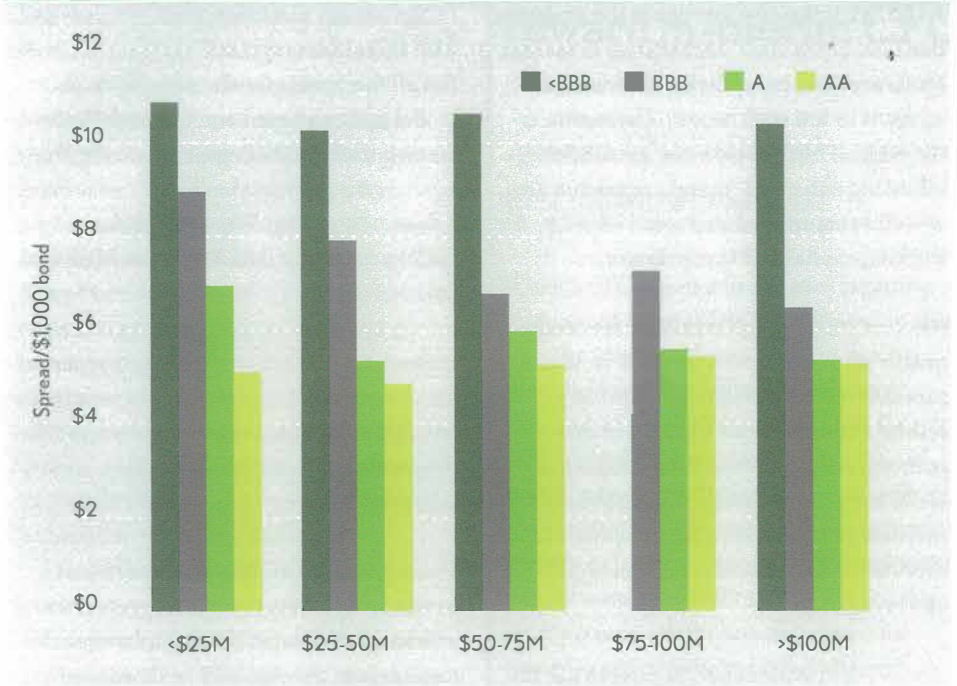
Hospital bond-weighted average underwriting spreads, by par amount 2013-19



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 nondisclosure/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.