



HFMA'S EXECUTIVE SURVEY:

# Value-Based Payment Readiness

Sponsored by Humana

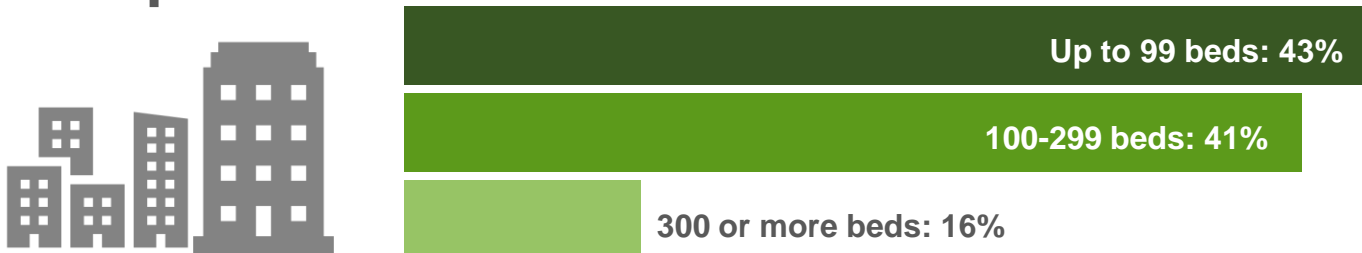
# Respondent Demographics

HFMA researchers surveyed 117 senior financial executives

## Respondents



## Hospitals



# Summary

- ✔ HFMA researchers surveyed 117 senior financial executives about their organization's value-based payment readiness in September 2017.
- ✔ The roll-out of commercial value-based programs may be somewhat slower than expected, although they have doubled in presence since 2015.
- ✔ External and internal interoperability may be a primary focus of providers in the coming years due to current shortcomings, anticipated future need, and the increasing demand for access to various sources of data.

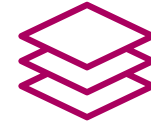
# Overview



1.  
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2.  
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IN READINESS**



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5.  
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AND SOLUTIONS**

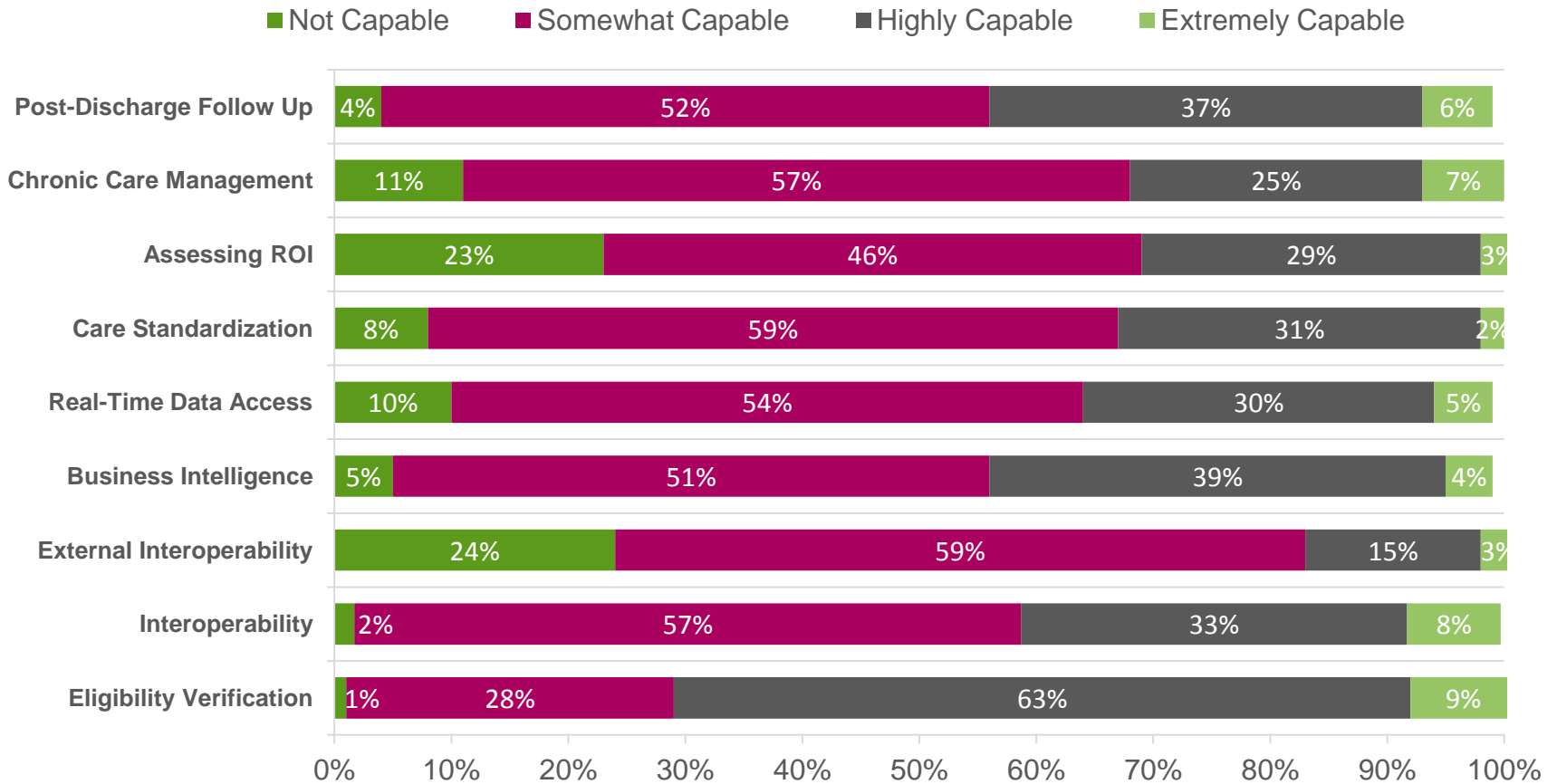
# Current State

- ✔ Financial executives generally do not view their organizations as highly capable in most areas that support value-based payment.
- ✔ External interoperability (the ability to aggregate clinical information across networks with payers and health plans) is the area where they are least likely to report feeling highly or extremely capable.
- ✔ Eligibility verification (the ability to easily verify patient eligibility) is the only area in which they rate themselves as highly or extremely capable more than 50 percent of the time.



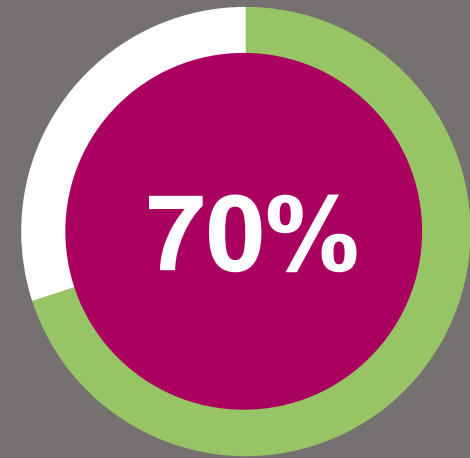
# Current State

## CAPABILITY TODAY



# Projected Needs

- ✓ Financial executives anticipate in three years that their organizations will need to be extremely capable in most of the areas that support value-based payment.
- ✓ More than 70 percent anticipate an extremely important need for capabilities around interoperability, and 50 percent around external interoperability.



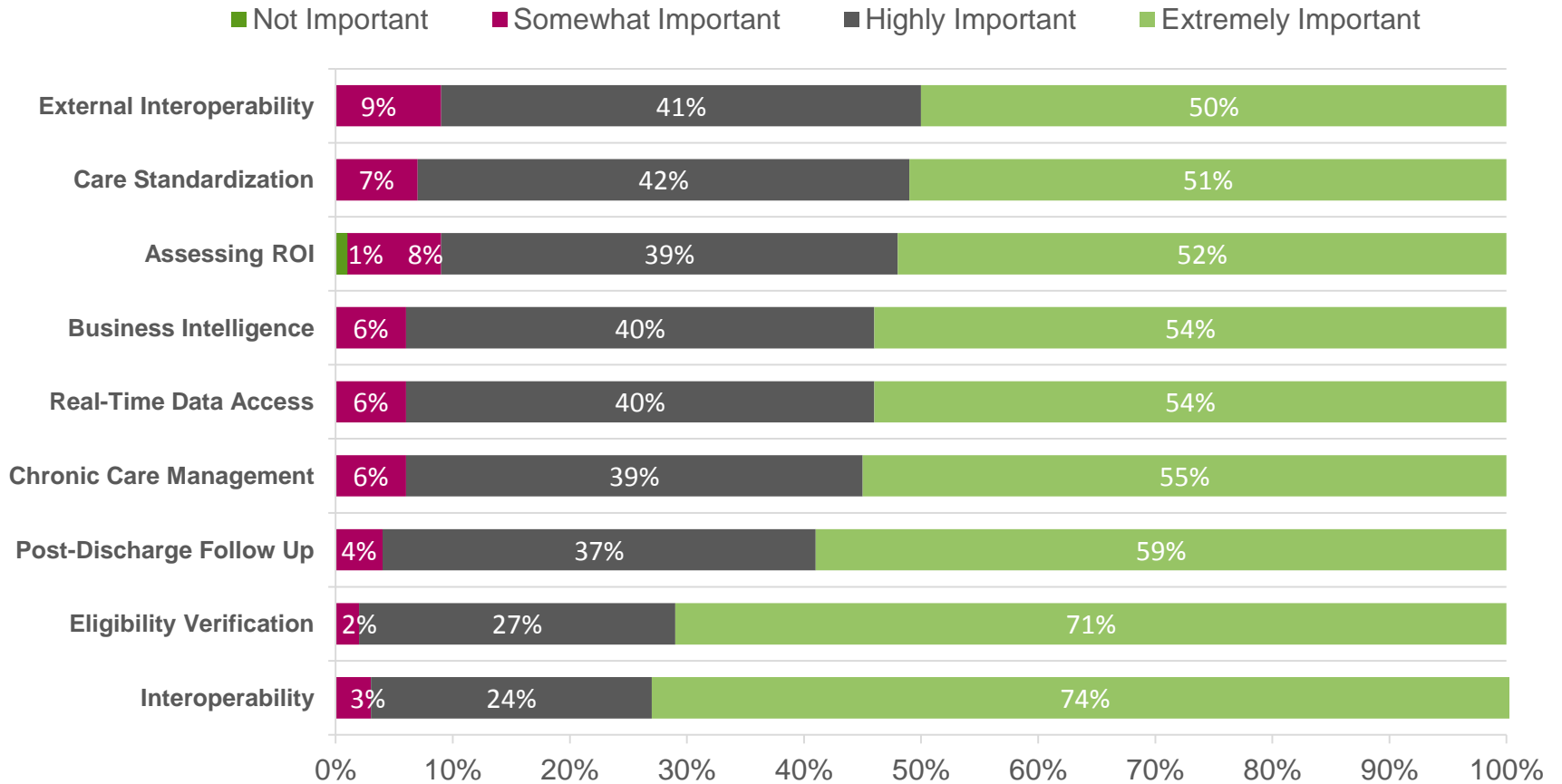
More than 70 percent anticipate an extremely important need for capabilities around interoperability



50 percent indicated a need for external interoperability

# Projected Needs

## IMPORTANCE IN 3 YEARS





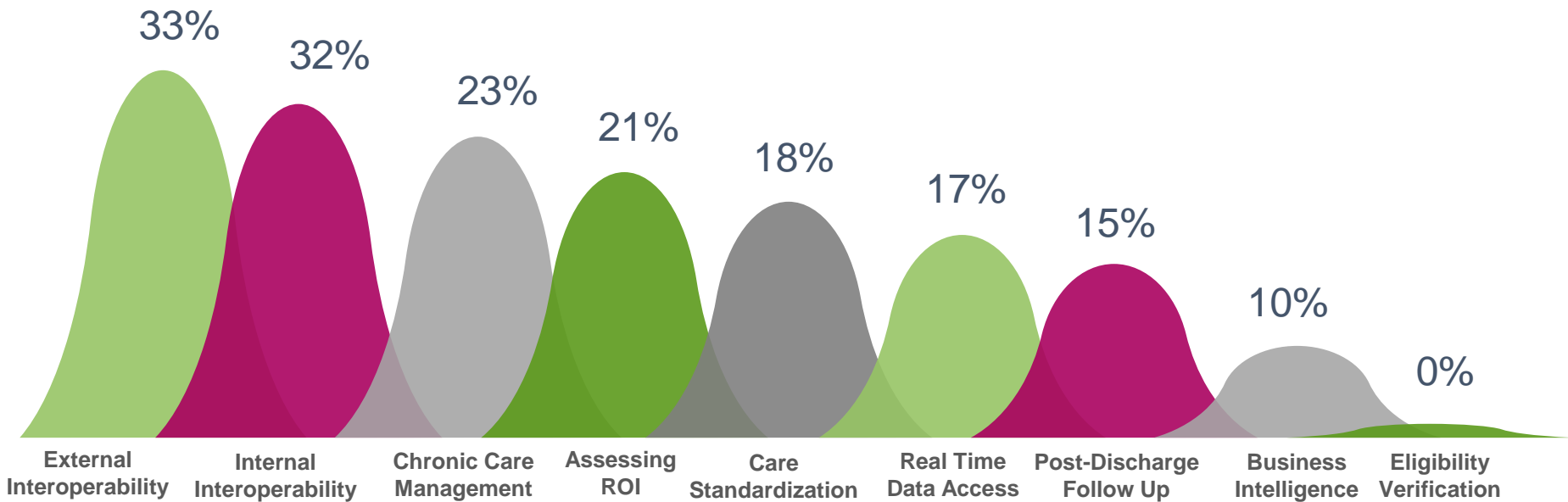
# Anticipated Gaps in Readiness

- ✔ Researchers define a “readiness gap” as the percentage viewing an area as “extremely important” in three years, less the percentage viewing their organization as likely to be “highly capable” or “extremely capable” in the area.
- ✔ Readiness gaps are dominated by internal interoperability and external interoperability, followed by chronic care management and assessing ROI.
- ✔ Anecdotally, there is some slight evidence that problems with interoperability are anticipated to be the most problematic.



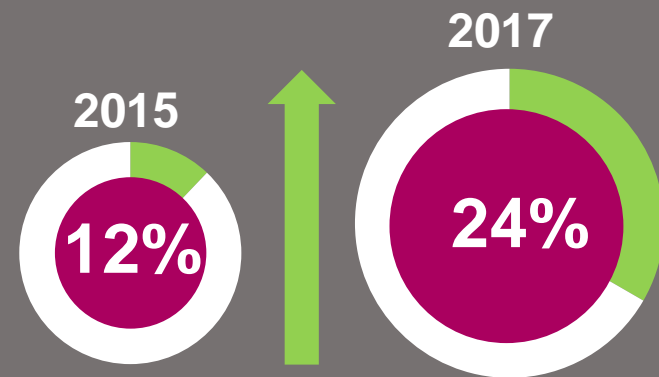
# Anticipated Gaps in Readiness

Percentage viewing an area as “Extremely Important” in three years less percentage viewing their organization as likely to be “Highly Capable” or “Extremely Capable” in the area.



# Penetration of Value-Based Payments

- ✓ Since 2015, commercial payers using value-based mechanisms have risen from 12 percent to 24 percent.
- ✓ This pace of change is probably somewhat slower than was anticipated in 2015, when commercial payers using value-based mechanisms were projected to be 50 percent in 2018.



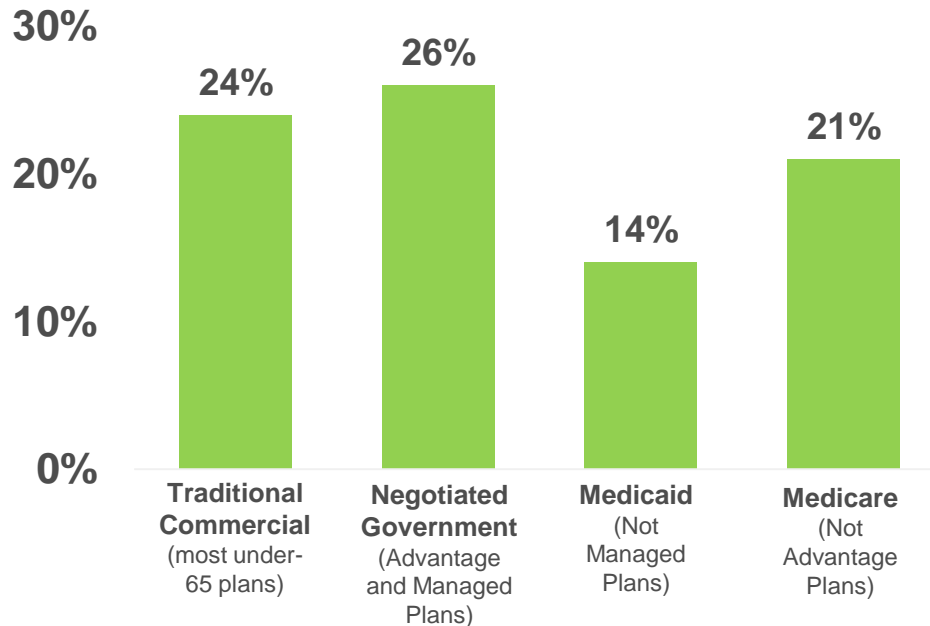
Value-based mechanisms rose from 12 percent to 24 percent since 2015



50 percent projection for 2018

# Penetration of Value-Based Payments

*Please indicate the overall percentage of your payments from the following health plans that incorporate value-based mechanisms today.*



N=47

Note: Question displayed to respondents reporting commercial payments incorporating value-based mechanisms today.



# Penetration of Value-based Payments

Of those providers receiving some form of risk-based compensation from commercial payers, more than 80 percent are compensated using either:

✔ Bonus-only (upside-only plans that reward you for meeting certain quality standards, but do not negatively influence normal reimbursement)

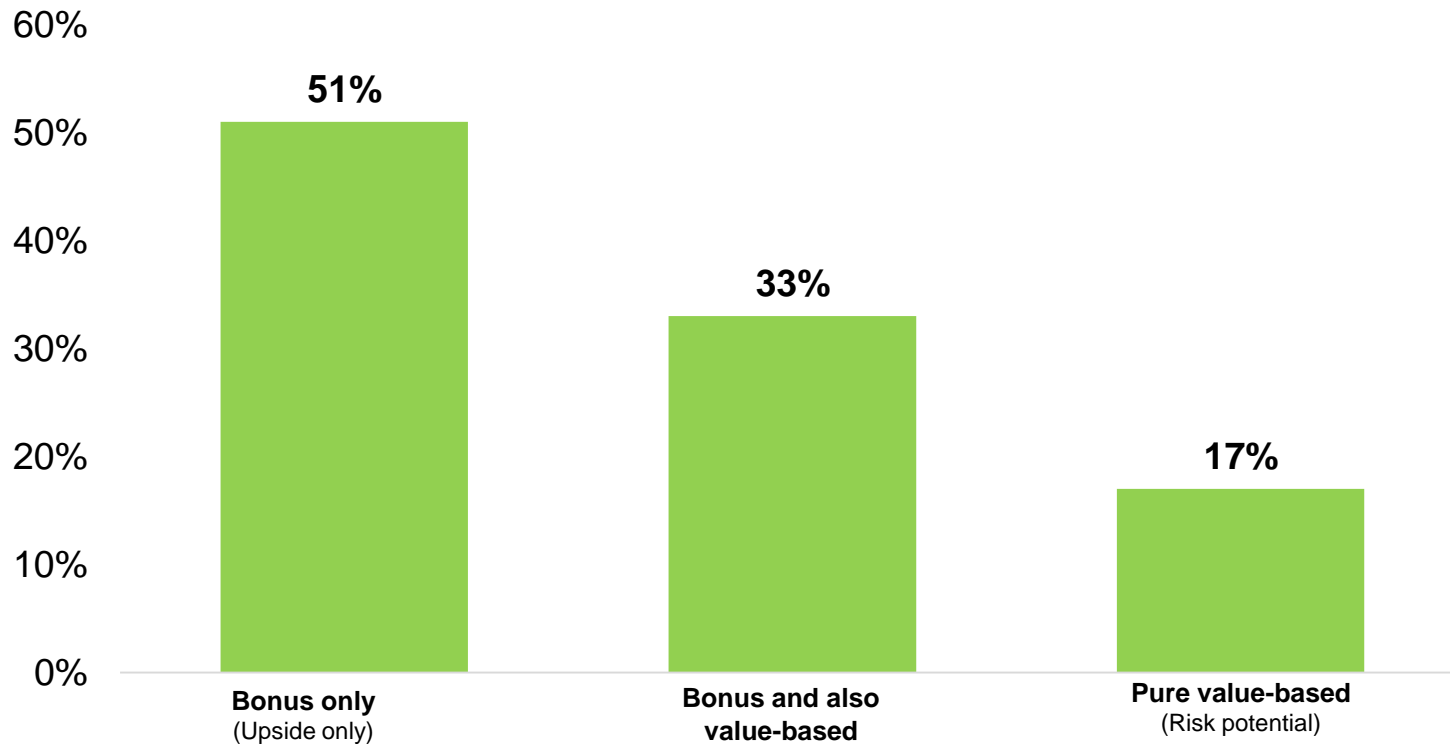
or

✔ A combination of bonus and value-based (reimbursement exclusively based upon value-based reimbursement standards and practices, with exposure to upside potential and downside risk)



# Penetration of Value-Based Payments

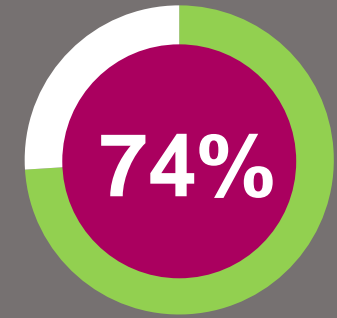
*Which of the following types of value-based mechanisms apply to payments to you by commercial health plans?*



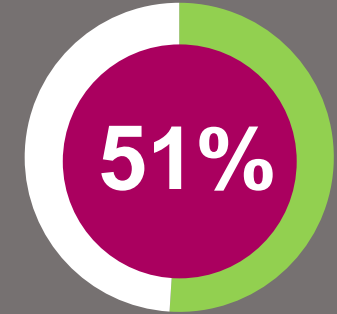
Note: Question displayed to respondents reporting commercial payments incorporating value-based mechanisms today.

# Financial Impact

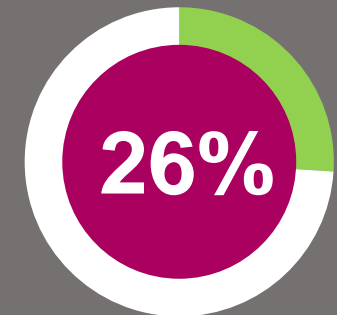
- ✔ Almost three-quarters of executives (74 percent) report their organizations have achieved positive financial results from value-based payment programs to date.
- ✔ This is notably higher than half (51 percent) of executives reporting positive financial results in 2015.
- ✔ Twenty-six percent of executives currently report unfavorable financial results for value-based payment programs.



Positive financial results to date



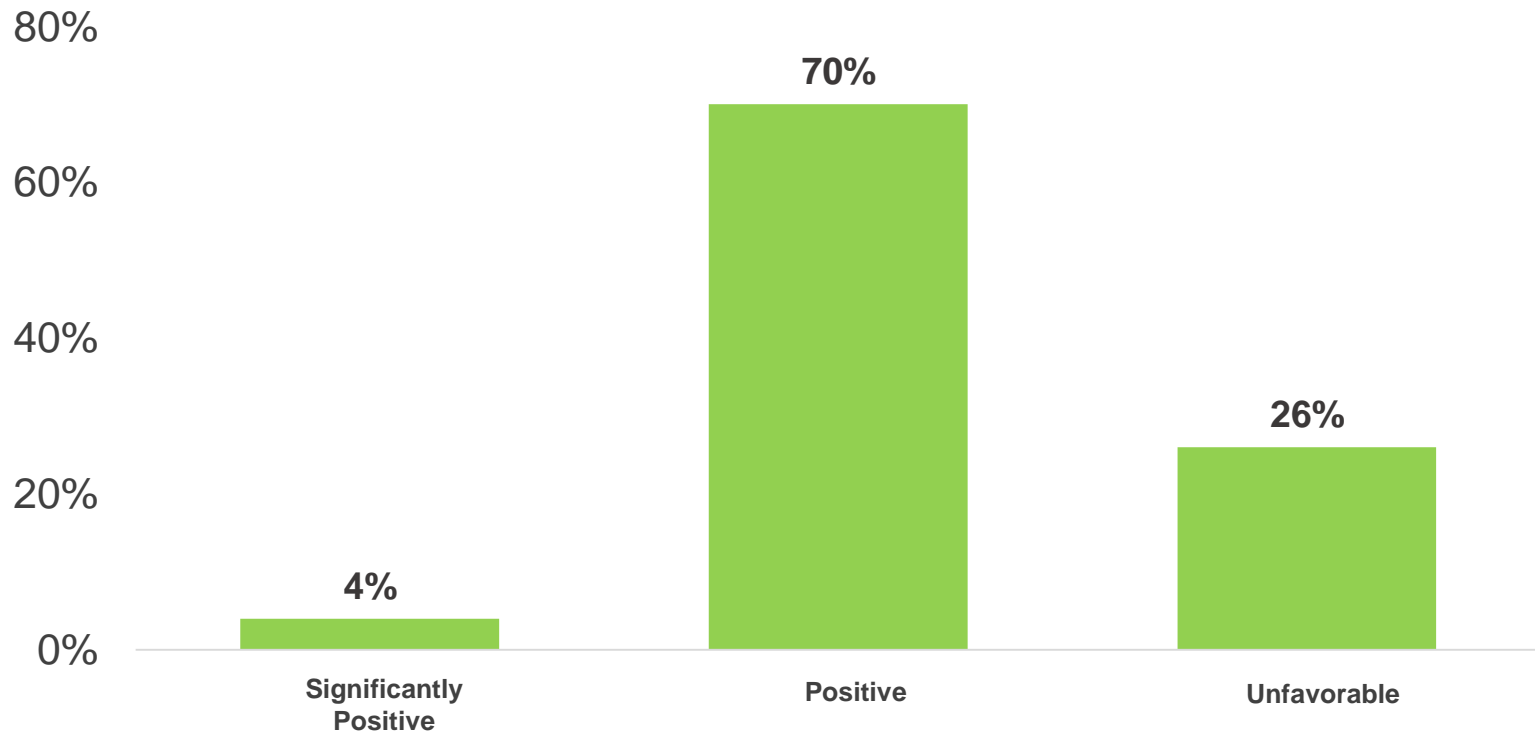
Positive financial results in 2015



Unfavorable financial results

# Financial Impact

*To what extent has your organization achieved favorable financial results for value-based payment programs?*

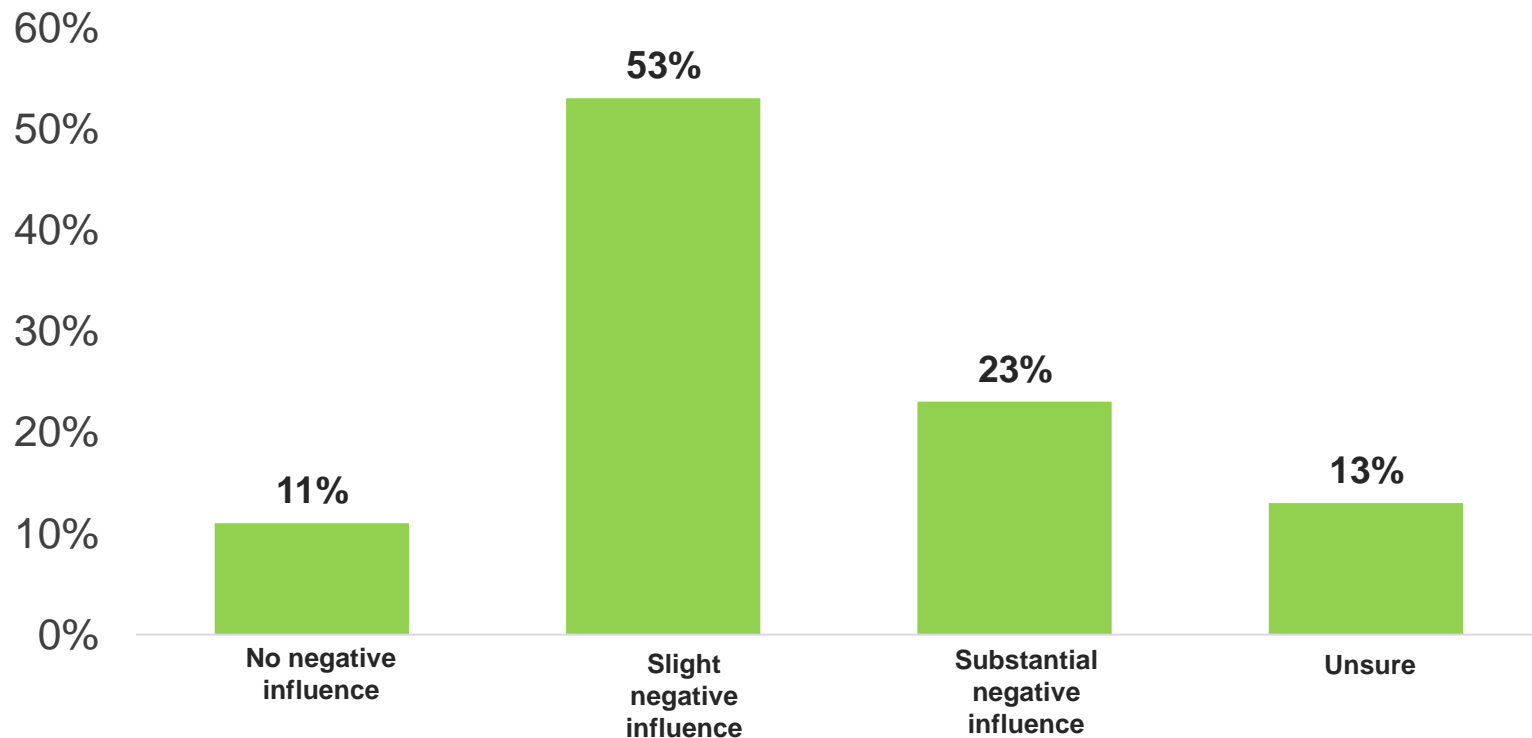


Note: Question displayed to respondents reporting commercial payments incorporating value-based mechanisms today.



# Financial Impact

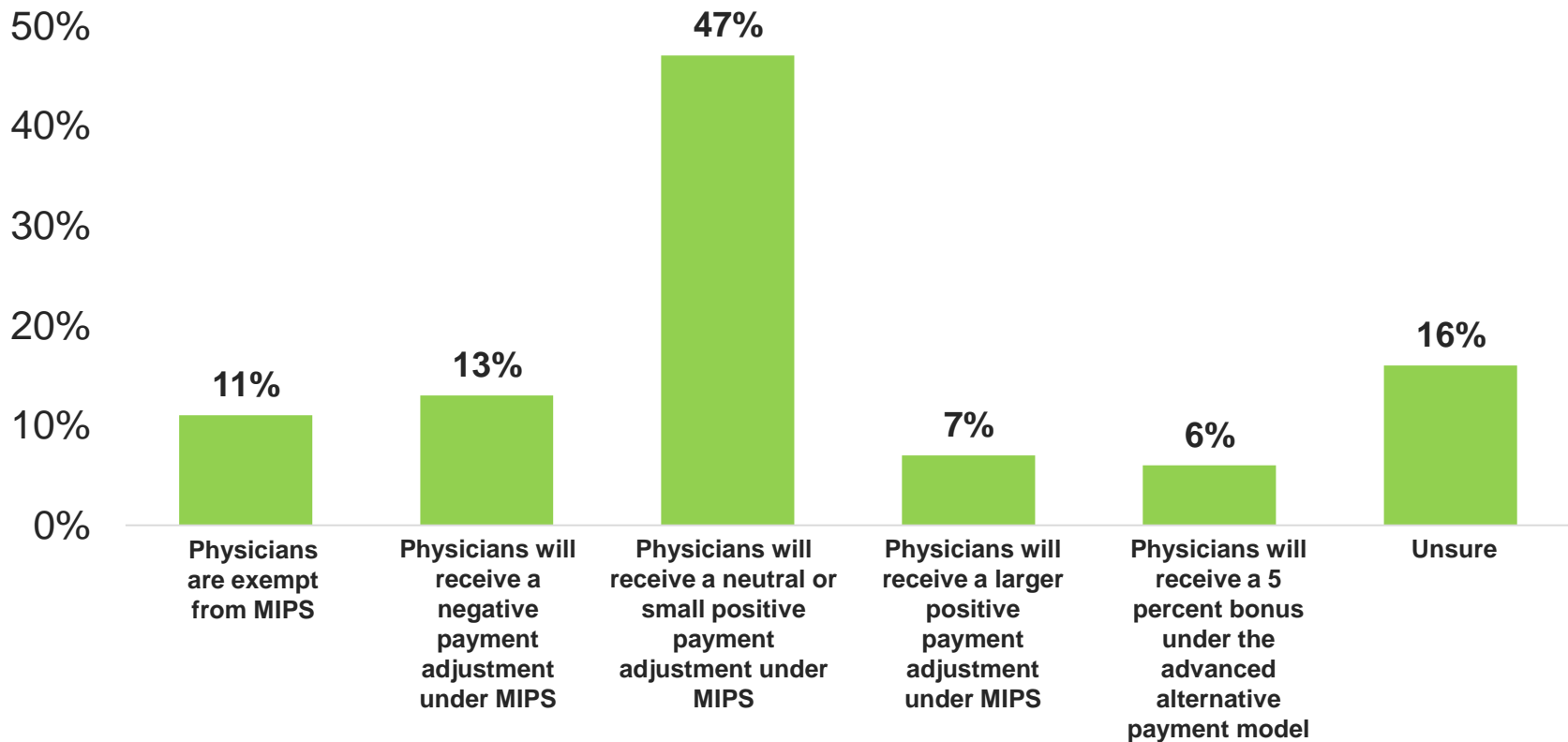
*To what degree is regulatory uncertainty, such as MACRA, negatively influencing your ability to forecast?*



Note: Question displayed to respondents reporting commercial payments incorporating value-based mechanisms today.

# Financial Impact

*How do you anticipate the majority of physicians in your organization will perform under MACRA in the 2019 payment year?*



Note: Question displayed to respondents reporting commercial payments incorporating value-based mechanisms today.

# Financial Impact

*Does your organization incentivize physicians (in addition to annual salary) based on quality outcomes and/or performance with patients?*

59%  
YES



41%  
NO

# Challenges and Solutions

The most significant challenges related to value-based payments:

- ✔ Poor data access and the inability to collect and manage data.
- ✔ Inconsistencies between payers (measures, admin, contracts).
- ✔ Lack of physician alignment, support, and buy-in.
- ✔ Lack of resources (personnel and financial—small hospitals mainly).
- ✔ Inability to project costs, lost revenue, and/or risk.

# Challenges and Solutions

## How health plans/payers can facilitate value-based payment:

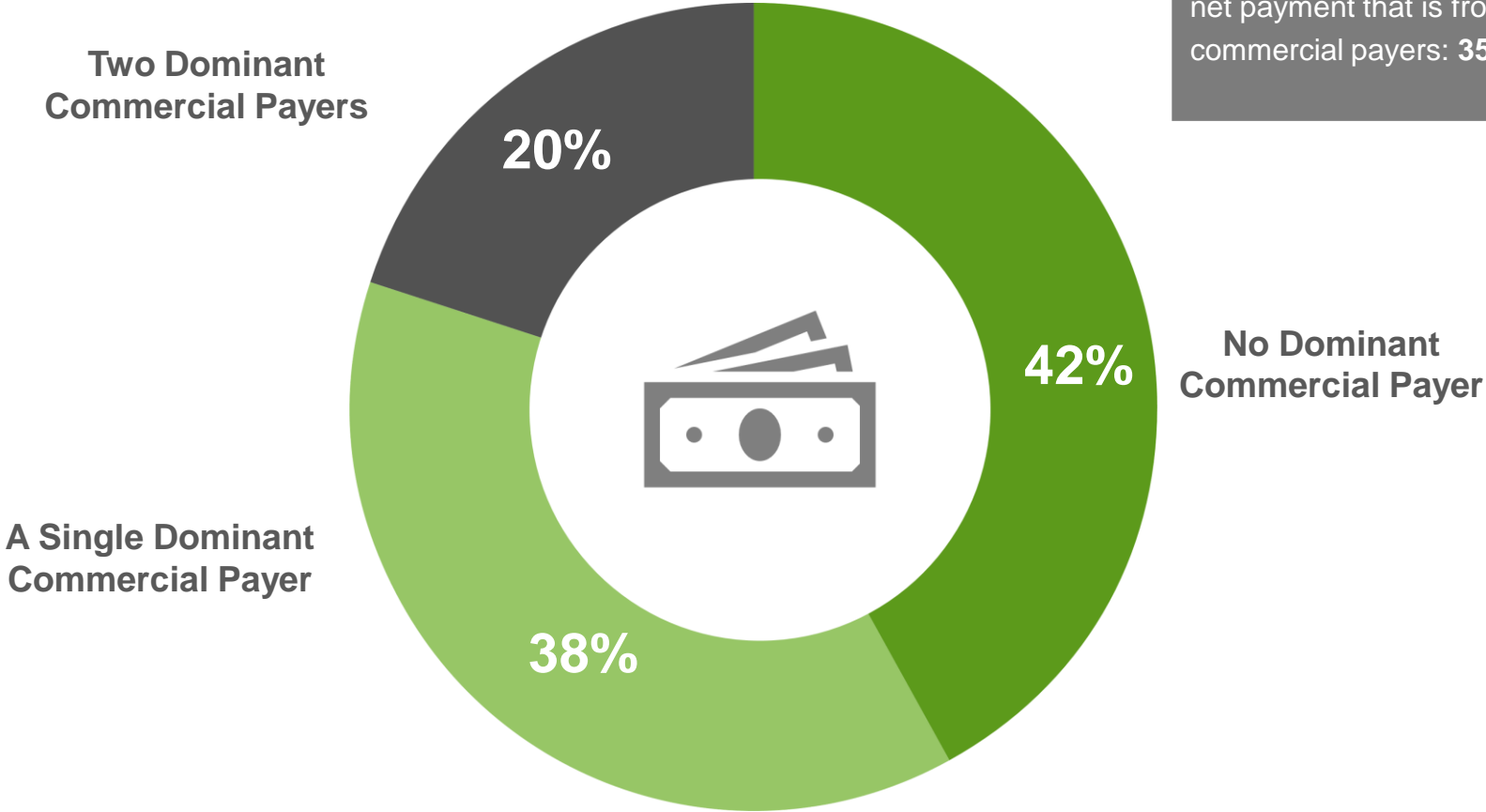
- Provide smarter incentives, aligned with provider needs and care objectives.
- Share their data with providers.
- Be more transparent; act as a partner.
- Standardize programs, measures, processes.

## Research note:

There is a simultaneous call for standardization between payer plans and programs, and individualization between providers according to size, type, and needs.

# Challenges and Solutions: Additional Analysis

Percentage of organizations' net payment that is from commercial payers: **35 percent**



# Challenges and Solutions: Additional Analysis

*Does your organization consider social determinants (e.g., food insecurity) in the overall strategy and cost planning?*

**37%**  
**YES**



**63%**  
**NO**

# Challenges and Solutions- Additional Analysis

*Does your organization have tools/technology to assist in specialty and/or inpatient care to help control/manage costs?*

65%  
YES



35%  
NO



# Larger Hospitals: Additional Analysis

Larger hospitals are statistically more likely to:

- ✓ Have greater capability with business intelligence.
- ✓ Have greater capability with assessing ROI.
- ✓ Foresee greater importance of business intelligence in three years.
- ✓ Have better tools and technology to assist in specialty and/or inpatient care to help control/manage costs.
- ✓ Are more likely to incentivize physicians (in addition to annual salary) based on quality outcomes and/or performance with patients.
- ✓ Have a higher percentage of net payments from commercial payers.



## Survey Procedures

- ✔ Survey participants were selected randomly from among HFMA members who are financial executives in hospitals and health systems.
- ✔ Findings are based on 117 responses received in September 2017.
- ✔ Survey instrument designed jointly by HFMA and Humana staff.

# Definitions

**Assessing ROI:** Ability to monitor value-based contracting revenue opportunities versus cost of implementation.

**Bonus-only:** Upside-only plans that reward providers for meeting certain quality standards, but do not negatively influence normal reimbursement.

**Business Intelligence:** Ability to collect, analyze, and model data.

**Care standardization:** Infrastructure to use data to standardize care processes.

**Chronic care management:** Systems and processes to support ongoing management of patients with high-volume, high-cost chronic diseases.

**Eligibility verification:** Ability to easily verify patient eligibility.

**External Interoperability:** Ability to aggregate clinical information across networks with payers and health plans.

**Interoperability:** Ability to aggregate clinical information across networks and between hospitals and physician practices.

**Post-discharge follow-up:** Systems in place to follow up with and support patients post-discharge (home health, patient follow-up).

**Pure value-based:** Reimbursement exclusively based upon value-based reimbursement standards and practices, with exposure to upside potential and downside risk.

**Real-time data access:** Ability to provide meaningful data to care providers at the point of service.