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# CFO Outlook 2014

**INTRODUCTION** Our traditional first issue of the year offers the healthcare C-suite a forum to share top IT strategies for the unfolding year. CEOs, CIOs and CMIOs have offered compelling perspectives on their organizations' IT-related initiatives and areas of focus. Given the healthcare industry's shift from a volume-based model to one based on value and accountable care, the 2014 Outlook welcomes the voice of the CFO.

We are fortunate. The head of the country's premier healthcare CFO organization broadly sketches the IT-related strategies CFOs face in 2014, and two CFOs of health systems advanced in the use of IT discuss specific IT objectives for the year. We use the opportunity to ask other key questions: How has CFOs' view of IT changed over the past decade? How do they define IT value? It's early in the year and the conversation is just beginning.

## Always two steps ahead

Besides the conversion to ICD-10 code, which continues to absorb huge resources as providers approach the Oct. 1 deadline, information integration is a top priority, says Joseph J. Fifer, FHFMA, CPA, president and CEO of the Chicago-based Healthcare Financial Management Association (HFMA).

Monolithic EHRs are no longer considered a panacea for integration. "There's still so much work to do to better integrate the myriad disparate IT systems" that riddle health systems, he says, and it's a problem exacerbated by accelerating mergers and consolidation.

The need for integrated IT intensifies as demand grows for risk sharing, which requires integration of payer and provider environments. "It seems like the shift toward risk and pay for performance always stays two steps ahead of the IT systems ability to integrate data. I see that as a focus in 2014 and beyond," says Fifer.

A closely related IT investment trend for 2014: health systems need to integrate their finance and clinical quality systems to support any number of pay-for-performance (P4P) arrangements that arise.

## Jumping with data

"Success at risk sharing depends on linking quality data and financial data. There will be a wide variety of financial structures. Some plans—Geisinger, Florida Blue, Priority Health, for example—are jumping at the chance to provide this kind of information because of their experience with linking financial data and actual treatment—healthcare usage—from claims data," he says.

Whether it's Medicare or private payers, health systems will have to face some kind of P4P and the need to manage risk, which hospitals don't know how to do. Managing



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risk can range from standard P4P contracts with fairly straightforward information needs to highly complex arrangements that require assumption of insurance risk for an entire population's health.

**Joseph Fifer, President/CEO, HFMA**

"You need to look at data that crosses various providers from outpatient, physicians, labs, pharmacy as well as hospitals. That's one element," says Fifer. Another element is to determine how to evaluate practice patterns and change physician behavior, which requires blending quality data and physician input—activities payers have been doing for many years.

The emerging era of value requires a renewed emphasis on financial systems, and a corresponding new emphasis on use of actuaries and actuarial data, a traditional blind spot for hospitals.

## CIOs & CFOs more attune

What's changed over the years is the continuous need to invest in IT. CFOs now resign themselves to this unrelenting investment as the price of doing business, a realization that has mitigated the traditional argument over IT between the CIO and the CFO.

"It starts to relax any kind of frustrational environment between CIOs and CFOs. We're now working together more to strategize, unlike five to 10 years ago," says Fifer.

While the CFO is understandably unprepared to make all those IT investment decisions, he says, it's the CFO's job to establish a systematic framework for the senior management team to make IT and other capital-investment decisions.

Assessing IT value is still a challenge in healthcare. "IT is more of a cost environment than an ROI. We don't have it down yet. In the past the capital-allocation process put a pretty significant weight on ROI, even though it was mostly nebulous for IT. The claims on ROI for IT amounted to mostly soft dollars. I see that easing a bit, but it would be better if we could develop a hard ROI," he says.

Still, IT always seems to add cost rather than cut cost. And it's difficult to isolate the variables to calculate IT value. "By the time you implement a new system—it often takes years—you probably have 100 new applications to invest in. It's too fluid an environment," Fifer says.

## No slowing down at Ascension

Katherine Arbuckle, Senior VP and CFO at Ascension Health, says the St. Louis-based, 131-hospital system is facing the same list of IT issues in 2014 as other health systems, with the top one being the increasing cost of IT.

"We need IT, and other industries are bringing interesting IT innovations to healthcare. But IT also brings an increased cost level onto a system, and there's no sign of it slowing down," she says.

IT is an asset that requires a continuing huge investment: continual upgrades and infrastructure support. For example, Ascension Health has completed more than 50 percent of its standardization on a single enterprise resource planning (ERP) system—business-process management

software that helps manage finance, supply chain and human resources—across facilities in 23 states, an incredibly complex job that requires coordination of data protection and security, access, standard business practices, user and information management. Ascension Health is also investing significantly in clinical business intelligence and population-health-management technology platforms.

Conversion to ICD-10 coding will require complex interfaces with provider and payer revenue-cycle software. "While there are many new bolt-on technologies and middleware improvements, there have been few major revenue-cycle advancements in recent decades," says Arbuckle. "With ICD-10 data, in many instances we will need to take our data in ICD-10, run it through multiple claims editors and supplemental technologies, then send the data to a payer where it will be received, converted back to ICD-9, edited and adjudicated, then converted back as ICD-10 data and returned to us. You see the translation opportunities. It's a constant challenge for providers and payers to resolve claim denials between the two systems, but our goal is to make progress in this area with the right technologies."

The ICD-10 conversion affects the productivity of coding thousands of procedures, expanding required codes to be more specific. For example, organizations will need to code which finger is broken rather than just "broken finger." This simple example is multiplied by thousands, causing clinicians and coders to spend more time identifying correct codes. Training costs for clinicians and coders, coding software and new transaction-compliant software will add initial and ongoing costs.

"Ascension Health is diligently working in its various locations and Health Ministries to advance our readiness for this enormous change. We have program management in place, clear and effective dashboard reporting and have developed goals for IT as well as our hospital and physician practice business leaders regarding ICD-10—we are all in this one together," says Arbuckle.

## MU, clinical systems & use of data

Meaningful Use payments are a positive incentive for needed investment, but they do not cover the full investment required. "We are spending significant capital and operating amounts on Stage 2 and will continue our EHR journey with Stage 3. We fully support the goals of MU, but the costs are huge," she says.

Then there are clinical systems. "We've been implementing CPOE for eleven years," says Arbuckle, "and until you have fully invested in all its components and operationalized all capabilities such as order set management and robust integration with lab and other systems, it is not optimized. Between the electronic medical record, ICD-10 and Meaningful Use investments, that's more than 70 percent of the IT capital budget."

A final IT focus for 2014, as mentioned, is the use of data. "These systems are so sophisticated, that connectivity of systems and integration of data are critical. Our clinical business intelligence (BI) and business decision support systems require complex decisions regarding which system is the single source of truth. We are dedicating significant effort to developing effective enterprise data warehouse capability that

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will enhance our overall business intelligence—not just clinical BI. You can have 99 percent accuracy, but if it takes six months to retrieve data that should be real-time, it's of low value. These BI solutions are critical to the success of operational, clinical, financial and business analytics and problem solving. Each area has information overlap and specific needs. It's absolutely essential to make these distinctions to manage population health whether managed in ACOs, Shared Savings programs or capitated payment arrangements. We are pursuing these programs in nearly every market," she says.

***"Between the electronic medical record, ICD-10 and Meaningful Use investments, that's more than 70 percent of the IT capital budget."***

***"You can have 99 percent accuracy, but if it takes six months to retrieve data that should be real-time, it's of low value."***

## No comfort zone

CFOs see IT cost in a much more granular and essential way today, notes Arbuckle. "Not one of us is comfortable with the continuing costs of continually acquiring and upgrading new systems. We understand it's the cost of doing business, but also know we can't keep adding to the cost of doing business, especially when the healthcare sector will likely need to cut costs by 20 percent or more in the next three to four years."

However, she says CFOs are "a little less skeptical" of IT than in previous years as a result of understanding the transformation of clinical care processes enabled by the massive investment by health systems in EHRs over the past decade.

Still, the decisions just get harder. "When you bring on a new system, you want to push standardization across all facilities, even throughout a multi-state system. In an ideal world, we would replace all existing systems with single, standard solutions and standard business rules and clinical protocols. But costs can be prohibitive because of existing system investments, and data still resides in disparate systems. We will not alter our environment in a single year--we are too large for that--but we are making progress having just committed to a single platform for infection control surveillance and refreshing our event reporting system," says Arbuckle.

**Katherine Arbuckle, SVP/CFO, Ascension Health**

Payers and providers have established various sophisticated clinical and cost systems, but data is rarely integrated or even transferable. "It's an area where the federal government could and should step in. The US highway system is dependent upon a national system, not just a composite of individual proprietary state roads," she asserts, adding that federal initiatives like Blue Button, which standardizes patient access to health information, could help streamline healthcare IT. "I'd like to see health information in the hands of the person who owns its. An individual should have access to his or her own portable medical record."

And there's no crisp answer to the IT value question.

"IT value-proposition templates continue to focus more on 'soft returns.' We do have a good discipline to provide business cases for all our IT investments including expected ROI. But valuing increased analytical or decision-making capability is difficult. While you may not get a perfect answer, it is important to undergo the

process to ensure users are more accountable for results and deliverables are measureable," she says.

Ascension has established a Value Creation Office to focus on programs that improve efficiency, positively impact revenue and reduce costs. "Even while our demand for IT is expanding," says Arbuckle, "we have a clear expectation that IT contribute to the cost reduction mentioned earlier. For Ascension Health a five year chart of projected revenue and costs looks like an alligator yawn—sharpening our attention and urgency to the need to reduce fixed and variable costs."

## Banner year ahead

Sometimes the window of opportunity involves fixing a window itself. Banner Health, a Phoenix-based healthcare system with 24 hospitals in Arizona and six other states, is rebuilding its patient portal after investing $6 million since 2010 with such disappointing results that it has considered litigation against the vendor.

"We've been less successful than expected on our patient portal, so we're in catch-up mode," says Dennis Dahlen, Banner senior VP and CFO.

As part of its second attempt at implementing a working patient portal, Banner is developing customer-facing apps to foster greater connectedness between patients and physicians and to help facilitate referrals. "That's a big focus because Meaningful Use requirements for patient portals are pretty onerous in terms of how much our patients must use them," he says.

A second area of IT focus for 2014 is to pilot a replacement ambulatory EMR, for an eventual multi-year roll out to Banner's 1,000-plus employed physicians. Five years ago, the organization implemented an ambulatory EMR, which has functioned well but lacks the interoperability with its inpatient EHR required to deliver coordinated care.

"Acquiring a billing system used to be the riskiest IT initiative for an organization, but implementing an EMR system makes that seem like a walk in the park. The EMR touches daily workflow in a much more granular fashion than billing and revenue-cycle systems do. Change involves virtually every clinician and we have to make it happen without either a decline in operating performance or impacting patient care," Dahlen says.

Adding to the mix is the growth in risk-based revenue. "We're a Pioneer ACO and have a broader medical network than our employed physicians for coverage. Our partners expect that we perform well under these risk-based arrangements so we can't let an EMR change limit our ability to do the right thing clinically for even a short time," he says.

## Connective tissue

Banner's ACO must also "create connective tissue" among independent providers, employed physicians and families. "We've 'rented' Aetna's ActiveHealth software to support population health initiatives, which has mobile apps for patients and providers, integrates claims data, tracks performance and incorporates predictive-analytics and medical-compliance modules. Our view is that EMRs are more like general ledger systems, basically transactional systems that can document things, but are largely unable

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to provide value by managing the care," Dahlen says.

Banner has been building the ActiveHealth software suite since late 2012 and is ready to launch its full capabilities in 2014. "We're using it to manage population health," he says, adding that Banner was given use of the system as an element of the partnership it has with Aetna—and both companies share in the results if successful.

Dennis Dahlen, SVP/CFO, Banner Health

"We have 60,000 lives in our employee health plan under full risk, part of the 284,000 total lives under various risk arrangements. Another 50,000 come under Medicare Advantage and the rest fall under attribution models. Between 15 percent and 18 percent of Banner's total revenue comes from risk-sharing arrangements, with mixed results, notes Dahlen.

The full-risk model is the most likely to generate positive financial returns for Banner, he says, while shared savings programs are increasingly not worth it. "There's not enough yield in these designs to influence care delivery. I'm more convinced with every passing day that these models are at best transitory," he says.

## Shared savings mean small savings

Slightly more than a third of Banner's 280,000-member ACO are at full risk. The other 168,000 members are in shared savings programs that generate about $20 million of revenue for the $5-billion organization.

While Banner will continue its Pioneer ACO into year three, "there's a very small upside. We decided to continue on the basis of its value as a tool for physician engagement," says Dahlen.

Despite the evidence that total risk is the best model for Banner taking on risk generally, that model is unlikely to emerge as a dominant one for government or commercial payers in the near future. The federal government seems disinclined to make Medicare Advantage programs a centerpiece strategy and self-insured employers seem intent on carving out only their most costly chronically ill lives for full risk coverage, he says. Also, employers want to offer more open risk plans to employees, allowing them to go outside provider networks. All these changes affect IT.

"The metrics are changing," says Dahlen, in reference to how CFOs look at the value of IT investments. Everything is measured when taking on risk. In IT that means using a constellation of tools like ActiveHealth to track performance and predict high-risk patient behavior, an enterprise data warehouse and specific kinds of functionality to support coordinated care. Underlying it all is the global capitation measurement of cost per member per month (pm/pm) which has to have a payable return.

## Shifting the universe

"We're a hospital legacy company. The center of the universe isn't hospitals any more. We have hundreds of people working on our clinical tools for the hospital environment and at some point you just have to say that's good enough. There's a built-in inertia, how-

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ever, because of the organization's comfort with the work on the inpatient side," he says.

A future IT-enabled driver for saving cost is in virtual remote presence. Banner is continually looking for partners to do video visits, which are designed to support risk contracts. Banner is also collaborating with Philips to develop an ambulatory ICU, which allows an ICU patient to stay at home using remote monitoring developed from eICU technology.

Scale and shared services hold great potential, and the cloud is a great example, although it has its own kind of inertia, Dahlen says. Banner is in discussion with vendors about using a shared services model for population health management and referral management.

Says Dahlen: "Healthcare is still a cottage industry, but with a few innovations we can accelerate IT and reduce cost."

## Conclusion

Information integration, patient portals, ICD-10, MU, analytics to support risk and population health management top the list of IT priorities (and cost challenges) for 2014, according to our CFO panel. The list could have easily come from CIOs. That's the point. IT has become part of the cost of doing business for healthcare organizations and CFOs and CIOs are working more closely together on strategic initiatives. Containing IT costs and finding ways to measure the value of IT remain elusive goals as always, but the struggle goes on. As risk sharing increases and the center of gravity shifts from the hospital to the community, the need to achieve both goals becomes even more of an imperative. Ironically, as innovations like virtual visits demonstrate, the more risk, the easier the IT value case may become.



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