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Planning a successful transition from fee-for-service to new revenue models may be the greatest impending challenge for finance executives of hospitals and health systems.

AT A GLANCE

A financial assessment aimed at gauging the true impact of the healthcare industry's new value-based payment models for a health system should begin with separate analyses of the following:

- The direct contract results
- The impact of volume changes on net income
- The impact of operational improvements
- Net income at risk from competitor actions

The results of these four analyses then should be evaluated in combination to identify the ultimate impact of the new revenue models on the health system's bottom line.

Hospital and health system finance leaders are presented with the challenge of deciding whether to embrace the healthcare industry's apparently inexorable trend away from fee-for-service payment and adopt a variety of emerging new value-based revenue models. These models include accountable care organizations (ACOs), bundled payment arrangements, quality performance incentives, gainsharing with physicians, narrow network arrangements, and shared-risk or full-risk contracts.

Making the transition to these new revenue models has been described as crossing a chasm. Yet finance leaders are charged with creating smooth financial paths forward, not making daring leaps across chasms.

To ensure a smooth transition, finance leaders need analytic models that allow them to plan thoughtfully and recognize all of the effects of these new revenue models. They also must decide how quickly to pursue these initiatives, how much revenue to shift, and how their organizations will succeed in this new environment. Choosing among potential contracts and setting the right pace may determine future success more than any other organizational strategy.

The Rationale for Pursuing the New Payment Models

The often repeated rationale for transitioning to new value-based revenue models is well known: Payers are demanding new value-based payment arrangements, believing they can yield both quality improvement and cost savings. Medicare has thrown its significant market scale into the endeavor. And perhaps most important, some leading providers in some markets are demonstrating results.

Nonetheless, many hospital finance leaders may be tempted to reject the common wisdom and view value-based payment as a fad, focusing on methodological flaws, complexity, and the perception that the new model may be promising more than it can deliver. Indeed, finance leaders *should* be appropriately skeptical of new fads, especially when they may undercut revenue.

So it is tempting for them in the case of value-based payment just to wait for the inevitable contracting failures and the rebound back to traditional fee-for-service. It's tempting—but not wise.

Carl von Clausewitz, the 19th Century military strategist, famously wrote, "War is the continuation of politics by other means." Similarly, it could be said that "New revenue models are the continuation of *competition* by other means."

Competition for market share and physician loyalty. Competition for operational success.

The reasons to transition to these new models are only partly about whether they will yield savings or additional revenue. The essential features of new revenue models are determined by how they will change the competitive marketplace.

Based on this perspective, it is important to measure new revenue models in four key ways:
> Contract results
> Market share
> Improved operational results
> Success in outmaneuvering competitors

Given the complex set of goals and benefits associated with new revenue models, a more involved analytic structure is required to assess their true impact.

How to Gauge the True Impact of New Revenue Models

The financial analysis for new revenue models is different from how hospital senior finance executives evaluate traditional fee-for-service contracts. Traditionally, a finance executive could focus on the direct contract results and in doing so, would know the impact of a contract on the health system bottom line. The new revenue models require several more layers of analysis to calculate their true impact on the health system.

In addition to the direct result of the contract, the greatest impact of these new revenue models may be in how they position a health system to secure market share, enhance operations, align with physicians, improve operational results, hedge against a competitor grabbing market share, and achieve other strategic benefits.

A health system's analysis should support consideration of all of these points.

A Sample Analysis

To illustrate the range of factors that should be addressed in an analysis of the potential impact of new revenue models, we offer the following sample financial analysis based on estimated results for four different hypothetical contracts:

> Medicare ACO with 10,000 lives
> Commercial ACO with 20,000 lives
> Medicare bundled payments with 275 expected cases
> Commercial narrow network with 10,000 lives

To effectively guide a health system to financial health, an analysis of new revenue models should take into account five factors:
> Direct contract results for the health system
> Impact of volume changes on net income
> Impact of operational improvements
> Revenue at risk from competitor actions
> Other strategic benefits

In such an analysis, each factor should be boiled down to its estimated impact on net income, so that the final analysis assesses the bottom-line results of new revenue models on the organization.

Direct Contract Results

Estimating the results of a contract involving a new revenue model is much more difficult than analyzing results of traditional fee-for-services contracts. Payments under the new revenue models are contingent on meeting quality targets, achieving population health savings, or meeting other performance measures. Despite these complications, estimating direct contract results is the first step in understanding the impact of such a contract on the health system's bottom line. Although ACO, bundled payment, and other new models all use different strategies to align interests, they can be analyzed side by side as demonstrated.

First, the approach to examine all of these new models should consider the payer spend that is being addressed, which will be different for the various models. For example, ACOs focus on total population health cost, while bundled payments target the payments for a particular clinical episode.

From this starting point, one can estimate the incentive the payer is offering to ensure its spend is well managed, the contract administration costs, and the discounts (e.g., bundled payment

discount to the Centers for Medicare and Medicaid Services [CMS]). In addition, incentives may be shared with physicians.

After all of these factors are considered, the direct financial result of the contract can be estimated for each type of contract. For example, in our sample analysis shown in the exhibit below, the estimated direct contract results are positive for some contracts and negative for others. In total, the four contracts would reduce net income by $740,000 on almost $200 million of payer spend. (Note that the $200 million of payer spend does not represent $200 million of health system revenue, as payers are spending some of these funds on other types of providers.)

In many cases, the direct result of the contract may be neutral or negative. As will be seen later, that does not mean the overall impact of the contract will be negative, particularly when competitor actions are considered.

Impact of Volume Changes on Net Income

New payment models will likely drive down utilization as patients will benefit from improvements in care coordination and other population health management efforts. However, successful health systems may achieve increases in market share as these new contracts support either preferred tiers in health plans, a better patient experience, or increased ability to recruit physicians who prefer a better coordinated model of care. It is important to consider these volume changes and their likely impact on net income.

In calculating the impact on utilization rates, health system leaders should remember that some reductions will be in the health system's own volume, and some may affect volume at other facilities delivering care to the same population the health system is managing. For example, an ACO may expect to reduce admissions (and hospital revenue) by 10 percent, but a third of the readmissions may have historically occurred at a competing facility. There is no loss to a facility from reducing a competitor's volume.

Market share growth may be more difficult to predict, but it should be considered nonetheless. The starting point for estimating market share growth should be the hospital's current fee-for-service revenue for the relevant payer (and clinical service, in the case of bundled payments). For example, ACOs and bundled payments can yield additional market share either by attracting more patients or physicians to its better coordinated set of services, or by helping to ensure that

ESTIMATED DIRECT CONTRACT RESULTS

	Medicare ACO	Commercial ACO	Medicare Bundled Payments	Commercial Narrow Network	Total
Units	Lives	Lives	Episodes	Lives	
Annual Volume	10,000 Lives	20,000 Lives	275 Episodes	10,000 Lives	
Average Payer Spend per Unit	$9,000/ Member	$3,200/ Member	$40,000/ Episode	$3,200/ Member	
Annual Payer Spend	$90,000,000	$64,000,000	$11,000,000	$32,000,000	$197,000,000
Estimated Incentive (as a % of payer spend)	2%	1%	2%	0%	
Estimated Incentive from Payer	$1,800,000	$640,000	$220,000	$0	$2,660,000
Contract Administration Costs	−$1,500,000	−$400,000	−$100,000	−$50,000	−$2,050,000
Impact of Discounts	$0	$0	−$220,000	−$800,000	−$1,020,000
Incentives Payments to Others (e.g., physicians)	−$150,000	−$120,000	−$60,000	$0	−$330,000
Direct Contract Results for Health System	**$150,000**	**$120,000**	**−$160,000**	**−$850,000**	**−$740,000**

Financial Model Notes

For simplicity, the illustrative example provided in this article assumes a single year of results for contracting options that might be available for a medium-size hospital. The central concept of the methodology is to start with the payer's spend, as the demonstration of value must yield savings for the population or episode. However, achieving that value has significant downstream effects on hospital net income. The model seeks to capture and quantify each of those impacts.

The sample analysis is for baseline estimates of results. With a model built, it will be possible to perform sensitivity analyses to assess the risks and benefits associated with each contract.

In addition, it will help to estimate results for multiple years, as the ability to achieve positive results will vary by year. It could become easier to succeed as infrastructure develops and experience grows. Or it could become more difficult if past success leads to higher targets for future performance.

current patients select the hospital for follow-on services they may have previously sought at competing hospitals. Under a narrow network contract, the market share gain is the main benefit. Restrictions on the use of other hospitals or lower patient copayments may induce or persuade more patients to select the hospital.

When considering the impact of market share, it also is important to consider whether the organization will be in a preferred position relative to competitors, or whether competitors are pursuing the same strategy, thereby offsetting some of the desired market share gains.

After translating utilization changes and market share to volume and revenue, variable cost savings (or increases) associated with the estimated change in volume should be considered to estimate the impact on net income. In the sample analysis below, the combined impact of market share and utilization across the four sample contracts yields a roughly $600,000 negative impact on net income.

Impact of Operational Improvements

Operational improvements gained through these efforts also will affect a health system's bottom line, in part by adding value through efficiencies in length of stay, supply chain, and other areas. ACO and bundled payments initiatives also could help address readmissions and other value-based performance measures. Such results can improve hospital revenue in the Medicare Hospital Value-Based Purchasing (VBP) Program and the Hospital Readmissions Reduction Program—which currently can combine to change inpatient reimbursement by as much as 3 percent, although this figure will increase in future years.

MARKET SHARE AND UTILIZATION IMPACT

	Medicare ACO	Commercial ACO	Medicare Bundled Payments	Commercial Narrow Network	Total
Change in Revenue from Utilization	−$2,700,000	−$2,369,000	−$198,000	$0	−$5,267,000
Change in Revenue from Market Share	$1,800,000	$1,280,000	$220,000	$960,000	$4,260,000
Impact of Volume Changes on Revenue	**−$900,000**	**−$1,089,000**	**$22,000**	**$960,000**	**−$1,007,000**
Variable Cost Savings	$360,000	$436,000	−$9,000	−$384,000	$403,000
Impact of Volume Changes on Net Income	**−$540,000**	**−$653,000**	**$13,000**	**$576,000**	**−$604,000**

Because these two Medicare programs are mandatory, we have not included them in our sample analysis as potential contracts to assess. However, because they do reward performance, they do magnify the benefits of the overlapping improvement initiatives in the other contracts.

It can be difficult to estimate this impact, as hospital performance is ranked against the performance of other hospitals to determine the incentive. In the sample analysis in the exhibit below, the VBP and Readmission Reduction Program have a relatively small impact (calculated as less than a half percent of the hospital's Medicare inpatient revenue). The larger component of the $1 million positive impact from operational improvement comes from savings in operational costs, including reduced length of stay and supply chain, that can be achieved with closer alignment with physicians.

One might argue that these figures are speculative and should not be included. But failure to estimate this impact may significantly underestimate the value of some of the new revenue models to impact care delivery and payments. In addition, savings on hospital operating costs may carry over to patients not in the particular contracting arrangement, magnifying the positive results from these efforts.

Net Income at Risk from Competitor Actions

Just as new revenue models offer a health system opportunities to increase market share, competitors may use them for the same purpose. So the point of comparison should not be historical results, because maintaining historical volumes may not be achievable; instead, expected results should be compared with potential future effects of inaction in the face of competitor action.

If, by piloting new arrangements, building partnerships with physicians, and pursuing new opportunities, a health system's competitors are able to steer patients away from the system, they could win market share at the health system's expense. Physician entities also could disrupt the health system's market by competing to take a central role in managing population health, driving down hospital utilization and/or comparison shopping among hospitals.

To calculate net income at risk from competitor actions, the health system should estimate possible market share losses and utilization reductions from competitor strategies. In particular, this analysis also should consider the degree to which the health system's pursuit of particular contracts helps to offset its competitors' ability to enter the breach and undermine its position. In the sample analysis shown in the exhibit on page 6, the value and impact of this risk have been estimated to be significant, totaling $2 million. Given the high fixed-cost nature of health systems, any reduction from utilization management or shifted market share can have a significant impact on profits.

Combined Net Impact on a Health System's Bottom Line

The exhibit on page 7 summarizes the results from each of the four prior analyses.

The direct contract results, impact from volume changes, and impact from operational improvements

IMPACT OF OPERATIONAL IMPROVEMENTS

	Medicare ACO	Commercial ACO	Medicare Bundled Payments	Commercial Narrow Network	Total
Operational Cost Savings	$480,000	$200,000	$180,000	$0	$860,000
Impact on Medicare Value-Based Purchasing	$80,000	$20,000	$28,000	$0	$128,000
Impact on Medicare Readmissions Penalties	$40,000	$10,000	$6,000	$0	$56,000
Total Impact of Operational Improvements	**$600,000**	**$230,000**	**$214,000**	**$0**	**$1,044,000**

REVENUE AT RISK FROM COMPETITOR ACTIONS

	Medicare ACO	Commercial ACO	Medicare Bundled Payments	Commercial Narrow Network	Total
From Competitor Utilization Reduction Strategies	$540,000	$384,000	$72,000	$0	$996,000
From Competitor Market Share Strategies	$900,000	$640,000	$110,000	$688,000	$2,338,000
Total Revenue at Risk	**$1,440,000**	**$1,024,000**	**$182,000**	**$688,000**	**$3,334,000**
Variable Cost Savings	−$576,000	−$410,000	−$73,000	−$275,000	−$1,334,000
Net Income at Risk from Competitor Actions	**$864,000**	**$614,000**	**$109,000**	**$413,000**	**$2,000,000**

(described earlier) will sum to indicate the combined impact on the health system from any new revenue models that are implemented. In our example, the result of these new models is a loss of $300,000. If all of the contracts are pursued, the system must find those savings somewhere to offset that loss.

If a loss is expected (overall or on a specific contract), why does it make sense to pursue the strategy? The response to this question should consider another question: "Compared with what other strategy?" When a health system's history, or status quo, is used as the basis for comparison, pursuing the new revenue models does not seem preferable. But the future is likely to upset the status quo, and it is important to factor into the analysis the very real likelihood of competitor activity threatening market share losses and utilization reductions—as well as the potential for a $2 million positive impact from countering this activity. Taking into account such considerations, the overall net impact becomes significantly positive, suggesting that it is best to pursue the contracting strategy.

Other Strategic Benefits

Despite our best efforts to quantify all of the impacts of new revenue models, some are more difficult to quantify, but still should be considered.

Strengthening physicians' economic opportunity. Some incentives in new revenue models accrue to physicians. Improvements to physician income can help ensure an adequate supply of physicians in a community. Incentive payments also can offset losses for physicians employed by a health system. In addition, if a health system fails to provide these economic opportunities, physicians may work directly with health plans to secure them.

Driving quality improvement and maintaining reputation. Virtually all new revenue models include a significant quality measurement component. As the quality of outcomes become increasingly transparent, failure to address quality deficiencies could harm a health system's attractiveness to patients, physicians, and health plans.

For better or worse, payers and physicians often view these new revenue models as representing advancement and as an indicator that a health system is "cutting edge," particularly when the quality improvements are notable. And the public sometimes shares this perception.

Factors Determining the Pace of the Transition

Armed with the analytic framework described above, a health system can begin to decide at what pace it should move forward with new revenue models. The health system should consider a number of important factors that will determine the speed of transition and the particular arrangements that the organization undertakes, including the competitive landscape, payer readiness, physician interest, and organizational

Aligning with physicians is one of the main benefits of pursuing new revenue models. Most models include some form of waiver to allow for relationships that regulations would otherwise prohibit.

capabilities (taking into account, in particular, required lead time and short-term impact).

Competitor actions. A health system may be forced to take quicker action or lose market share if competing health systems are entering the new revenue models. Health systems also face the threat of physician entities disrupting the marketplace as they are pursuing care and cost management efforts. Physician-only ACOs, as well as patient-centered medical home (PCMH) contracts, are broadening the appeal for physicians to use their central role in care delivery to manage population health and steer patients to cooperative hospitals.

Payer interest. The capabilities and interests of payers in each local market will determine the availability of new revenue model opportunities. The major payers, including most Blues plans, are experimenting with some kind of new approach. Some are generous, and others are less so. Some focus on health systems, while others focus on physicians.

It is helpful to start with what payers want to pursue, as they have usually developed the IT and related capabilities to manage these initiatives. It can be risky to enter agreements that the payers are not capable of adequately administering. Payers also often want to demonstrate that providers have accepted their initiative. They therefore may be more likely to put additional funds on the table to avoid the embarrassment and waste of launching an initiative that providers reject.

It is usually easier to start many of these initiatives with HMO populations because of a clearer identification of the patient population being addressed. Over time, these initiatives can be expanded to include PPO populations for which responsibility for the member would be attributed based on historical utilization.

Physician interest. Aligning with physicians is one of the main benefits of pursuing new revenue models. Most models include some form of waiver to allow for relationships that regulations would otherwise prohibit. However, physicians are often skeptical of new revenue models and distrustful of hospitals. At the same time, they usually lack the time to investigate these options on their own. Hospitals must pursue a careful balance of engaging, educating, and crafting

SUMMARY: COMBINED IMPACT

	Medicare ACO	Commercial ACO	Medicare Bundled Payments	Commercial Narrow Network	Total
Direct Contract Results for Health System	$150,000	$120,000	−$160,000	−$850,000	−$740,000
Impact of Volume Changes on Net Income	−$540,000	−$653,000	$13,000	$576,000	−$604,000
Total Impact of Operational Improvements	$600,000	$230,000	$214,000	$0	$1,044,000
Combined Net Impact on Health System Bottom Line	**$210,000**	**−$303,000**	**$67,000**	**−$274,000**	**−$300,000**
Net Income at Risk from Competitor Actions	$864,000	$614,000	$109,000	$413,000	$2,000,000
Net Impact Compared with Risk from Competitor Actions	**$1,074,000**	**$311,000**	**$176,000**	**$139,000**	**$1,700,000**

opportunities together with their physicians to build trust and interest.

It is easiest to work first with physicians employed by the hospital. However, the greatest benefits come from engaging independent physicians and aligning interests with them. Care should be taken to avoid alienating independent physicians by assuming they are not interested, or by pushing them too hard to participate if they are not ready.

Lead time. Developing familiarity and expertise in new revenue models does not occur overnight. New decision support tools will be needed to feed key data into the type of net impact analysis included above and to track results. Such tools ideally will allow a health system to compare contract results and evaluate future contract options. Even if the finance suite has such experience, physicians and key hospital departments will require time to gain expertise and skill, particularly in light of the actuarial skills and physician leadership that will be needed.

Short-term impact. Organizations should balance the short-term revenue impact with the benefits of a strong vision and drive that acknowledges the strategic and intrinsic value of these efforts. Finance leaders should consider how ready and willing their organizations are to handle potential short-term negative variances in revenue and volume, and what proportion of revenue should be shifted to the new payment models initially. In addition to addressing these difficult questions, these leaders should identify and consider the factors influencing how much revenue will be affected and be ready to manage the impact.

A Winning Strategy

As they make the transition to new payment models, organizations also should continue to assess their capabilities and develop competencies to manage care and cost. High costs (both unit costs and population health costs) will lead to vulnerabilities in market share and position. Engaging physicians in addressing and managing operating costs will help to decrease hospital unit costs. Other physician alignment efforts will provide opportunities to better manage population health.

Finance leaders should understand that the short-term impact of these new revenue models will most likely be negative, and they may prove difficult to defend as all payments are being squeezed and financial results are likely to be less positive in the coming years. However, the tendency to compare current circumstances with historical figures, while natural, is flawed when market share and competitive position are at stake.

Finance leaders should assess what opportunities are appropriate for the organization, budgeting conservatively while innovating boldly, recognizing that future market success may depend on new revenue models. Organizations that thoughtfully engage in and prepare for the transition from volume-based to value-based payments will be well positioned for the future and the challenges of the changing healthcare market. ●

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