

Capital Planning for Emerging Revenue Models

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New value-based payment models, including bundled payments and shared savings ACOs, will affect hospital and health system operating revenues and earnings (see “The Transition to Emerging Revenue Models,” hfm, April 2013). They will also create new demands for capital. It’s not about bricks and mortar; it is all about infrastructure requirements, working capital and reserves.



Infrastructure requirements. New value-based revenue models require investment in infrastructure and new capabilities. The infrastructure dollars will go primarily to IT, to help aggregate disparate data, track quality measures, and support care management. Staff will need to develop care management programs and initiatives before contracts actually begin. These start-up activities require capital investment with no offsetting revenues. Required investments can be in the millions of dollars, depending on the scope, approach, and what capabilities an organization already has in place.

Working capital for cash flow. New revenue models may increase accounts receivable. Shared savings models, for example, are typically reconciled annually. Unfortunately, the reconciliation cannot occur until several months after the end of the performance year because of the “claims lag” – the need to wait until claims from the end of the period have been paid. Any shared savings incentives won’t be paid for 6 to 18 months after the service was provided.

A successful Medicare accountable care organization (ACO) may be waiting for several million dollars of expected shared savings. Meanwhile, it likely will have incurred significant operating expenses that need to be paid as they are incurred. The ACO also will have reduced hospital utilization, and the impact of lost admissions on the hospital will be felt long before the reconciliation results in shared savings. It will be essential to have working capital available to cover the gap while waiting for reconciliation.

Reserves to cover potential losses. When a new revenue model includes downside risk, providers will need to set aside reserves, reinsure, or otherwise protect against losses.

Downside risk will affect providers in the Medicare Bundled Payment for Care Improvement initiative from the outset, and accepting downside risk will also be mandatory for Medicare ACOs after three years of an upside only option. As providers pursue more arrangements with greater risk and reward, capital requirements will increase.

Adding capital requirements to concerns about the profitability of new revenue models may dampen your enthusiasm about these models. However, if you don't pursue one or more of these models, you may be risking painful market share losses. If you initiate these models at a later point, you may be playing catch-up with organizations that now have well-developed risk management capabilities. Steering the right course will require a thorough understanding of your market, your organization's capabilities, and your ability to generate the capital required. ●

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