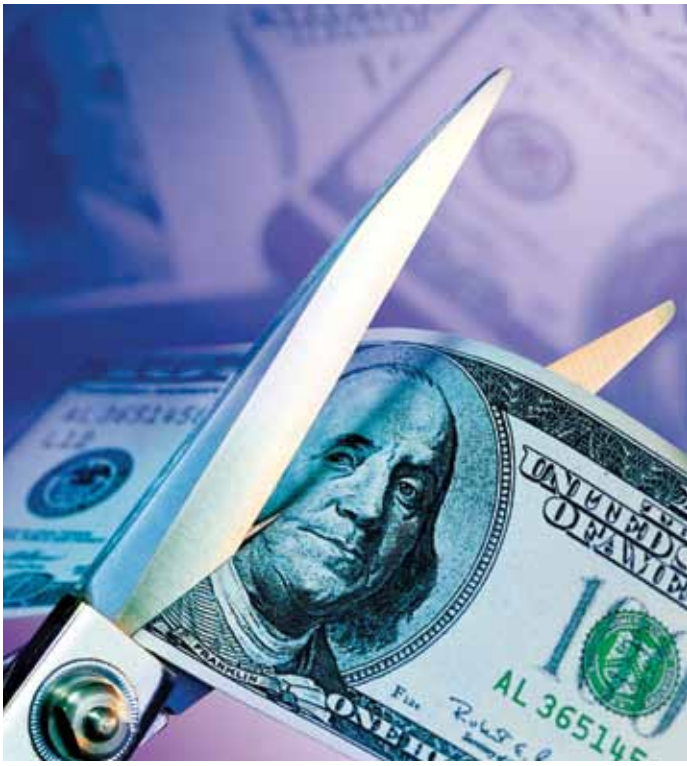
ROUNDTABLE

Cost-Cutting, Efficiencies, and the Revenue Cycle

As healthcare margins tighten and cost-cutting takes center stage, professionally run healthcare organizations seek efficiency gains in their financial operations. Large cost-saving opportunities lie in the revenue cycle and vendor management. Financial officers must learn to work smarter with a range of vendors, contractors, and outsourcers; with payers; and with self-pay patients through revenue cycle and payment channels. From high-deductible health plans that cause bad debt problems to Recovery Audit Contractors to coding changes to medical necessity judgment, providers have to be sophisticated in order to get paid. Yet still-emerging models of payment offer the promise of improved finances and a better patient experience. HealthLeaders Media recently joined with five executives for an in-depth, three-hour conversation on tightening budgets, the difficulty of collecting at point of service, and readiness for the crucial shift to value-based reimbursement.



PANELIST PROFILES

MARK BOGEN
Senior Vice President and CFO
South Nassau Communities Hospital
Oceanside, N.Y.

ALLEN JOHNSON
CFO
Truman Medical Centers
Kansas City, Mo.

ROBIN KILFEATHER-MACKEY
CFO
Dartmouth-Hitchcock
Lebanon, N.H.

RICHARD SILVERIA
Senior Vice President of Finance and CFO
Boston Medical Center

LYNN WIATROWSKI
Executive Vice President
National Treasury Executive Specialized Industries
Bank of America Merrill Lynch
Boston

RENÉ LETOURNEAU (CO-MODERATOR)
Senior Finance Editor
HealthLeaders Media
Brentwood, Tenn.

EDWARD PREWITT (CO-MODERATOR)
Editorial Director
HealthLeaders Media
Danvers, Mass.

Roundtable Highlights

HEALTHLEADERS: *When we survey healthcare CEOs and CFOs, we hear that cost-cutting is a top priority. What percentage of your operating budget do you think your organization needs to eliminate this year?*

ALLEN JOHNSON: If you look at your overall cost and say you're going to cut 10% out, that's a huge challenge. That's a lot of money because so much of your cost is fixed. You can't reduce it. You can't reduce depreciation. You can only cut supply costs so much. ... Last budget year we made significant budget reductions, including consolidating our two inpatient behavior health units. We also changed our nursing staffing ratios in several units. We reduced many non–patient care positions. But with all the things we did last budget session, including the change to our defined benefit [pension] plan and the labor cost reductions, we still only took 3% out of our operating budget. So this next budget cycle, which will be starting very soon, we're going to be looking at probably taking out 7%. I think we have to do that.

MARK BOGEN: When you talk about cost-cutting, people naturally assume something negative is going to happen as a result. I'm trying to get my organization to use the vernacular that is in play today, and that's value-based purchasing. I'm trying to take our organization to the point of spending wisely on the resources that we need. ... As a $400-plus million organization, my goal in the '14 budget is to take something close to 5% out.

RICHARD SILVERIA: It's at least 10%, and it's probably closer to 20%. I think as a CFO, I would characterize it more as performance improvement. It doesn't have to be expense, it could be top-line growth, or it could be improvement in the revenue cycle. I think our responsibility is to constantly nourish and replenish a portfolio of ideas that has maybe 30% worth of ideas or more, because you usually hope to get 10% or 20%.

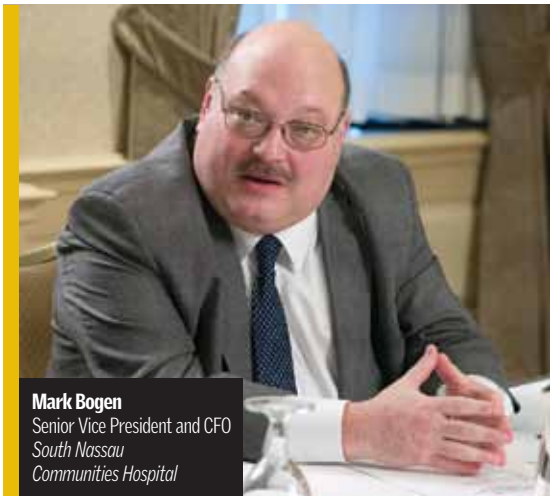
We've done a lot of the improvements already. We initially cut about $100 million, and we have about another $120 million to go. We're hoping to do some top-line growth, but I think the easy things are largely done. We can do more, but now it's really getting into the practice of medicine. ... We're going to go right into the headwind of the way [physicians] are trained. They are frequently very autonomous and independent-minded. I've often heard the aversion to "cookbook medicine" ... [but] ultimately what has to happen with the hospitals [is there has to be] decreased overall utilization and predictability: predictable outcomes, predictable quality, and predictable cost.

ROBIN KILFEATHER-MACKEY: We're taking a longer view and really looking at cost-per-unit reductions. We have cost-per-unit targets for every department, and in each budget cycle they have a cost-per-unit reduction target. Last year it was 5% to 10%.

Our institutional mission is to create a sustainable health system, and to do that, financial sustainability plays a big role. We very much believe that at some point in the future, maybe five, six, seven years, payment rates will essentially be equal to Medicare rates. We recently completed a study that took all of our commercial payment rates and remodeled them if we were only paid Medicare rates. That's about a $300 million reduction. Our current challenge is, how do you improve performance to offset the $300 million hit? That's a little over a 20% reduction in expenses for us over the next five to seven years.

LYNN WIATROWSKI: At Bank of America Merrill Lynch, we bank 82% of the top hospitals nationally. What we are hearing is much more about cost efficiencies, back-shop operations, and clinical and administrative system integration and design. It used to be as a banker, it was all about capital finance and "Can I borrow money? How much money can I borrow?" Now the conversation with CEOs and CFOs alike is about driving toward a more efficient process with financings focused on technology and process change. That has been a huge shift.

For years in our business—and I've been around healthcare for a long time—it was M&A for the sake of scale and buying power. It's still M&A, but in the past it was very much about the bricks and mortar side of what our hospitals needed. It's now all about, "OK, how do I bring costs out?" It's more about redesign and transforming how healthcare is done. I think it really is a different model, and building efficiencies from that perspective is just a huge priority for providers.



Mark Bogen
Senior Vice President and CFO
South Nassau Communities Hospital

HEALTHLEADERS: *When you look at your revenue cycle and getting paid for all services rendered, what are the biggest challenges you are facing and what are some of the solutions?*

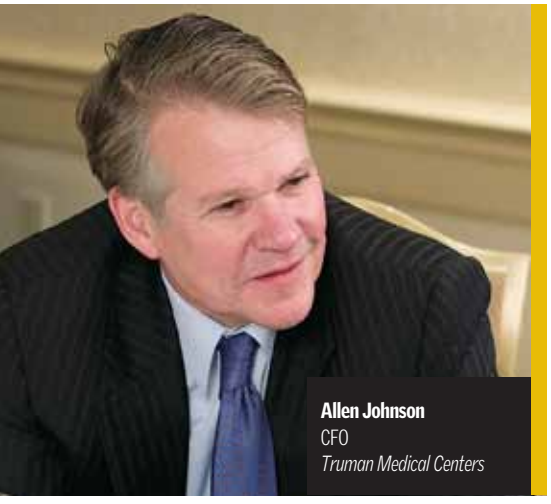
BOGEN: Certainly, the skill sets that are involved today that are necessary for front-end people to really be the guardians of that revenue cycle system have changed dramatically, as they tend to be the most neglected component of the revenue cycle process. What I've

been trying to do is to start there and start raising skill set training and start looking at pay ... I think it's that recognition now that ... if you don't collect the information correctly on the front end, you're never going to get paid for it on the back end. I don't think it's ever been as important as it is today and [will be] into the future as we talk about the movement toward consumer-driven healthcare.

KILFEATHER-MACKEY: I definitely agree with Mark's comment about understanding the skill set of front-end employees. It's really important. We actually have a new role in the front end called financial counselors. We've got about 14 of them across our system, and their job is to find payment solutions for people that show up that are uninsured or underinsured. For that population, almost 85% of the time we're able to find payment solutions.

We're trying to do a lot on the front end, especially with the insurance exchanges. We've had people get certified to help be navigators. ... Once a person's identified as uninsured or underinsured, they go through a carefully designed path of assistance to help. Now, literally, the 15% that we couldn't find solutions are for the most part people that wouldn't work with us.

JOHNSON: Truman has about 28 financial counselors at both our campuses.



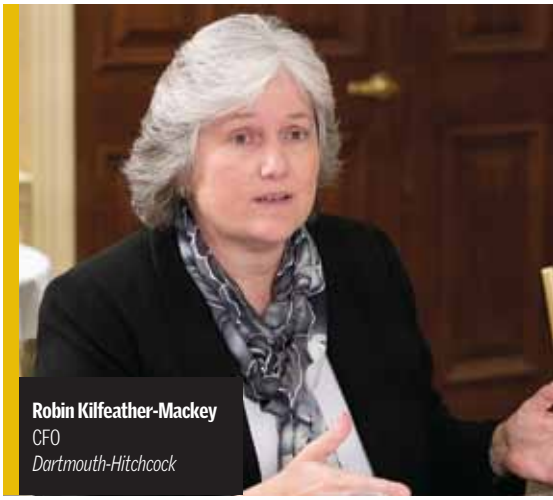
Allen Johnson
CFO
Truman Medical Centers

We've had a financial counseling department for the past 10-plus years, and it's been very, very beneficial to us. We also have an outsource relationship with a vendor who also has had some pretty good success. We use them for cases in which we cannot get the patient to comply with the Medicaid application process. ... Our best success is to capture patients while they're in-house at Truman. We try to capture 100% of the inpatient. In the outpatient area, it's a little more challenging.

SILVERIA: [With] the revenue cycle, I think that providers need to think about it as kind of one care process, one service delivery process. ... You really have to marry the clinical and the administrative together. So in terms of registering a person, I think we have to make some investments in the process, the technology, and the right people who can address clinical and administrative complexities. ... Then, thinking about not a clinical system and a revenue system, but a kind of service rendering system that's tightly integrated so that when a physician orders, it fires off rules for not just care pathways, but also [determining if it] is medically necessary given the diagnosis, and has coverage or authorization rules ...

There are so many dimensions to the revenue cycle; we have to become much more retail-like. If you think about it, we're the largest part of the economy, and we're in the dark ages. We're far from the service standards found in the banking or travel industries.

WIATROWSKI: Healthcare has got to act more like a retailer. The amount of patient responsibility or self-pay payments is going to go up significantly because of high-deductible plans. ... I think a number of our clients are starting to say, "I'm going to make sure I don't just write that off as 'Oh, well that was self-pay so I'm not going to collect it.' " Instead we've been talking a lot about point-of-service options for how to actually collect the cash, check, or whatever payment it may be so that providers are well prepared. I also think the points about financial counseling are really important. There are lots of different pockets where payments can come from to take care of the patient side of the responsibility. ... The conversation is much less about collecting on the back end now, and more about the front-end point of service.



Robin Kilfeather-Mackey
CFO
Dartmouth-Hitchcock

KILFEATHER-MACKEY: Collecting at the point of service is really hard culturally. I've had a few patient complaints because people have been really angry that they were asked for payment at point of registration. ... If somebody goes to our cancer center, should we ask for payment? Should we ask for payment everywhere but our cancer center entrances? It's a cultural shift, especially with patients that are new to high deductibles. They're getting surprised by insurance that is not really what they think it is, and we have to explain it.

JOHNSON: Our biggest challenge is our patient population is not familiar with terms such as *deductibles* and *copayments*. Many of our patients have never had insurance, and the exchanges are introducing them to a new world of cost-sharing and health plan choices. In response, all of our financial counselors have been receiving training to assist our patient population through the marketplace exchange process.

WIATROWSKI: The exchanges are actually spending a lot of time trying to figure out how they're going to collect payments—premiums—from the newly insured because there are many who do not have bank accounts. It's introducing a completely different dynamic in the industry. In part, though, I think it's very positive because it puts responsibility for the cost of care that we're getting back to us as consumers.

HEALTHLEADERS: *How are you using data and IT capabilities to reduce clinical utilization and overall costs?*

KILFEATHER-MACKEY: From a data perspective, the challenge we have is that there aren't really systems out there that give us what we really need. We're trying to actually build an infrastructure that gives us the utilization data, outcomes data—so we can focus on value-based care—and then our actual delivery costs. We don't have all three of those in the same system right now. You can lower your utilization, you can hit it out of the park with outcomes, but if you don't have a handle on how many resources you're consuming when you're delivering that care, there's a gap. Having all three in the same system would be the holy grail. We're trying to construct and create an environment that gives us that. The data infrastructure is going to be a really important component of our future.

BOGEN: From a technology standpoint, we would tend to buy technology, but never implement it in a way that would allow us to understand the depth and breadth of what technology can offer. If we had a particular problem, we went out and bought technology or we learned one component of the technology and didn't realize that the technology had greater power. Then someone else may have gone out and bought technology to solve their problem, and didn't realize that the technology that we had just purchased may not have been exactly the solution, but it may have had some of the benefits, [and we] could have done a modification. It's really eye-opening for me. ... You have these 'aha' moments all the time when you get people to recognize that throughout the organization as well.

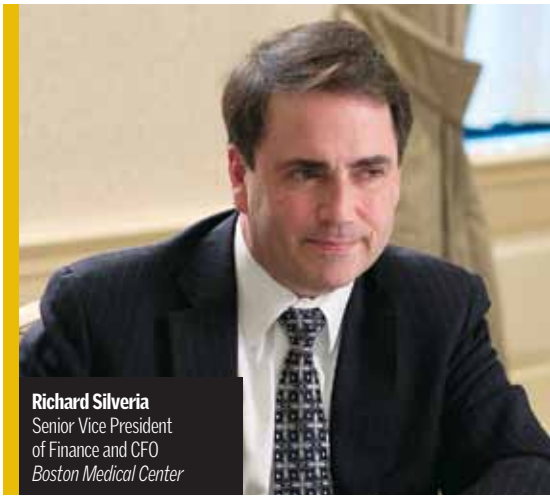
WIATROWSKI: In the banking industry, we went through an enormous consolidation, as you all watched and we all lived through. There were so many emergencies of the moment, and you deal with those. Then you need to think about, "OK, what are the big-picture issues and opportunities for our industry?" It's that drive toward efficiency and effectiveness. ... The priority I am also hearing about is that data is where it's at. Understanding what it costs to provide what kind of care and how that patient is being treated holistically—it's really important. It's been fascinating to see the shift in the conversation.

HEALTHLEADERS: *Do you use Lean, Six Sigma, or another process improvement program to find efficiencies?*

KILFEATHER-MACKEY: We actually created a process that's a hybrid of Lean and Six Sigma. We interfaced with Corning, who has done a lot in this space, and established a Dartmouth-Hitchcock way. We didn't use any jargon. We have normal nomenclature that we would see in our culture. We tried to make it feel more like a D-H way than something foreign. We didn't bring consultants in. It was internally developed by our chief quality officer.

The process that we do when we're looking at variation is called an RPIW, which is a Rapid Process Improvement Workshop. It's a five-day intensive session where you get all the key stakeholders—a multidisciplinary group—in the room. But there has been a lot of prework by frontline staff and process innovators to prepare for the five-day session.

So you have this five-day session, then the output of that gets implemented and trialed, and we look at the results. ... We had a project where we went into the OR, looked at everything that was used in a standard surgical kit—actually many of the kits that various surgeons used. ...We actually went through the entire kit and questioned whether every item was currently being used. Based on that feedback, we reduced/reconfigured the contents of many kits. There was a real-time reduction in the contents of kits, so sterilization costs went down. There were some devices that are in these kits that nobody used; we're not purchasing those anymore. We've seen small incremental changes to the kits that reduced overall costs. After an RPIW is finished, there is a six-month period of review and measurement. We go and assess the whole process, including time spent to do the project. We went through a project, as an example, which resulted in an annual cost savings of $400,000, but in year one it took us $100,000 of team time and resources to get that $400,000 savings. So the net for year one was a $300,000 savings.



Richard Silveria
Senior Vice President
of Finance and CFO
Boston Medical Center

JOHNSON: We made a big investment in Six Sigma some seven or eight years ago, and I think we went overboard too fast. We hired a number of people who were very well trained in Six Sigma. The problem we had with it is they really were not very well trained in healthcare, and because of that we had a bad first experience. Now we've tried other variations of the Lean model. There is a consulting firm that actually came in and helped us, I think, improve some of our processes within our revenue cycle.

The problem we had with it is it just took months and months of testing because you were testing these different combinations of processes. In the end, it wasn't very successful, and at least in our revenue cycle, it really didn't yield any real big, positive results.

BOGEN: We do Lean, although it's been unfortunately very slow to take hold. I think that the philosophy has been we wanted to do it in such a way that it came from the bottom up, so that the people, whether they're the department heads or people in their departments, were the ones bringing these suggestions to the senior leadership team rather than senior leadership always recommending what they thought were the right things to do for projects. It's been somewhat slow to develop, and again the sustainability sometimes is questionable, even though there are required report-outs and updates on a quarterly basis.

At the heart of Lean is really taking an interdisciplinary group of folks, leaving egos behind, and really trying to figure out process. ... Without the staff involvement, nothing really succeeds.

SILVERIA: Regardless of the improvement approach, I think you have to create a culture where you're not satisfied, and you're always constantly improving. ... You have goals, and you set metrics on those goals. You sell a vision as a senior team, and you march on it. ... Sometimes it catches on organically, and you reach a tipping point. But you need a few VPs to kind of drive that. One thing that is a common thread is that you have to have improvement objectives, and you have to measure them. You have to drive toward them, and whatever works works, but you have to create the environment to do that.

HEALTHLEADERS: *You are all moving toward population health management while still living in a fee-for-service world. It's hard to know where that tipping point is, but when it hits, it's going to hit quickly, and you're going to have be ready for it. How do you figure out the timing?*

WIATROWSKI: Timing and sequencing is the big challenge.

SILVERIA: I think that's the million-dollar question. We've all been asking that. It's increasingly difficult to execute on both.

JOHNSON: That's a gigantic challenge. That's the biggest dilemma we face. We depend so much on fee-for-service reimbursement, and at the same time, we have all these different risk-based payment models out there that are being tested today. We're kind of torn because we know we have to be more of a risk-bearing entity in the future, which means we need tighter physician- hospital alignment. However, today we function in a volume-driven financial model. Converting that model requires a significant capital investment, which we don't have today.

SILVERIA: You really wonder if we can do this as a society. ... Can we really drive the transformation of this industry given individual choice and the mixed incentives for care created by benefit design? ... [W]e also need a little help from policymakers, because you think about this transformation toward population health management, but superimposed on that are demands for meaningful use and ICD-10. ... We also have to figure out how to manage that risk, but any kind of risk has to be shared within payer/provider constituents ... until we get down to an appropriate delivery system capacity level.

HEALTHLEADERS: *Redesigning the healthcare delivery system is going to require revisiting everything about your organizations. Is there a way to tackle the problems you're facing by looking at the short term, such as labor and supply chain, and the longer-term issues around clinical redesign?*

BOGEN: As we go through what we can do from a CFO position, whether it's supply chain or revenue cycle, I think the realization is that we all have to start dealing in the variability of clinical practice. That really is where the next generation of ability to right-size our organizations is going to exist. That really is the most difficult part, because that is the terrain that none of us have any control over directly or even indirectly. That is where working with the chief medical officer, the clinical chairs, and others is going to be so important. ... Being able to convince [physicians] of the need to change medical and clinical practices that they have achieved over a 25- to 35-year career is probably going to be the most difficult part.

KILFEATHER-MACKEY: We've always had an employed physician model and currently have more than 1,000 physicians that are employed and have been for years and years associated with a closed hospital. ... One of the things that we really need to come to terms with is the construction or the composition of our clinical teams. We have a very physician-centric clinical delivery model. Once you standardize the care path and eliminate variation, then you are challenged with how do you continue to lower your cost per unit? From our standpoint, you then need to look at associate providers/midlevels and community health workers. It's really opening up the spectrum of care delivery and making sure you're using the right resource for the right type/intensity of care.

Reprint HLR0214-5