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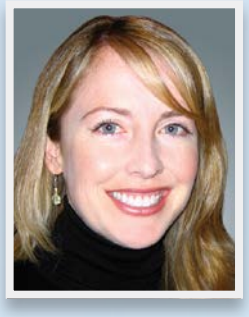
The New Rules of Healthcare Demand



The New Rules

The movement of care continues from inpatient to outpatient and beyond. Demand for healthcare services remains high but the nature of that demand is changing. What is a hospital board to do? How to cope? Do we hang on until the very end and keep doing what we always have been, hoping that it will all turn out ok? Or do we face the tea leaves and clean the slate?

Well, we know that in practical reality the answer lies somewhere in between. Boards have to continue to oversee inpatient care and fulfill their fiduciary duties of oversight. But as the articles in this issue emphasize, there is so much more to be done in order to fill the ever-expanding hot-air balloon of healthcare governance. Boards have the opportunity to not only deliver high-quality, value-based healthcare, but also to enhance the overall health of their communities. Boards have the opportunity to develop a more complete understanding of their customer's wants, needs, preferences, behaviors, and experiences, to redesign and redeliver care and fill in the gaps inhibiting customer loyalty. Boards have the opportunity to develop a new, integrated enterprise strategy oriented around digital healthcare platforms, in order to move towards a materially different future position in the merging digital delivery ecosystem. Boards have the opportunity to build a consumer-focused platform with a compelling brand and value proposition that supports innovation in order to compete for changing patient demands.

For each of these opportunities, the common thread is attracting essential partners and maximizing partnerships to get these things done. The strange thing is, as competition becomes more fierce, so does the need for collaboration. We hope this collection of articles provides valuable takeaways for your board in order to develop your own new set of rules.

Kathryn C. Peisert, *Managing Editor*

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Collaborations for Value-Based Care: Necessary and Advantageous for All

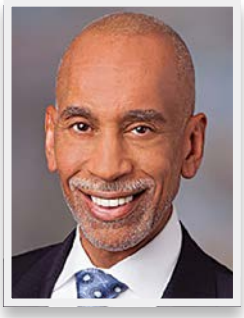
By Donald E. Wesson, M.D., M.B.A., Baylor Scott & White Health and Wellness Center and Texas A&M Health Sciences Center College of Medicine

Key Board Takeaways

Hospitals and health systems can expand their traditional focus on quality healthcare to incorporate enhancing overall population health by:

- Collaborating with non-healthcare entities to provide complementary assets like healthy nutrition and means to increase physical activity.
- Leveraging the positive health outcomes that are achieved from these partnerships to succeed in the growing environment of value-based care that rewards these good outcomes.
- Ensuring senior leaders and the board lead the formation of a successful collaboration of stakeholders by showing that each derives returns from their asset investment.

Focus on Health, Not Just Healthcare Delivery



Donald E. Wesson, M.D., M.B.A.

Hospitals and health systems contribute importantly to their communities through delivering high-quality *healthcare*, but they also have the opportunity to enhance overall *health* of the communities they serve, including historically underserved areas with comparatively poor health outcomes. The current focus on the *process* of healthcare delivery nevertheless has not improved overall health outcomes[1] and populations, particularly historically underserved ones, seek improved health outcomes, not just equitable and high-quality healthcare.[2] Improving the populations' health obligates that hospitals and health systems collaborate with partners outside the industry that can invest non-healthcare needed assets to yield the improved health outcome returns. Healthcare boards and senior leaders have the opportunity to initiate and even lead this creative approach.

The Need

Reimbursement systems are evolving from rewarding processes and episodes of healthcare delivery to rewarding good health outcomes. In this environment of so-called value-based care[3] (VBC), hospitals and health systems suffer financially for poor health outcomes, even those outcomes related to contributing factors for which they have no direct control. Contributing factors include social determinants of health (SDOHs), which disproportionately cause poor health outcomes for underserved populations.[4] Traditional healthcare models do not address or routinely consider SDOHs in clinical care.[5]

The Challenge

A VBC reimbursement environment challenges hospitals and health systems to address the many factors outside of healthcare that contribute to good health outcomes, recognizing that delivered healthcare makes a proportionately smaller contribution to good health outcomes than SDOHs.[6] In addition, members of underserved communities have generally had limited access to healthcare so a continued focus on healthcare delivery alone will fail to reach these individuals who, when they do need healthcare, often access it emergently and at increased cost.[7] Together, this incentivizes healthcare organizations to develop strategies to address SDOHs to function in a VBC environment. Achieving VBC therefore obligates hospitals and health systems to reach beyond the boundaries of clinical care.[8] Healthcare organizations will need to reach out to the communities they serve and develop functional relationships,[9] particularly with historically underserved communities.[10]

The Opportunity

Evolution of the reimbursement environment to VBC, with its focus on good health outcomes, provides a common vision around which healthcare organizations and communities can align. This alignment will lead to efforts to achieve good health outcomes among all populations, including eliminating the effects of SDOHs on historically underserved populations. This approach also harmonizes the historic dissonant focus on healthcare delivery verses health outcomes between hospitals and health systems and communities, respectively.

Because achieving good health outcomes requires investment of non-healthcare assets, hospitals and health systems must collaborate with entities such as food producers/distributors and fitness centers that can invest these assets in ways that will achieve these returns. Examples of such assets include adequate nutrition and resources to facilitate increased physical activity. Holders of these needed additional assets historically have not integrated them functionally with traditional healthcare delivery.

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1 Joseph Dieleman, et al., "Factors Associated with Increases in U.S. Health Care Spending, 1996–2013," *JAMA*, November 7, 2017.
2 P. Braveman, et al., *What Is Health Equity? And What Difference Does a Definition Make?*, Robert Wood Johnson Foundation, April 2017.
3 Sylvia M. Burwell, "Setting Value-Based Payment Goals—HHS Efforts to Improve U.S. Health Care," *The New England Journal of Medicine*, March 5, 2015.
4 Susanne B. Nicholas, Kamyar Kalantar-Zadeh, and Keith C. Norris, "Socioeconomic Disparities in Chronic Kidney Disease," *Advances in Chronic Kidney Disease*, January 2015.
5 American Hospital Association Committee on Research, *Next Generation on Community Health*, 2016.
6 Bridget C. Booske, et al., *Different Perspectives for Assigning Weights to Determinants of Health*, University of Wisconsin, Population Health Institute, February 2010.
7 American Hospital Association Committee on Research, 2016.
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Loyalty 2.0: Insight Gaps Inhibiting Customer Loyalty

By Brian Wynne, NRC Health

Hospital and health system executives and industry experts fill podiums, pages, and boardrooms debating the importance of customer loyalty in the oh-so-unique healthcare space. This has quickly become an antiquated argument. Studies provide ample evidence that confidence in healthcare wanes[1] and consumers claiming loyalty to a healthcare provider are near all-time lows at 61 percent. Also not up for debate is the threat lack of customer loyalty represents to the present and future success of organizations operating in nearly any industry. Why the surge of disloyalty in healthcare?

At the crux of the issue is a matter of centricity. As in, for whom are your healthcare organization's *goods*—services and experiences—designed? The healthcare industry has seen many transformations in centricity. Most recently patient-centered care dominated dollar, time, and effort expenditure, undoubtedly spurred on by incentive-based measures like HCAHPS. This focus on what matters most to patients *during* a care experience was preceded by an era of provider-centricity. Recruitment, incentive, and hierarchical models making the provider, not the patient, the primary customer of the health system. Both models were appropriate for their time, but now we are squarely in the era of consumerism in healthcare. So, with a new customer—the *actual*, paying customer—at the center of acquisition and retention strategies, a need arises to reimagine customer experience and what it means for one to be loyal, calling into question sources of insight informing design and execution strategy.

This *customer-centricity* can produce a deep understanding of what's important to those you serve, leading to better experiences in all aspects of the customer journey. Better experiences lead to increased customer loyalty, and increased loyalty leads to better outcomes for health system and consumer alike.

Reliance on standalone market research, patient satisfaction, or measures like CAHPS fails to fully illuminate the meaningful experiences customers are having with your brand. These experience "blind spots" allow expectations to go unmet, leakage to occur, and would-be loyalists lost.

Customer-Centricity Gut Check

What does the board know about your customer today? Both out-of-industry and progressive homegrown leaders would likely reply "not nearly enough." This begs the question: if you had a more complete understanding of their wants, needs, preferences, behaviors, and experiences, what would that enable your hospital or health system to do by way of design and delivery? How might that impact the long-term success of the organization's brand?

Thankfully, customers are quick to say what matters most along their self-described healthcare journey. The art is in the ask—the right question, of the right customer, in the right way, at the right time. Organizations that consistently listen and tune that approach are well-positioned to meet and exceed customer expectations, provided they take appropriate action on the insight gleaned.

Boards should focus on these aspects where customers feel healthcare organizations can have the greatest impact in their journey:

- **Discovery**: Well before becoming a patient, consumers are researching options, primarily online. Prospective customers need to be aware of your brand, what makes you different than other providers, the accessibility of your services, and the ease and convenience with which those services can be utilized.
- **Transparency**: Given the importance customers put on quality and cost transparency, this part of discovery deserves its own domain. Quality transparency via publicly reported measures are difficult for the lay consumer to find or comprehend. However, the recent surge of organizations publishing verified patient experience rating and reviews to their Web site has redefined "quality" at least in the consumer sense. Nationwide, patient ratings and reviews are consistently one of the most important items for consumers on a hospital Web site.[2] Cost transparency is in its infancy, but we'll see a rapid evolution in price transparency for a wide range of services and procedures. How long should we expect today's consumer to tolerate anything less?
- **Experience**: 73 percent of healthcare customers prefer to provide experience feedback within minutes to a few days after an encounter. Key to collecting feedback is the manner in which it is solicited. Short-form digital, multi-mode outreach yields the best response rates, and offers customers a frictionless way to provide real-time consultation on how to improve their experience.
- **Service recovery**: Hospitals and health systems simply must have visibility to experiences that fall short of expectations, and real-time experience outreach provides that needed visibility. Service recovery is a staple of customer-centric industries, complete with issue identification, triage, and multi-faceted approaches to resolution. The same concept can, and should, be applied in a healthcare setting. In fact, 84 percent of healthcare consumers expect to hear from a hospital or provider if they report a negative experience. Loyalists are often created from a negative experience that ultimately results in optimal, timely resolution.
- **Billing**: Intuitive invoicing and bill pay is overdue and represents a massive

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Key Board Takeaways

As boards are thinking through their customer loyalty strategy, they should consider the following questions:

- Are customers aware of your brand? What makes you stand out against your competitors?
- Are patient ratings and reviews easy to find (e.g., on your Web site)? How transparent is your organization when it comes to healthcare costs?
- How is customer feedback collected? Does this need to be improved to receive better response rates? What steps are taken if a negative experience is reported?
- What are you doing to ensure your brand is relevant to all customers (including those who are healthy)?

1 *The Consumer Confidence Crisis*, NRC Health, 2018.
2 NRC Health, 2018 Market Insights Study.

Health System Planning in a Disrupted Future

By Thomas Kiesau and Brian Silverstein, M.D., The Chartis Group

Digital industrialization has disrupted entire industries over the last two decades, introducing new players and business models while threatening established companies. This disruption is pronounced as innovators unlock the value of digital capabilities and convert technology from a cost center to a differentiated strategic asset. While the healthcare industry has been slower to evolve than some, it will not be spared from a similar digital industrialization. Indeed, its effects are already beginning to emerge in a number of healthcare domains and its impact will only increase in both breadth and depth over time. Hospitals and health systems must choose to develop these capabilities as a reaction to the emerging future context or proactively embrace and leverage them to define the organization's future.

Hospitals and health systems are grappling with this emerging reality and the associated uncertain future. However, for most providers, digital healthcare delivery is one of many important strategic priorities rather than a critical and central area of focus. As a result, organizations are engaging in a host of "digital pilots," many of which lack the underlying strategy and rollout plans to drive an enterprise-wide digital transformation. While most expect it will take several years before digital transformation materially impacts healthcare delivery, they also acknowledge the significant degree of change needed within their organizations considering the scale of the potential disruption that digital transformation represents.

Challenges Known and Unknown

Healthcare providers face a challenging strategic landscape even before considering the threat of disruption. Continued uncertainty related to government-based funding sources and pressure from commercial payers to hold the growth rate in check have amplified the need for hospitals and health systems to better manage costs in order to maintain financial viability. Yet, at the same time, incremental investments to replace aging facilities and acquire leading-edge medical equipment and core information technology systems point to the need for *more* capital spending, not less. Even as an aging population's increased utilization is straining existing acute care capacity, new entrants, many private investor-backed, are descending on the growing healthcare outpatient environment with new urgent care centers, walk-up clinics, diagnostic imaging, surgery centers, and physician enterprises, introducing entirely new forms of healthcare competition.

Yet today's challenges are increasingly representing yesterday's war as digital industrialization begins to alter the value chain. The future will bring entirely new competitive threats from three domains: healthcare delivery (both legacy and new providers), healthcare financing (payers), and consumer health (via major technology companies, including Amazon, Apple, Google, and Microsoft). Where healthcare is currently constructed around producer capital, assets and outputs, the future value chain centers on end-user activity, accountability, and personalized experiences. On-demand global service will be the new norm as production, distribution, and consumption converge via technological- and data-driven access and operating models that connect across both digital and physical mediums. From a consumer or patient standpoint, digital interaction is becoming the norm as people engage in online searches to obtain health information before engaging with healthcare organizations. (For an example of how rapidly digital industrialization can change an industry, see sidebar, "Lessons from the Blockbuster Video Experience.")

Key Board Takeaways

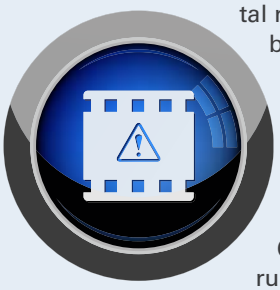
- Inventory your current digital platform and programmatic goals.
- Assess the current healthcare market landscape in your market and define market requirements in your planning horizon.
- Develop an organizational viewpoint and investment philosophy for the role of digital, and your vision for the organization in that emerging context.
- Incorporate digital into your planning approach, through one of three ways:
  - » Develop a discrete digital plan to augment existing enterprise strategy.
  - » Refine your enterprise strategy to incorporate digital plans.
  - » Develop a new integrated enterprise strategy oriented around digital.
- Explicitly define what success looks like, including specific metrics, timelines, and ROI, to track your digital efforts' progress and results.

Lessons from the Blockbuster Video Experience

Blockbuster Video's rise and fall provides several lessons that parallel the potential threats and opportunities that digital industrialization poses to health systems and hospitals. Founded in 1985, Blockbuster swiftly grew to dominate the video- and videogame-rental industry. By 1991 it was a multi-billion dollar company that had forced many smaller chain and independent competitors out of business and become ubiquitous with video rentals. Even then, however, Blockbuster's Wayne Huizenga (founder of Waste Management and owner of several Florida professional sports teams) worried about the threats posed by new technology such as cable television video-on-demand services and sold the company to Viacom for $8.4 billion in 1994.

Viacom did not fear new technology; rather, it could almost be said that its Blockbuster leadership team scarcely even acknowledged digital threats until it was far too late. The presciently named Netflix, founded in 1997, bested Blockbuster in several ways and ultimately drove the latter into bankruptcy by 2010. Blockbuster essentially failed to realize what business it was in. The company saw itself as a DVD rental business; in fact, it was a physical distributor that acted as an intermediary between content creators and consumers.

Netflix initially also served solely as an intermediary (minus the significant expense of brick-and-mortar stores), acting akin to an e-tailer by mailing out a seemingly bottomless selection of DVDs and videogame disks to customers from its handful of distribution centers. As Netflix grew, Blockbuster dug in its heels on its physical rental business, introducing a DVD-by-mail service in mid-2004. At this point in time Netflix was looking to bring the "Net" portion of its name into play. It initially planned a hardware launch that would allow customers to download movies overnight to a device before scrapping this plan when it saw how Internet bandwidth had increased to allow YouTube to provide streaming content, which Netflix itself began to offer in 2007. By 2010 its streaming business had become the single-largest source of nighttime Internet streaming traffic. The next year it expanded upon its practice of exclusively licensing the digital rights to certain titles by introducing Netflix Originals—brand-new, exclusive content that further redefined the company while Blockbuster filed for Chapter 11 bankruptcy protection.



Where did Blockbuster err? Its chief failing was that the company underestimated the pace of change, thinking it had years to adapt to the dual threats posed by innovative competitors like Netflix and Redbox, who introduced retailer-based DVD rental kiosks across the nation. As recently as 2008 CEO Jim Keyes remarked that Blockbuster considered mega-corporations like Wal-Mart and Apple to be its competition rather than the small upstarts that were quickly eroding its business, misidentifying the real threats. The company also failed to acknowledge how central convenience was for its customers' consumption of media, as their preferences quickly changed to "streaming first," despite the objectively inferior viewing quality experience and lack of "extras" relative to those offered by disk-based media. For most viewers, "good enough" picture and sound quality was all it took to alter their habits, especially as it began to enable entirely new means of consumption, including on smartphones, tablets, and computers. (Similarly, healthcare consumers today desire more than hands-on care; health is also about information, decisions, and behaviors that are not the exclusive domain of providers.) Most importantly, Blockbuster chose to *do* digital rather than *be* digital; it invested in mail fulfillment, streaming, and even in-store download kiosks in response to competitive threats and went out of business at a time when Netflix was still primarily in the disk-mailing business.

The Three Dimensions of Digital Healthcare Delivery

Digital healthcare delivery encompasses three dimensions: healthcare consumers, care teams, and business units. Health systems must serve the needs of healthcare consumers through a comprehensive, digitally enabled delivery network. They must also deliver exceptional patient-centered care through integrated digital care models while seamlessly and cost-effectively coordinating business operations through a cohesive digital operating environment.

As has already happened in other industries, healthcare delivery will move away from traditional care delivery networks limited by geography to integrated, patient-centric digital networks that can effectively deliver care anywhere. Technology start-ups are swiftly emerging in several areas, including pharmaceutical fulfillment and delivery, on-demand care, and chronic care management. Patients need to be able to receive convenient, real-time, on-demand care in both physical spaces (e.g., walk-in clinics) and virtual ones, and obtain access to pharmaceuticals through present-day methods as well as more futuristic ones (e.g., drones that deliver pill packs). Providers entrenched in traditional operating models are at a disadvantage against technology companies that can quickly create new digital services and offerings without the expensive encumbrance posed by legacy physical assets and personnel.

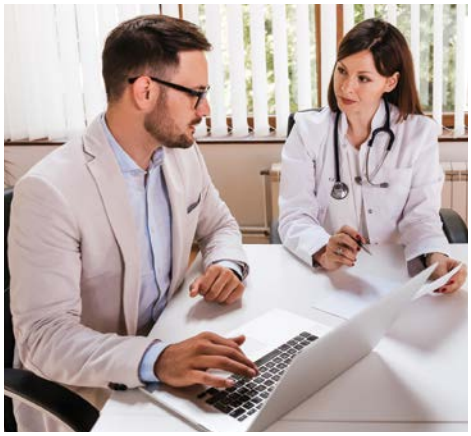
Digital care models represent a fundamental shift away from the traditional linear, physician-centric model of care in which a patient is expected to navigate a sequential series of discrete, often uncoordinated, healthcare professional interactions. The digital care model supports better real-time coordination and collaboration among myriad healthcare providers and changes the paradigm such that tech-enabled and augmented care teams, with a more diverse set of skillsets, can seamlessly assist the patient with all of their health needs.

Health systems and hospitals are just beginning to tap into the potential offered by the integrated digital operating ecosystem, which improves upon traditional functional models through efficient, cross-functional, data-driven processes. Initial efforts aimed at quick returns on investments are emerging as organizations determine which processes can be efficiently rewritten

and improved. Many have already invested in upgrades to their technical infrastructure and now need to shift their focus toward how best to realize value from these investments. Opportunities also exist to digitize processes even in areas where the infrastructure may not be as sophisticated. Other industries have demonstrated how legacy IT infrastructure can be leveraged and retained in these efforts; for example, airlines quickly revamped the flight check-in and boarding pass processes and made them app-centric through the development of overlays and new interfaces that tie in to their legacy IT systems. Online scheduling and claims automation are just the beginning of what can and will be done in healthcare; smart environments and new communications and collaboration tools are also on the horizon.

Planning and Visioning

As hospitals and health systems plan for their digital future, it will be important to consider the full range of capabilities that will be at their disposal. They will also need to contemplate how to enable sustainable advantage in the short-term competitive landscape and the long-term business model. Not every capability will be relevant for every provider, and even if they were, capital constraints will necessitate careful planning to prioritize these initiatives over a long-term planning horizon. While virtual care tends to dominate much of the digital discussion, it represents only one of five key care delivery capabilities that must be considered



collectively when developing impactful digital solutions:

- Virtual care (communications-enabled care delivery at a distance, like e-visits, video consultations, and telemonitoring)
- Patient self-service (technology that empowers patients to manage their own health and treatment, such as direct scheduling, self-triage, and patient-directed referrals)
- Connected solutions (smart devices that drive decision support, monitoring, and interventions, including wearables, smart diagnostics, and care environment sensors)
- Personalized care (tailored, effective treatments and customized experiences, like genomic data and patient interaction preferences)
- Automation, artificial intelligence, predictive analytics, and machine learning (technology that eliminates or automates entire processes and/or business functions)

Data will underlie the development of these capabilities and simultaneously become an essential byproduct as they are deployed and adopted by patients. Of course, it is not enough to simply generate, collect, and analyze data; data must drive insight. Leading business-to-consumer e-commerce companies already excel at the practice of using complex integrated datasets to target "recommendations" based on the deep customer knowledge they possess. The power of this predictive insight applied in healthcare presents enormous promise for enhancing care outcomes and delivering a radically improved and individualized healthcare experience.

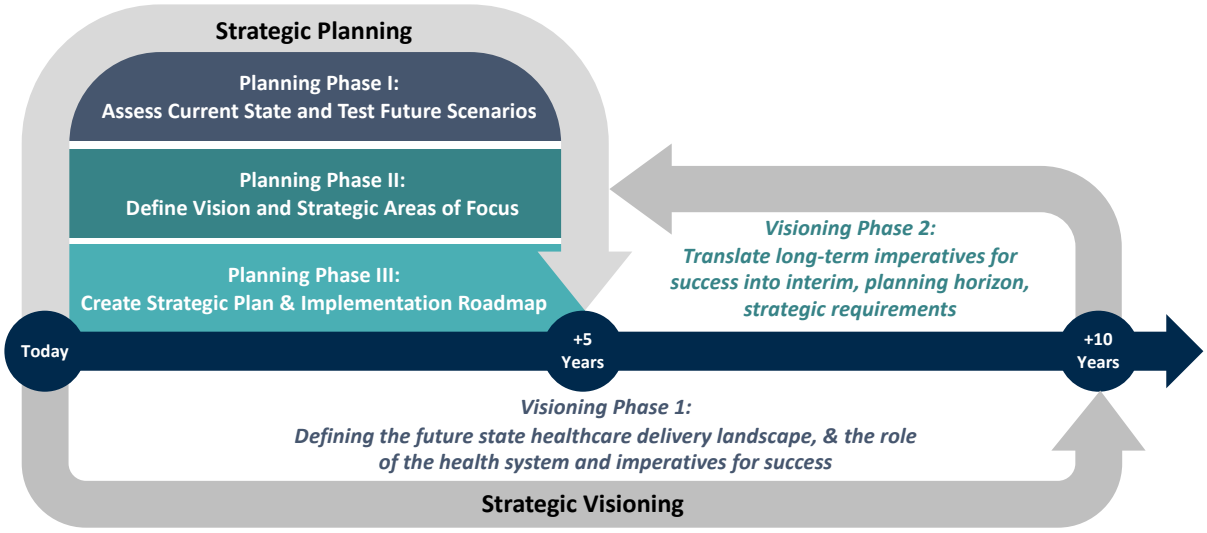
As the healthcare industry increasingly feels the effects of digital industrialization, hospitals and health systems must consider their current state realities and how to respond to them. They must also proactively define and advance the organization toward a viable position in the future health and healthcare context. A robust combination of strategic planning and strategic visioning is needed to survive and ultimately thrive.

As shown in **Exhibit 1** on the next page, strategic planning moves the organization forward along a fairly predictable set of pragmatic, phased activities:

1. Assess the current state, identify trends, and articulate future scenarios.
2. Define the organization's direction and strategic areas of focus.
3. Create the enterprise strategic plan, associated digital tactics, and a granular implementation roadmap.

Exhibit 1. The Two-Pronged Strategic Planning Approach

Health system planning must consider both the practical current state realities, as well as meaningfully move the organization toward a materially different interim position in the emerging digital delivery ecosystem.



Doing so will allow an organization to maximize its present-day strategic position, while simultaneously defining a viable, broadly supported path forward. At the same time, hospital and health system leaders should consider the strategic market context over the next decade or more to ensure their organization is positioned for continued relevance in the disrupted future. Organizations will need to:

1. Define the future-state healthcare delivery ecosystem and the role it will play relative to other converging ecosystems (i.e., healthcare financing and consumer health ecosystems).
2. Determine the future role of the organization and articulate the requirements (or "what must be true") for it to fulfill that role.
3. Translate long-term organizational requirements into a discrete strategic roadmap, defining specific initiatives, timing, and sequencing to reach the transformed future.

The Path Forward

There is no single "right" path forward to the future, but there are a number of key considerations that every healthcare organization should be thinking through to define how they will exist in a fundamentally different future. Organizations should begin by developing a shared understanding of where they are in the transformation process. Most health systems have a range of pilot programs under way, but many lack clarity around how those pilots will be monitored, assessed, and, if deemed effective, rolled out more broadly. A formalized and structured plan is essential to ensure strategic differentiation in the current context, but also to ensure the outcomes taken collectively are moving the organization toward the role it intends to play in the industry's transformed future.

To succeed, digital health must be an enterprise-wide initiative, with a consistent organizational focus, supported by the entire leadership team. It requires a shared organization-wide viewpoint over both the short- and long-term planning horizons, as well as a sustainable investment philosophy linked to a specific ROI. Because everyone is impacted by (and accountable for) digital health, the organization must be structured and incentivized as such. Success must be explicitly defined and measured through specific metrics, timelines, and ROI targets to track progress and results throughout the journey. There are many ways for an organization to undertake the development of its digital strategy, including creating a discrete digital plan that augments the current enterprise strategy, refining the enterprise strategy to incorporate digital plans, or developing a new integrated enterprise strategy that is oriented around digital health. While the specific approach can vary, digital health's prominent presence on the agenda is essential.

The Governance Institute thanks Thomas Kiesau, Director and Digital Health Leader, The Chartis Group, and Brian Silverstein, M.D., Director, Value-Based Care Practice, The Chartis Group, and Governance Institute Advisor, for contributing this article. They can be reached at tkiesau@chartis.com and bsilverstein@chartis.com.

Excise Taxes on Compensation: Overview of Interim IRS Guidance

By Bruce Greenblatt and Stuart Harvey, SullivanCotter, Inc.

On December 31, 2018, the IRS released interim guidance on the provisions of the Tax Cuts and Jobs Act of 2017 regarding the excise tax that is assessed on certain compensation arrangements of tax-exempt organizations. Specifically, two excise taxes of 21 percent apply to the following for "covered employees":

- Compensation in excess of $1 million
- "Excess parachute payments" (payments made contingent on an "involuntary" termination of employment)

The tax is employer-paid and is effective for tax years beginning after December 31, 2017.

Summary of the Interim Guidance

Calendar year remuneration used for determining covered employees and the excise tax: The determination of covered employees and the calculation of the excise tax is based on compensation for the calendar year that ends with or within the organization's tax year. For example, for a June 30 year-end organization's 2020 fiscal year, the compensation "paid" to the employee for the 2019 calendar year is used. There is one transition rule for calculating the excise tax in the first year it is applied: for non-calendar fiscal year organizations, any compensation "paid" before the start of the employer's FY2019 fiscal year is not included (thus, for a June 30, 2019 year-end, only compensation for July 1, 2018 to December 31, 2018 is considered).

Covered employees: The excise tax applies to the five highest-paid employees for the current tax year or any prior tax year beginning after *December 31, 2016*. Once an individual is a covered employee, that employee remains a covered employee:

- Covered employees are determined for each tax-exempt organization. Thus, for a group consisting of multiple tax-exempt organizations, there will be multiple sets of covered employees. An individual may be a covered employee of more than one tax-exempt organization if paid by multiple related entities.
- When determining the covered employees, remuneration paid by the organization and related organizations is included. Related organizations generally are determined based on a 50 percent ownership or control test. If an organization pays less than 10 percent of an individual's remuneration, the individual generally is not considered a covered employee of that organization.
- Covered employees are determined regardless of pay level. While a covered employee's current compensation may be below the $1 million threshold, their compensation will be subject to excise taxes if in the future it is above $1 million or if they receive an excess parachute payment.
- An individual is considered an "employee" of the tax-exempt organization for purposes of determining covered employees based on the services provided, regardless of whether the individual is paid by the entity itself or through a third-party payer arrangement (e.g., management services agreement) or other similar arrangement.

Definition of "remuneration" for purposes of calculating excise taxes: With limited exceptions, remuneration includes all compensation subject to tax withholding that is "paid" by the organization or a related organization during the tax year ending with or within the employer's fiscal year:

- For nonqualified deferred compensation, amounts are considered "paid" at the time of vesting, not when received by the individual. So, if deferred compensation vests at the end of 2019 and is paid in 2020, the amount is included in 2019 compensation for purposes of the excise tax.
- The guidance limits the exclusion of compensation paid to licensed medical professionals to amounts paid for the direct performance of medical services to patients. Thus, compensation for physicians that is paid for research, teaching, and administration is included for purposes of determining covered employees and the excise tax. Organizations must make a reasonable, good faith allocation between remuneration for medical and other services.
- Net earnings on previously vested deferred compensation, including 457(b) plans (but excluding qualified plans), are included annually.
- If a covered employee has excess parachute payments subject to the excise tax, the excess parachute payments are excluded when determining the excise tax on remuneration exceeding $1 million.

Excess parachute payments: There are two steps for assessing the amount of the excise tax on "excess parachute payments":

1. The excise tax is triggered when "parachute payments"—the present

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Key Board Takeaways

Working with legal, tax, compliance, and compensation staff and advisors, boards should consider the following actions.

Estimate projected excise tax liability:

- Determine applicable tax-exempt organizations and related entities.
- Quantify total compensation subject to the tax.
- Attribute physician compensation for the direct provision of medical services.
- Determine the covered employees and excise tax liability for the current and future years.
- Assess exposure to excise taxes on excess parachute payments made on involuntary termination.

Determine processes and strategies for reporting and managing the tax liability:

- Assess the impact of the excise tax when annual compensation decisions are made, highly paid individuals are hired or terminate employment, and changes occur in physician clinical allocations.
- Determine if any program or structural changes should be evaluated and quantify the impact of the excise tax (e.g., deferred compensation strategy, severance provisions, and employment structures that limit the number of total covered employees within a related group).
- Establish administrative processes to identify and track all covered employees, as well as to determine and report the excise tax liability.
- Prepare for potential scrutiny from disclosures related to the excise tax liability.

Collaborations for Value-Based Care…

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Consequently, healthcare organizations must develop the new skill of integrating these additional assets into their routine operations. Healthcare leaders will most likely have to initiate the conversations that will lead to building these functional collaborations.

The Results

Our experience at the Baylor Scott & White Health and Wellness Center in Dallas, Texas, supports that mutual asset investment yields returns for each contributing stakeholder, making this an attractive approach. Healthcare leaders often have the standing and gravitas within the larger community to facilitate the necessary collaborations. For example, executive leadership of Baylor Scott & White Health (BSWH) proactively established a collaborative partnership with the City of Dallas Park and Recreation Department and with local churches to develop VBC strategies for five contiguous low-income Dallas zip codes. The collaboration consisted of a level-three family medicine clinic placed in a local parks and recreation center and "farm stands" located in select recreation centers and churches that distributed fresh fruits and vegetables at very low cost to this official "food desert" community. Making the clinic contiguous with resources to support increased physical activity and provide healthy nutrition allowed integration of evidence-based lifestyle changes with traditional outpatient healthcare delivery. The collaboration increased use of the recreation center with the accompanying financial and social benefit to the City of Dallas, improved health outcomes of church members and their leaders, and significantly reduced utilization of the BSWH's emergency department and inpatient resources with the attendant reduction in healthcare expenses for care of this largely uninsured population.[11] These mutually beneficial outcomes incentivize each collaborator to invest in the partnership. Establishing these effective working relationships required first establishing mutual trust, beginning with system leaders reaching out to these collaborating entities and demonstrating early "wins" in the process.[12]

A Proposed Approach

Hospitals and health systems must evolve with the rapidly changing healthcare environment and, as discussed, will very likely do so in collaboration with leadership of entities outside of healthcare. Going forward, boards and senior leaders should consider doing the following:

- Begin internal conversations around how best to reconfigure operations that would allow for integration with non-health system assets in support of achieving good health outcomes.
- Develop the skills to identify needed partners for achieving good health outcomes and to work collaboratively with them on an ongoing basis.
- Establish an ongoing process of monitoring the effectiveness of the collaboration.

Concluding Remarks

It's critical that hospitals and health systems work towards achieving good population health outcomes, but they cannot do so alone; they must collaborate with other entities that can invest the needed additional assets for success. The partnership will sustain when collaborators see mutual returns for their mutual investments. Healthcare leaders have the opportunity to reach out and proactively help establish this needed collaboration and ensure that these partnerships are continuing to make a difference in the communities they serve.

The Governance Institute thanks Donald E. Wesson, M.D., M.B.A., President of the Baylor Scott & White Health and Wellness Center, and Professor of Medicine at Texas A&M Health Sciences Center College of Medicine, for contributing this article. He can be reached at donald.wesson@bswhealth.org.

11 Wesson, et al., April 2018.
12 Wesson and Kitzman-Ulrich, June 2018.

Loyalty 2.0…

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source of customer frustration. In many cases, a shocking and/or confusing bill is the final touch the healthcare organization has with their customer. Billing navigation and digital modes of pre and post payment, informed and designed by customer feedback, is a worthy undertaking for the customer-friendly health system.

- **Wellness**: Most Americans spend a small percentage of time directly receiving, or even considering, healthcare. How can you position your brand to be relevant in the lives of individuals who are well, and wish to stay that way? This is a question deserving of an answer for an aspiring 365-day healthcare brand.

None of the above should read differently than how healthcare boards (also healthcare consumers), or anyone else (still healthcare consumers) expect their favorite brands to behave in their daily life. From hospitality to banking to consumer goods, these aspects are table stakes to attract and retain customers.

As other customer-driven industries can attest, efforts to build brand loyalists are not picked up and put down. For healthcare organizations, a shift to becoming customer-centric requires meaningful, *transformational* change. What will separate successful hospitals and health systems from their peers is commitment to enabling change, execution rigor, and the proper customer-centric insight. The prospect of brand loyalists hangs in the balance, and stakes are high.

The Governance Institute thanks Brian Wynne, Vice President and General Manager, NRC Health, for contributing this article. He can be reached at bwynne@nrchealth.com.

Excise Taxes on Compensation...

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value of amounts paid by the organization and related organizations contingent on an involuntary separation from service—are more than *three times* the individual's average annual taxable compensation for the five years prior to the separation ("base amount").

2. If triggered, the tax is assessed on "excess parachute payments," which are amounts that exceed *one times* the base amount. Thus, a substantial excise tax results even if parachute payments are only marginally above three times the base amount, and the tax could apply to covered employees whose compensation is less than $1 million.

The guidance indicates that an involuntary separation from service includes not only typical involuntary terminations, but also an employer's failure to renew an employment contract and a bona fide "good reason" termination. The guidance also provides details on the types of payments that are included, their timing and valuation.

Allocation of liability across related organizations: When a covered employee receives compensation from multiple related organizations, the excise tax liability is allocated among the entities in proportion to the total compensation paid by each.

Reporting and Payment of Excise Tax

In Form 990, Part V, a box must be checked to indicate if the organization is liable for the excise tax on remuneration exceeding $1 million or excess parachute payments. The tax is reported on Form 4720, which includes the names of the covered employees and their associated excess remuneration and excess parachute payments, as well as the amount of the resulting excise tax. The tax must be paid by the 15th day of the fifth month after the end of the organization's fiscal year (i.e., May 15 for calendar year organizations).

Next Steps

After receiving comments on the interim guidance, the IRS will issue final regulations. For some tax-exempt organizations, the new excise tax may result in significant financial liability, add administrative complexity to compensation decision-making, and prompt reconsideration of the design of some compensation arrangements. Since excise taxes for calendar year organizations are due by May 15, boards should immediately assess the implications of the interim guidance (see "Key Board Takeaways" sidebar).

The Governance Institute thanks Bruce Greenblatt, Managing Principal, and Stuart Harvey, Principal, SullivanCotter, Inc., for contributing this article. They can be reached at brucegreenblatt@sullivancotter.com and stuartharvey@sullivancotter.com. The guidance provided in this article is for informational purposes and is not intended to be legal or tax advice.

The New Rules of Healthcare Demand

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example, closed their $69 billion merger in November 2018. The two companies had combined revenues of $240 billion in 2017, more than five times that of HCA, and more than eight times as much as Dignity Health and Catholic Health Initiatives' (i.e., CommonSpirit Health's) combined revenues.

With more than 1,100 clinics and retail stores within 10 miles of half of Americans, Larry Merlo, CEO of CVS Health, said the combined organization will "create an innovative, new healthcare platform that will be easier to use, less expensive for consumers, and integrated broadly within the marketplace to deliver superior, coordinated care."[8]

Initial plans include targeting chronic disease management, improving care transitions, and managing high-risk patients through retail clinics, home-based services, virtual care, and data and advanced analytics. Merlo estimates the company will see an additional $500 million in operating margin for every 50-basis-point reduction it contributes to the medical cost trend.[9]

Faced with such competitors, hospital and health system leaders must rethink traditional care delivery. The industry imperative is shifting from a focus on providers to a focus on consumers. To be successful in the future, legacy healthcare organizations need:

- A consumer-focused platform that emphasizes convenience and access through both digital and physical care sites
- A distinct and compelling brand and value proposition
- A culture and governance structure that supports innovation and change
- Market presence across a sufficiently broad geography
- Capital and resources for innovation, research, and development
- Ability to attract, develop, and retain top talent at all levels
- Ability to attract essential partners, and strategies to maximize those partnerships

Yes, overall healthcare demand is strong, but there is no shortage of competitors seeking to draw upon that demand and disrupt legacy providers. Hospital and health system leaders must broaden their focus to appeal to all generations. They cannot endure by serving only older, sicker patients. As famed business professor and author Peter Drucker put it: "The greatest danger in turbulent times is not the turbulence, but to act with yesterday's logic."

The Governance Institute thanks Mark E. Grube, Managing Director and National Strategy Leader, Kaufman, Hall & Associates, LLC, and Governance Institute Advisor, for contributing this article. He can be reached at mgrube@kaufmanhall.com.

8 Larry Merlo, *First Quarter 2018 Earnings Presentation*, CVS Health, May 2018.
9 Tomi Kilgore, "CVS Health Looks to Cut Health-Care Costs and Boost Profit with New-Look Stores," *MarketWatch*, January 9, 2019.

The New Rules of Healthcare Demand

By Mark E. Grube, Kaufman, Hall & Associates, LLC

Healthcare is an industry in which demand is growing, but the nature of that demand is rapidly changing. Hospitals and health systems face new forces that are reshaping the rules of healthcare demand, including:

- Medical and technological advancements that are pushing more care to non-hospital settings
- Consumer demand for the same level of access and convenience they encounter elsewhere
- Concerted efforts by payers to lower costs
- New competitors that seek to peel services away from legacy organizations, unburdened by the costs of providing inpatient care

Movement toward lower-cost, more convenient, high-quality care is a common denominator and forms the basis of the new rules of healthcare demand. Legacy providers need to acknowledge—and adapt to—these new rules. Hospital and health system executives and directors should focus on broadening their view of healthcare to establish a role for their organizations within an even more diversified future delivery system.

Movement Away from Hospitals

Total healthcare expenditures are projected to continue a rapid upward trajectory, growing 55 percent over the next eight years, from $3.68 trillion in 2018 to an estimated $5.7 trillion by 2026.[1] Most healthcare sectors have a positive outlook, including non-hospital outpatient care, ambulatory surgery centers, physician services, home care, and virtual care. The outlooks for acute inpatient and hospital-based outpatient care, however, are not so optimistic.

Not surprisingly, acute inpatient care is projected to continue to decline as technology and care delivery advances shift more care to outpatient and home-based services. Continued pressure from payers, employers, and consumers to provide care in lower-cost settings is another accelerating factor.

Hospital-based outpatient care is projected to fall with the rise of numerous competitors, including retail chains, physician groups, insurers, and other for-profit ventures. Payers are aggressively redirecting enrollees to non-hospital settings. Anthem BlueCross BlueShield, for example, no longer pays for ambulatory MRIs and CT scans performed in hospitals without preauthorization,[2] and the Centers for Medicare and Medicaid Services reduced payments for outpatient services in hospitals and off-campus hospital outpatient departments.[3]

How care is paid for also is shifting, as individuals and government payers assume an increasing share of healthcare costs. Private employer-based plans make up 46 percent of health plan enrollments, down from 48 percent in 2008. Conversely, Medicare and Medicaid increased from 24 to 31 percent of total enrollments over the last decade. High-deductible health plan enrollments rose from 16 percent in 2008 to 43 percent in 2017.[4]

These shifts contribute to new consumer attitudes about healthcare access, experience, and costs. Eighty-one percent of consumers are unhappy with their healthcare experience.[5] Consumers' dissatisfaction and the emergence of new competitors mean that hospitals and health systems risk losing out on rising demand if they do not adapt.

New Competition for Rising Demand

Despite declining demand for hospitals, overall demand for healthcare services is robust due to a growing population and associated healthcare spending increases. The U.S. population is projected to grow 3.4 percent to 339 million within the next five years and surpass 388 million by 2050.[6]

Younger adults ages 19–44 make up the largest segment at approximately 35 percent. Ages 45–64 is the next largest at 26 percent, and 65 and over is 16 percent. Those percentages run inverse to total health expenditures. Just 21 percent of healthcare expenditures are attributed to individuals ages 19–44, while ages 45–64 comprise 33 percent, and ages 65 and older make up 36 percent.[7]

Individuals ages 65 and older will continue to generate the most healthcare demand, but legacy hospitals and health systems can ill afford to lose younger generations, as they will be the base from which future demand will grow. Even with high spending among seniors, adults ages 19–64 constitute 54 percent of healthcare expenditures. This represents significant opportunity. The loyalty of these groups is the primary target of new competitors looking to reshape healthcare delivery with low-cost, digitally enabled services.

Many competitors are combining across sectors to combat legacy organizations, bringing a new level of scale to the industry. CVS Health and Aetna, for

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Key Board Takeaways

Demand for hospital-based services is declining, but overall healthcare demand is robust. Hospitals and health systems risk losing out if they do not adapt to the new rules of healthcare demand. To compete, legacy organizations need:

- A consumer-focused platform
- A compelling brand and value proposition
- Culture and governance that supports innovation
- Broad market presence
- Capital and resources for innovation
- Ability to attract, develop, and retain top talent
- Ability to attract essential partners, and maximize partnerships

1 Centers for Medicare and Medicaid Services, *National Health Expenditures Projections 2017–2026.*
2 Anthem Blue Cross and Blue Shield, "Imaging Program Expands to Include Level of Care Reviews: FAQs" (Press Release), 2017.
3 Virgil Dickson, "CMS Dials Back Plan to Slash Payment for Off-Campus Services by Half," *Modern Healthcare,* November 2, 2017.
4 Robin A. Cohen and Emily P. Zammitti, "High-Deductible Health Plan Enrollment Among Adults Aged 18–64 with Employment-Based Insurance Coverage," Centers for Disease Control and Prevention, August 2018.
5 GE Healthcare Camden Group, *The Current State of the Patient Experience*, 2018.
6 U.S. Census Bureau, "Projected Population Size and Births, Deaths, and Migration, 2017–2060," Last revised September 2018.
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