



THE EVOLVING ROLE OF THE CHIEF FINANCIAL OFFICER IN A MULTI-HOSPITAL SETTING

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A quiet discussion has been underway for the past several years as systems review the role of hospital based Chief Financial Officers. The evolving systems have strong incentives to move traditional roles such as cash management, investments, treasury functions and debt to the central office. Technology has made departments that have traditionally been part of the revenue process and a concomitant consumer of CFO time, able to be managed as a corporate resource. It is important to note that these resources need not be physically based at the corporate office and in fact can, aided by technology, be housed on various hospital campuses. These departments include:

1. Creation of central business offices to manage the billed patient receivable.
2. Creation of central coding functions so that coding can be managed as a corporate resource and not a local challenge based on hospital access to community coders.
3. Centralized patient registration, test scheduling, admission management and other intake functions. It is possible that the access department of the future will be more like a guest relations function rather than the current process.

This trend is expected to continue into the future, thus the role of the hospital based CFO is also expected to change. This review is not about if change will occur but how the revisions in traditional roles might lead to even stronger local hospitals.

Traditional Responses

For many CFO's facing these changes in the 1990's and earlier, the movement of duties to the central office meant the elimination of the local position. If not selected for the system CFO position, the remaining candidates had to seek employment at other institutions. The replacement positions at the hospital unit were often called Directors of Finance and did not hold the stature and career opportunities represented by the former CFO position. This out migration of very experienced executives often left the organization weaker.

This article presents a different future for the hospital-based system CFO. It does not include a reduction in responsibilities but rather a substantive refocus to achieve superior results in a local market. As the management of many financial functions migrate to the central office, the critical determinates of market success remain firmly rooting the community. These factors will have more influence on overall success than the cumulative impact of centralized services.

The Change Imperative

The community hospital threat level has been significantly increased because of two related reimbursement factors. They are the rapid decline in employer paid healthcare, with the replacement product being a defined contribution currently classified as “Consumer Driven Healthcare”. This is coupled with a rapidly growing consumer dissatisfaction with the hospitals retail price policies and how they shift large pieces of cost to the patient and their families. To the extent that hospitals have painted themselves into the “stop loss” corner, it will be extraordinarily difficult to make meaningful reductions in retail prices. Attempting to halt the conversion to defined contribution plans many seems equally difficult, but the existence of 125-plans and health savings accounts hold some promise of stabilizing patient financial relationships. These trends contain the seeds of an expanded CFO portfolio and will be more fully explored as this article continues.

Moving Towards a New Model

We see the future CFO as an integral part of the business development group that grows the local hospitals business. The unique training in reimbursement, budgets, and business planning makes the local CFO uniquely qualified to be the business development officer. Included in this work would be the dominant responsibility to create an effective employer relations effort. Many hospitals fail to understand and meet the needs of their patients because they focus their attention on other issues. They really fail to understand who and why they buy services from the hospital. They fail to appreciate how many patients come from which employers and hence are unable to partner with the employer to reduce utilization.

Reducing utilization will be an important skill set of the hospital executive of the future. Hospitals are unable to create enough capital to meet the current demand of an aging population, mandated nursing ratios, and increasing technology. They will have to create ways to use their existing plant property and equipment more effectively and treat the entire community. One way to do that is to work with the major sources of patients to (employers) to improve in a meaningful (way with data) community health. Helping employers understand that it is in their interest to create economic incentives for their employees who have high-risk pregnancies to be off work so that the patient and the baby are healthier is new thinking for both employers and hospital executives. Who will lead this new thought wave.... we suggest the CFO.

Hospitals have a less than successful history in seriously engaging the business and government communities in how to organize, finance and control the cost and quality of local healthcare. This effort must be so much more than a health fair and should include a focused discussion of those items, like billing and collection that create dissatisfaction with employees. An example of these news roles could include:

1. Present a detailed report of work related injuries to selected employees including ideas on how to return more employees to work sooner, hours of operations, fast track urgent care response and other ideas.
2. Work with employees to promote the use of 125-plans and healthcare spending accounts (FSA's) to pay for future expenses with tax avoided income. This reduces the employees' bill by as much as 40%.
3. Create a community wide Master Employer Index that records employer specific information related to coverage, co-payments, deductibles and other critical information so it is not necessary to gather the information thousand of times each year. The index could be a cooperative venture involving multiple healthcare entities.
4. Train hospital financial counselors to specifically understand employer coverage issues. Financial counselors would work with employer benefits officers to learn the intricacies of specific plans and help the patient understand their coverage. Hospitals could house current copies of benefit plans in their Access departments.

The other component of the evolving relationship is the message to the community related to efforts being made to mitigate the negative aspects of years of price increases. Patients are going to need to understand their hospitals at a level never before discussed. Their reaction to this information will often determine the long-term viability of the hospital. The policy decision must be perceived as fair but not go so far as to threaten the future of the hospital. Once again the hospital based CFO in a new focus can be the executive needed to convey this message to the community. Some specific ideas on how to articulate this new role would include:

1. Lead the effort to convert traditional payment on demand healthcare practices to a retail installment contract. This program has several distinct advantages including:
 - a. By financing patient balances many hospitals would enjoy as much as 1000 basis points of income.
 - b. Patients would have many more choices of how long to finance their purchases.
 - c. Hospitals could extend this feature to affiliated physicians thus contributing to the overall relationship.
 - d. Patients would be protected by state and federal collection laws thereby reducing plaintiff's bar arguments.

The combination of a reasonable charity policy, assistance for the patient to obtain access to Medicaid and other programs, reduced dependence of third party collection services

and reasonable repayment plans must be communicated to the consumer in a consistent, professional manner.

These are two major roles that may become more part of the hospital-based system CFO. Other roles related to growing the business by creating a decision support function tied to understanding the managed care contract matrix that allows for resources to flow to services that have the potential of producing a consistent margin. Hospitals must not only pay for current operations from patient service income but also fund uncompensated care and accumulate funds for capital replacement. The CFO based at a community hospital can play a key role on the team that is focused on maintain the clinical relevance of that hospital for future generations.

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