit to her eye doctor, Mrs. Davidson's condition is diagnosed as cataracts. Cataracts, most commonly occurring in older people, is clouding that develops over time in the crystalline lens of the eye. During Mrs. Davidson's nursing career, cataract patients needed to be hospitalized for several days after surgery. The current procedure is to remove the clouded lens and replace it with an intraocular lens implant in an outpatient setting. This procedure is now performed over 3 million times annually in the United States. Mrs. Davidson was able to resume her normal lifestyle the next day with very few restrictions.

Improvements in technology and surgical procedures have provided the double benefit of reducing the costs related to cataract surgery and allow patients to recuperate in the comfort of their homes rather than in a hospital setting.

The outpatient facility will commonly serve as the initial point of a patient's care. The primary care physician, either at a doctor's office or a walk-in clinic, provides *primary medical care* to the patient and also coordinates ongoing medical care by referring the patient to specialists and providing medical advice. *Secondary medical care*, such as hospitalization, surgery, and rehabilitation, will be initiated by the primary care physician. *Tertiary medical care*, highly specialized care such as burn centers, is used as needed. The Institute of Medicine has defined primary care as:

> "The provision of integrated, accessible heath care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."
>
> *Defining Primary Care: An Interim Report* (1994),
> The Institute of Medicine (IOM), page 1.

As discussed earlier, hospitals witnessed the shrinking of medical procedures requiring hospitalization starting in the 1980s, with the corresponding increase in procedures conducted in outpatient facilities. Hospitals responded by expanding their outpatient departments in direct competition to physicians who have established their own outpatient treatment centers. The result has been cost savings for patients and their insurers, patient access to a wider variety of treatment facilities, and the convenience of outpatient procedures rather than required hospitalization.

The next logical step in the evolution away from hospital-based services to outpatient sites has been the expansion of home healthcare services. Services provided in the patient's home have the same advantages that outpatient facilities have over hospitals: lower cost of service and patient preference. Home health care has a long tradition, dating back to the Visiting Nurse Associations (VNAs) of the late 19th century. Services provided by home healthcare agencies are primarily nursing care, such as changing dressings and monitoring medications. Services will also include short-term physical and occupational therapy and providing assistance in bathing and dressing. Many home healthcare agencies will also provide assistance in basic living needs such as transportation, shopping, and meal preparation. Home health care has expanded rapidly over the past two decades with Medicare and Medicaid approval of cost reimbursement for specified services. Private insurance companies have also come to realize that supporting patients in their homes is more cost-efficient than hospital stays for patients who are unable to fully function independently.

Long-Term Care

Long-term care is a broad category that encompasses a wide variety of services provided to patients with chronic conditions over a lengthy period of time. The most common example of long-term care is the nursing home, providing inpatient services primarily to the elderly. Long-term-care services will also include adult day care facilities, sheltered workshops for those who are developmentally disabled, and services provided to allow patients to continue living in their homes, such as Meals-on-Wheels.

In-patient long-term care facilities have changed dramatically over the past several decades. The old standard model for a nursing home was a single building designed to accommodate the needs of those who are aged, permanently disabled, or recuperating from major illness or surgery. Services provided would include housing, meal preparation, personal care such as assistance with dressing and bathing, and socialization services such as games and crafts. Medical and nursing care services are based on the needs of the individual patient.

The new standard for meeting the needs of an aging population has expanded the concept of the nursing home into life-care facilities (LCFs) or continuing-care retirement communities (CCRCs) tailored to the needs and preferences of their residents. The single-building nursing home has expanded into a campus, with independent-living accommodations for those not needing personal care or custodial care services. Commonly, independent living units will include full kitchens and availability of parking to allow residents to continue to maintain their lifestyles. Residents will have access to communal dining facilities, transportation, and socialization services on an as-requested basis.

As residents lose their ability to function independently, services are available to meet their changing conditions. The physical and emotional status of residents is monitored to provide the level of services required at each step in the aging process. Living units that provide personal and custodial care are a transition step between independent living and the more intensive service needs provided in assisted living and skilled nursing units. Specialized units within the life-care facility provide

rehabilitation therapy in an inpatient setting for individuals recovering from surgery or accidents, and secured areas are available for patients suffering from dementia.

In 2008, there were 15,531 nursing home facilities in the United States. Ownership is predominately private with over 67% of all facilities in the for-profit sector. The not-for-profit sector operates over 26% of the nursing homes, with various levels of government operating the remaining 5% to 6% of nursing homes. The Centers for Medicare and Medicaid Services (CMS) reports that there are more than 1.6 million nursing home beds, with Medicaid covering 64% of the payments to nursing homes. Medicare covers approximately 14%, and private pay represents the remaining 22% of payments.

Nursing homes and life-care facilities run the spectrum between basic and luxury. Facilities eligible for Medicare and Medicaid reimbursement must meet certification requirements to ensure that residents receive the level of care they need. Facilities that cater to private-pay patients expand the basic patient care requirements to include such amenities as private golf courses and executive chefs. Individuals reaching the stage of life where moving out of their homes is either required or preferred choose a facility based on the services provided and their personal budgets.

Spend-down is the term used for the process that takes place when an individual's financial resources are exhausted, and he or she becomes eligible for Medicaid. Medicare will not cover long-term costs of residential treatment, and Medicaid is only available for individuals who have exhausted their financial resources. Many private-pay facilities will have financial arrangements with residents that will allow them to stay in the facility after they become Medicaid eligible. Additional protection is available through the purchase of long-term-care insurance. Long-term-care insurance is attractive with the increasing costs of nursing home services, but has remained a minor part of the financing of nursing home and life-care facility services due to the complexity of the insurance products and premium costs.

Hospice Care

The previous sections discussed the medical professionals and facilities involved in maintaining and improving the health of patients they serve. **Hospice care** has a totally different function: providing assistance to the special needs of patients in the last months of life and meeting the needs of their family members. The medical side of hospice care is **palliative care**, managing the symptoms of the patient's final illness and relieving pain. Palliative care is combined with psychological and spiritual support, addressing the emotional needs of the patient and loved ones. Hospice services provide a consolidated care program, addressing a number of issues faced by the patient and family at the end of life:

- Providing a system of care that promotes quality of life rather than attempting to extend life
- Keeping the patient free of pain and in as much comfort as possible
- Addressing the spiritual and emotional needs of the patient and loved ones
- Meeting the needs of family members after the death of the patient

Hospice care is provided in a variety of settings, based on the needs and wishes of the patient and family members. Hospice care can be provided to supplement existing home-based services for patients wishing to spend their final days in familiar surroundings. Nursing homes, life-care facilities, and continuing-care retirement communities may have established hospice care within their facilities or have made arrangements with a hospice provider to coordinate care in the nursing home setting. Inpatient hospice facilities are also available to meet community needs. Physicians and staff members in hospice organizations receive specialized training in end-of-life issues to provide the appropriate care to patients and their loved ones.

1. Describe the impact of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) on hospital finances.

2. What is the major difference between a general hospital and a specialty hospital? Provide examples of specialty hospitals.

3. What has been the financial impact on hospitals of the decline in inpatient care over the past 25 years?

4. Which of the following would not be considered an outpatient facility?
   - **A.** A physician's family care office practice
   - **B.** A walk-in clinic
   - **C.** A dental surgery office
   - **D.** A rehabilitation hospital that provides short-term stays for recovery and rehabilitation treatments
   - **E.** All of the above are outpatient facilities.

5. What are the basic services provided by home health care organizations?

continues

6. Describe the physical and service changes in the transition from traditional nursing homes to modern model of life-care facilities.

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7. How does hospice care differ from traditional medical care?

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8. Define palliative care.

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Key Concepts

- Financial management in health care shares many of the basic functions with other types of business, but comes with its own unique set of circumstances and requirements.
- A proprietorship is a business owned by a single individual; in health care, it is most commonly found as the legal structure for physician practices.
- A partnership is a business entity owned by two or more individuals or entities.
- A for-profit corporation is a legal structure designed to have an unlimited life. Publicly held for-profit corporations have stockholders and are established to return value to the stockholders.
- A not-for-profit corporation is structured with a board of trustees and is designed to provide for the public good.
- Medical services provided in an inpatient setting peaked in the mid-1980s and have been declining with the expansion of outpatient services.
- Outpatient services, those not requiring an overnight stay, provide ambulatory and primary care to patients in a wide variety of specialties.
- Home-based medical services have expanded from a combination of a lower cost of providing services and patient preference for treatment in familiar surroundings.
- The scope of services provided in traditional nursing homes has expanded into the current model of life-care facilities, meeting the needs of residents throughout the later stages of life.
- Hospice care is a specialty in medicine, providing medical and emotional services to the patient and family members in the patient's last months of life.