ROUNDTABLE: COMPETING AS A NONPROFIT

NONPROFITS INSTILL FINANCIAL DISCIPLINE TO COMBAT MARGIN WOES

Succeeding as a nonprofit health system in the rapidly consolidating provider market is a challenge. Margins are tight, and the financial leaders of these organizations are constantly tasked with finding reliable sources to drive revenue.

These executives need to balance short-term goals with expectations for long-term stability. There are several other factors that contribute to their sizable workload, including negotiations with payer organizations, approaches to cutting costs without reducing the amount of full-time employees, and initiatives that seek to break down the traditional barriers to care in order to meet patients where they are.

In this HealthLeaders Roundtable, the panel discussed such topics as instilling financial discipline within their respective organizations, handling shrinking operating margins, and expense control strategies.

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HIGHLIGHTS

HealthLeaders: *What's the most significant obstacle impeding your organization's financial success?*

John McGovern: The most significant obstacle is maintaining our margin. We are a large organization, and we have a relatively modest margin. I would say that up until recently, we were primarily focused on growth of top-line revenue, volume, and everything that drives revenue. Keeping that volume trend going, acquiring physician practices who contribute to that volume—that's one side of the margin equation.

Expenses are the other side, and we're evolving into a phase where we're focused on optimizing our assets, expense control, and ideas to operate more efficiently. We look at all the opportunities that exist within the scale of a $12 billion operation to control expenses while keeping the revenue growth apace and expanding that margin.

Rob McMurray: The first thing that comes to mind are revenue pressures, and because of those revenue pressures, we're seeing decreases in the rate our revenue grows. There are pressures from both the governmental payers and commercial payers.

During the past two years, our expenses grew at a rate faster than our revenue. I looked back at the 15 years before that, and it only happened one year.

There are a lot of things that come into play, and I think that some of the challenges are not only convincing our organization that we need to be better prepared for a value-based payment world, [they're] educating our governance groups and our board.

We are allocating more time in governance meetings for strategic issues and what it means to assume responsibility for the health, well-being, and total cost of care for a defined population. If the governance committees don't understand what this means, then we're in for some challenges down the road. The challenge is getting all of us ready for that value-based world.

HealthLeaders: *When you talk about expense control, what sort of strategies go into that?*

McGovern: We recently launched an initiative called "Ideas at Northwell." We've built out a platform to capture ideas from the grassroots level up.

Anyone—nurses, clinical staff, administrative staff—can try to bubble up ideas. In addition to enhancing employee engagement, there could be ideas that will be successful at controlling cost. We also continually look at the basics: staffing efficiency, staffing hours, nursing care hours, full-time employee (FTE) tracking, overtime control, all of the nuts and bolts of expense management.

Magda Hayden: Unlike for-profit businesses, many nonprofits do not generate operating surpluses, even after accounting for revenue sources such as tuition or membership fees. They typically operate at breakeven to support their mission.

McMurray: When it comes to expense control, it should never stop. We're in the process of taking out $100 million of cost permanently over a three-year period, and we're starting it differently

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than I would say a traditional campaign like this would go. You would think the low-hanging fruit is the easy stuff and you would chunk your largest part in year one.

We're doing it differently. We're saying there's a $10 million goal in year one, a $30 million goal in year two, and a $60 million goal in year three. We've achieved the year one goal, but it took the organization a while to think about this and what it meant. With 60% of our expenses in labor, the real savings are in becoming more efficient.

HealthLeaders: *What are some novel approaches that you've utilized to effectively cut costs without reducing your FTEs?*

Robert Ehinger: We had a surgical sterile pack that would come in and it had 10 [items] in it. Eight were used, two were never used, and there was a third that was rarely used. They went back and priced it and said, "Let's get a custom pack," getting our pack down to be seven things and then [having] number eight on the shelf while getting rid of the other two. [The 10-item pack] was at one hospital, it had generated a couple hundred thousand dollars a year—but then you take it across a system, that's huge, and somebody starts adding commas to it. This was something that someone had negotiated thinking they were

saving money, but then the day-to-day person says, "This is ridiculous; I keep throwing them out."

McMurray: There's a great opportunity to shift some of the ways we think and look for cost savings or efficiencies. One of the areas in which we are having success is in supply chain. The traditional way supply chain contributed to cost savings was by focusing solely on unit price. Through effective collaboration between supply chain leadership and our service line physician leaders, the goals of supply chain are aligned with the goals of the service lines. The end result is a better total cost of ownership, of which unit cost supported by effective negotiation is a component. Total cost of ownership takes into account much more than unit cost; it includes other costs such as logistics, clinician labor, and security. By connecting with physicians, we are able to consider unit cost as a component of value from a patient perspective.

HealthLeaders: *What have been the most effective approaches your organization has made to instill financial discipline for the enterprise?*

Ehinger: We share our financial results on a monthly basis with our leadership team. We have a monthly leadership meeting where we put up our gross revenue, net revenue, and expenses, compared to the budget. We challenge our departments when we see variances as we're going through the month end, asking them why their supplies are up $300,000. We have a parameter, but it's "why are your purchase services going up?" They've got to be able to substantiate what that cost is and whether or not it's needed.

John P. McGovern
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McMurray: It comes down to accountability and execution, which ultimately leads to discipline. From a finance perspective, there's a whole continuum of where we can be in managing the budget process. We can be gatekeepers, and we can be the ones that say no. We can monitor every last expenditure, or we can turn it completely over to the departments and say, "Tell me your budget. Run with it. I'll ask you questions throughout the year." Somewhere in there, depending upon the culture and level of trust you have, is where you'll land.

We're currently intentionally pushing away from the gatekeeper side, in part because we're after that $100 million expense goal, and giving more authority and accountability to the operating departments. It's based on trust and communication throughout the year to convince the departments that if you tell me what your accurate budget is and don't pad it, I'm not coming after you during the year to say, "OK, you need to not hire that position," or, "You need to not do that program."

HealthLeaders: *How do you balance setting your organization up for short-term success but also striving for long-term financial stability?*

Ehinger: We do what's called integrated strategic financial planning; it's a five-year plan, and that's the guide by which we drive our next budget and subsequent ones. Now, we do an update every year to adjust for the reality versus what you would hope for, and you have to make the adjustments based off of that.

With the trust of the departments, we work collaboratively to build the best budgets and financial models possible.

We've been diligent about asking when [departments] are doing their budget, "Did you buy anything this year?" Even when we're approving capital expenditures, make sure you put in your budget that maintenance element for whenever it comes in. Even though it's going to drive up your cost, we'd rather have it in the budget to know about it than have it pop up. You can see that it starts like a snowball—things start clicking because you're not adversarial.

Hayden: At Bank of America, we are constantly looking at long-term and short-term growth as it relates to our employees, our clients, and our communities. For example, Bank of America assists the boards and investment committees of our not-for-profit clients in managing their endowments. [The bank] provides investment management services that seek to align the investment process with the goals of the nonprofit, with the goal of enabling the endowment to serve as a steady source of support for the organization.

McMurray: It's challenging to balance the short term versus long term. We have the five-year forecast, we compile it and run all the ratios to show what the picture is, but it's more of a strategic vision builder for the executives. There are several ways that we have to then manage that message, and one of them is to the organization, but the other is to the governing body saying, "Yes, we believe we want to achieve an acceptable operating margin."

We have a certain margin as a floor that helps sustain what we do, but while we may want an even higher margin, we realize that to maintain that margin in the future, we have to make investments. We'll deliver a certain budget to the board for approval and say, "We have this margin target,

but a lot has changed in the last year." And it continues to change since there is a real shift towards value-based payment models.

HealthLeaders: *Discuss how each of you are breaking down the traditional barriers to care so you can meet patients and consumers where they are.*

Hayden: Digitization is a big differentiator for how we are able to serve our clients. We know that by 2020, more people will have mobile phones than electricity, running water, or cars. As mobile devices have become more prevalent in our personal lives, they are becoming more relevant in our business lives.

Through our digital platform, we provide our clients with access to their accounts 24/7 from any location via their mobile devices. In the event of a natural disaster or other emergency, this can make a world of difference. For example, the American Red Cross used digital disbursements to provide emergency funds to those impacted by Hurricane Harvey in Houston in real time.

McGovern: The least traditional access point has become an important access point. There will be 55 urgent care centers throughout our market that we've developed over the last three to four years in a joint venture. It's co-branded Northwell Health-GoHealth Urgent Care. Five years ago, urgent care was nowhere near the presence that it is now, where you can't drive down the street without seeing several. But not to exclusively focus on urgent care, we do have a network of ambulatory surgery centers that we've developed over the last several years because that care is moving out of the hospital walls.

We are expanding and investing in nontraditional points of access across the spectrum, which relates to value-based payments. We want to have various options to care for our community and do it in low-cost settings. However, the flip side of it is that it doesn't take away the need to maintain hospitals. That's the dilemma of being a health system and having to commit the capital to own these expensive and increasingly intensified places of care.

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Ehinger: I agree; we acquired an urgent care company and we're looking to grow the number of urgent care facilities [we have] over the next five years. I was thinking about the fact that 50% of millennials don't want a relationship with the doctor, they don't want to sit in a waiting room. They want to go in, get taken care of, and leave.

Another aspect that we look at as a positive for urgent care is it helps our primary care physicians, putting less pressure on them because now they can have regular hours and don't have to worry about getting calls on weekends. The ability to have that tied to your network so that it's not some place [the patient] goes where they don't know who the provider is. If there's a relationship, [urgent care] has the ability to say, "You have Dr. Smith, we're going to send him a note." His records are tied to ours and he'll have this updated so [the patient] can follow up with him if [the patient] has that relationship with the primary care.

We also have a partnership with an ambulatory surgery [center]. We've only had a few but we're looking to grow those because treatment that you would have had five years ago in the hospital, [patients] now want to do them in an ambulatory surgery center. It's expanding more with pressure from the insurance industry because it's a lower-cost setting. However, that doesn't mean that you have less obligation at the brick-and-mortar mothership; we still have to maintain that.

Rob McMurray
Chief Financial Officer
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Hayden: How do you incent the doctors to be cost conscious?

McMurray: I will say from my perspective that we have not yet given them the full opportunity to be part of the decision-making process with certain clinical supplies. The supply chain has goals that, in the past, haven't been linked with clinical goals. We've seen positive results with physicians as decision-makers in our bundle programs, and we realized cost savings. I think that if we continue to provide physicians with a fair chance to become leaders in the decision-making process for supplies, we will realize even greater cost savings.

Hayden: I go back to our Simplify and Improve at Bank of America. They went to certain businesses and said, "If you achieve those savings, you'll have the power to reinvest it into your businesses."

This is ongoing, and it is our sum of the big businesses as we move from one business to another. They all have their objectives continuing Simplify and Improve at some big processes. Our CEO was personally involved meeting heads of every business to ask where they think they can have cuts, how they are going to do it, and where they are going to improve.

HealthLeaders: *How would you assess your ability to negotiate payer contracts? Do you see any room for improvement?*

Ehinger: It's right in line with what we were talking about: It's difficult right now. They want to reduce the way they're currently paying us, and as healthcare expenses regionally and nationally increase, providers are looking for ways to balance the bottom line while providing the highest-quality care. There's that difficulty, but on the other end, you've got both sides looking at trying to do these other types of shared savings risk models, because we know the change is coming. Nobody is willing to give up the current system, but they're slowly peeling that off.

McGovern: We've been successful over a long period of time in being a must-have provider network in our market. We've amassed this system, the whole continuum, postacute, urgent care, the hospitals, and the doctors. We all love fee-for-service, but at what point do we reach the time where the essential provider in the network is unable to obtain the increases needed to cross-subsidize the increasing amount of Medicare and Medicaid patients we have?

We also have "payer bad behavior;" the increasing percentage of denials that we have is astounding. It's a contentious, somewhat adversarial relationship because they want to pay less and we want to get paid for the services provided. There is room for improvement, but I would suggest that it is preferable that the providers and payers figure it out together and not have the government come in with reform towards a single-payer system.

Magda Hayden
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McMurray: Our ability to negotiate payer contracts is good because I feel like the payers are our partners. Yes, there are moments when it's adversarial, and we continue to struggle with denials, the cost of managing denials, and a significant amount of waste goes into that. But in the end, we're trying to provide care to members of our community. The third-party payers are trying to create a way that the community members can access insurance to get care, and at the end of the day, we spend time debating contracts, denials, and other issues.

Is there a different way to start over and think about new types of partnerships?

If we're serious about being successful in a value-based payment world, one of the things we're going to change is how we work with the third-party payers and negotiate differently, partner differently. There's no playbook on it; we have to sit down and figure it out.

HealthLeaders: *Do you think payers are equally as open to changing the rules of the game?*

McMurray: In a low-margin business, who risks getting cut out? It's the intermediaries. They see it, and they're willing to have those discussions. The hard part of those discussions is leaving our baggage outside of the room and sitting down with someone who, weeks or months ago, we had a discussion around settling some long-stay cases or going to arbitration. Trying to forget all that stuff and starting over is a challenge, but I am confident they're open to it.

McGovern: I'm going to inject a little skepticism against that point and maybe bring baggage in. I think you're right about that, but it goes back to institutional and organizational sponsorship structure and purpose. A lot of the commercial payers are large, consolidated public companies that exist to maximize shareholder value, which doesn't necessarily align with community health.

I do think there are some inherently structural differences and purposes when you talk about going in with that blank sheet of paper. It has to happen—and you're right, they are at risk of getting disintermediated—but there are structural impediments to getting to that.

Ehinger: I agree, and some of the incentive that will force them to change is keeping that market share for themselves, because it's becoming more competitive amongst [insurers] since employers are shopping to control their costs.

On the other side, you've got hospitals that are looking for the top side of their income statement. They're going to have to become more innovative in those areas to say, "OK, how can we partner so we both are successful?"