

# STRATEGIC FINANCIAL PLANNING

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## How has price transparency impacted the hospital industry?

Scott Houk

A recent survey of healthcare organizations on price transparency indicates posting prices online has had little positive or negative impact on most hospitals.

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// transparency //

## How has price transparency impacted the hospital industry?

Scott Houk

*A recent survey focused on the importance of price transparency, community reaction to posted prices and the impact on pricing.*

A recent survey by Cleverley & Associates on healthcare price transparency shows insight into changes in industry attitudes and actions compared to a similar survey the firm conducted in 2016.

Having several months in an environment where all hospitals have been required by the Centers for Medicare & Medicaid Services (CMS) to post on their websites their chargemaster prices for all services in addition to inpatient charges by MS-DRGs, the survey's goals were the following:

- > Whether posting of prices has had much impact on how hospitals price services.
- > Community reaction to posted prices.

### Survey timing

The survey of about 2,500 U.S. hospitals and health systems wrapped up just before President Trump signed an executive order on June 24, directing the secretary of Health and Human Services to propose a regulation requiring not just the posting of prices but negotiated rates with payers.

The Trump Administration's hope is that the order will not only provide up-front cost information to patients, but also foster competition that would ultimately lower the cost of healthcare. Had the survey return date been extended beyond the issuing of this order, survey authors indicate they believed more feedback from hospitals would have been received.

Only 26 responses to the current survey on price transparency were received compared to 77 in 2016 as well as 100 responses earlier this year to questions about the implementation of the CMS requirement to post chargemaster prices.

### Three key survey findings

Based on the responses received, there were three key findings:

1. Pricing transparency is still important.
2. The industry may have reached a level of fatigue on this subject, based on the low response rate.
3. The effect of posting prices online has had little positive or negative impact on most hospitals.

### Survey results

The survey focused on the importance of price transparency, community reaction to posted prices and the impact on pricing.

*Has the importance of price transparency changed compared to two years ago for your organization?* The majority of 2019 survey respondents (58%) said the importance of price transparency for their organization had not changed while 42% indicated it was more important now. When asked the same question in the 2016 survey, 83% of respondents said it was more important at that time compared to two years earlier.

Several factors may have contributed to the decrease in those saying it is more important.

- > Because 2016 was an election year, healthcare and the cost of healthcare was a hot topic.
- > The 2016 survey followed a few years of news coverage about high patient bills and hospitals being the core of the problem
- > Now that hospitals have complied with posting their prices and CMS did not propose any new requirements with the proposed FY20 IPPS rule, many organizations may have turned their attentions to other concerns.

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*The impacts on external stakeholders of hospitals posting prices online.* The majority of 2019 survey respondents (58%) said that it created more confusion. Only one respondent said that it had improved transparency and the remainder indicated the rule had no impact.

*Community reaction to prices being posted and available online.* The majority of 2019 survey respondents (65%) said that posting prices online has created little interest. Only four respondents indicated high interest. One of those respondents noted the interest was high at first but had since diminished, while the other three indicated continued high interest.

*The impact of price transparency on hospital pricing strategies.* Interestingly, more respondents (50%) in the current survey acknowledged that price transparency is not a factor considered when setting prices while only 20% in the 2016 survey indicated the same. This increase in respondents saying price transparency is not factored into price setting could be due to many hospitals feeling as though they already have remedied any pricing concerns through past actions.

*What have hospitals done in response to price transparency?* All 2019 survey respondents indicated the hospitals they represented have taken some course of action in response to price transparency. Respondents, who were asked to identify all actions regarding price transparency, indicated the following in order of popularity:

- > Freeze prices for certain areas (i.e., highly shoppable services) — 46%.
- > Create lower retail outpatient prices — 35%.
- > Promote value and/or quality of services as a differentiator for higher prices — 27%
- > Build, purchase or enter into a joint venture with competition to retain volume in a lower-priced location — 19%.
- > Reduce prices for both inpatient and outpatient services — 8%.

### Chargemaster areas with the most pricing pressure, 2016-19

This chart indicates areas receiving the most significant pricing pressure in declining order. Results with 1 indicate significant pressure, 2 indicates some pressure and 3 indicates little or no pressure.

Chargemaster area	2019 score	2016 score
Advanced imaging - CTs and MRIs	1.6	1.6
Laboratory tests	1.7	1.8
Standard imaging - X-rays, ultra-sounds	2.0	2.0
Outpatient surgery	2.0	n/a
Drugs	2.5	2.2
Supplies/implants	2.6	2.6
Room rates	2.7	2.6

Source: Cleverley & Associates. Used with permission.

When respondents answered a similar question in 2016, 49% indicated the top action was reducing both inpatient and outpatient prices in response.

*What was the impact of having taken the actions indicated?* A strong majority, 62%, responded that they had little or no impact on revenue. When asked if hospitals have had to restructure contracts in response to price transparency, the overwhelming response, 96%, said no. Unless a hospital was making a major overhaul to its pricing structure, such as a 25% overall price drop, it is likely that it would have been able to absorb any negative impact through increases to other areas of its chargemaster that are not quite as shoppable.

### Pricing pressures

Another segment of the survey inquired about where the external pricing pressure was coming from and what areas of the chargemaster received the most scrutiny.

On the question of where the pressure is arising from, there was consistency in responses between the 2016 and 2019 surveys. A strong majority of respondents (84% in 2016 and 58% in 2019) identified patients with high-deductible health plans as the top source of pressure followed by statutory requirements and free-standing centers as the next highest sources of pressure in both periods.

The chargemaster areas where hospitals are receiving the most pressure has also remained consistent between 2016 and today,

### Benchmark for Medicare outpatient service price comparison, 2014-17

The U.S. average Medicare charge per visit adjusted to a relative weight = 1 can be used to compare Medicare outpatient data.

	U.S. average 2014	U.S. average 2017	Annual growth rate
Average charge per Medicare visit, RW=1	\$370.91	\$425.84	4.7%

Source: Cleverley & Associates. Used with permission.

## Price increases for various HCPCS procedures, 2014-17

The highest volume CT and MRI prices have increased between 1.8% and 2.8% annually. In addition, the top laboratory test prices have increased between 2.1% and 2.6%.

HCPCS	Description	U.S. average 2014	U.S. average 2017	Annual growth rate
74177	CT abd & pelv w/contrast	3,975.22	4,233.12	2.1%
70450	CT head/brain w/o dye	1,770.54	1,921.29	2.8%
74176	CT abd & pelvis w/o contrast	3,293.21	3,511.04	2.2%
70553	MRI brain stem w/o & w/dye	4,029.74	4,276.10	2.0%
72148	MRI lumbar spine w/o dye	2,920.89	3,078.12	1.8%
70551	MRI brain stem w/o dye	2,783.02	2,958.81	2.1%
80053	Comprehensive metabolic panel	204.86	221.23	2.6%
85025	Complete CBC w/auto diff WBC	96.48	102.90	2.2%
80048	Metabolic panel total ca	148.55	158.28	2.1%
71020	Chest X-ray 2vw frontal & lateral	332.42	373.17	3.9%
66984	Cataract surgery w/iol 1 stage	4,069.69	4,651.98	4.6%
43239	EGD biopsy single/multiple	2,139.53	2,500.25	5.3%

Source: Cleverley & Associates. Used with permission.

emphasizing imaging and lab tests (see the chart at the top of page 3).

Because the areas of the chargemaster receiving the most pricing pressure have remained mostly unchanged, one goal was to find out how prices have changed for some of the top volume imaging, laboratory tests and outpatient surgeries.

The latest Medicare outpatient comparative data that is available publicly is 2017 so researchers compared those prices to 2014 prices to see if those areas have been treated differently by hospitals (see the chart above). The benchmark used as the standard rate of increase over the period for all outpatient services was the U.S. average Medicare charge per visit adjusted to relative weight = 1 (see the chart at the bottom of page 3).

The average charges per Medicare visit over a period from 2014 to 2017 are as follows:

- > The annual growth rate in outpatient charges was 4.7%.

- > The highest volume CT and MRI prices have increased in the range of 1.8% to 2.8% annually.
- > The top laboratory test prices have increased between 2.1% and 2.6%.

These rates of increase are well below the average outpatient rate growth for the period. The annual growth rate in price for chest X-ray 2 view was also below the outpatient average.

However, the top two outpatient surgical procedures — cataract surgery and EGD biopsy — were closer to the overall average. Though this sample of services is small, it does indicate that hospitals have treated the areas of highest pressure, especially CTs, MRIs and lab tests, more conservatively than other outpatient areas when applying price changes.

### Priorities

One of the final survey questions probed where the topic of pricing ranks on each

organization's priority list. Results for 2019 show no one identified it as a top concern, two respondents stated it was not a priority, 54% indicated that it was low priority and 38% said that it is among top concerns.

In 2016, two-thirds of respondents listed it as among their organization's top priorities. This change in view about price transparency correlates to many other responses we have seen in the current survey: Fewer consider price transparency as a factor in their pricing strategies and the vast majority believe the posting of charge-master prices has not been useful to their communities and created little interest.

### Future requirements

Overall, the survey on price transparency found the following results:

- > There has been little impact on external users from hospitals posting prices on their websites.
- > Hospitals have made changes to reduce prices or limit increases in areas where they are receiving the greatest pricing pressure (i.e., CTs, MRIs and lab tests).
- > The topic of price transparency is no longer as much of a priority for the healthcare industry as it was three years ago.

While price transparency may have peaked as a concern, the industry could experience a significant pivot if the details of negotiated rates with commercial payers becomes a requirement as a result of President Trump's recent executive order. It will be a topic that generates angst and discussion as more details become known.

What is apparent is the issue of greater transparency continues to gain national attention and hospitals will once again be asked to provide additional information to patients in a complex environment. //

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## Ask these 14 questions to help select the best underwriter for the job

Errol Brick

*Each firm should be asked to outline its process for evaluating hospital credit, its proposed credit and marketing strategy, and its recommended plan of finance.*

At first glance, large investment banking firms may look very much alike, and many not-for-profit hospitals and other health-care providers simply hire firms with the lowest fees to sell their bonds in the public market.

However, to identify the underwriter that will deliver the best results, it is important to understand the services that underwriters provide. Developing a list of questions to ask candidates can help hospitals, health systems and other providers find the best-suited firm.

For example, hospitals should identify whether their offerings present specific challenges and ask candidate firms about their expertise in those areas. Factors such as complicated credit, highly regulated environments, competitive service areas or other unique situations should be considered during the selection process.

Each question should be assigned a weighting, so answers from the firms interviewed can be scored. Weights will vary depending on the situation. For example, issuers in the AA category can place less weight on the strength of the underwriter's credit professionals because credit will be a lesser concern for investors.

### Four groups involved in underwriting

Before developing a scorecard, it is helpful to understand that underwriting a bond issue requires input from four groups within the investment banking firm: bankers, credit staff, underwriting and trading professionals, and sales.

**Bankers.** These professionals explain the issuer's credit characteristics and financing

needs to other areas of the firm, and they structure the terms of the offering. They can also assist hospital or health system financial advisers in preparing rating presentations and "road shows" for prospective investors.

**Credit staff.** The credit staff ensures that the offering meets the firm's minimum requirements and assists bankers in preparing credit analyses as part of presentations.

**Underwriting and trading professionals.** These professionals determine the most appropriate mix of securities to be offered to investors based on market conditions. Underwriting and trading professionals also coordinate pricing and structuring ideas with co-managers, and they determine the need for a selling group to round out the underwriter's sales force.

**Sales force.** The sales force contacts potential investors prior to the formal sale to determine their interest level and respond to any credit concerns. The sales force also informs the underwriting staff of expected yield levels, as well as market preferences regarding the issue structure. This feedback allows the underwriting staff to adjust the structure seeking to maximize investor demand. Finally, the sales force actively markets the bonds to customers and secures orders.

### Underwriter interview questions

It is prudent to ask the following questions when conducting a request for proposals or when interviewing underwriters:

#### Bankers

1. How well do bankers understand the hospital's unique structural or credit needs?
2. Do they have a track record of providing creative financing solutions?
3. Do they have the skills necessary to assist in preparing credit presentations?
4. How well do they understand the market for the hospital's bonds?
5. Does the firm have clients who compete in the hospital's current or future marketplace?

#### Credit staff

6. How well does the credit staff understand the credit and proposed structure?
7. How experienced are they with the same type of credit?
8. How well would they communicate key credit considerations to their internal sales force?

#### Underwriting and trading professionals

9. How experienced are they in underwriting the same or a similar type of bonds?
10. Do they have a track record of aggressively pricing similar credits?
11. Have they demonstrated willingness to purchase unsold bonds for their own account?
12. Do they have a history of maintaining a visible secondary market presence and a special commitment to making markets in senior-managed underwritings?

#### Sales force

13. Does the sales force have relationships with major institutional investors and/or a substantial retail customer base?
14. Have they demonstrated the capacity to market the same or a similar type of bonds?

### Quantitative evaluations

In addition to asking the 14 questions, the following factors should be considered and evaluated:

**Potential conflicts of interest.** The underwriter typically should not represent directly an existing or potential competitor.

**Overall experience.** Underwriters' experience can be evaluated based on a list of each firm's bond issues in the last 12 to 24 months. Most bond issues are reported on Electronic Municipal Market Access (EMMA). Once relevant bond issues are presented, the hospital can contact some of the entities on the list and request feedback on each underwriter's performance.

### Pricing expertise

Underwriters should have experience in the following areas and be able to share their past performance:

**Fixed-rate issues.** An underwriter's performance in pricing fixed-rate bonds can be evaluated based on a comparison of yields on bonds the firm sold to benchmarks in the last year. For taxable issues, the typical convention is a comparison to U.S. Treasury yields on the day the bonds were sold.

For tax-exempt issues, the comparable benchmark is the Municipal Market Data (MMD) AAA scale, which is published daily and reflects yields offered on high-grade, tax-exempt bonds that day.

In both cases, the spread (difference in yield between bonds sold and the associated benchmark) for each maturity is compared. Typically, the lower the spread, the better the firm's pricing and structuring expertise.

**Variable-rate issues.** Pricing performance for variable-rate issues can be evaluated by asking the underwriter to provide rate histories for several of their clients. For tax-exempt variable rate bonds, the spread can then be calculated based on the Securities Industry and Financial Markets Association Municipal Swap Index (SIFMA) published weekly and compared with spreads for other similarly rated issues.

**Willingness to underwrite.** To determine the underwriter's willingness to underwrite, consider a review of their pricing expertise and interview comparable clients. In general, narrow spreads to benchmarks signal that the underwriter is willing to risk using its own capital to achieve lower yields.

Alternatively, wider spreads show that the firm may price issues less aggressively at higher yields to avoid the risk of being left with unsold bonds it will have to purchase for its own account.

### Qualitative evaluations

Starting with the initial meeting, the bankers' creativity and presentation skills can be assessed by observing and interacting with them. In addition, bankers' responses to interview questions will help reveal their level of professionalism, presentation skills and readiness.

To gain a stronger sense of each candidate's suitability, each firm can be asked to outline its process for evaluating the hospital's credit, its proposed credit and marketing strategy, and its recommended plan of finance.

### Fee considerations

An underwriter's fee or "spread" is generally composed of three elements:

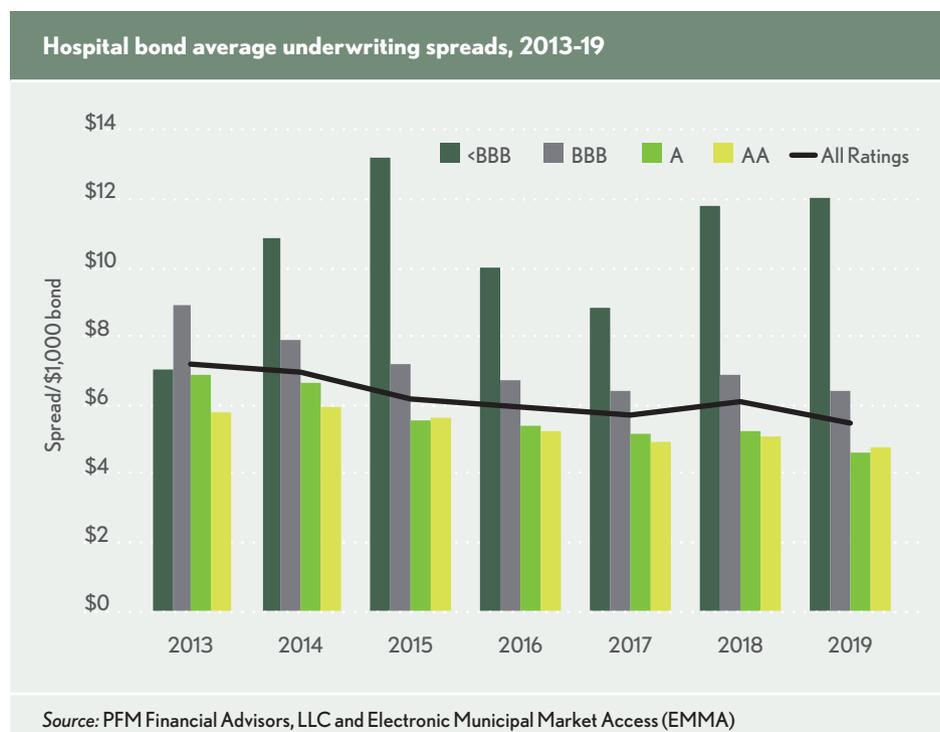
1. Management fee
2. "Takedown" or sales commission
3. Reimbursement for expenses incurred

Expenses include fees paid to the underwriter's counsel, fees for travel and — to a lesser extent — charges imposed by regulatory authorities. It is important to note that a seemingly low "all-in" fee quote assumes that the hospital will pay fees charged by the underwriter's counsel. Therefore, expense quotes should be adjusted to make them comparable.

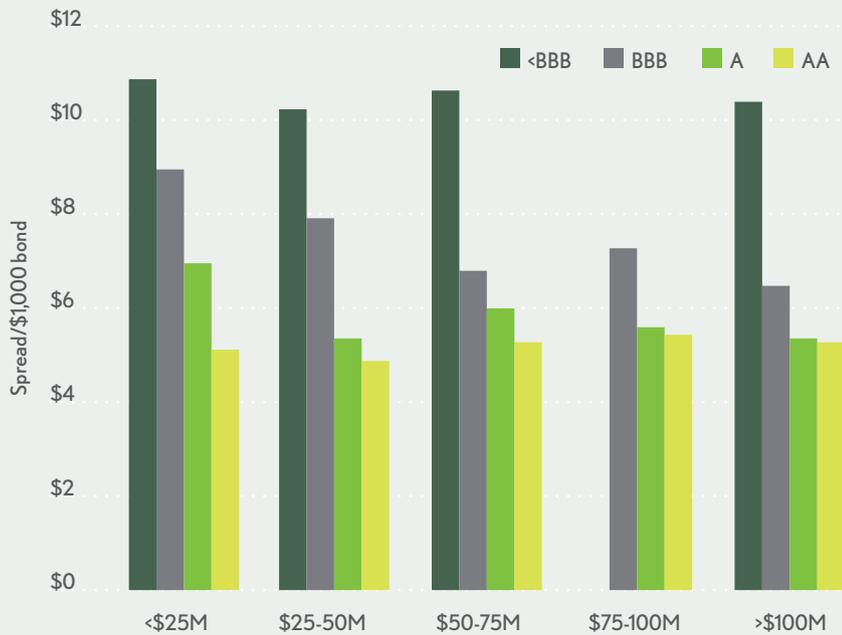
In considering evaluation criteria, borrowers commonly place the greatest weight on fees. After all, prioritizing fees makes the ranking process easier. Since 2013, the average underwriting spread for hospital bonds went from \$7.22 to \$5.50 per bond (see the bar graph below).

While fees paid to underwriters are important, they have a lesser impact on the cost of capital than the total interest cost on the bonds. The reasons for this are twofold:

- > The largest component of an underwriting fee is the commission paid to the firm's sales force. Logically, salespeople working for a minimal fee may have less incentive to develop a robust market for an issuer's bonds than a firm expecting a higher fee.



Hospital bond-weighted average underwriting spreads, by par amount 2013-19



Source: PFM Financial Advisors, LLC and Electronic Municipal Market Access (EMMA)

> A low fee can work against the issuer by increasing the underwriter's risk aversion. In other words, a firm charging a low fee would likely be unwilling to expose itself to the risk that rising rates will lead to a fall in the market value of unsold bonds. In such cases, issuers can expect a higher interest cost on bonds than if the firm were working for a market-based fee.

On average, underwriter fees do not vary significantly based on issue size, although due to minimum underwriting costs, fees for smaller issues below \$25 million tend to be higher as a percentage of par (see the bar graph above).

Typically, it may be best to negotiate fees after settling structural components, receiving credit ratings and evaluating market conditions. Only then do hospitals and health systems have all the information necessary to determine what may constitute fair fees.

### Careful consideration of underwriters

Prior to selecting an underwriter, it is crucial to consider the proposed firm's demonstrated marketing and structuring expertise, its understanding of the hospital's unique situation and challenges, the suggested plan of finance and sales commission and management fees. Healthcare organizations will likely benefit from assigning less importance to fee quotes and emphasizing investment banking firms' proven abilities to deliver financing that meets hospital and health system needs at the lowest available cost of capital. //

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## Direct contracting models offer promise of expedited shift to value-based care

Allen Miller and Evan King

*The options consist of three new voluntary risk-sharing payment models.*

A major step forward for population health management and value-based care occurred when the U.S. Department of Health and Human Services (HHS) announced a new set of voluntary payment models for Medicare fee-for-service (FFS) patients and healthcare providers.

Participants in the Centers for Medicare & Medicaid Services (CMS) Direct Contracting (DC) Model can expect financial and regulatory benefits and improved metrics. Based on the initial HHS information, the new model offers opportunities for most healthcare organizations, including medical groups, independent practice associations, accountable care organizations (ACOs), Federally Qualified Health Centers (FQHCs), health systems and health plans. (Health plans are only eligible for the geographic model.)

### What are the DC Model options?

DC Model options consist of three new voluntary risk-sharing payment models, each spanning five years plus an initial year to align enough Medicare beneficiaries. Per CMS, the model options are as follows:

- > The *Professional* option has the lower risk-sharing arrangement — 50% savings/losses and primary care capitation, a risk-adjusted per-member per-month (PMPM) payment for enhanced primary care services priced at 7% of total care cost of care.
- > The *Global* option offers 100% risk-sharing of savings or losses, with two payment options: primary care

capitation or total care capitation, a risk-adjusted monthly PMPM payment for all services provided by DC participants and preferred providers with which the DC entity has an agreement.

- > The *Geographic* option is still in development, with CMS having sought input in May. This possible option would have similar features to the Global model, with participants assuming responsibility for the total cost of care for all Medicare FFS beneficiaries in a defined region. Health plans would be eligible for this option as well as providers.

### New payment model key points

The new payment model options are CMS's most ambitious to date in breadth and scale outside of Medicare Advantage. The approach CMS is taking should help to extend the move to value-based payment (VBP) and particularly capitation across the country and well beyond current concentrations in the Northeast, Florida and Southern California.

- > The models are financially attractive to a wider range of providers, including primary care practices, large health systems and potentially health plans, even in communities with lower Medicare Advantage penetration. This is because they focus on enabling primary care physicians and groups to take more accountability and access greater premium dollars through risk arrangements for Medicare members who have *not chosen* Medicare Advantage.
- > The programs are designed to complement other value-based models in use today, such as bundled payments, Medicare Advantage and ACOs.
- > They serve equally well as relatively low-risk entry points with a strong upside for healthcare organizations without existing VBP arrangements and as a lever for expanding capitation for those with more limited existing value-based arrangements.

### Substantial participant benefits

The new payment model options also offer participants substantial benefits.

**Financial.** With 50% or 100% access to total-cost-of-care risk for Medicare Part A and B, participants can choose the program that best meets their capabilities to manage Medicare members. Payments are made up front in full each month. Capitation is the highest form of provider gainsharing, affording enhanced-margin opportunities, as well as significant increased liquidity for working capital and investments.

**Regulatory relief.** With a smaller set of core quality measures and waivers to facilitate care delivery, the programs promise to reduce administrative burdens of documenting compliance and meeting other Medicare requirements. This approach will increase productivity, enhance provider experience and decrease non-medical operating costs.

**Flexibility.** Providers have leeway to use the PMPMs as they deem appropriate to pay for more efficient care modalities and services not subject to rigid historical payment criteria. Participants also can target member incentives to encourage good behaviors focused on prevention/wellness and chronic care management.

**Improved metrics.** The payment models will include a refined set of quality measures that focus more on outcomes and beneficiary experience.

**Beneficiaries.** Medicare FFS members will be encouraged to become actively engaged through voluntary alignment and potential benefit enhancement choices while maintaining all original Medicare benefits.

It is anticipated that over time, program participants will improve their population health management competencies and realize increased financial benefits under these CMS models. In addition, high-performing participants can leverage their expertise and reputation to expand VBP arrangements to other payers.

As participants' VBP arrangements scale, financial gains will contribute to margin enhancement and produce additional resources to invest in innovation and an

enhanced population health management infrastructure.

### Still to be determined

Not all the details for the new payment model options have been fully established. Some questions that remain include:

**Rules and reporting.** What will be the rules and reporting for dual Medicare-Medicaid beneficiaries?

**Alignment model.** Must primary care participants include all their Medicare patients, or can they opt for a subset of patients? How will the beneficiary voluntary-alignment work?

**Measurement.** What quality metrics, outcomes and patient experience measures will be used? How will baseline and performance-year benchmarks be developed?

**Risk scoring and risk adjustment.** What will the risk-scoring and risk-adjustment models be and how will they impact the benchmark?

### The impetus for the new models?

The DC Model options focus on the largest consumer group of medical services, totaling 40 million FFS Medicare beneficiaries. This group accounts for two-thirds of Medicare patients compared to 20 million in capitated Medicare Advantage plans.

- > About 20% or 12 million people are duals — receiving both Medicare and Medicaid benefits (“*Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006 through 2017*,” CMS, December 2018)
- > Duals account for more than 34% of Medicare's total spending (*Medicare Spending Growth for Dual-Eligible Beneficiaries Has Trended Down Since 2011*, The Commonwealth Fund, Aug. 7, 2018)

Similarly, duals account for more than 15% of Medicaid patients (*Seniors & Medicare and Medicaid Enrollees*, Medicaid.gov) while accounting for 35% of Medicaid spending in FY17 (*Total Medicaid Spending*,

the Kaiser Family Foundation). These patients, on average, have far more complex and chronic care issues than the overall Medicare and Medicaid populations.

Collectively, Medicare patients offer the largest opportunity to reduce healthcare spending and therefore generate value-based contract gains for high-performing participating provider organizations. Achieving the Quadruple Aim of better quality and access with lower costs and greater provider satisfaction becomes more urgent as the population continues to age and 10,000 boomers turn 65 every day until the 2030s (Gibson, W.E., "Age 65-plus Adults Are Projected to Outnumber Children by 2030," American Association of Retired Persons).

The ROI and cash-flow impact for participating providers can be substantial, depending on the details of the new payment models. With the DC Model, for the first time, providers will have access to capitation payments for Medicare FFS members — without the investment costs in brokers and marketing to move members into Medicare Advantage.

### Timing

The payment models start in January 2020, with the initial year spent by organizations aligning beneficiaries to meet the minimum-beneficiary requirements. Performance periods begin in January 2021.

Having sought public input on the Geographic payment model option, CMS will issue further guidance including refined design parameters. //

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## Understanding the permanent reward in interim CFO roles

Brian Krehbiel

*Interim CFOs can make a sizeable impact in a matter of months.*

When a CFO leaves a healthcare organization, a void often is felt enterprisewide that must be filled until a permanent replacement is hired. Experienced healthcare CFOs undoubtedly have the skillset for an interim CFO assignment. This type of experience can address the increasingly challenging finance responsibilities that include balancing financial outcomes with patient outcomes and reaching across the enterprise to collaborate and communicate with physicians and other clinical executives.

### The interim CFO role

An interim CFO will usually spend six months to a year in the role and can offer a healthcare organization these key benefits:

- > Buying the organization time to recruit a permanent CFO
- > Keeping the financial ship on course to prevent a backlog of tasks from accumulating
- > Providing a fresh set of eyes on the state of an organization's finances and on the roles and responsibilities of the CFO position

### Tricks of the trade

High-performing interim CFOs have a "bag of tricks" that they can use in various situations, says Ken Robinson, an experienced former healthcare CFO who has completed more than a dozen interim assignments.

Interim CFOs like Robinson have typically been sitting CFOs in the past.

Interim CFOs often have the following abilities:

- > Welcome the variety that interim work brings.
- > Adapt well to different environments — making tough decisions if needed

or reinvigorating a finance team that's been without its leader.

- > Get up to speed in a new role within days or a few weeks.
- > Accept assignments they have been brought in to do, such as forging ahead with new initiatives, managing a merger or acquisition or shaking up the finance team. It's just a perception that an interim is someone simply to maintain financial operations.
- > Spot an inefficiency or cut costs. One interim CFO renegotiated an organization's long-term debt in the bond market and consequently improved its bond rating, saving it millions of dollars. This type of story is common.
- > Passion and people skills to make an impact in a short period of time.
- > Integrity because even though a non-disclosure/noncompete agreement is signed at the start of an engagement, the interim becomes privy to detailed insider information on the organization. CFOs who take on interim roles take seriously their fiduciary obligation to the organization and stakeholders.
- > Enjoy, or at least tolerate, travel.
- > Temporarily relocate, which means being without family and other support mechanisms and achieving work/life balance in a new location.

### Internal finance leader as interim

There are a few reasons to avoid appointing an existing finance team member as an interim. First, it places undue strain on that leader — and the entire leadership team — to essentially do two jobs at once. Second, if that individual is in the running for the permanent role, it can cloud the process and discourage other applicants.

### The interim CFO profile

Like Robinson, a typical interim CFO has seen and done a little bit of everything in their careers. This type of person tends to be a seasoned finance executive who knows their way around a balance sheet, understands standards and regulations from generally accepted accounting principles (GAAP) to the Stark Law and has the confidence, gravitas and experience to navigate the C-suite.

Many late-career finance leaders relish the chance to do interim work. The work is demanding but rewarding, and there's the opportunity to make a sizeable impact in a matter of months.

It's a great career option for executives who want to find variety in their career, says Robinson. Interim executives get the opportunity to experience new organizations, and, on longer assignments, become vested in a city, state or region.

Each assignment presents lessons that can be carried on to the next, Robinson adds. Even in situations where organizations are in financial distress, there are best practices and poor practices to learn from and use to provide value for future clients.

### Filling the gaps

Interim healthcare CFOs can be valuable team members when a healthcare organization is in transition. They can fill the gap during the hiring process by keeping finance operations running smoothly. In addition, they can offer an objective view and suggest valuable changes. //

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## The value journey, disrupted

Walter W. Morrissey

*When you imagine the future of healthcare, what comes to mind: an accountable care organization or a CVS HealthHUB store?*

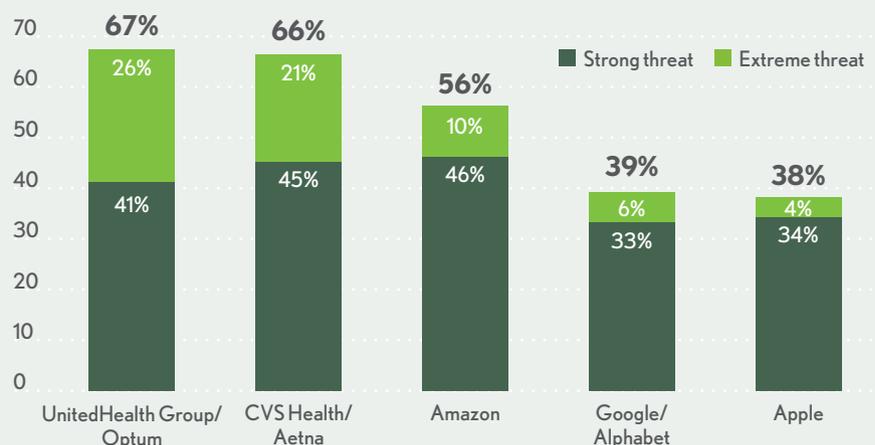
A decade into the transition to value-based care, there is general consensus that the transition has been slower than expected. Healthcare providers have been working to build capabilities and structures needed to deliver value-based care. For example, the number of accountable care organizations (ACOs) in the country has grown from 58 ACOs in 2011 to more than 1,000 today. Yet only one in 10 Americans receives care from an ACO. In 14 of the nation's 306 hospital referral regions (HRRs), ACOs cover less than 2% of the population, while on the other end of the scale, only 14 HRRs have 30% or more of the population covered by ACOs (Muhlestein, D., Saunders, R., Richards, R., et al., "Recent Progress in the Value Journey: Growth of ACOs and Value-based Payment Models in 2018," *Health Affairs*, Aug. 14, 2018).

In June, CVS Health Corp. announced plans to open 1,500 HealthHUB stores by 2021. Within two years, there could be more CVS HealthHUBs across the nation than there are ACOs. HealthHUBs are expanded in-store clinics that focus on prevention and treatment of chronic conditions. One estimate says that if CVS expanded its 1,100 existing MinuteClinics into HealthHUBs, 75% of U.S. households would be within 10 miles of a HealthHUB (Tully, S., "CVS Wants to Make Your Drugstore Your Doctor," *Fortune*, May 17, 2019).

Healthcare organizations have taken notice. In a recent Kaufman Hall survey on consumerism, 66% of respondents said that CVS Health/Aetna poses a "strong" or "extreme" competitive threat to hospitals and health systems over the next five years (see the bar graph below). A similar

### Perceptions of competitive threats

Question: Over the next five years, what degree of competitive threat do the following companies pose to hospitals and health systems.



Source: Kaufman Hall 2019 State of Consumerism in Healthcare report, Kaufman Hall & Associates, LLC. Used with permission.

number saw an equally significant threat in UnitedHealth Group/Optum, which has targeted 75 markets for growth in primary and outpatient services provided outside the control of hospitals and health systems. UnitedHealth Group CEO David Wichmann recently said that it has no interest in adding hospitals to its OptumCare portfolio but would be interested in health system partnerships “in markets where there [are] maybe less assets for us to accumulate and build from” (Haefner, M., “UnitedHealth CEO: Optum Won’t Build Hospitals,” *Becker’s Hospital Review*, June 5, 2019).

On the slow road to value, hospitals and health systems are now at risk of being overtaken by disruptive new business models that are working hard and fast to shift the center of healthcare away from hospital-based systems.

### A new front door to healthcare

Both CVS and Optum have spoken of offering a new “front door” to healthcare. Optum is pursuing the more traditional route, acquiring and redeploying an existing network of independent physician practices and freestanding surgical centers. The front door to this network will be Rally Health, a digital health platform that steers consumers to Optum’s network of high-quality, low-cost providers.

This strategy builds on a known fact: Independent physician groups have proven more successful than hospital-based health systems in controlling patient care costs in programs such as the Medicare Shared Savings Plan. They can be more easily incentivized to reduce utilization of inpatient or hospital-based outpatient and ancillary services because these reductions do not affect their revenues.

CVS’s approach is more radical in that it is creating a new form of provider

experience for consumers, with convenient, low-cost settings of care built within its existing retail pharmacy footprint. HealthHUBs within the retail pharmacies will be CVS’s new front door.

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*Health systems have too often been organized around the needs of those who work inside the system instead of the needs of those who are trying to enter the system for care.*

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Optum and CVS are targeting the same patients who have been the focus of value-based payment initiatives: the 60% of Americans with one or more chronic conditions who account for 90% of healthcare spending in the United States. Their shared bet is that by unbolting much of the care for these patients from hospital-based health systems, they can drive reductions in cost that will reduce expenses for their own health plan members, improve the customer experience and create a service that will be attractive to other payers.

### A paradigm shift for health systems

The new emphasis on healthcare’s front door requires a paradigm shift for health systems. The front door envisioned by Optum, CVS and a host of other new entrants in the healthcare marketplace is a door that is easily found and always open to the consumer. Once inside, the consumer can expect minimal delays, attentive service and a focus on providing quality care in the most cost-effective way possible.

In contrast, health systems have too often been organized around the needs of

those who work inside the system instead of the needs of those who are trying to enter the system for care. Their front doors often have been hard to find, with long lines waiting to get in. Incentives for those working within the system have not been sufficiently aligned to ensure a focused attention on the cost-effectiveness of care. Physicians have been reluctant to adjust their schedules or build team-based care models that could improve the convenience of care for patients. To the extent that ACOs have been an outgrowth of these systems, they have been burdened by the same problems and have struggled to achieve the results that would support further growth.

The changes required are both significant and difficult.

- > Making services available when and where patients want them, not when and where it is convenient to deliver them.
- > Transforming cost structure to ensure that primary care, outpatient and ancillary services can be delivered at a competitive price point.
- > Understanding the many needs and interests of the consumer — health-related, financial, emotional — and placing them at the center of decision-making across the organization.

By placing consumers at the center of their business models, new competitors have redrawn the road map to value. Health systems that fail to realign themselves around consumer needs will find their journey to value not only disrupted but headed down the wrong path. //

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## Consider the ethical challenges of early retirement program offers

William Marty Martin

*Different individuals and groups will frame an issue as ethical or unethical. To understand these varying world views, a stakeholder analysis should be conducted.*

Regardless of why early retirement programs are being implemented by hospitals and health systems, considering ethical challenges before moving forward with any retirement program action can help healthcare financial leaders protect their organization's reputation.

Hospitals and health systems implement retirement programs for a variety of reasons, such as meeting the goals of a merger or acquisition or cutting costs. Here are some recent examples of healthcare systems that implemented early-retirement programs:

- > AdvocateAurora announced an early retirement buyout targeting 300 managers (Goldberg, S., "Advocate Aurora Health offers early retirement buyouts," *Crain's Chicago Business*, 2019).
- > Brigham and Women's Hospital announced a voluntary buyout targeting 1,600 employees who were 60 years old or older (LaPointe, J., "Hospitals turning to staff buyouts to reduce healthcare costs," *Recycle Intelligence*, 2017).

Some organizations such as M.D. Anderson combine layoffs with voluntary retirement offers, where 1,000 jobs were eliminated in response to \$100 million in losses in a single quarter (Ackerman, T., "MD Anderson cutting staff by 1,000 workers via layoff, retirement; no doctors affected," *Chron*, 2017).

### Planning ahead to deal with intended or unintended consequences

An example of an intended consequence would be drain brain, where some of the most skilled workers are removed from

their roles. An example of an unintended consequences could be similar to what occurred with Osawatomie State Hospital, where an increased workload for remaining employees increased voluntary turnover (Wingerter, M., "Staff departures created 'dangerous situation' at Osawatomie State Hospital," Kansas Health Institute (KHI) archives, 2016). Moreover, the same KHI archive article says, after federal inspectors investigated, a patient death was attributed to understaffing due to the early retirement.

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*The decision to structure an early retirement offer has ripple effects beyond the eligible employee.*

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### Ethical challenges to consider

Just some of the ethical challenges that should be considered by healthcare leaders before moving forward with a retirement program offering are discussed in full below. These challenges include the following:

- > Who are the direct and indirect stakeholders in any retirement decision?
- > Are employees presented with the retirement program given all the information to make the best decisions?
- > Do they have the capacity to make such decisions?
- > Are the decisions purely financial?
- > What are the possible design considerations for a retirement program

and how will each impact targeted employees?

### Stakeholder analysis

Different individuals and groups will frame an issue as ethical or unethical based upon a different understanding of the world and the nature of the relationship between individuals and organizations. To understand these different world views, a stakeholder analysis should be conducted.

The first step in the analysis is cataloging the stakeholders who are directly and indirectly impacted by the decision to accept or reject an early retirement buyout. The stakeholders include the following:

- > The direct stakeholders are the employee and the agent of the organization who is typically a human resources representative.
- > Indirect stakeholders are the family, friends and dependents of the employee as well as the co-workers of the employee and patients and family members of patients.
- > The employees' supervisors are also indirect stakeholders.

Although the decision to accept or reject the early retirement buyout is up to each individual, the impact may affect more than just the individual employee.

### Motivations

Is the early retirement offer a purely a financial one? The decision to structure an early retirement offer has ripple effects beyond the eligible individual employee. For example, those who are not eligible may question whether the eligibility criteria are

right or wrong. In addition, early retirement impacts the lives of others in the eligible employee's household or someone who is under their care. As such, ethically sensitive healthcare financial leaders should ask three questions to challenge the notion that this is a financial decision alone because for many an early retirement is a major life decision.

- > Who beyond the individual employee may be affected?
- > Are the possible effects of the employee accepting the early retirement offer beneficial, neutral and/or harmful to the individual employee, other direct stakeholders and indirect stakeholders?
- > What are the costs associated with these potentially beneficial, neutral and/or harmful effects?

### Individual rights analysis

Another ethical challenge is considering whether the individual employee has the capacity or autonomy to make a fully informed decision and hence accept or reject the offer. The individual employee should be armed with the right information, right expert input and enough time to make a fully informed decision. The four questions to ask to help preserve the rights of

employees as autonomous decision-makers are as follows:

- > Does the individual employee have all the information in advance to make a fully informed decision?
- > Does the individual employee understand the short- and long-term consequences of their decision given any possible information asymmetry between the individual employee and the employer?
- > Do individual employees at all salary levels, educational levels and occupational groups have access to employer-sponsored or employer-covered retirement planning services to guide them in decision-making?
- > Does the individual employee feel as if this early retirement buyout decision is separate and independent from any future layoffs, buyouts or reductions in force so as not to create a situation of coercion?

### 3 behavioral finance principles

The design of the early retirement offer and whether it is referred to as a buyout, early retirement, voluntary retirement or some other name is critical because of three behavioral finance principles.

1. Framing tells the designer that what you decide to call the program matters in terms of impacting the decision and action. For example, if you use the word "offer," then it suggests a greater sense of agency than "buyout."
2. If the "offer" is the default option and individual employees must communicate that they want to reject the offer, then you would have relied upon choice architecture — the design of ways choices can be presented — or a nudge. A nudge is a factor that influences behavior while maintaining choice. Some would assert that default options undermine agency and autonomy.
3. If the early retirement offer is expressed as a multiple of base salary or some other type of formula, then the lump sum amount, particularly if taxes are not deducted, may unduly influence the individual employee to take the offer because of loss aversion. Loss aversion states that humans are hardwired to avoid losses and that a loss and gain of equal magnitude is not experienced the same way. Losses are more emotionally salient than gains of the same magnitude.

## 10 actions to minimize early retirement package ethical challenges

Many of these ethical actions are not limited to early retirement packages but other decisions involving the financial health and well-being of employees and their dependents. And for major employers in a community, it's important to note how the financial well-being of the community also can be an outgrowth of organizational decisions. This approach embodies the true meaning of financial stewardship.

### Distributive justice

1. Identify direct and indirect stakeholders.
2. Model the impact on direct and indirect stakeholders along different time horizons and different scenarios such as tax scenarios.

### Procedural justice

3. Assess the common and unique needs of all stakeholders.
4. Include representatives of stakeholders into the design phase of the early retirement package.
5. Consider obtaining the view of all stakeholders in framing the problem for which early retirement is the solution not to mention considering other solutions to the problem.

### Interpersonal justice

6. Embrace the saying, "It's not so much what you say but how you say it."
7. Treat others in a way that promotes beneficence and minimizes maleficence.

### Informational justice

8. Adhere to one of the tenets of the HFMA Code of Ethics: Striving for the objective and fair representation of financial information.
9. Ensure that eligible employees are financially literate to make this decision.
10. Inform those who are not eligible employees about any other cost-reduction initiatives on the horizon.

Source: Four Corner Approach to Minimizing Ethical Challenges, William Marty Martin. Used with permission

### Cornerstones of organizational justice

There are four cornerstones of organizational justice: distributive, procedural, informational and interpersonal. Each one is briefly described below followed by its connection to early retirement offers.

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*The design of the early retirement offer and whether it is referred to as a buyout, early retirement, voluntary retirement or some other name is critical because of three behavioral finance principles.*

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**Distributive justice.** The focus for distributive justice is about the outcome of a process, decision or action. In the case of early retirement, the formula, the amount of money and the timing of the payout make up distributive justice. For example, is it perceived as fair to structure the buyout as 1.5 or 2 times the base salary? Should the buyout be grossed up for taxes or not?

**Procedural justice.** Procedural justice considers how the decision was made and by whom in deciding if an early retirement offer was even necessary or the right solution. Was it aligned to the right problem, or how the buyout was structured? Was the decision driven by a board committee? Was the decision isolated to finance, human resources and legal? Was the process delegated to an outside consulting firm?

**Interpersonal.** The focus of the interpersonal cornerstone is how the decision-makers, the communicators of the decision and the employees eligible for the early retirement offer are treated by those with more formal organizational authority over this decision/process. Are eligible employees hurriedly pressured to decide? Are the authorities in the process treating individual employees and the class of employees, which in this

case is all eligible employees who meet a certain chronological age and years of service requirement, with dignity and respect?

**Informational.** The informational cornerstone stresses information ranging from the explanation as to why an early retirement package is the solution to the technical details of the package, ranging from tax consequences to retiree health benefits.

**Distributive justice: A deeper dive** “Advocate Aurora initiates early retirement program for up to 300 managers” reads the June 12, 2019, headline of the lead story in the *Milwaukee Business Journal*. Contrast the headlines of early retirement offers and voluntary buyouts with lavish gains in executive compensation in the very same organizations in the same industry. Consider Alex Kacik’s June 22, 2019, *Modern Healthcare* article titled “Highest-paid not-for-profit health system executives earn 33% raise in 2017.” In at least one of the health systems mentioned in this article, the media profiled top pay for the health system executive while another media outlet profiled an early retirement buyout for employees. These two articles were published in the same month and year.

Imagine that there is a perceived inequitable pay discrepancy between the CEO and other members of the C-suite and the rank-and-file employees; then this situation within the walls of a healthcare organization should be regarded as a risk for the organization and perhaps a risk for the reputations of the CEO and members of the C-suite.

The 2017 Edelman Trust Barometer shows that only 37% of respondents perceive CEOs as credible, which represents both a 17-year low and a decline by 12% from 2016 (Karlsson, P., Aguirre, D. and Rivera, K., “Are CEOs Less Ethical Than in the Past?” *PwC*, 2017).

Healthcare leaders would be wise to consider what is the perceived credibility of your organization? Is it advancing the strategic direction or serving as an obstacle,

recognizing that there are multiple sources for credibility beyond compensation?

### Distributive justice: Surgeons and physicians are taking note and keeping score

A relatively recent wrinkle in the pay disparity literature are comparisons between CEO pay and physician pay. The article, “The Growing Executive-Physician Wage Gap and Burden of Nonclinical Workers on the U.S. Healthcare System,” published in *Clinical Orthopaedics and Related Research*, 2018 highlighted two examples of pay disparity between 2005 and 2015:

- > The wage gap between CEO compensation and orthopaedic surgeon compensation increased from 3:1 to 5:1.
- > The wage gap between CEO compensation and pediatrician compensation increased from 7:1 to 12:1.

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*Healthcare leaders would be wise to consider what is the perceived credibility of your organization? Is this advancing the strategic direction or serving as an obstacle?*

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To be fair and balanced, CEOs and other members of the C-suite including CFOs, vice presidents of finance, comptrollers and treasurers have enormous responsibility to lead and manage increasingly complex healthcare organizations in increasingly turbulent environments. Yet, human perception of events is not always rational because as humans our emotions enter the equation. //

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// finance at a glance //

Announced hospital M&A transactions, 2009 - Q1 2019

The first quarter of 2019 marked a 10-year low in quarterly announced acute care hospital merger and acquisition (M&A) transactions, according to a Ponder & Co. report on mergers and acquisitions.



Source: Announced Quarterly Hospital M&A Volume is the Lowest in Nearly 10 Years, Ponder & Co.