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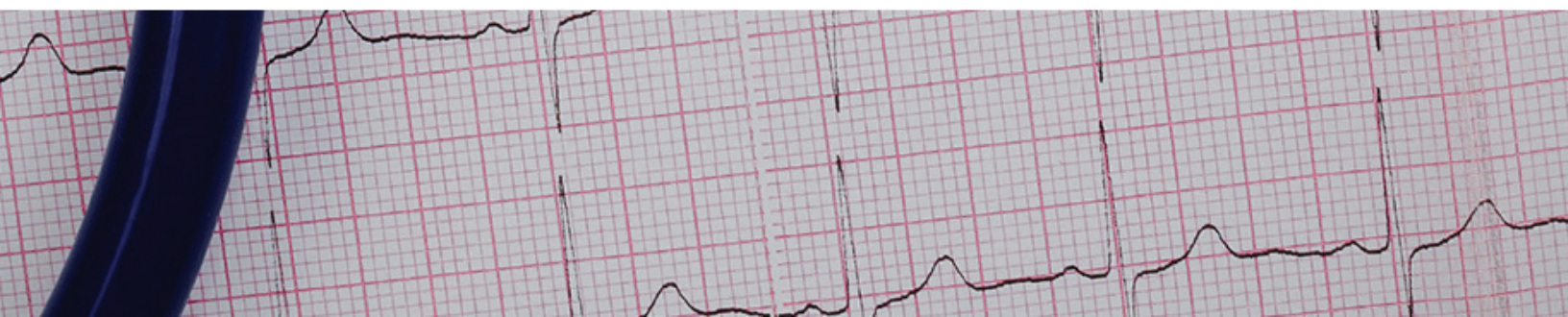
The Association of Accountants and Financial Professionals in Business

The Current State of Finance and Accounting Management in the Healthcare Industry



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IMA®, the association of accountants and financial professionals in business, is one of the largest and most respected associations focused exclusively on advancing the management accounting profession.

Globally, IMA supports the profession through research, the CMA® (Certified Management Accountant) program, continuing education, networking, and advocacy of the highest ethical business practices. IMA has a global network of more than 65,000 members in 120 countries and 200 local chapter communities. IMA provides localized services through its offices in Montvale, N.J., USA; Zurich, Switzerland; Dubai, UAE; and Beijing, China. For more information about IMA, please visit www.imanet.org.

The Current State of Finance and Accounting Management in the Healthcare Industry

Published by Institute of Management Accountants
10 Paragon Drive, Suite 1
Montvale, NJ 07645
www.imanet.org

Table of Contents

Exhibits

THE CURRENT STATE OF FINANCE AND ACCOUNTING MANAGEMENT IN THE HEALTHCARE INDUSTRY

Healthcare in the United States is a very big business, amounting to just over $2.1 trillion annually—one sixth of the U.S. Gross Domestic Product—and is the largest single source of public expenditures. Despite calls for heightened efficiency, the industry's cost structure continues to grow at nearly double the rate of the broader economy. Companies in the industry are being asked to deliver services in a much more efficient and effective way. To do this, finance and accounting professionals in these organizations will be called upon to deliver more innovation, creativity, and ideas to help control and balance efficiency and quality. In this report we assess the trends and best practices of financial management in the healthcare industry. Major findings suggest a heightened focus on internal controls and business analytics, significant growth and potential for management accountants, and an evolution toward more strategic interactions for finance executives within their organizations.

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KEY FINDINGS

Despite the size and complexity of the healthcare industry, there appears to be little information documented with respect to its current financial management practices. This IMA-supported study examined the nature and extent of such practices. It shows an industry striving to adapt to environmental and market changes. Four areas of importance were noted, including:

- Evolving Finance Roles. The roles, structure, and relationships of healthcare finance and accounting executives in the senior management structure are evolving and becoming more integral to the production and delivery processes. Nearly 70% of chief financial officers (CFOs) have reported a broader role in strategic initiatives than in years past, and over 80% report greater frequency of interactions with the chief executive officer (CEO) and board finance chairs than in previous years. Finance executives are taking a lead role in integrating operations and finance.

- Enhanced Controls. Significant resources create the potential for fraud and abuse. Finance executives are adapting internal controls and risk management practices that are more similar to the traditional for-profit industry. For instance, nearly half of hospitals surveyed are adopting Sarbanes-Oxley (SOX) programs and following generally accepted accounting principles (GAAP) despite the fact that they are not legally required to do so.

- Focus on Business Analytics. Finance executives are taking the lead role in utilizing business analytics and data mining practices to improve their performance monitoring and management processes, although less than one in four organizations reported the use of true "balanced scorecards."

- Industry Growth and Potential for Management Accountants. Over 25% of organizations surveyed reported having at least one certified management accountant (CMA) on staff, which was the second most prevalent designation besides the CPA in the finance departments of healthcare organizations.

The report presented here is organized around further discussion of these important findings. After a brief background discussion of the healthcare

industry, details on these findings and their potential impact on the management accounting profession will be presented.

AN OVERVIEW OF THE INDUSTRY

Healthcare is unique in some respects. Perhaps most unique is the fact that the actual decision to use many medical services is not entirely that of the patient. When medical procedures or prescription medications are involved, a physician must be involved to actually prescribe or provide the treatment service. The physician is in the position of both deciding what services a patient needs as well as being paid for providing those services. The potential conflict in this relationship has recently come under scrutiny as the healthcare reform debate in the United States challenges the prevalent fee-for-service payment system.

Physicians practice medicine in a variety of different organizational forms ranging from a solo practitioner operating as a stand-alone small business to employment in a large physician clinic such as the Mayo Clinic, the Cleveland Clinic, and the Permanente Medical Group. They usually do not have the facilities to provide sophisticated testing or surgical services in their offices and rely on hospitals and clinic facilities to deliver more technically advanced services such as emergency rooms, surgery, lab testing, and x-ray imaging services. Hospitals essentially serve as a workshop in which the physician delivers more sophisticated services.

Most hospitals are non-profit in nature, either operated by non-profit community organizations or governmental entities. Others are for-profit, owned by investor-owned corporations. (See Exhibit 1.)

Payments to physicians account for 21.4% of all healthcare expenditures in the U.S., with hospitals and prescription drugs accounting for 52.5% and 10.1% respectively (Kaiser Family Foundation, 2009). The presence of these multiple providers of services to a patient often leads to confusion over which party is getting paid for what service, and creates a complicated series of transactions to resolve payments for services. Patients rarely make direct payment to providers for services except for small co-payments, instead relying on a third-party insurer (referred to in the industry as the "payer") to settle the payment for services.

Health insurance can come from different sources. Private insurance is purchased by an individual or by an

Exhibit 1: Count of Hospitals by Type of Organization

Hospital Type	# of Facilities	% of All Facilities
Government-owned	1,472	23.3%
Non-profit	3,160	50.1%
Investor-owned	1,500	23.8%
Military and Veterans	180	2.8%
Total	6,312	100%

Source: Author's analysis from American Hospital Association, 2007.

employer (as an employee benefit). Examples of some of the larger private (or "commercial") insurers include Blue Cross/Blue Shield, Aetna, Humana, Met Life, and Travelers. Insurance coverage can also come from a public program, with the largest two being Medicare and Medicaid. Medicare is a U.S. federal government program intended to provide health insurance for the elderly (over age 65) and disabled. Medicaid is a collection of state-based insurance programs jointly funded by individual states and the U.S. federal government to pay for care to the poor.

Medical insurance does not cover all persons seeking healthcare services. There are currently about 47 million persons in the United States without insurance resources sufficient to pay for needed care (Kaiser Family Foundation, 2009). Under a current U.S. federal law called the Emergency Medical Treatment and Active Labor Act (EMTALA), hospital providers are required to provide services sufficient to resolve a life-threatening condition or care for a woman in childbirth, regardless of availability of resources to pay for that care. An unintended conse-

quence of this law has been increased pressure on hospitals to fund the costs of care to the uninsured from other sources, including increasing collections from insured patients to offset losses from care to the uninsured. Hospitals face the challenge of documenting the extent of these losses and justifying price-setting methods (Veach, 2005).

Healthcare services are paid based on fees that are set by individual provider entities. Those prices are not regulated and the fee charged by one provider for a given service (such as an x-ray) will likely differ from that of another competitor. Yet some insurance programs such as Medicare, Medicaid, and the larger commercial insurance plans dictate the price they will pay and offer a "take it or leave it" proposition to providers. Other insurers do not wield quite such market power, but are still able to negotiate discounts from providers. This results in providers billing their customary fees but having to account for a "discount" given to those insurers through regulation or contractual arrangements.

INDUSTRY CHALLENGES

Finance and accounting professionals in the healthcare industry are faced with several challenges. The conduct of an efficient healthcare business can seem opposed to a mission of providing potentially life-saving services. While the demand for healthcare services is episodic, when services are needed they are often needed immediately. This requires many providers of services to maintain constant availability of care for emergency needs. That constant availability of services can create challenges to maintaining productivity for providers of care during times of slack demand.

Healthcare providers operate in a fee-for-service payment system, where they are paid based on the number of services provided—essentially a piece-rate system. That creates an economic incentive to the provider to provide as many services to the patient as can be reasonably justified. In response to this incentive and observed increases in service volumes, insurers have instituted the policy of denying payment for care that they believe is not necessary or properly justified. About one in seven claims for payment to health insurers is denied (Veach, 2005). This creates an additional challenge for healthcare providers because they can render care to a patient in good faith yet be refused payment due to an error in documentation or billing procedures. To further

raise the stakes for providers, many insurer contracts—or regulations by the Medicare and Medicaid programs—prohibit billing the patient for fees denied for payment by the insurer. Monitoring the numerous steps in the billing and collection process to minimize these revenue losses is an additional challenge to the practice of finance and accountant professionals working for a provider entity in the healthcare industry.

EVOLVING FINANCE ROLES

The finance function is evolving in the healthcare industry. We see evidence of this in multiple areas. 71% of all chief financial officers in our study reported an expansion of their overall roles in the last five years.

Historically, finance and accounting professionals in the healthcare industry have remained fairly focused on traditional functions such as managing accounts receivable, negotiating reimbursement rates, managing accounting entries, budgeting, and overseeing debt policies. Now, senior level accounting and finance officers are starting to get involved in a variety of projects that were typically outside the scope of finance. Several CFOs have reported that strategic planning responsibilities were given to them, and most are being asked to take a lead role in strategic projects—for example, managing large capital projects such as building construction and technology implementation.

In addition, finance and accounting professionals are increasingly reporting increased involvement in strategy and governance functions. Most report more frequent interaction with other executives and the board of directors (or trustees). Nearly 80% of responding CFOs suggested a more frequent interaction with the board during recent years. In our analysis, we found that the average number of meetings between the CFO and CEO is just over three times per week, although 28% of our sample reported only one meeting per week. Discussions with specific board members, or the chair of the board's finance committee, were less common. Most CFOs (56%) reported at least one meeting per month.

ENHANCED CONTROLS

Due to the sheer size of the U.S. healthcare system, there are potential opportunities for financial fraud and abuse. In 2008, the National Health Care Anti-Fraud Association (NHCAA)

published a "conservative estimate" that 3% of all healthcare spending (an amount totaling $68 billion) was diverted to fraudulent ends. The Association of Certified Fraud Examiners (ACFE) further refined some quantitative estimates of fraud in healthcare compiled another series of estimates in 2008:

- The Centers for Medicare and Medicaid Services (CMS) estimated that $133 billion or 7% of all payments governed by that agency were disbursed improperly due to the filing of illegitimate claims;
- The Blue Cross/Blue Shield associations estimate that $50 billion (10%) of payments made from their organizations were for fraudulent payments; and
- $100 billion in other private insurer or patient payments (20% of that payment population) were for some form of improper billing (Busch, 2008).

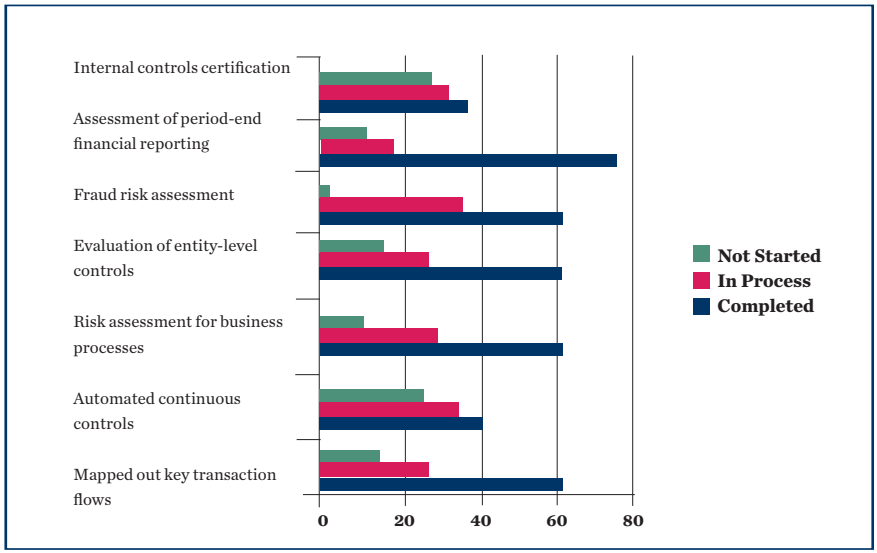
Because of this, we have seen a trend towards enhancing the internal controls and risk management frameworks within the industry. Specifically, there is a move towards greater standardization of accounting procedures, greater use of Sarbanes-Oxley, more elaborate documentation of business and administrative processes, and more diligence around financial reporting.

As noted earlier, about half of hospitals are organized as nonprofit entities. Our survey of hospital financial leaders indicated that the majority of organizations used GAAP (67.5%) while nonprofit GAAP was adopted in another 22% of hospitals. Government accounting standards were in use at 9% of facilities, and one facility reported maintaining financial records using fund accounting methods.

It appears that selection of accounting methods has some influence on selection of audit firms used to review annual financial statements. Among respondents, 48% indicated that they used a "Big Four" audit firm and of those, 87% used GAAP or nonprofit GAAP methods. Regional or local firms were noted as auditing primarily non-GAAP organizations. Management accountants in the hospital industry need a broad-based background in accounting methods should they elect to work in that 10% of organizations not using GAAP methods.

Internal controls are an opportunity and a challenge in the hospital sector. Given the large proportion of nonprofit hospital organizations and the fact that many others are not subject to direct

Exhibit 2: Comparison of Progress on Internal Control Framework Components



Source: American Hospital Association, 2007

oversight by the Public Corporation Accounting Oversight Board (PCAOB), the implementation of internal controls under a framework such as Section 404 of Sarbanes-Oxley (SOX) has been limited. In our survey, 51% of organizations reported a SOX compliance program in place, with another 12% considering such an implementation. There are fewer than three employees in the typical SOX program in a hospital. Yet those organizations that have such a program in place appear to have made significant progress toward full implementation, as noted in Exhibit 2.

The degree of investment by hospitals in their SOX programs is also impressive, with total funds committed to these efforts ranging from $10,000 to $8,000,000 and averaging $944,000. Staffing dedicated to assessment and monitoring of internal controls appeared a bit more limited, as a range of 0 to 12 FTE employees were devoted

to this effort, with an average of 1.9 FTE per organization. Only 9% of facilities reported having staff with certified internal auditor credentials, so it would appear that much of the progress on SOX compliance has been accomplished through outsourced contract work or noninternal-audit-trained staff. The management accountant's training on internal controls may be of great use in the hospital industry as the SOX compliance effort continues onward.

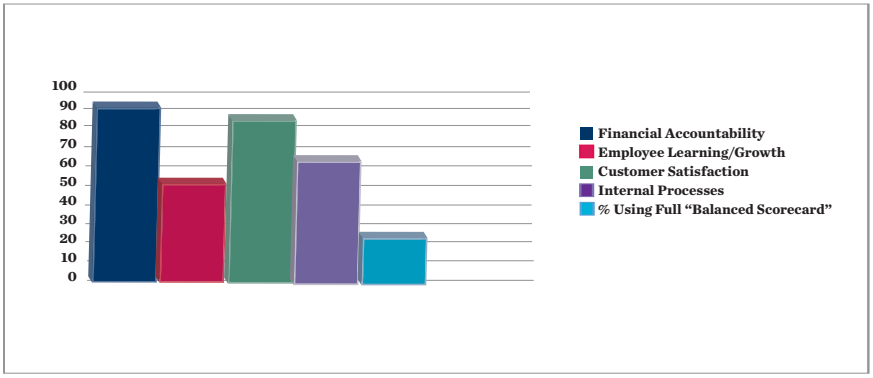
Unfortunately, only 20% of respondents feel that the investment made in the SOX program will have a positive return on investment. Just over 17% feel that SOX is a bad investment, and the overwhelming majority (63%) is unsure about the benefits.

FOCUS ON BUSINESS ANALYTICS

In healthcare finance, there are a number of common key performance indicators (KPIs) that have been used as a gauge of financial condition. Treasury functions typically aim for a specific financing mix, or manage debt burdens based on debt service coverage ratios. Another common KPI is days of cash on hand. While the development and monitoring of key indicators in finance is an excellent governance tool, when numbers are generically assigned as targets, they become heuristics. For example, days of cash on hand is typically targeted to fall somewhere in the range of 75 to 100 days for most hospitals. To a certain degree, the use of generalized ranges for acceptable performance is useful to simplify decision making, but when they become stated financial policies, they become troublesome.

There are a number of problems with these heuristics. When most heuristics are established, they possibly have some degree of significance and meaning. Yet, over time the accuracy of heuristics is questionable. They cannot be relied upon year after year in a changing environment. They also lack relevance across different hospital types, regions, and sizes. Different payer mix, different patient acuity levels, and different service offerings all impact heuristics, making heuristics irrelevant and incomparable from one organization to another. Finally, the referential basis for the heuristic is often initially based on gut-feel, not the sophistication or rigor that is necessary. The basis on which these heuristics are established is the problem of generalizing for all organizations. Many researchers have found that heuristics and rules of thumb are ineffective for other psychological or behavioral reasons. Overly optimistic CFOs

Exhibit 3: Components of Performance Scorecard



tend to look at problems through a less rational perspective than they should, and many frame or present the environment in ways that both simplify and distort the actual situation.

As financial performance remains a challenge and establishment of internal control frameworks is still a work in progress, ongoing monitoring of organizational operations gains a higher degree of importance. Our survey indicated that 91% of respondents used some form of performance scorecard—either manual (46.8%) or through an automated decision support system (44.2%). The financial and accounting professional can play a significant role in this effort, as much of the performance tracking conducted is financially or operations performance-oriented.

Exhibit 3 shows the proportion of respondents using various measures as a part of their performance scorecard process.

Data mining is also a key opportunity to improve financial practices. This technique involves the use of computerized data analysis to canvass paid claim data for potential fraudulent activity, including unusual billing or referral patterns exhibited by providers or unusual treatment patterns seen in a particular plan beneficiary.

Hospitals surveyed for this report state that they routinely benchmark themselves against competitors (44%). Other sources of information about performance comparison data include the American Hospital Association data, Solucient, and the Hackett Group.

Exhibit 4: Key Financial Performance Metrics

Metric	Last 2 Year Average	Benchmark from Airline Industry
% Beds Occupied (capacity utilization)	65%	80%
Operating Margin %	<.5%>	8.27
Current Ratio	1.92	1.15
Days Cash on Hand	37.0	53
Days in Accounts Receivable	68.2	9.2
Average Age of Plant	14.7	3.16

Source: Adapted from Hoovers Database (2009) and HFMA Magazine (2008)

Approximately 6% of the hospitals state that they do not benchmark performance externally.

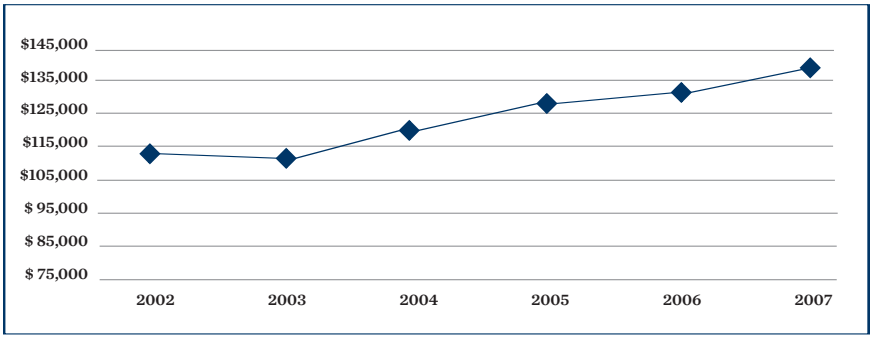
The healthcare industry uses some standard efficiency or performance metrics (such as operating margin, or days in accounts receivable), but also has a variety of specific indicators not found elsewhere. These include unique metrics such as:

- Percent of beds occupied or adjusted occupied beds (measure of capacity utilization)
- Growth in "adjusted patient days" (a volume measure reflecting the mix of in- and out-patient volumes)
- Census (counts of patient volumes)

To show how healthcare industry performance metrics differ, we contrast the average industry metrics against a sample industry (in this case, airlines) using annualized data from 2006 and 2007. (See Exhibit 4.)

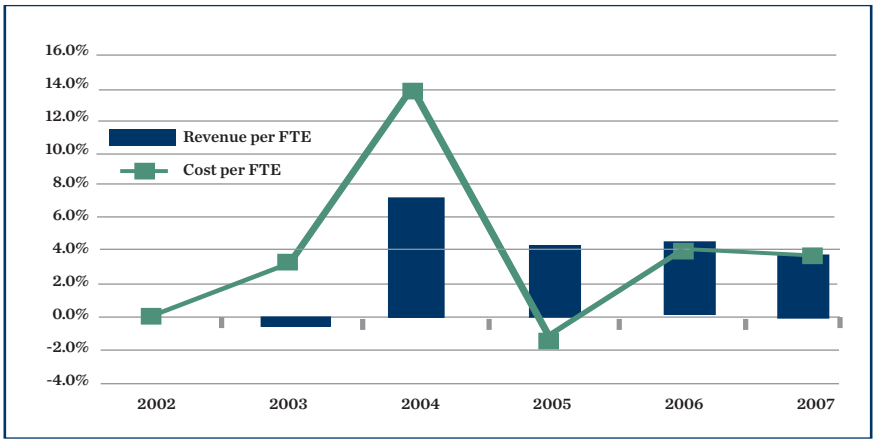
Hospital operating losses have been common for several years as organiza-

Exhibit 5: Hospital Labor Productivity



Source: Author's analysis from AHA database for all community hospitals

Exhibit 6: Annual Changes in Labor Efficiency



Source: Author's analysis from AHA database for all community hospitals

tions have struggled with pressures to reduce payments to them while facing significant increases in labor costs, which amount to over 50% of operating expenses (Langabeer, 2008). With increases in the number of persons losing insurance and requiring essentially free care under EMTALA, the burdens of revenue loss are magnified when noting decreases in current ratios and corresponding increases in days in accounts receivable and average payment period over the same time frame (2002 to 2007). This picture is further evidenced by the fact that these organizations operated at slightly higher levels of capacity during the last two years studied (2006 and 2007). The percent of beds occupied statistic represents the average percentage of hospital beds occupied by patients during the period. Exhibits 5 and 6 provide information on productivity and efficiency changes over the last five years.

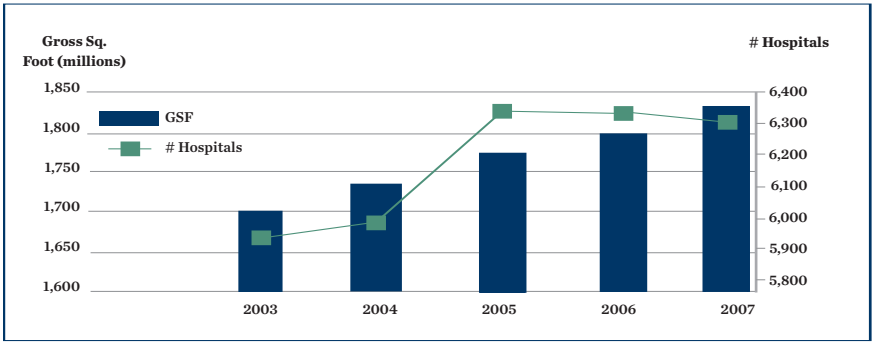
Unfortunately, until recently, in most years the change in costs per employee each year has outpaced the revenue generated per employee. During the past two years cost and revenue growth has been fairly consistent. Exhibit 6 below demonstrates the annual change in labor efficiency over this time frame.

INDUSTRY GROWTH AND POTENTIAL FOR MANAGEMENT ACCOUNTANTS

The healthcare industry is growing rapidly. Several of the largest free-standing hospitals would rival that of Fortune 500 firms, as would the largest hospital systems (such as Tenet or HCA), with revenues between $5-15 billion dollars. Using the AHA database, we analyzed each organization's capacity, and then summed it across the entire industry. We find that there was a 5% expansion in the number of hospitals, and that on average each facility grew 14% during the last five years. Growth in the total industry capacity (in terms of hospital square footage) hovered around 2% annually using the same measure. For an industry with negative operating margins, this is unprecedented growth. Exhibit 7 presents this growth from 2003 to 2007.

From variations in legal organization, to accounting for a variety of revenue discounting methods, to facilitating internal controls, the state of hospital operations these days is in need of the skill of the management accountant. Yet the landscape shows few management accountants in hospital organizations,

Exhibit 7: Facility Growth, Annually



Source: Author's analysis from American Hospital Association annual database, 2003- 2007

Exhibit 8: Accounting and Financial Positions in Healthcare

Position Type	# Persons employed	Average Annual Wage
Financial Manager	9,670	$104,550
Accountants & Auditors	16,340	57,330
Financial Analyst	3,970	63,960
Other Financial Specialists	3,820	51,610
Management Analysts	6,150	67,550

Source: Bureau of Labor Statistics, May 2008 http://data.bls.gov

as only 12% of survey respondents noted CMA-qualified persons in their financial management staff. Instead, a heavy reliance on the CPA credential is prevalent, with 50% of respondents noting staff with that qualification.

The hospital sector therefore represents an opportunity for growth in the practice of management accounting. Indeed, from February 2008 to August 2009, there was a 66% increase in the number of accountants employed by hospitals (www.simplyhired.com). Exhibit 8 presents a breakdown of the number of accounting and financial positions in healthcare by position type.

CONCLUSION

The healthcare industry in the United States faces turbulent times as its unprecedented growth begins to face questions of sustainability. The complexity of operations, financial transactions, and reporting, and the challenges of improving operational efficiency appear daunting. Yet these challenges pose a significant opportunity for the management accounting profession. As the healthcare industry seeks to improve operational efficiency, the skill of the management accountant can prove invaluable. As internal control frameworks evolve, the ability to implement and monitor those controls falls squarely into the management accountant's skill set. Assessment of business processes for improvement is fast becoming a necessity as ongoing operating losses can only be absorbed as long as non-operating incomes offer sufficient offsetting subsidy. Tracking operational results and identifying opportunities to improve—long a bastion of the management accountant's practice—represent a need yet unfulfilled in this evolving and substantial industry.

In this study, we found four overall trends for the current state of finance and accounting management in the healthcare industry:

- The role of finance and accounting professionals is evolving and growing.
- There is an enhanced focus on internal controls and risk management.
- Executives are focusing much more on business analytics and performance.
- The industry's growth curve is creating huge potential for finance and accountants professionals.

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