Evolving Hospital Finance Roles and Strategic Financial Planning

2014 SC HFMA Annual Institute

Myrtle Beach

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Agenda-Two Key Aspects of the CFO's Role

- **Financial Services Delivery**
  - Historic Hospital Finance Functions
  - Integrated Health System Functions
  - Emerging Needs/Functions
- **Strategic Financial Planning**
  - Goals
  - Process
  - Tools

A Little Personal Background

- Healthcare auditor-Arthur Young & Co. – 1976 - 1981
- Full-Time/Long-Term CFO Roles:
  - 1981 – 1990: 440-bed **Sacred Heart Medical Center** (OR)
  - 1990 – 1995: 657-bed **Saint Joseph Medical Center** (CA)
  - 2005 – 2009: **Oregon Health & Science University** (OR)
- Interim CFO Roles:
  - 300-bed **Pikeville Medical Center** (KY) – twice
  - 250-bed **Ashtabula County Medical Center** (OH)
  - 715-bed **Hennepin County Medical Center** (MN)
  - **Department of Mental Health** (DC), including 305-bed **St. Elizabeth's Hosp.**
  - **University Hospital** (OR), 510-bed adult hosp., 112-bed childrens hosp.
  - 110-bed **Proctor Hospital** (IL)
- Consultant – M&A, bond issue "independent consultant," general strategic & managed care planning, special projects

Group Background-Who's here today?

- Current or past **Chief Financial Officers**?
  - At Critical Access Hospital?
  - At standalone independent community hospital?
  - At not-for-profit multi-hospital system?
  - At a for-profit system-owned hospital?
- Current or past **Controllers**?
  - At Critical Access Hospital?
  - At standalone independent community hospital?
  - At not-for-profit multi-hospital system?
  - At a for-profit system-owned hospital?
- Current or past **Revenue Cycle VPs/Dirs**.?
  - At Critical Access Hospital?
  - At standalone independent community hospital?
  - At not-for-profit multi-hospital system?
  - At a for-profit system-owned hospital?

Financial Services Delivery

Past, Present & Future

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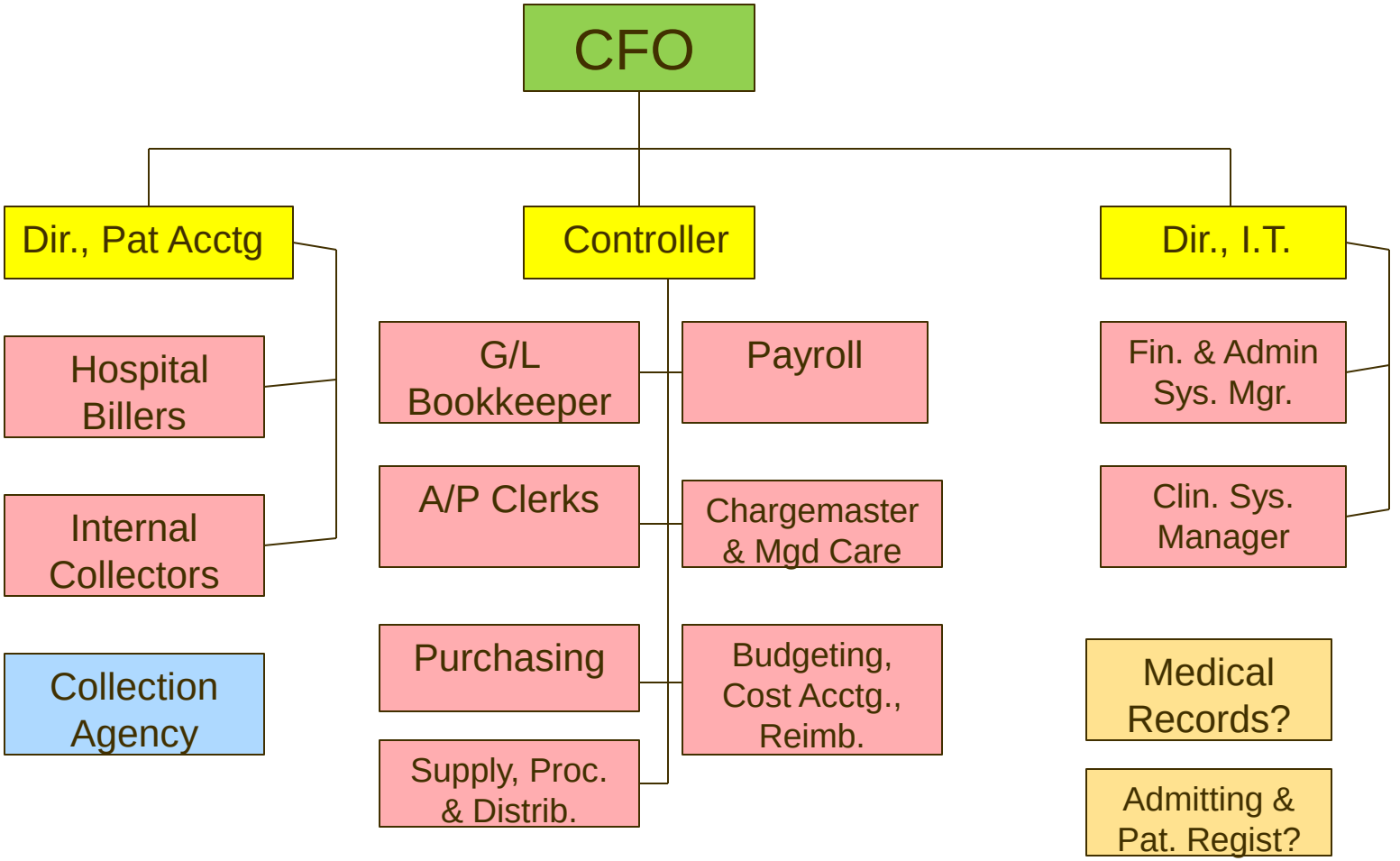
Historic Functions

- For the **hospital**
  1. Budgeting – volumes, rate increases, cost inflation
  2. Patient Financial Services
     - ◊ Charging- chargemaster, payor contracting
     - ◊ Billing
     - ◊ Collecting
  3. Financial Reporting (internal & external fin. stmts., 990)
     - ◊ Net revenue – inpatient & outpatient
     - ◊ Patient service costs
     - ◊ Support and administrative costs
     - ◊ Nonoperating revenue/expense
     - ◊ Net income/loss
  4. Payroll
     - ◊ Heavy interaction with human resources

Historic Functions (Cont'd)

- For the hospital
  5. Treasury Function
     - ◊ Cash management
     - ◊ Debt management
  6. Asset Management (property, plant & equipment)
  7. Purchasing
     - ◊ Ordering, receiving & accounts payable
     - ◊ Inventory management
  8. Cost Reporting (Medicare & Medicaid)
  9. Tax Reporting (990)
- **Sometimes also included**
  10. Medical Records (particularly post-DRG; coding)
  11. Information Systems (due to heavy financial systems focus)

Historic Finance Organization



Historic Finance Team

- Strong **Controller/GL Bookkeeper** (depending on hospital size)
  - Prior audit/accounting experience
  - Most likely internal CFO candidate
- Strong **Director of Patient Accounting**
  - Financial counselors
  - Billers
  - Collectors
  - Interface w/external collection firm
- **Director of Information Systems**, perhaps outsourced
  - Focus on financial applications (general accounting, payroll, charge capture, patient accounting, and purchasing/materials management)
  - "Dumb terminals," performing specific functions

Status Check

- How well has your hospital historically done these things?
  - Have needs been met on a timely basis?
  - Have there been major subsequent corrections or restatements?
  - How well has your hospital benchmarked on key financial indicators
    - ◊ labor productivity?
    - ◊ Overall cost per case?
    - ◊ Pricing mark-up ratios?
    - ◊ Days cash on hand?
    - ◊ Debt service coverage?
  - Adequate tools, people, expertise?

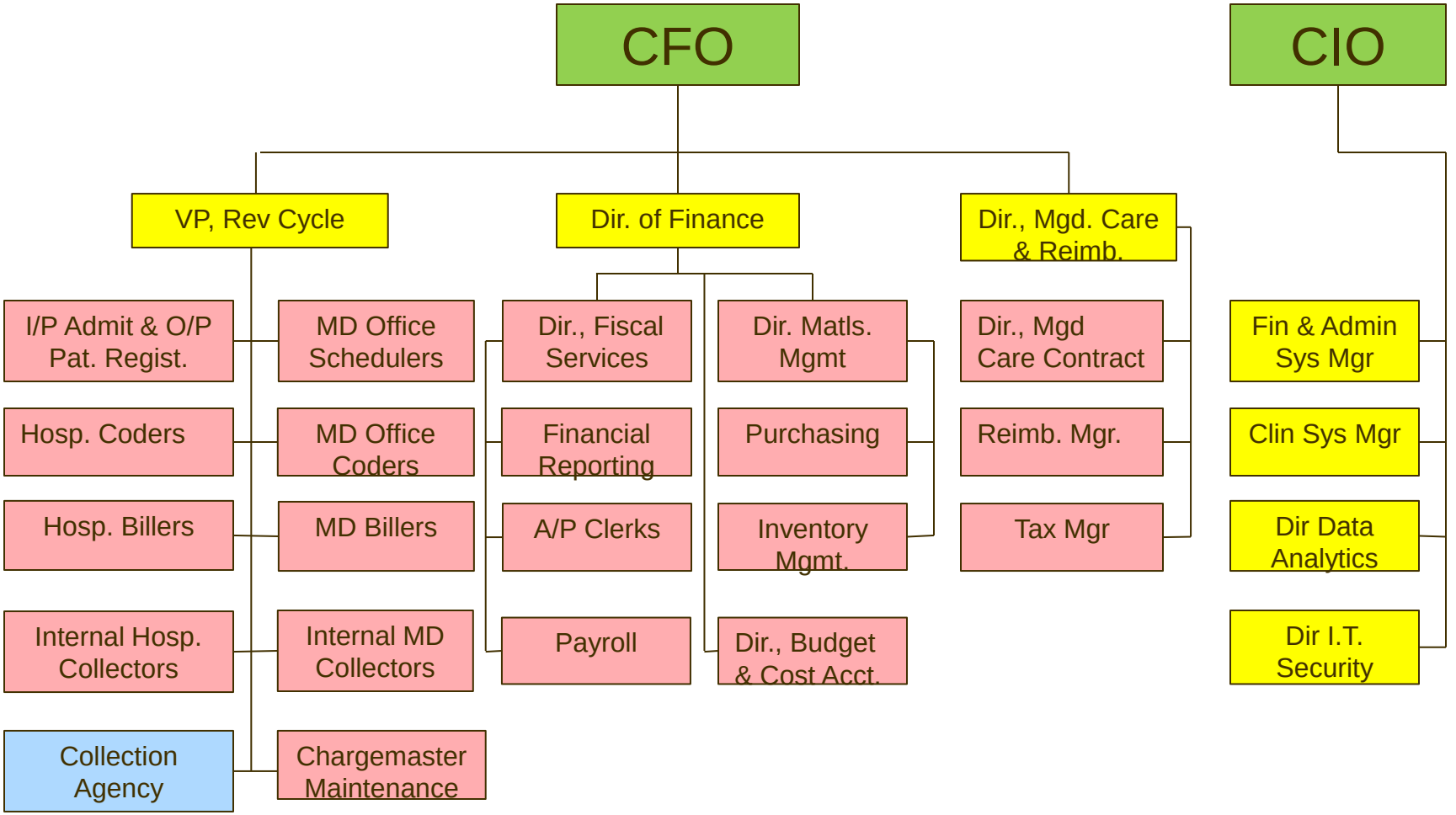
Health System Integration

- **Historic finance functions**
- **Plus**
  - Physician office finance functions
    - ◊ Physician services chargemaster
    - ◊ Managed care contracting
    - ◊ Billing & Collection
    - ◊ Financial reporting
    - ◊ Physician compensation calculations
  - Home health, hospice, skilled nursing facility finance functions
    - ◊ Unique chargemasters
    - ◊ Unique reimbursement, contracting, billing & collection
    - ◊ Unique cost reporting
    - ◊ Financial reporting
  - Joint venture, merger & acquisition analysis

Health System Integration (Cont'd)

- **Plus**
  - Electronic health records (& meaningful use stages)
    - ◊ Hospital, home health & hospice, ambulatory centers, physician offices, skilled nursing facilities
- **Other Changes**
  - From Patient Accounting > Revenue Cycle Management
    - ◊ Adding
      - Admitting & Patient Registration
      - Point-of-service collection
      - Health Information Management (documentation & coding)
    - ◊ Medicare RAC audits
  - Expanded 990 reporting (community health needs assess.)
  - Sometimes
    - ◊ Detailed procedure level cost accounting
    - ◊ Physician practice management services
    - ◊ FQHC's, RHC's

Integrated Health System Finance Organization



Integrated Health System Finance Team(s)

- Multiple Controllers/CFOs
  - By type of delivery
  - By region
- VP, Revenue Cycle & Patient Access
  - Specialty revenue cycle managers
    - Hospital revenue cycle
    - Physician revenue cycle
    - Home health & hospice revenue cycle
    - Skilled nursing facility revenue cycle
- Dir. Of Materials Management/Logistics
  - Working with sophisticated GPO & tools
- Dir., Reimbursement & Managed Care

Status Check

- How well is your hospital or system doing these things?
  - Are the necessary additional services being provided?
  - Have needs been met on a timely basis?
  - Have there been major subsequent corrections or restatements?
  - How well does the overall Southeastern Health system benchmark on key financial indicators (productivity, cost per case, pricing mark-up ratios, days cash on hand, etc.)?
  - Adequate tools, people, expertise?

Emerging Needs

- **Historic & Integrated System Finance Functions**
- **Plus**
  - Costing & pricing changing payment methodologies, such as
    - Value-based care
    - Bundled payments
    - Global package pricing
    - Accountable care organizations
    - Primary care medical homes
    - High deductible plans
    - Other “innovations”
  - Enhanced negotiating skills
  - Population health management
    - Data analytics
    - Actuarial expertise

CMS Bundled Payment Initiatives: BPCI Models

Timeline

- **Nov. 2012 – Sept. 2014: Phase One:** No-risk prep period.
- **Oct. 1, 2014: Final Phase 2 Go-Live Date**
- Risk Bearing Implementation Period

- **Model 1 – Acute Care Hospital Stay Only (Retrospective):** 3 participants representing 32 organizations
- **Model 2 –Acute Care Hospital Stay + Post Acute Care Episode (retrospective):** 55 participants representing 192 organizations.
- **Model 3 – Post Acute Care Only (Retrospective):** 14 participants representing 165 organizations
- **Model 4 – Acute Care Hospital Stay Only (Prospective):** 37 participants representing 75 organizations

Source: The Advisory Board: "What are BPCI participants bundling?" by Rob Lazerow dated February 1, 2013

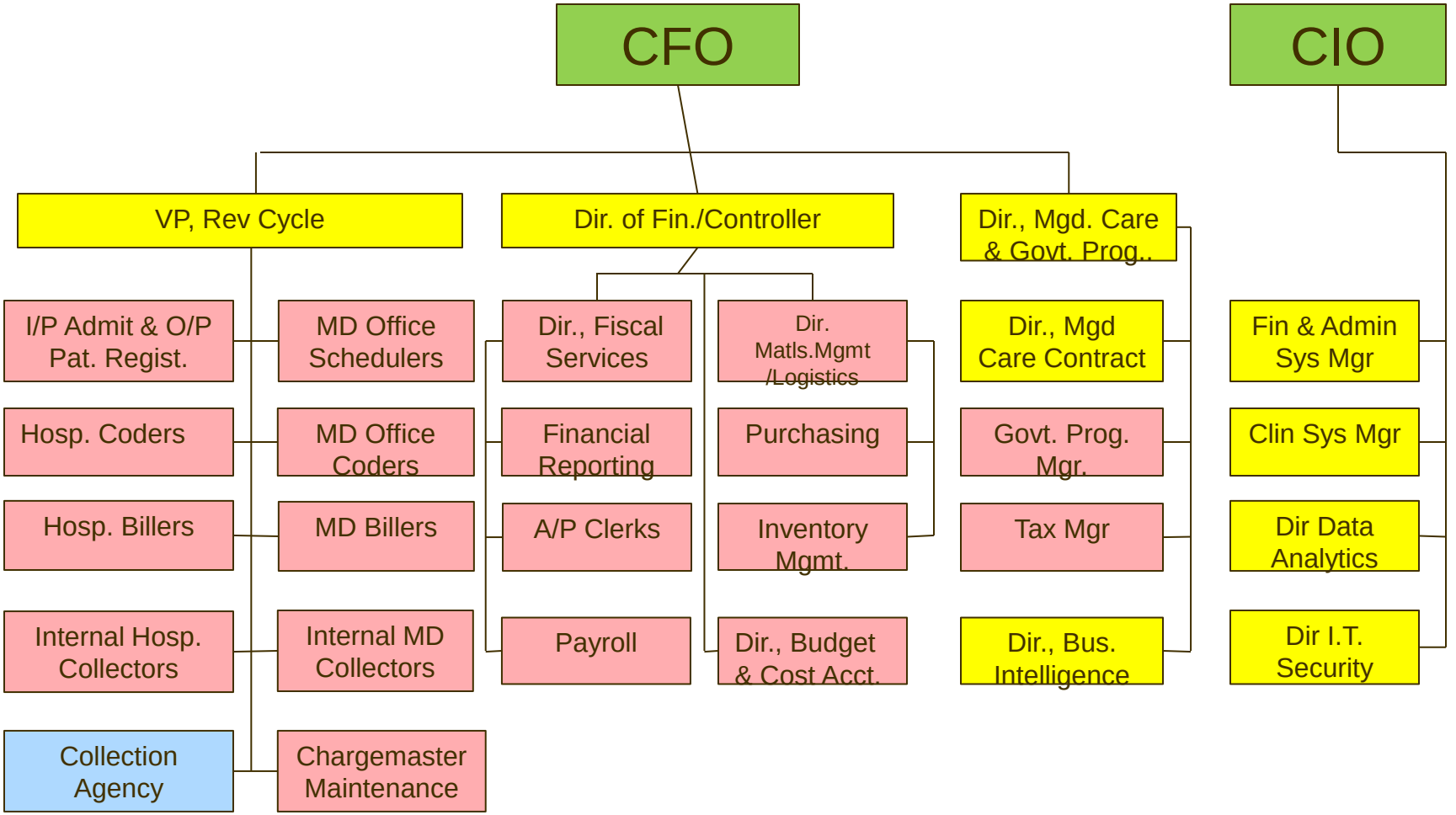
Emerging Needs (Cont'd)

- Plus:
  - Dedicated regulatory monitoring and management
  - Increased managed care complexity
    - Health insurance exchanges
    - Payor network monitoring (exclusive and narrow network plans)
    - Medicare advantage plan changes
  - Increased Medicare reimbursement complexity
    - Sequestration
    - SGR remediation
    - Home health (and other) payment reductions
    - 2 midnight rule, HAI, readmissions, etc.
  - Larger system acquisition approaches
  - Information systems security

Emerging Needs (Cont'd)

- **Increased Payment Uncertainty**
  - Value-based purchasing withholds
  - EHR meaningful use criteria (stage-by-stage)
  - RAC audits
  - Demonstration projects performance
  - ICD-10 Implementation
- **Even some uncertainty re. costs**
  - 340(b) pricing on pharmaceuticals threatened

Emerging Finance Organization



Emerging Finance Team

- **Absolutely Key**
  - Very strong VP Revenue Cycle/PFS Director
    - ◊ May be centralized at regional or national level
    - ◊ Dir. of Patient Access?
  - Dir., Cost Accounting, Financial Planning & Budgeting?
    - ◊ Financial modelling capabilities (“what-Ifs”)
  - **Medical Economics Capabilities**
    - ◊ Strong/frequent CMO interaction
    - ◊ CMFO (Chief Medical Finance Officer) – MD?
    - ◊ Medical data analytics

Status Check

- How well positioned is your Hospital Finance Team to do these things?
  - Are the necessary additional services being provided?
  - Have needs been met on a timely basis?
  - Have there been major subsequent corrections or restatements?
  - How well does your overall system benchmark on key financial indicators (productivity, cost per case, pricing mark-up ratios, days cash on hand, etc.)?
  - Adequate tools, people, expertise?

Strategic Financial Planning

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The Fit

The Long Range Financial Planning Process

1. Determine long-term financial goals
2. Establish a historical baseline
3. Analyze financial impact of strategic plan strategies and tactics
4. Layer financial impacts on historical baseline
5. Test results against long-term financial goals
6. Modify iteratively as necessary to accomplish long-term financial goals

Long Range Financial Goals

- Most commonly – Attain specific credit rating
  - Examples
    - ◊ Income from Operations – 3%
    - ◊ Total Margin – 5%
    - ◊ Debt Service Coverage – 1.25+
    - ◊ Days Cash On Hand – 150+
  - Generally minimum target = BBB+
  - More desirable = A

Establishing the Baseline

- Trending based on prior two – three years and current year-to-date performance
- Core assumptions:
  - Patient service volume
  - Payor mix, pricing & payment levels
  - Labor productivity & salary expectations
  - Other expense inflation rates
  - Any financial impact of significant known future events

Analyzing Strategic Plan Impact
(Tactic by Tactic)

Strategy Lead	
Name:	
Title:	
Phone #:	

Strategy -Brief Description

	Major Individual Tactics																							
										Resource Requirements													
#	Brief Description	Incremental Revenue				FTE Change (#)				Estimated Annual Cost (of FTEs)				Non-Staff Operating Expenses				Capital Costs (Acquisition Cost)			
A		FY2014	FY2015	FY2016	FY2017	FY2014	FY2015	FY2016	FY2017	FY2014	FY2015	FY2016	FY2017	FY2014	FY2015	FY2016	FY2017	FY2014	FY2015	FY2016	FY2017
	Estimated New Revenue Generated																				
	Staffing Reasoning/Description																				
	Other Operating Expenses (if changing)																				
	Capital Costs (if changing)																				
	Incremental Revenue Generated	-	-	-	-																
	Total Resources Required																				
	Staffing					-	-	-	-	$ -	$ -	$ -	$ -								
	Other Operating Expenses													$ -	$ -	$ -	$ -				
	Capital Costs																	$ -	$ -	$ -	$ -

Analyzing Strategic Plan Impact
(Tactic by Tactic)

Strategy Lead	
Name:	Brad King
Title:	CLA Principal
Phone #:	704-998-5291

Strategy -Brief Description

Improve and leverage information technology

Tactics

#	Brief Description	Incremental Revenue				FTE Change from Current Staff (#)				Resource Requirements: Estimated Annual Cost (of FTEs)				Resource Requirements: Non-Staff Operating Expenses				Capital Costs (Acquisition Cost)			
		ESTIMATED IMPACT OF TACTIC																			
Ex	Acquire & Implement New Electronic Health Record	FY2014	FY2015	FY2016	FY2017	FY2014	FY2015	FY2016	FY2017	FY2014	FY2015	FY2016	FY2017	FY2014	FY2015	FY2016	FY2017	FY2014	FY2015	FY2016	FY2017
	Estimated New Revenue Generated																				
	Medicare Meaningful Use Incentive Payments-Hospital	-	2,400,000	2,400,000	2,400,000																
	Meaningful Use Incentive Payments-Physicians	-	720,000	480,000	320,000																
	Staffing-Position/ Justiufication																				
	I.T. System Implementer					0.50	1.00	0.50	-	50,000	100,000	50,000	-								
	I.T. Business Analyst					0.75	1.00	-	-	63,750	85,000	-	-								
	I.T. Programmer/Analyst					0.75	1.00	-	-	63,750	85,000	-	-								
	Support Staff					2.00	3.00	1.50	-	80,000	120,000	60,000	-								
	Other Operating Expenses (if changing)																				
	Training													16,000	8,000						
	Travel													3,200	4,800	1,600					
	Professional Meetings													1,200	1,800	600					
	Office Supplies													1,000	1,500	500					
	Telephone													2,400	3,600	1,200					
	Capital Costs (if changing)																				
	EHR system application																	3,000,000	1,500,000		
	Servers & peripherals																	400,000	200,000		
	Staff laptops/desktops																	24,000	12,000		
	Incremental Revcenue Generated	-	3,120,000	2,880,000	2,720,000																
	Total Resources Required																				
	Staffing					4.00	6.00	2.00	-	$257,500	$390,000	$110,000	$ -								
	Other Operating Expenses													$ 23,800	$ 19,700	$ 3,900	$ -				
	Capital Costs																	$ 3,424,000	1,712,000	$ -	$ -

Layer Tactics Impact on Baseline

- Add incremental financial impact of each tactic to prior baseline
- Calculate cumulative impact

Test Results Against Long-Term Financial Goals

- Compare modified financial performance against key/bond issue-required long-term financial goals
  - Gain/loss from operations
  - Total margin
  - Debt service coverage
  - Days cash on hand

Modify Iteratively

- First run of modified projections almost always fails to meet long-term financial goals
  - Natural desire to accomplish individual responsibilities as soon as possible
  - Capital needs often exceed available capital
    - ◊ Inadequate cash on hand
    - ◊ Limited philanthropy available
    - ◊ Limited additional debt capacity
  - (benchmarked, specific related plans)
- Prioritize accomplishment of tactics
  - Mandated due dates (such as EHR & ICD-10 implementation)
  - Return on investment of each

Key Tool – Financial Modeling Program

- Various options, such as:
  - Kaufman Hall
  - CLA Intuition
  - Others
- Different Approaches
  - Remote processing versus internal use
  - Cost differences
  - Degree of external assistance required

Key Tool – Financial Modeling Program

-Sample Basic Assumptions – p.1

Community Regional Health **3/2/14**
Assumptions Summary with Action

	Description	Historical Information (If applicable)	Current Assumption	Assumption Action:	Assumption Low Range	Assumption High Range
1)	Using the year-to-date activity to project year 2014		June YTD Annualized	Update with management 2014 Projected		
2)	Projecting 2015		Calculating per volume, payer mix, and inflation assumptions	Should we book year 2014 to the 2014 Budget?		
3)	Net Assessment Impact		No add-back to margin	Should we add $1.3 million for a number of years?		
4)	Volume Growth					
	Volume Growth Percentages					
	Inpatient	Acute admissions %variance was -1.0% 2008-to-2009 and -6.1% 2009-to-2010	1.0%			
	Outpatient	OP surgery cases %variance was -4.7% 2009-to-2010	1.0%			
	Clinic	*n/a - no historical data*	1.0%			
	Variable Expense Assumption on volume growth	*n/a - no historical data*	50% variable expense			
5)	Physician Growth		No additional margin being added from physcian growth	Please see "Physician Development" Worksheet		

Key Tool – Financial Modeling Program

-Sample Basic Assumptions – p.2

6)	Inflation / Health care reform					
	Reimbursement					
	Medicare	*n/a - no historical data*	-2.0%			
	Medicaid	*n/a - no historical data*	-2.0%			
	True Self-pay	*n/a - no historical data*	3.0%			
	Commercial and Other	*n/a - no historical data*	3.0%			
	Health Care Reform					
	Uninsured shift		25% in years 2013-2016 to 100% Medicaid Rates			
	DSH Reimbursement		Reduced			
	Market Basket		Reduced - MCR inflation reduced 0.25% and 0.10% beginning 10/1/11			
	IP Coding		Not Included			
	Quality Add-on		Included at 70-80th Percentile			
	Productivity Adjustment		Not Included			
	Readmission / HAI Penalty		Not Included			
	Expense Cost of Living	*n/a - no historical data*	3.0%			
7)	OP / OP Project					
	Capital Cost		$ 7,200,000			
	Interest Rate		4.90%			
	Timing		Jul. 1, 2011 - Oct. 1, 2013			
8)	HITECH EMR					
	Amount		$ 4,800,000			
	Timing		Oct. 1, 2014 - Sep. 30, 2017			
9)	Routine (Replacement) Capital Expenditures	Capital expenditures of $2.56m in 2012, $2.42m in 2013, and $2.20m for all years in forecast	$2,400,000 per year			
10)	Contributions / Grants	Including temporarily restricted, there were contributions of $142k in 2012, $201k in 2013, and $193k in 2014	$150,000 per year			
11)	Investment Income	$406k in 2012, $130k in 2013, and $531k in 2014	1.50% of average cash/investments ($370K in year 2014)			

CLA Intuition- 5 year Look Forward (Baseline)

GVH | DRAFT STRATEGIC DASHBOARD - SUBJECT TO CHANGE | CLA Intuition™

PHYSICIAN DEVELOPMENT PLAN

- [ ] No Family Medicine Plan
- [ ] No General Surgery Plan

Specialty	FTE's	Prac Cost	Addt Comp
[ ] No Integrate Cardiology			
[ ] No Integrate Endocrinology			
[ ] No Integrate Neurology			
[ ] No Integrate Primary Care			

LABOR / NON-LABOR PERFORMANCE IMPROVEMENTS

- [ ] No Labor Cost Savings
- [x] $2,976 = 2014 Non-Labor Cost Savings (5.5% over 3 Years)

MEDICAL MALPRACTICE COSTS

- [ ] No Change in Malpractice Costs

MEDICARE PAYMENT RATES

- [ ] No Quality Add On
- [ ] No Readmission / HAI Penalty
- [ ] No Sequester Impact
- [ ] No Change in Provider Based Billing

ACA: PAYOR MIX IMPACTS | Rate

- [ ] No Change in Uninsured Mix
- [ ] No Exchange Shift

PAYOR MIX SHIFT (Aging Population)

- [x] 7.0% Shift to Medicare by 2019 (2015 Start)

MAJOR PROJECT CAPITAL NEEDS

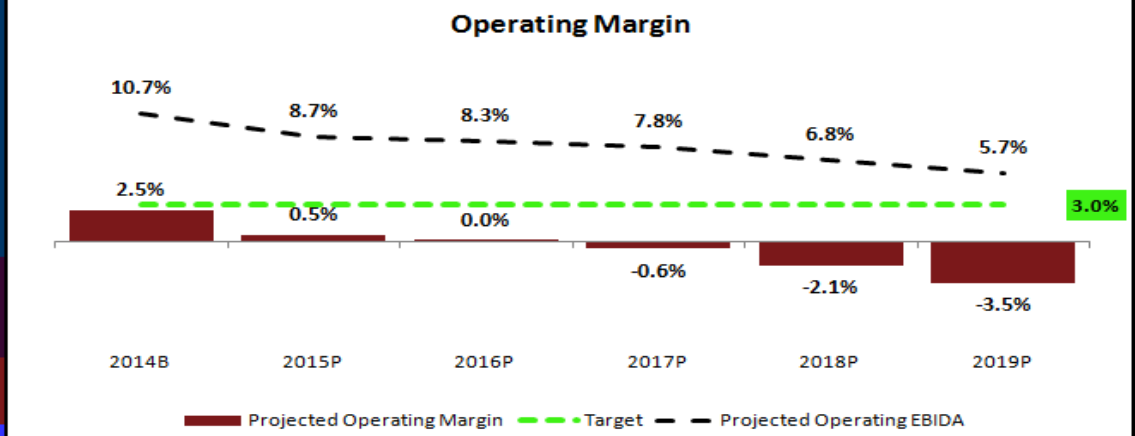
- [ ] No Surgery Center
- [ ] No Diagnostic Center
- [x] $8,000 HealthPlex — 2015 Start

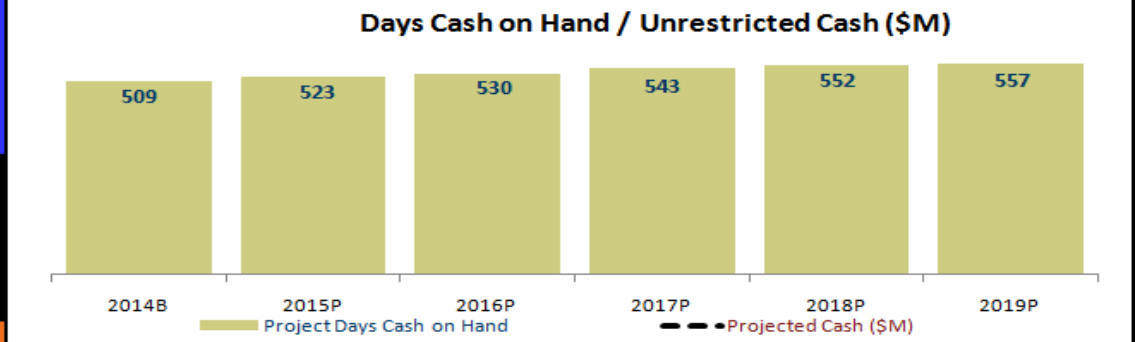
MAJOR PROJECT CAPITAL SOURCES

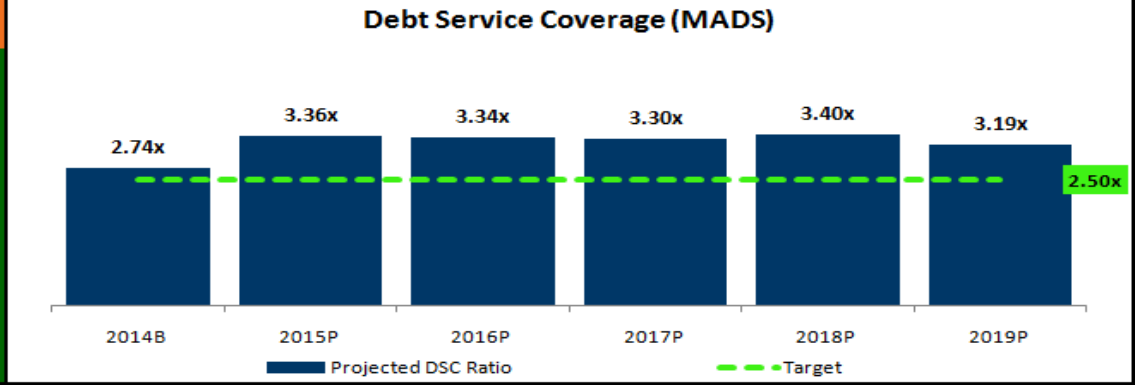
- [x] $4,000 Philanthropy
- [x] 75% Cash

VOLUME GROWTH FROM CAPITAL PROJECTS

- [ ] No Inpatient Volume Growth
- [ ] No Outpatient Volume Growth







Conclusion

- So, overall, how financially prepared is your hospital or system to meet needed future financial services?

- Can you still “go it alone?”