An analysis of the retail pricing strategies of 156 hospitals and health systems points to the need for a thoughtful approach to balancing prices, costs, and operating margins.
Hospital pricing strategies have become more complex in recent years due to mounting pressures from a number of parties—including patients, payers, physicians, and the business community—to compete on prices and reduce the cost to consumers.

We have recognized that, when developing a pricing strategy, many hospitals focus first on retail services, or frequently used patient services that are delivered by multiple providers in different settings.

Retail services are price-sensitive, meaning that some patients will choose where to have the service performed based on price.

We conducted a survey of hospital executives to find out more about their retail pricing strategies, pressures, and concerns. We received responses from 58 hospital executives representing 156 hospitals and health systems. Most respondents (83 percent) indicate that addressing retail pricing is of moderate to high concern.

To dig deeper, we compared the executives’ survey responses to their hospital charges and operating margins. Given the correlations that we saw, we can draw three conclusions: First, retail services face strong market pressures. Second, prices for these retail services substantially exceed costs. Finally, hospitals must balance maintaining operating margins with establishing a retail pricing strategy.

**Retail Price Pressures**

When asked what services they identify as retail services, more than 80 percent of hospital executive respondents cited laboratory testing and diagnostic imaging (see the exhibit above).

Medicare cost report data helps shed some light on why many hospitals are looking to reduce prices for these services. The price-to-cost relationship for hospital services is the highest for radiology and laboratory services with prices at 7.72 times cost and 7.19 times cost, respectively (see the top exhibit on page 3). Hospitals have arrived at this large mark up because these services are more often reimbursed on a percent-of-charge basis.

You will find the opposite of this in routine care where the mark up is 1.41 times cost because inpatient services have generally been paid under fixed payment terms, such as MS-DRGs or per diems.

**Price Pressure Versus Charges**

Our survey results suggest that the greatest pressure to reduce prices comes from patients, payers, and free-standing providers (see the bottom exhibit on page 3).

Retail services, such as lab and radiology, are typically performed in the outpatient setting. Since these patients are ambulatory, they are more likely to “shop around” for the best value. With the continued growth in high-deductible
health plans, we don’t expect this trend to subside.

To provide context to the survey responses, we looked at the 2013 Hospital Charge Index® (HCI) for each hospital that participated. The HCI compares the Medicare charge per discharge and Medicare charge per visit (both adjusted for case complexity and wage index differences) to the U.S. median hospital.

A higher HCI indicates higher prices. We found that survey respondents who reported feeling strong price pressure from patients work at hospitals with the highest HCI median of 105.8, compared to a median of 95.3 for all hospitals in the survey.

**Defense Strategies**

When asked how their hospitals are defending their current pricing strategy (see the top exhibit on page 4), the majority of respondents report using one or more of these three strategies:

- By comparing their prices to peer prices
- By showing a cost–based relationship
- By using a value proposition (i.e., higher-quality) argument

Only 21 percent use an ROI approach, which is similar to how public utilities set their rates.

Looking again at HCI, we found that the hospitals using the value proposition and cost–based relationship defenses had the lowest median HCIs of 92 and 96, respectively, while those that use the ROI approach had the highest average HCI of 100.8.

Interestingly, those that use the cost or value defenses also had the lowest average operating margins of 5.6 percent, compared to those that use a peer-pricing (6.6 percent) or ROI approach (8.2 percent).

Those hospitals that have kept their prices lower likely have a lower price-to-cost relationship because we were unable to find significant differences in cost position among the hospitals that use different methods to defend their current pricing position.

We also asked executives if they believed their hospitals’ current pricing position was defensible. Sixty-four percent responded “yes,” while 36 percent said “no.” The “no” responses came from hospitals with a higher-average HCI of

<table>
<thead>
<tr>
<th>U.S. Hospital Price-to-Cost Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine care</td>
</tr>
<tr>
<td>1.41</td>
</tr>
</tbody>
</table>


Considering how far radiology and laboratory services have moved from a relationship to cost, it is no surprise that many hospitals are feeling pressure to address price reductions in these areas.

<table>
<thead>
<tr>
<th>Sources of Hospital Price Pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source of Pressure</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>Patients</td>
</tr>
<tr>
<td>Payers</td>
</tr>
<tr>
<td>Free-standing providers</td>
</tr>
<tr>
<td>Physicians</td>
</tr>
<tr>
<td>Business/employer community</td>
</tr>
<tr>
<td>Media</td>
</tr>
<tr>
<td>Hospital providers</td>
</tr>
</tbody>
</table>

Source: Cleverley & Associates. Used with permission. Data from a 2015 survey of 58 hospital executives representing 156 hospitals and health systems.

Patients, payers, and free-standing providers are putting the most pressure on hospitals to reduce prices.
101, compared to the average HCI of 96 at hospitals with executives who said their prices were defensible.

**Pricing Strategies**
Some of the hospitals surveyed had already implemented retail pricing strategies, while others are in the planning stages (see the bottom exhibit on this page). Strategies being used include:
> Reducing outpatient price to compete for volume
> Reducing inpatient and outpatient prices
> Building, purchasing, or entering into a joint venture to retain some of the volume and profit from services that have migrated out of the hospital
> Promoting the value and quality of hospital services as a differentiator for being higher priced in some areas

Those facilities that had already created lower outpatient prices had the highest average 2013 HCI scores among the survey participants. We assume these hospitals recognized their position and responded by lowering prices.

**Concerns About Margins/Revenue**
When asked what was preventing a hospital from implementing a retail service strategy, the top response (80 percent) was pressure to maintain or improve operating margins.

The next two reasons (tied at 62.5 percent) were uncertainty that volumes would increase enough to offset losses in net revenue and concerns that contracts would need to be renegotiated so that the hospitals did not take a hit to net revenue from reducing prices.

Interestingly, about 14 percent of respondents indicated that they could charge more than free-standing providers for their services because of better quality and/or reputation. These hospitals also had an operating margin (9.6 percent) that was almost twice the average of the group (5.4 percent).

Regarding hospitals’ desires related to retail services, 86 percent of those responding to the survey hope to experience an increase in volumes, 66 percent hope to minimize or eliminate negative publicity related to their prices, and 59 percent want to see an enhancement to net revenue as a result. Other anticipated outcomes include appeasing referring physicians (45 percent) and establishing better relationships with payers (41 percent).

**Hospital Pricing Defenses**

<table>
<thead>
<tr>
<th>How do you defend your pricing position?</th>
<th>Responses*</th>
<th>Hospital Charge Index**</th>
<th>Operating Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROI</td>
<td>21.0%</td>
<td>100.8</td>
<td>8.22</td>
</tr>
<tr>
<td>Cost-based</td>
<td>56.1%</td>
<td>96</td>
<td>5.58</td>
</tr>
<tr>
<td>Value proposition</td>
<td>56.1%</td>
<td>92</td>
<td>5.64</td>
</tr>
<tr>
<td>Peer pricing relationships</td>
<td>59.6%</td>
<td>98.5</td>
<td>6.62</td>
</tr>
</tbody>
</table>

*Respondents could select more than one answer, which is why the results do not add up to 100 percent.
**The Hospital Charge Index (HCI) compares the Medicare charge per discharge and Medicare charge per visit (both adjusted for case complexity and wage index differences) to the U.S. median hospital.


Hospitals that use a cost-based or value proposition (i.e., higher-quality) argument to defend their prices also had the lowest median HCI and lowest average operating margins.

**Hospital Pricing Strategies**

<table>
<thead>
<tr>
<th>Solution</th>
<th>Already Implemented</th>
<th>Plan to Implement</th>
<th>Not Sure</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce inpatient and outpatient prices</td>
<td>25%</td>
<td>18%</td>
<td>49%</td>
<td>8%</td>
</tr>
<tr>
<td>Create a reduced outpatient price to compete for volume</td>
<td>22%</td>
<td>30%</td>
<td>41%</td>
<td>7%</td>
</tr>
<tr>
<td>Build, purchase, or enter joint venture with competition to retain some of the volume and profit from services that have migrated out of the hospital</td>
<td>21%</td>
<td>28%</td>
<td>45%</td>
<td>6%</td>
</tr>
<tr>
<td>Promote value/quality as a differentiator for higher pricing</td>
<td>34%</td>
<td>36%</td>
<td>28%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Source: Cleverley & Associates. Used with permission. Data from a 2015 survey of 58 hospital executives representing 156 hospitals and health systems.

The most common pricing strategy reported by hospital executives is differentiating services based on quality, thus justifying the higher prices.

**Case Example**
As seen in the survey results, multiple retail solutions exist for hospitals. But it is vital to analyze the potential outcome before pursuing any strategy.

We recently performed a procedure-pricing study for a rural hospital client. The hospital leaders asked us to estimate the volume increase for CT and MRI procedures that would be required to remain net revenue neutral if they
reduced their prices to the state average for free-standing imaging centers.

This hospital has a majority of commercial contracts that pay on discount–from-billed charges so the net revenue impact was significant. To reduce current charges to the free–standing imaging center state average, the hospital would see an average price reduction of almost 60 percent.

We then determined that this hospital would need to increase CT/MRI volume by an estimated 33 percent to break even from such a significant price decrease. Hospital leaders were left questioning if there was even enough volume in the market to make this a reality.

**A Careful Balance**

This is the type of analysis that hospitals should be performing before making large price reductions. Some hospital leaders think that price reductions will have little, if any, impact to net revenue because many of their contract terms are fixed payment arrangements. But then an analysis shows that significant price reductions would cause prices to fall below the commercial fee–schedule payment rates. The hospitals would then be paid at their charge rate because it is lower than the fee–schedule payment, leaving a gap in net revenue.

Hospitals must balance the need to respond to market pressures and maintain margins with the reality of contracted payment arrangements. All three must be carefully coordinated to avoid a financial shock.

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### Getting to the Essentials in Evaluating Value/Risk Contracts

Thorough assessment of contracting options and specific contracts is essential to succeed under value-based payment.

Transition of the nation’s healthcare system toward a value-based business model requires healthcare providers to move toward value-based contracts and care delivery models. Twenty-two percent of hospital and health system leaders anticipate such contracts will constitute 50 percent or more of their payment arrangements within 24 months, up from 7 percent of those leaders six months ago, according to a recent Kaufman Hall survey.

Under many value-based contracts, organizations accept greater financial risk by agreeing to deliver defined services to a specified population at a predetermined price and quality level. Organizations must develop a contracting and corresponding care delivery strategy that involves careful planning, skills development, and a phased approach.

**Identifying Best-Fit Contracting Options**

Evaluating risk- and value-based payment arrangements involves weighing organizational resources, capabilities, and goals against contract terms, including potential risks and rewards. Executives must be able to articulate the organization’s short- and longer-term goals, and its most appropriate role in the emerging population health management environment.

Examples include an integrated delivery system suited to be a “population health manager” responsible for the full care continuum, a regional provider best positioned to maintain a clinically integrated delivery network of defined scope as a “population health co-manager,” or a community hospital that will be part of a network managed by a population health manager or co-manager.

Healthcare leaders should assess the hospital’s or health system’s care delivery model and network, and identify the appropriate contracting scope based on how much risk the organization can carry. All forms of risk should be considered, including strategic and operating risk, actuarial or “insurance” risk, financial/asset and liability risk, and comprehensive risk.

Organizations then can narrow down the types of arrangements they should participate in. This is not a one-size-fits-all proposition. Most providers will manage a variety of contracting models based on payers, costs, capabilities, and market dynamics. Models range from traditional fee for service to full risk, in which providers receive a fixed amount per patient per month or a set percentage of insurance premiums, and are responsible for all cost variances. Other options may include pay for performance, bundled payments, shared savings, or shared/partial risk.

Healthcare leaders must consider external market forces and internal resources and capabilities in determining the pace of change. The further along in the value transition a market is, the faster an organization should act. This may be signaled by various factors, including broad physician alignment, successful care coordination across the continuum, or the prevalence of value-based contracts among other providers.

**Evaluating Contract Terms**

Once a general course is defined, organizations can evaluate how well specific contract terms align with their goals and capabilities. Executives should be alert to the contract’s payment methodologies, timeframe, dissolution provisions, and care delivery or quality performance metrics. The latter may influence whether the hospital has the flexibility or need to subcontract certain services. Organizations need to assess what services are carved in/carved out, what support services are required (e.g., pharmacy, post-acute), and what the geographic coverage area is—including demographics and risks associated with specific subgroups, such as the uninsured or dual eligible.
Understanding the contract’s financial and clinical implications is critical. Organizations should know the required capital reserves, and financial and operational investments—such as whether additional infrastructure or personnel are needed. Assessment of the organization’s current financial position, including credit rating, capital position, debt capacity, and minimum cash position, is strongly recommended. Revenue projections should be conservative. Initial losses may persist for three to five years while initial investments are recouped.

Lastly, executives should consider how to measure the success of new arrangements. Organizations must be able to collect, aggregate, and analyze clinical, financial, and operational data on populations served. This includes analyzing and improving measures of patient satisfaction, consumer engagement, and care quality and costs.

Investing for the Long-Term

Value-based contracts are more complex and demand greater accountability than fee-for-service contracts, but moving forward with the new model is imperative. Engagement and coordination of all stakeholders is required for long-term success.

Earlier this year, the federal government pledged to tie 50 percent of Medicare payments to quality or value by the end of 2018. A consortium of 20 major providers and commercial insurers followed up with a goal of moving 75 percent of its businesses into value-based arrangements by 2020. Such goals indicate that continued focus on non-value-based arrangements is riskier than exploring alternative payment options.

Healthcare leaders should look at their value-based contracting plan as a long-term investment, and be aware that achieving success in managing risk takes time and requires major behavioral shifts.

Park Nicollet Health Says Goodbye to the Line-Item Budget

The Minnesota health system has succeeded with a rolling financial monitoring and forecasting process instead of a budget.

The line-item budget, an age-old financial planning tool, is no longer welcome at Park Nicollet Health Services in St. Louis Park, Minn. Since 2006, Park Nicollet has used a rolling financial monitoring and forecasting process that eliminates much of the minutiae of preparing a yearly revenue forecast and allocating expenses across it.

Today the health system uses a model of continuous improvement—one derived from the so-called Lean culture model—in which departments are simply expected to do better than the previous year.

B.J. Miller, senior director of performance and planning at Park Nicollet, says the model helps the system deal with the current economic environment.

“We have about $20 to $25 million in margin deterioration annually because of macro factors and expense inflation,” he says. “We either have to grow or become more productive or more efficient, or we will lose ground.”

Margin Improvement

The new approach replaces budgetary line-item fixation with a process driven by regular reviews of department performance. “Conventional budgets,” Miller observes, “are burdened with detail that explain how much you are spending on administrative supplies, on continuing education, on salaries, on benefits, on categories of FTEs. You end up trying to guess the future and, when it arrives, explaining why your guess was wrong. “We don’t do any of that,” he continues. “We avoid a lot of that detail. We work under the assumption that this year and next year will be similar, so we just look at the bottom line. What is your direct margin?”

Park Nicollet divides its financial planning into six service lines: primary care, specialty services, surgery, inpatient treatment, behavioral health, and support areas, such as human resources and IT. Each department is expected to show improved margins year to year.

“We set an incremental growth target,” Miller explains. “You have to improve every year. If you did $84 million last year, let’s shoot for $85 million. We won’t let you slide back to $80 million. It is a hard argument to make that we should be allowed to do worse. There may be some exceptional circumstances, but then you have to ask ‘How will we minimize the damage?’”

Different Pressures

Although department leaders cheered the idea of being freed from writing detailed budgets, they have faced new challenges in the continuous growth model.

“Our approach puts a different level of pressure on department leaders,” Miller says. “It is a different expectation and skill set. We want people to think and reflect about what is happening in reality. We don’t want them to follow a budget on autopilot. In real time, they have to ask themselves: ‘Why do we need to hire three FTEs?’”

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But department leaders do not work in a data vacuum. They have access to a financial reporting and forecasting software that the finance department uses. Using the software, the financial team enters assumptions about future volumes, staffing levels, and expense inflation. The software then calculates the metrics with projections across time, which helps the finance team and operational leaders keep tabs on performance.

“It helps impose some discipline on us to do the monitoring more regularly,” Miller says.

### Regular Meetings with Service Line Leaders

However, bottom-line analysis is only part of the picture. Once a year, Miller and his department of 10 (five senior financial strategists and five analysts) convene formal budget meetings. At those meetings, the focus is not on budget-line items on a spreadsheet, but rather on the overall performance and potential of the department, such as the growth of new procedures or shifts in the local population.

“In cardiology, if the number of cath procedures is growing and resulting in less open heart procedures, we will discuss how to react,” Miller says.

At the meetings, department and finance leaders focus on just a handful of metrics:

- Volume (measured by encounters, procedures, or admissions)
- The number of physicians/clinicians
- The number of support staff

Miller’s team converts the volume to revenue and the FTEs to salary expenses. All the data—consolidated by the forecasting software—is then fed back to the departments (see the exhibit).

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**Sample Report: Projected and Annual Income Data**

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUE:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross charges</td>
<td>4,904</td>
<td>5,610</td>
<td>1,312</td>
<td>5,774</td>
<td>6,161</td>
</tr>
<tr>
<td>Clinic revenue</td>
<td>3,411</td>
<td>3,808</td>
<td>892</td>
<td>3,917</td>
<td>4,193</td>
</tr>
<tr>
<td>Charity care allocation</td>
<td>(9)</td>
<td>(52)</td>
<td>(12)</td>
<td>(15)</td>
<td>(16)</td>
</tr>
<tr>
<td>Net patient revenue</td>
<td>3,402</td>
<td>3,756</td>
<td>880</td>
<td>3,902</td>
<td>4,178</td>
</tr>
<tr>
<td><strong>DIRECT EXPENSES:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total clinician compensation</td>
<td>1,208</td>
<td>1,457</td>
<td>326</td>
<td>1,373</td>
<td>1,423</td>
</tr>
<tr>
<td>Clinician benefit allocation</td>
<td>193</td>
<td>230</td>
<td>52</td>
<td>218</td>
<td>225</td>
</tr>
<tr>
<td>Total professional compensation and benefits</td>
<td>1,402</td>
<td>1,687</td>
<td>378</td>
<td>1,591</td>
<td>1,648</td>
</tr>
<tr>
<td>Support compensation</td>
<td>658</td>
<td>678</td>
<td>173</td>
<td>678</td>
<td>695</td>
</tr>
<tr>
<td>Support comp - benefit allocation</td>
<td>186</td>
<td>190</td>
<td>48</td>
<td>190</td>
<td>195</td>
</tr>
<tr>
<td>Total support compensation</td>
<td>843</td>
<td>868</td>
<td>221</td>
<td>868</td>
<td>889</td>
</tr>
<tr>
<td>Total supplies</td>
<td>413</td>
<td>456</td>
<td>118</td>
<td>514</td>
<td>527</td>
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<tr>
<td>Total purchased services</td>
<td>75</td>
<td>77</td>
<td>18</td>
<td>32</td>
<td>33</td>
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<tr>
<td>Controllable occupancy</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Telephone expenses</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other expenses</td>
<td>11</td>
<td>11</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Total direct expenses</td>
<td>2,749</td>
<td>3,105</td>
<td>741</td>
<td>3,011</td>
<td>3,102</td>
</tr>
<tr>
<td>Direct margin</td>
<td>653</td>
<td>651</td>
<td>139</td>
<td>891</td>
<td>1,075</td>
</tr>
<tr>
<td><strong>INDIRECT EXPENSES:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2</td>
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<tr>
<td>Occupancy allocation (based on square ft)</td>
<td>148</td>
<td>148</td>
<td>35</td>
<td>145</td>
<td>145</td>
</tr>
<tr>
<td>Minnesota care tax allocation</td>
<td>58</td>
<td>68</td>
<td>15</td>
<td>65</td>
<td>-</td>
</tr>
<tr>
<td>Bad debt allocation</td>
<td>89</td>
<td>105</td>
<td>18</td>
<td>94</td>
<td>-</td>
</tr>
<tr>
<td>Total indirect expenses</td>
<td>297</td>
<td>323</td>
<td>68</td>
<td>305</td>
<td>146</td>
</tr>
<tr>
<td>Indirect margin</td>
<td>356</td>
<td>328</td>
<td>71</td>
<td>586</td>
<td>929</td>
</tr>
<tr>
<td><strong>STATISTICS &amp; RATIOS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>FTEs:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support FTEs</td>
<td>13.6</td>
<td>14.3</td>
<td>14.3</td>
<td>13.7</td>
<td>13.7</td>
</tr>
<tr>
<td>Clinician FTEs</td>
<td>4.8</td>
<td>5.4</td>
<td>5.3</td>
<td>5.3</td>
<td>5.3</td>
</tr>
<tr>
<td>Productivity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work RVUs per physician FTE</td>
<td>5,758</td>
<td>5,572</td>
<td>1,289</td>
<td>5,697</td>
<td>5,697</td>
</tr>
<tr>
<td>Physician work RVUs</td>
<td>27,567</td>
<td>29,921</td>
<td>6,867</td>
<td>30,317</td>
<td>30,317</td>
</tr>
</tbody>
</table>

Source: Strata Decision Technology and Park Nicollet Health. Used with permission.

At Park Nicollet, finance leaders meet with service line leaders to review reports such as this one, which shows projected and actual income data.
Monthly performance monitoring is led by a senior strategist and an assisting analyst who support all of the departments in a service line. The surgery service line, for example, has some 20 sub-specialty departments, each of which has its own performance targets. This approach leads to a lot of meetings—with 80 departments across the organization—but reinforces the importance of monitoring performance and adapting to market realities, Miller says.

In addition to monthly department meetings, Miller’s team sets up quarterly review sessions with each service line to monitor performance at that level. “We can feed back their volume assumptions and see how that translates to dollars on both the revenue and expense side,” Miller says. “If their margin is improving, they get a lot less scrutiny than if not.”

**Clinical Leaders as Business Owners**

The payer mix is a big factor in overall performance—and right now, it is working against the health system, Miller says. “If last week you came in for treatment at age 64, and then next week you come back at 65 for the same service, our revenue will go down 40 percent because you are on Medicare.”

Miller estimates the annual impact of patients leaving a commercial plan and going on Medicare is as much as $8 million. “We have to work with our operational leaders to figure it out. If they keep the same staff and same volumes, their performance will get worse.”

Against that backdrop, Miller says the biggest challenge in transitioning to the no-budget approach is the lack of business training among department leaders. Many rose through the ranks as clinical caregivers.

“Rather than just manage expenses, they have to run a business. But understanding the financial implications of your choices is more intuitive for finance leaders than clinically trained operational leaders. We have to help operational leaders understand the financial impact of their month-to-month and even their hour-to-hour decisions,” he says.

For example, if the department has no more patients scheduled at some point late in the day, it behooves the manager to send staff home early. “It hurts the person who gets their check cut by 15 minutes, but if we let everybody stay with no reason, we spend ourselves to a bad position,” Miller observes.

Miller says the training includes classroom time during the on-boarding process that introduces new managers to the overall financial picture and the metrics they should use. On-the-job training and follow-up occur as needed.

**Lessons Learned**

Miller has some advice to others contemplating the move to this type of system.

First, it’s important to make sure the entire executive team is in agreement with the change, he says. Unity in the C-suite is vital.

Second, be prepared to adapt. He says it’s more important to flexibly deal with challenges as they arise than to set hard goals and struggle to meet them. “It’s not as much about setting numbers in the beginning of the year than it is reacting to unforeseeable changes and adapting to them,” he says.

Finally, don’t be overly concerned about details in the planning stage. “The details can be dealt with in the day-to-day and weekly decisions,” he says. “There are too many things you won’t know about in the beginning.”

**Stable Finances**

Miller says the new system has been well adopted by the staff, and today they are more aware of the financial impact of operational decisions. The health system has had a stable margin since 2009, which he attributes to the staff’s conscious effort to adapt to economic realities.

At the same time, there are still challenges, he acknowledges. “When you tell people they can’t do worse than last year, they get that. But making it happen is hard. People who need the most help are sometimes the most frustrating to educate. Our finance team has to take the time to get everybody up the learning curve.”

Frank Stevens is vice president of financial planning at Strata Decision Technology, Chicago (fstevens@stratadecision.com).

**Interviewed for this article:** B.J. Miller, senior director of performance planning, Park Nicollet Health Services, St. Louis Park, Minn.
M&A Issues for Healthcare CFOs

When buyers see a well-organized financial team run by an effective CFO, it reflects well on the organization and enhances the potential outcome for all involved.

“The most effective CFOs are those that imbue their organizations with a sense of urgency,” says Carsten Beith, managing director and group head, hospitals and physician groups, Cain Brothers, who has been involved in numerous healthcare mergers & acquisitions (M&As).

“In any M&A process, time is an enemy as it allows for uncontrollable events to undermine a preferred outcome.”

In the following Q&A, Beith shares some additional insights for finance leaders who are getting ready to embark on an M&A journey.

What part of the M&A process causes the most stress for healthcare finance leaders?

In my experience, one of the more significant stresses for CFOs during a merger process is what’s known as “QoE” or “quality of earnings” analysis. This is an analysis that determines the expected ongoing performance of the selling organization.

QoE involves a rigorous analysis of the recent history of the selling organization’s financial and operational performance. It includes conducting a predictive analysis of future performance based on the concept of a “normalized run rate.”

The CFO involved in the QoE provides details, sometimes excruciatingly granular, on the revenue and expense structure of the organization. This usually includes a detailed analysis of an organization’s revenue stream, including adjustments to revenue that should be anticipated based on expected changes to payer contracts, volumes, payer mix, etc. This analysis will focus on identifying recurring and non-recurring changes to the income statement to develop a normalized run rate, which is critical because it drives valuation and other financial terms.

Which contracts are most important to focus on?

Any contract that has material financial terms needs to be carefully scrutinized by the CFO prior to beginning the diligence process. This is especially true of physician contracts. In more than 20 years of hospital M&A advisory, I’ve yet to see a hospital sale without some compliance issue related to physician contracts, whether problems with the financial terms, lapsed dates, lack of fair market value substantiation or, in some cases, complete lack of documentation.

We often see financially favorable contracts with physicians who perform clinical services at the hospital, such as medical directorships or clinical co-management. If not properly documented and structured, these contracts can have negative financial implications for the buyer, so buyers typically will want bad contracts corrected prior to closing. This requires substantial analysis and self-reporting to CMS. Any organization that is contemplating an affiliation transaction in the future would be well-advised to preemptively review all of its physician contracts for compliance.

What other steps in the M&A process should CFOs pay close attention to?

CFOs should be involved in educating their board of directors. When we advise an organization on an affiliation transaction, a key step is for the board to identify the objectives it seeks to achieve from a potential transaction. CFOs can be very helpful in providing financial context to the objectives-setting process and in assessing options, particularly from a financial point of view.

Most boards will seek meaningful capital commitments from any affiliation partner. Boards often seek to maintain as much local control as possible. Or they will focus on partnering with an organization that has strong and compatible IT capabilities, or one that has the ability to expand service lines and recruit physicians. In addition, quality infrastructure and population management capabilities are increasingly important characteristics sought in most deals.

CFOs can help their boards stay disciplined in evaluating alternatives based on the established objectives and in providing the financial rationale. Agreeing upfront to the decision guideposts allows boards to stay focused, which ultimately leads to better decision making.

What were some of the biggest errors you’ve seen CFOs make during M&As?

There is always a desire to bring out good news and downplay bad news. However, in most situations bad news is eventually uncovered.

Thus, a mistake we sometimes see a CFO make is not being forthcoming as problems develop or are uncovered in diligence. If bad news develops later in a process, after terms have been negotiated, it becomes much harder to mitigate because the selling organization’s leverage is typically reduced as the process progresses.

Another mistake is not planning and anticipating for the massive volume of due diligence information that is generated in a transaction. CFOs should begin the process by asking for a comprehensive due diligence list as well as examples of completed transaction documents, including schedules, to get a sense of the data needed to conclude a transaction. To reduce the stress that often occurs as a transaction progresses, have a plan to manage the data accumulation process. Designating a highly organized point person to coordinate data assembly can be very helpful.

Avoid advocating for the buyer. Keep in mind that, in many situations, the process itself is like a long job interview so a desire to please a potential new employer is natural. However, being a strong advocate for the selling organization and overseeing the process effectively will reflect better on the CFO and, in many cases, provides a solid foundation for ensuring a position post-transaction.
What are some strategies CFOs can use to avoid these and other errors?

A helpful tactic is to prepare a transaction “road map” that lays out all the tasks that need to be completed in a transaction and assigns responsibility. Elements of the road map that involve the CFO include development of marketing material, evaluation of proposals, due diligence, negotiation of definitive agreements, regulatory approval process, debt analysis and discharge, transition planning, and post-closing wind-down planning and communications. The road map guides the process and helps ensure issues are identified and addressed as early as possible.

Do you have any other advice for CFOs involved in an M&A transaction?

Balancing the demands of the transaction with the regular job of running the hospital will be stressful and can be daunting for many on the management team. It is, thus, essential for CFOs to get their teams well organized up front and to delegate responsibility to the right team members.

Finally, it will be important for the organization to ensure that key members of the management team are protected with stay bonuses or severance packages. The CFO has to keep the team motivated and intact in a scenario that is often fraught with insecurity. CFOs need to monitor events to ensure that the process does no harm to the organization. In fact, it is important that a focus remains on continuing to operate the hospital as effectively as possible during a transaction process.

Carsten Beith is managing director and group head, hospitals and physician groups, Cain Brothers, and a member of HFMA’s Eastern Michigan Chapter (cbeith@cainbrothers.com).

What It Takes to Be a Player in the Private Exchange Market

Not all health systems are ready to enter the growing private exchange market. For those that qualify, timing is all.

There’s no question that private health insurance exchanges, which are the employer-based equivalent of public exchanges, are gaining traction (see the sidebar on page 11). How far they will go and how fast are still up for debate, but the possibilities in this relatively new retail market are enough to prompt a number of large health systems to seek entry.

There are two types of private exchanges: Single-carrier exchanges are typically run by insurers and offer only that insurer’s plans. In contrast, multi-carrier exchanges, which offer numerous plan design options from multiple insurers, are usually run by benefits consultants and other third parties. One of the features that draw employers to this market is that premium rates are generally lower.

In exchange for those lower rates, progressive health systems are looking for new revenue streams, more lives to manage in their shift to population health, and more direct relationships with purchasers.

First Things First

What does it take to become an effective player in this market? There are some basic qualifications for participation in the private exchange market, according to Michael E. Nugent, CHSP, managing director, healthcare, Navigant.

Size and share. The first is a care network of sufficient size and breadth within a concentrated (driveable) geography. The second is significant market share, say 30 percent or more. If a health system doesn’t have that, it will need to affiliate with others to make up the difference. The third is the ability to deliver a particular price point, a per-member-per-month (PMPM) premium, demanded by the market.

Cost position. A third requirement: Leaders need to evaluate their health system’s total cost position, says Nugent: How much does it cost the organization to deliver care to a population?

“This means they need to understand the organization’s utilization patterns and how much the system charges for every unit of service. They need to benchmark these relative to their competitors. And there must be a meeting of minds internally among the strategists, the finance and operations people, and the physicians that they will make a true commitment to getting avoidable cost and utilization out of the system.”

Insurance license. The provider may need an insurance license to carry risk, depending on whether the employers they’re interested in working with are self-insured (meaning they take all the financial risk themselves) or looking for fully insured products (meaning they pass the risk along to someone else). Exchanges may handle self-insured or fully insured companies, or both. This is a critical distinction many providers don’t appreciate, says Nugent.

“A system that wants to develop products for fully-insured exchanges has two
choices: Get licensed or find a carrier to partner with.”

**Strategy.** Leaders also have to agree on their strategy, which means figuring out why the organization wants to be in the private exchange market. There are three basic reasons, says Nugent:

> They really want to be a health plan.
> They want a hedge against payment reform and/or competitor actions.
> They see it as a community benefit—managing the total cost of care in the long term by changing the way care is delivered and financed.

“Most are doing it as a hedge, but many also recognize that they may need to become a health plan eventually,” says Nugent. “Increasingly, private exchange operators looking for more competitive options are interested in provider-sponsored health plans.”

Points of Sale

Up to now, health plans have often lumped all providers within a network together: The purchaser is buying the network, not provider A or B, says Tom Cassels, executive director, Research and Insights, The Advisory Board Company.

“This is why private exchanges are so important: They offer a new channel where a health system can get out in front and present itself, its product, and the value of its own integrated network more directly to the consumer.”

Cassels points out that this opportunity comes with a challenge to health systems, which traditionally “have not been organized to be relevant in a retail marketplace.” There are, he says, three separate points of service in the exchange market:

> Being chosen at the point of care from among other providers in network, respectively
> Being chosen at the time a network is being assembled, whether by an employer sponsoring a self-insured plan, an insurance carrier creating a network of providers for a specific product, or a health system creating its own insurance product

“Being chosen at the time the consumer is selecting a network, ideally because he or she looked for the system by name is selecting a network, ideally because of the value of its own integrated network. This is why private exchanges are so important: They offer a new channel where a health system can get out in front and present itself, its product, and the value of its own integrated network...”

> Being chosen at the point of care from among other providers in network, which means the system has to be available, accessible, and affordable.

A healthcare system with a carefully crafted plan for winning business at each point of service—assuming it includes a comprehensive care network with a track record as a successful population health manager—is ready to become a player in the private exchange market.

**First Steps**

For health systems interested in pursuing the private exchange market, says Nugent, the time is ripe, as exchange operators are already starting to look for potential health plan participants for January 2017 enrollment.

“You have to keep in mind that private exchanges are new to employers, even to payers. At this early stage, relationships matter. So providers need to get out there and shake the hands of the people running the exchanges.” If they wait to be invited, he says, they may be waiting a long time.

Lauren Phillips is president of Phillips Medical Writers, Ltd. in Bellingham, Wash., and a frequent contributor to Strategic Financial Planning (Lauren_Don_Phillips@comcast.net).

**Interviewed for this article:** Thomas Cassels is executive director, research and insights, The Advisory Board Company, Washington D.C. (casselst@advisory.com). Michael E. Nugent is managing director, healthcare, Navigant, Chicago, and a member of HFMA’s First Illinois Chapter (mnugent@navigator.com).
How Two Minnesota Health Systems and a Payer Brought a Private Exchange Product to Market

The carrier, Medica, and the Vantage ACO share the risks and rewards of their private exchange product.

In the Twin Cities area, Minnesota’s largest accountable care organization (ACO) has entered the private exchange market in partnership with the insurance carrier Medica. See the sidebar on page 13 for a history of the relationship.

Called the “Fairview and North Memorial Vantage with Medica” (or Vantage for short), the ACO combines two major health systems: Fairview Health System, a not-for-profit academic medical center with six hospitals, and North Memorial Health Care, which has two hospitals, including a Level 1 Trauma Center. Between them, Fairview and North Memorial also offer 2,500+ primary and specialty care physicians, 50 owned primary care clinics, more than 70 specialty clinics, and 30 retail pharmacies.

Benefits and risks. While it is still in the early days, the rewards for the providers include new business gained at three key points of service:

- Forty percent of employees using the Medica exchange chose an ACO instead of an open access plan.
- Sixty percent of employees who selected an ACO chose Vantage (7,000 members), of which 25 percent were new to the ACO partners.
- Ninety-two percent of members stay within the ACO network.

In addition to the high-performing, affordable network of services, locations, and clinicians, Vantage’s unique value proposition includes some pretty compelling plan benefits:

- No referral needed to see a specialist within the network
- 24/7 online appointment scheduling
- Same-day primary care appointments
- Online access to medical records and lab results
- Access to Zipnosis, Fairview’s online diagnostic tool for members, which can be faster and less expensive than seeing a provider in person
- One phone number connects members to all their coverage and care resources, from benefit questions to scheduling appointments

That single phone number is key, says Rene Coult-Calendine, vice president, market and product development, Fairview Health Services. “We don’t want people who select Vantage to ping-pong between the health plan and the care system. So we’ve brought the financial and care components together, to make it easier for individuals to navigate.”

Attributed versus assigned lives. For Fairview, perhaps the biggest advantage to playing on the private exchange market is actually knowing who the individual members are. When you’re just one component in someone else’s network, you don’t know who has selected you until they come into the system as a patient, Coult-Calendine explains. But Fairview gets a membership file with demographics for each person who chooses Vantage, which means they can get proactive with this group. It’s the difference between assigned and attributed populations.

“This allows us to jump start a relationship,” says Coult-Calendine. “We reach out to them with mailings, email, and phone calls to thank them for choosing us, welcome them to the system, and help them understand what is available to them. If they’re new to Fairview, which is something else

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Private Health Insurance Exchanges: What Matters to Employers?

<table>
<thead>
<tr>
<th>Important to Employers</th>
<th>Important to the Consumer and Shopping Experience</th>
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<tbody>
<tr>
<td>Flexible employee contributions</td>
<td>Ease of use</td>
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<tr>
<td>Tools that aide in plan selection</td>
<td>Administrative and claims advocacy</td>
</tr>
<tr>
<td>Cost of plan options</td>
<td>Broad network access</td>
</tr>
<tr>
<td>Implementation assistance</td>
<td>Employee communication support</td>
</tr>
<tr>
<td>Experience and track record</td>
<td>Call center/instant chat</td>
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<tr>
<td>Financial stability</td>
<td>Variety of plan options and designs</td>
</tr>
<tr>
<td>Reduce benefits staff’s administrative effort</td>
<td>Portal with care management and claims information</td>
</tr>
<tr>
<td>Data and reports</td>
<td>Health education tools and library</td>
</tr>
<tr>
<td>Level and transparency of fees</td>
<td>High-performing networks</td>
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</table>


More than 80 percent of employer respondents said the factors listed above are somewhat or very important elements of a private exchange.
Chronology of the Private Exchange Product

2008-09: Fairview and Medica brokered the first shared savings model in region.

2011: Medica Health Plans partnered with Bloom Health Private Exchange Platform to offer a first-in-market defined contribution private exchange called My Plan by Medica(TM).

2012: Medica and Fairview developed an ACO-based product (Fairview Health Advantage) to offer on MyPlan by Medica(TM).

2013: The partners added North Memorial Health Care to create Fairview and North Memorial Vantage with Medica; it is one of five ACO products the MyPlan by Medica(TM) exchange offers.

Even before the first contact, she says, there is value to the system in the more active selection process itself, which is a powerful reinforcer of Fairview's brand.

Infrastructure. Prior to entering Medica’s private exchange, Fairview was investing in a population health infrastructure, including developing pay-for-performance contracts with payers and ensuring every clinic in the system was certified as a Medicare medical home (i.e., to promote consistency of processes).

“The next project was figuring out how to leverage this infrastructure more actively in the market so individuals could have the option of our ACO. And this was just when defined contribution exchanges were emerging, so it was a natural fit.”

One of the most critical components of this strategy, Coult-Calendine explains, is care coordination. So Fairview hired a care coordination staff of primarily nurses and social workers, putting one in almost every clinic.

"Their job is to work closely with clinical staff to follow up with individuals, reach out to them if they’ve missed an appointment, and call them after hospitalization to make sure everything’s going OK. The whole idea is to add touch points to better manage the patient population."

Employers and employees both seem very satisfied with the result, judging by Vantage’s 95 percent retention rate.

Lauren Phillips is president of Phillips Medical Writers, Ltd. in Bellingham, Wash., and a frequent contributor to Strategic Financial Planning (Lauren_Don_Phillips@comcast.net).

Interviewed for this article: Rene’ Coult-Calendine is senior director, marketing, outreach and product development, Fairview Health Services, Minneapolis (Rcoultc1@fairview.org).
Consolidating Debt Post-Merger: The Penn Highlands Story

The story of Penn Highlands Healthcare is a great example of how a newly formed system can successfully consolidate its debt in a beneficial manner.

You just completed a merger and successfully formed a hospital system. Time to relax? Not quite. By analyzing the financial profile and debt structure of the combined system post-merger, you can identify debt synergies that will save money and improve the system’s fiscal outlook.

Given the amount of time and due diligence invested in considering mergers and consolidations, one post-merger synergy that must be considered is improving the debt structure of the newly-combined system. Such debt synergies can be defined as cash-saving opportunities derived from refinancing, consolidating, or restructuring debt post-merger.

Penn Highlands’ leadership recognized the need to create a scalable debt structure as well as obtain capital for facility improvements. Penn Highlands worked with an investment bank to structure a full recapitalization by refunding $65 million in existing debt across the system, as well as obtaining $25 million in new money for six planned capital projects.

The Back Story
Penn Highlands is an independent health system in north central Pennsylvania consisting of four hospitals: Penn Highlands Brookville, Penn Highlands Clearfield, Penn Highlands DuBois, and Penn Highlands Elk. With a combined 418 beds and over 80 critical healthcare service offerings, Penn Highlands had an overall market share of 58 percent with potential to grow with further physician recruitment and planned capital projects.

In the fall of 2011, the system experienced decreased cash flow and negative financial trends due, in part, to the recent consolidation of the hospitals. The system had not yet achieved integrated system efficiencies.

After considering all funding options, Penn Highlands chose to pursue a private placement. Its investment banker articulated Penn Highlands’ aggressive turnaround plan and credit strengths to banks and institutional investors and put together a syndicate of nine regional and local banks to purchase the $90 million issuance in tax-exempt bonds for a five-year term amortizing over 25 years.

An interest rate swap fixed 75 percent of the debt and the total projected cost of capital was under 3 percent. Additionally, the investment bank arranged a $10 million revolving line of credit with the syndicate for additional projects.

By refunding the consolidated debt, Penn Highlands will save $16 million in debt service over the next five years. The restructuring also allowed the new health system to remove the risks associated with the previous debt structures of the four hospitals, while allowing its leadership the flexibility to explore a permanent, long-term financing structure in the future.

In addition, the system was able to obtain new money for capital projects, including a medical office building, IT system upgrade, and a retail pharmacy. These improvements, as well as continued integration and operational efficiencies, will increase the health system’s market share and financial strength in the future.

Debt Synergies
So how did Penn Highlands achieve such a beneficial debt consolidation that will allow the system to reap the benefits for years to come? It all begins with an analysis of the financial profile and debt structure of the combined system post-merger.

The Big Five Financial Ratios
Which financial ratios should be calculated? The Big Five financial ratios, as we’ve labeled them, are the ones debt providers are most interested in when evaluating the credit quality of the system:
- Net debt to EBIDA
- Days cash on hand
- Debt service coverage
- Debt to capitalization
- Cash and unrestricted investments to debt

Comparing these ratios on an as-is and proforma basis to rating agency medians will give the hospital management perspective on what the health system’s rating would be. This, in turn, helps the organization determine its financing options and projected cost of capital.
This is easier said than done. Not-for-profit hospitals and health systems have historically been financed with many varieties of debt and structures: fixed or variable interest rates, a range of terms and amortizations, sinking funds or escrows, taxable or tax-exempt structures, derivatives, capital leases, and obligated groups among other structures.

Since the devil is in the details, a thorough review and understanding of the existing debt structures and corresponding agreements for the combined system—coupled with an assessment of the combined system’s pro forma financial profile—is paramount to understanding if potential debt synergies exist.

When assessing the financial profile of the combined system, management needs to understand where the system stacks up in terms of “as-is” operations. This is based on the actual combined last 12 months (LTM) operating earnings before interest, depreciation, and amortization (EBIDA) of the entities that merged.

It also considers pro forma operations, which incorporate the projected operating synergies gained from the consolidation. These operating synergies are generated by either revenue enhancement opportunities (i.e., specifically driving volumes, gaining market share) or cost reductions (i.e., eliminating duplicative procedures or overhead, renegotiating contracts).

These should be quantified as part of the post-merger plan along with specific timetables assigned for each synergy initiative. Management will need to be able to clearly articulate the plan to potential debt providers and provide support for the projected gains from the operating synergies.

Once the as-is and pro forma LTM operating EBIDA is mapped out, management should ensure it has a strong understanding of the combined financial position of the system (i.e., the consolidating balance sheet). Breaking down the balance sheet into a consolidating schedule by entity, as of the effective date of the merger, is key to understanding the following:

- Which entities within the system are holding the majority of the liquid assets (unrestricted cash and investment)
- Which entities are obligated under the existing debt obligations
- If there are any restricted cash accounts associated with existing debt

The EBIDA and balance sheet analysis can then be used to calculate the financial ratios, the basis for the financial profile of the system.

**Cash Flow Savings**

Once the system’s pro forma financial profile and its existing debt structure have been determined, it is time to evaluate savings opportunities. In today’s low interest rate environment, the most obvious savings opportunity is reducing overall debt service. If the financial profile, or credit, on a pro forma basis is significantly improved from the as-is scenario, there would most likely be an opportunity to take advantage of refinancing debt at a lower interest rate.

However, there are other ways to extract cash savings or other benefits, including:

- Extend amortization on existing debt to lower debt service
- Restructure the obligated group
- Renegotiate covenants
- Release restricted assets

In addition, the importance of liquidity is often emphasized by the rating agencies and debt investors because it provides the ability to augment operating cash flow from investment returns. Systems can effectively maintain liquidity by managing debt levels, annual debt service, and how capital purchases are financed.

**Debt-Synergy Opportunities**

As demonstrated by the example of Penn Highlands, hospital CFOs need to be aware of debt-synergy opportunities post-merger to optimize overall capital structure and maximize the benefits of the merger. Working with their investment banker or financial advisor, health systems can identify ways to take advantage of today’s low rates and increase the financial flexibility of their newly combined system.

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Brian Cafarella is an associate, Lancaster Pollard, Columbus, Ohio (bcafarella@lancasterpollard.com).
## HFMA Hospital Financial Statistics and Ratio Medians, 2014

<table>
<thead>
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<th>Measure</th>
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<th>Standard &amp; Poor’sc</th>
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a. Fitch Ratings, 2014 Median Ratios for Nonprofit Hospitals and Healthcare Systems. 2014 medians based on fiscal 2013 audited numbers. Data is reported at system or obligated group level.
b. Truven Health Analytics ACTION OITM Program (2013 FY hospital medians). Copyright 2014. Ratios prepared using 2013 hospital data reported at individual facility level. The sample is heavily influenced by a significant number of major teaching hospitals, and Truven uses a restrictive definition of capital, resulting in a smaller ratio for days cash on hand and cushion ratio.
c. Standard & Poor’s 2014 medians are based on 2013 audited financial reports for stand-alone hospitals and health systems.
d. Optum data from the 2015 Almanac of Hospital Financial and Operating Indicators.

Source: HFMA, December 2014 (hfma.org/hospitalstats). Data from sources listed in footnotes.

In December of every year, HFMA gathers data trends for certain ratios, including the ones presented here for 2014. Healthcare finance leaders should use professional judgment, analysis, and advice when using this information.

For the complete list of statistics and ratios, along with definitions, visit hfma.org/hospitalstats.