The New Role of the CFO: Getting Equipped for a Changing Financial Landscape
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You aren’t a bean counter. You aren’t the king or queen of compliance. You aren’t solely focused on debits and credits. You are focused on the sustainability of the enterprise.

CFOs can see that the rate of change in health care is faster than ever and the price of making the wrong move or no move is too high to pay. As Kent Thiry, Co-Chairman and Chief Executive Of DaVita HealthCare Partners, puts it, “In the next 10 years, winners may be determined three to four years before it becomes evident to competitors. It may be too late for competitors to respond because the change process that the frontrunners embarked upon with huge investments may not be noticeable for years and by then, the winner already is determined. Many organizations will fail, or take incremental action and avoid failure, but not succeed.”

Astute CFOs understand what Thiry is saying to be true. They know that to build a highly successful organization, they must skate to where the puck is going, not to where it is now. Where CFOs were traditionally asked to manage revenue cycle and fine comb balance sheets, now they are engaged in innovative reimbursement solutions and new business models to generate revenue growth. Whenever possible – especially at larger health systems – CFOs need to delegate core activities, such as revenue cycle management, to capable controllers and VPs of finance so they can focus even more on the financial strategies that will drive long term viability.

The big challenges facing hospital finances today include, but are not limited to:

- When many health systems are burdened with a huge fixed cost base, how do they maintain financial flexibility?
- Care is shifting to the outpatient world, yet the majority of margin and revenue is from facilities-based care. How do health systems navigate to an outpatient world when they could potentially lose upwards of $150-$200k per provider for the first three years post-acquisition? How do they align incentives with their physician networks in an era of huge uncertainty?
- How – and when – do they transition to value-based care when fee-for-service revenue is still paying the bills and is unlikely to disappear in the foreseeable future?
- How do they measure ROI on IT investments and operational improvement projects? Are there any opportunities to increase capital efficiency? What type of visibility do they have over their enterprise?

Given all this financial volatility, what is clear is that the role of the CFO is under evolution. The good news: the role is more valued than ever. The bad news: the job is tougher than ever. CFOs must focus their attention on advancing along three distinct strategic tiers:

1) Optimize the health system’s fiscal health. Even if it’s already good it needs to be even better to weather inevitable industry changes.
2) Think outside the walls of the health system by optimizing the ecosystem of providers, the system of care, and physician loyalty.
3) Optimize the patient experience: harness the health system to deliver what patients value most.
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1) Optimize Fiscal Health: Get Your House in Order

Over the last five years, maintaining fiscal health has moved beyond the traditional focus on investment and revenue cycle management. Many CFOs have already spent several years focused on costs and expense reduction, efficiencies of scale, supply chain initiatives, and sourcing. There is some relief in the fact that at least some of the traditional kinds of CFO activities can now be handed off. Blaine Petersen, chief financial officer of Saint Alphonsus Health System in Boise, Idaho, says, “We used to be much more focused on financial statements and reports. Now those functions are handled by the system on a consolidated basis. Revenue cycle management, patient accounts, investments, IT and supply chain are all shared services.”

Handing off some of these responsibilities frees the CFO up to be strategic regarding fiscal management, including two areas that will demand even more of the CFO’s attention in the next five years.

CFOs will need to make “lean” the new normal. Health care trends of the last few years make it clear that the likelihood of substantial revenue growth from the current mix is slim for most institutions. Some health systems have fared better than others in recent years—the rich getting richer” is a noticeable trend, as buoyant equity markets have allowed wealthy systems to increase their already sizable reserves through investments. Yet nearly all institutions have worked to trim costs, with some even flirting with the death spiral of cutting services to reduce expenses and preserve cash. “Sustainability, long-term, will be a serious challenge,” says Carl Biber, CFO of Columbus Regional Healthcare System in Whiteville, N.C. “For the first time, we hear about institutions talking about hours of cash [on hand]. The normal metric is days cash. I’ve never heard of that before, and that’s very concerning. No community should be put into that position. It’s terrible to hear a hospital could be hours away from closing its doors.”

“The new reimbursement landscape will require more expertise in risk management. The movement to managing populations requires complex assessments of patient risk and system risk. As Rich Rothberger, CFO of Scripps Health in San Diego, says, “risk-adjusted commercial capitation [must be] based on a neutral actuary recommendation so that no one takes a disproportionate loss on the utilization of sicker patients. Adverse selection was a big deal in the old days of capitation and as we’re moving again to commercial capitation, how do we do it differently than 20 years ago when a lot of providers lost a ton of money?”

Benjamin Carter, senior vice president and chief financial officer of Trinity Health in Novi, Mich., says, “the ability to predict actuarially is becoming a required skill. We have to understand risk contracting and delivery costs, and we have much less margin for error in these analyses.”

Some health systems are hiring expertise from insurance companies, especially if they want to enter the insurance business, or even if they want to take on risk in a wise way.

2) Optimize The Ecosystem: Build a Valued Provider Network

Proactive CFOs are thinking outside the walls of the health system by optimizing their networks. It’s no longer just the hospital’s balance sheet that matters, but rather the whole surrounding ecosystem of providers that utilize the hospital’s facilities and contribute to the health of a population. The CFO of St. Francis Healthcare in Memphis says, “hospitals will no longer be the center of the health care enterprise. […] It’s going to be a totally different model.”

The whole spectrum of caregivers must be optimized so that patients can be served by an effective continuum of care.

Be strategic in acquiring or affiliating. Many health systems have been aggressively acquiring physicians who are now critical to the health system’s financial stability. St. Vincent’s HealthCare in Jacksonville, Fla, for example, went from employing five physicians to employing 92 in one year. “You can see a rapid expansion… and it’s all to manage the entire spectrum of a patient’s health,” CFO Mark Doyle says. CFOs sometimes need to ask the hard questions about whether acquisitions or “hard” consolidations offer the only, or best, path to a strong network.

As Fitch ratings analyst James LeBuhn points out, “While hard consolidations provide better integration, ‘soft’ consolidations such as joint purchasing and best practice collaboratives are more flexible.”

Sarah Vennekotter at Moody’s notes, “our higher rated organizations are not just looking to employ, they use different strategies to align with doctors, including setting up IPAs, PHOs, and clinical integration networks.”

Baylor Medical Center, for example, has done a lot of joint ventures to grow their organization in an outpatient setting. Mary Greeley Medical Center in Ames, Iowa started a joint venture with its dialysis center and a dialysis center operator. “We were able to monetize our outpatient dialysis service line and in essence got value of $11 million,” CFO Mike
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The bottom line when it comes to alignment strategy is “the CFO needs to be very involved, both in terms of planning and strategy,” says David Ebel, CFO of the Mayo Clinic in Rochester, Minn. “Ask the questions that need to be asked so you know you’re not buying a toxic waste site.”13

Manage Alignment Closely to Achieve Care Coordination.
Regardless of whether the health system employs physicians or aligns with affiliates, what has changed from five years ago is that there is growing financial risk in clinical performance, and that will only continue to increase over time. This is most readily apparent, of course, if organizations are in risk contracts. Accountable care arrangements, both upside and downside, put a financial premium on the ability to align and manage physicians. “It can drive a lot of value…if you’re able to coordinate care in your own system,” says Sharon Rudnick, vice president of outpatient care management at Advocate Health Care in Downers Grove, Ill., which participates in both commercial and Medicare risk contracts.14

Move from Utilization Monitoring to Redesigning Care Models.
Optimizing the provider network requires that CFOs partner closer than ever before with clinical leadership. Jordan Hospital, a 155-bed, not-for-profit system in Plymouth, Mass., became a Medicare ACO, and now Gail Robbins, the organization’s administrative director of financial planning, spends significantly more of her time with physicians. To reduce the downside exposure of the ACO contract, Robbins needs to know “what’s being used to excess, where physicians are operating out of bounds of reasonable utilization rates.”15 The next phase of arriving at a competitive cost of care will require the redesign of patient care models, standardizing clinical care, and reducing variation. “Listening to physicians in protocol development and operations design […] is essential because the physicians know where the waste is and how to make the system more efficient. Physician leaders are very much aligned with our system quality and efficiency goals,” says Trinity Health’s Carter.16

As care moves from inpatient to outpatient and patients become the center of care instead of the hospital, it’s more important than ever to create high performing networks to deliver high quality care across the entire continuum.

3) Optimize The Patient Experience: Deliver Value and Services

Once CFOs have mastered the financial health of their organization and built out a valued provider network, the final strategic tier to master is building a high-performing patient-centric system. Patients will have choices as to where they seek care, and with transparency of cost and quality on the rise, organizations will need to work harder to attract and retain their business.

Moody’s rating analyst Lisa Martin points to improving the patient experience as a key objective for hospitals to pursue in order to create a sound business model. “The industry’s move from a wholesale to a retail model requires extensive focus on improving the patient experience,” says Martin.17 The patient experience needs to be improved in most health systems from start to finish by connecting patients to providers more directly, offering effortless scheduling, providing better customer service than the competition, and allowing patients to move seamlessly through the system of care despite multiple touch points.

The health care industry often says it values patients, but when a patient initiates care with their provider or at the hospital, what they experience is often sub-par. There are four areas where the CFO can immediately impact the patient experience to build loyalty.

“CFOs have to get comfortable and speak the same language as the clinical team in order to have full visibility and control over the organization’s financial picture.”

- Pamela Vukovich, former CFO of Legacy Health System of OregonHealthcare System in Whiteville, N.C.

Even if organizations are not operating under risk, there is still plenty to manage to make financial sense out of their physician acquisitions (at an estimated loss of $150,000 per doctor per year for the first three years18). Essentially, improving physician engagement is critical in both the fee-for-service and the fee-for-value model. Physicians need to be kept apprised of all their in-network options and reminded that other in-network providers share quality and experience goals and can deliver coordinated care and a more streamlined patient experience. And since an estimated two-thirds of inpatient and ancillary revenue still comes from non-employed physicians, alignment of the broader provider community will continue to be vitally important. “CFOs have to become partners with the clinical side,” says Pamela Vukovich, former CFO of Legacy Health System of Oregon. “Not all CFOs are comfortable doing that, but they have to get comfortable and speak the same language as physicians and the clinical team in order to have full visibility and control over the organization’s financial picture. CFOs are not always known for their communication skills, but they must learn how to step outside that box.”19

“The industry’s move from a wholesale to a retail model requires extensive focus on improving the patient experience.”

– Lisa Martin, Moody’s ratings analyst
Help consumers find value. More consumers are seeking value from health systems when spending their own dollars in high deductible plans. As Dave Storm, CFO of St. Anthony’s Memorial Hospital in Effingham, Ill., says, “The CFO has a big role in helping the organization respond to those consumer issues quickly by making cost and quality data accessible. With value-based purchasing and payment based on patient satisfaction, patient perceptions have a big impact on financial performance and strategic market position, and you need to respond to them quickly.”

CFOs may need to help marketing teams with explaining payment structures and setting up additional payment plan options for patients who may have sizable personal-pay liability in the lower tier products bought on the exchanges, for example. “That is going to be a bit of a sticker shock for those individuals who have not been used to that in the past,” says Stephen Forney, vice president and CFO at Lovelace Health System, a 606-bed system based in Albuquerque, NM.

Patients who are on insurance for the first time may struggle to pay for the patient share of a CAT scan or procedure that doctors refer them for. In addition, many CFOs are also seeing increased seasonality as patients hit their deductibles in the fourth quarter and then volume swings upward. Hospitals need to consider how to handle this surge in demand without long wait times and poor service experiences for patients when a hospital is operating at full capacity. Much like a utility company, whose service is most tested on the hottest days of summer, hospitals have to develop strategies for forecasting and serving peak demand.

Know your Customers. To be able to deliver a superior experience to patients, use technology to know your customer better. Other industries do it through a combination of customer relationship management (CRM) applications, like the software-as-a-service Salesforce.com, and social media marketing to intimately engage their customers in their now-ubiquitous mobile lifestyles.

Iowa City-based University of Iowa Health Care (UIHC) is part of a Medicare ACO and has been trying to integrate disparate sources of data to truly manage their population. “With ACOs having complete claims data, we now have access to all the elements that ensure we are not missing any component of the patient activity,” says Mark Henrichs, assistant CFO. “Ultimately, this supports our ability to create accurate population-based clinical resource groupings. When elements of care are missing, the potential for an error in that clinical resource grouping increases.” Care coordinators had the information and data necessary to create a positive impact on care delivery, quality, and cost. The combination of these elements reduced risk-adjusted population care costs in both the Medicare and commercial ACO populations.

Still, the health care industry significantly lags other industries in this capacity. There should be pre-visit planning before the patient even shows up. There should be a technology-enabled follow-up when a patient misses an appointment or doesn’t book a screening or test. There should be risk stratification of populations in different categories of wellness and health. Ideally, the health system should be able to know exactly how each visit will be adjudicated before it happens. There are immense possibilities for using technology and services to provide better care for patients.

Move patients to the center of technology decisions. Regardless of the future state of reimbursement, high quality care necessitates that health systems have the technology and services to stratify and monitor populations, and to track quality metrics and utilization rates, use of in-network resources and low-cost alternatives. Even if the providers are not doing population health, they need to be able to identify, and act on, gaps in care where potential revenue is being left on the table and patient care is being compromised.

CLOSE GAPS IN CARE. CAPTURE LOST REVENUE.*

83.6% of patients have not had their Medicare Annual Well Patient Visits

74% of patients haven’t had their colorectal cancer screenings

68.4% of women don’t get their mammograms

Do you know who these patients are in your network? Are you able to get them in for care?

*Based on 2014 athenahealth network data across 55,000 providers, et al. (as of 9/18/14)

“If you don’t make wise decisions about health IT hardware and infrastructure, you could easily spend an unlimited amount of money,” says Tim Jodway, the CFO of Garden City (Mich.) Hospital. But with tens of millions invested, the CFO needs to take a hard look at what the risks and exposure are. Because of meaningful use incentives, the entire health care community has been able to participate in a buying spree without demonstrating viable outcomes. For hospitals, debt has historically been cheap the last five years and capex has been easy to come by. As a result, the CIO can have a bias to select IT that makes the technology organization ever larger and more powerful, but those decisions may have nothing to do with selecting IT systems which either improves clinical quality or the financial bottom line.

Operations should drive IT strategy and the CFO needs to hold people accountable to delivering value for patient care with each major IT purchase. Health systems can no longer afford the risky burden of...
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decade-long IT projects that become an albatross. Organizations must remain financially flexible and nimble to adapt to where the future opportunities will be. The criterion of engaging with patients more effectively must be front and center. This applies not just to hospital operations but also the provider organization, the patient access team, and marketing.

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- Tim Jodway, the CFO of Garden City (Mich.) Hospital

Invest in Analytics that Directly Support Care Management Needs. The CFO needs to scrutinize not just what the specific IT investment is, but also how it might compromise other areas of growth and innovation. Compare a technology purchase to buying a new linear accelerator for the oncology center and ask which will have the better return on investment? Utilization analysis, performance measurement against contractual goals, and care management focused on populations under risk contracts: CFOs need all of this, at a minimum, from these IT systems. These features won’t generate revenue directly, but should drive system change in a way that yields profits. The highest ROI on technology spend right now is analytics that extract insights from the mounds of data collected from paid claims and clinical systems, and apply them directly to creating seamless transitions across the care continuum, beating quality gates, and efficiently delivering care management to reduce utilization and improve patients’ lives. Risk adjustment is also an essential ingredient to focus providers on performance improvement and get past the “my patients are sicker” mentality of providers whose utilization exceeds predicted spend.

Predictive analytics is also in vogue as reports of IBM’s Watson and other expensive systems hit the press. These systems purport to predict expensive episodes of care before they occur (like hospitalization or re-admission). While promising, true predictive analytics is in its infancy, and there is usually no question as to which patients are at risk for generating higher costs – they are the patients who’ve generated costs in the past. Money on these systems is better spent on investments to better coordinate care for patients requiring intensive care management.

What used to be coding and billing is now medical informatics, where an entire flow of data can be analyzed to create value. One head of clinical information technology at a major health system highlighted the desire and need to move beyond the EMR as a system of patient records in favor of partnering with sophisticated analytics companies. This health system owns their data and has it stored in a central data warehouse. However, the Application Programming Interfaces (APIs) to access this data inside the warehouse are still controlled by their

What Does A Superior Patient Experience Look Like?

Iora Health is a health care provider offering prepaid primary care throughout practices across multiple locations in the country. The management team had adopted net promoter scores, a widely used customer loyalty metric in retail, to measure patient satisfaction because they wanted to bring service culture to the center of the organization. In some months, Iora has achieved average scores of 85 and even 91 out of a total score of 100. A net promoter score of 50+ is generally considered excellent and Iora’s scores are typically higher than many famed customer-first service businesses such as Apple or Amazon. Your health system will be competing with new players like Iora to deliver patient satisfaction and ultimately patient loyalty. So ask yourself - Can patients in your health system:

Schedule same day or next day appointments
Access medical providers via telephone 24 hours per day, 7 days per week
Immediately resolve most minor medical issues via a phone call, email, video conferencing such as Skype or FaceTime, or text message without needing an office visit
Access mental health counseling as part of a primary care visit for no additional fee
Access group health education counseling onsite for no additional fee
Access alternative health treatments, such as acupuncture, yoga, and meditation onsite for no additional fee
Partner with a health coach between medical provider appointments to help manage care plans and overall wellness at no additional fee

EMR vendor. While the EMR vendor says their platform is “open,” only about 5% of those APIs actually are.

Essentially, one of the top 10 medical centers in the world finds itself constrained by its EMR vendor setting the pace, control and the budget demands. The vendor is determining the future IT strategy of the health system instead of the organization. The need for analytics is growing, but so is the frustration inside a world leading organization like this one because it wants to take on more risk contracts, but is hamstrung to do it well due to the leverage of their IT partner. Worse, despite acknowledging the benefits of some more nimble startups in the analytics space – like Castlight Health – the health system can’t take advantage of those startups because its vendor controls the APIs to its data.

What Does A Superior Patient Experience Look Like?

New England Quality Care Alliance (NEQCA) is the Tufts Medical Center affiliated physician network, including nearly 1,800 multi-specialty physicians in 460 practices in Massachusetts that are responsible for 475,000 patients. NEQCA entered into a new payer contract that combined per-patient global budget with significant performance incentives based on quality measures. NEQCA needed actionable data and now uses athenaCoordinator Enterprise to transform population health data into a single, consolidated workflow for care teams, allowing providers and staff to effectively monitor and manage patient populations.

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<th>BEFORE</th>
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<tr>
<td>• Manually tracking patient quality metrics</td>
<td>• Generate higher reimbursements through improved quality bonuses</td>
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<td>• Existing patient management software had difficulty analyzing complex data sets, requiring significant user time.</td>
<td>• Automatically track compliance and performance against contractual quality goals</td>
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<td>• Difficult to identify at-risk patient populations who were costliest to treat</td>
<td>• Improve patient quality metrics by 50%</td>
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<td>• Low visibility on patient outcomes, claims, and billing data.</td>
<td>• Influence at-risk patient behavior at the point of care</td>
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Conclusion

The writing is on the wall that finance in this era will be fundamentally different than it was in the past, and an indication of that is how ratings agencies are reconfiguring the assessment of a hospital’s financial picture. Moody’s was the first rating agency to announce it will use new indicators to measure the quality of care provided and the volume of services rated organizations provide under a value-based payment structure. These include demand indicators such as unique patients and covered lives, and risk indicators such as risk-based revenues, employed physicians, and Medicare readmission rates.24

No one is expecting the CFO to actually take on the jobs of chief medical officer, chief technology officer, chief marketing officer, and head of strategy. However, simply overseeing the financial picture is no longer enough. CFOs must strengthen their skills in these varying areas and then build upon them by hiring the right talent to round out the capabilities of the CFO office. The CFO must press on investments made by the CMO and CIO and ask the basic question of how these investments will directly contribute to operating income. Too often these other C-suite leaders resort to hand-waving around perceived technology “must-haves” without the ability to connect technology to measured performance improvements and financial success under new contracts. They might also press on how much technology investments in patient relationship management will result in improved patient loyalty. For example, a “portal strategy” centered on the hospital may make sense to an inpatient-centric management team. However, only a tiny fraction of patients in a population under risk will ever see the inside of the hospital. In fact, up to 50% of patients requiring routine care may not even see their primary care physician, and a “patient relationship strategy” centered on primary care for all beneficiaries may make more sense.

The myriad industry changes have made the CFO role all the more challenging but also all the more important. One former chief financial officer predicted that “being a major contributor to the firm’s competitive advantage will be more essential than the compliance aspects of the traditional role” for future CFOs. While a recent survey revealed that headhunters are replacing hospital CEOs with industry outsiders an astonishing 60% of the time, the CFO role is one where the bedrock core of health care expertise and health care finance will be essential. But if the CFO can’t build on that bedrock to expand their skillsets into new areas of the operation, they will be left behind by the speed with which these organizations need to make life-or-death decisions. It will be crucial for tomorrow’s CFO to go both financially deep and operationally wide to help lead health systems toward a successful, sustainable future.
Endnotes

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A leading provider of cloud-based services and mobile tools for medical groups and health systems. Our mission is to be the most trusted service to health care providers, helping them do well by doing the right thing.