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INTRODUCTION

As health care reform gains momentum, the industry shift toward value-based payment models is accelerating. These emerging models compensate physicians based on patient care and outcomes rather than services rendered, putting the focus on quality over volume. As we learned in Availity’s latest research study, *Health Plan Readiness to Operationalize Value-Based Payment Models*, health plans expect the tipping point for these models will be reached in the next five years—when 50 percent or more of their business has transitioned from traditional fee-for-service arrangements to value-based compensation.

Additionally, health plans resoundingly agree that they need different kinds of information from providers in order to process and pay claims under value-based models. The information being exchanged under traditional fee-for-service models will not suffice. They also report that the most efficient way to exchange this information is in real-time.

So where do the providers stand in this evolution? How would they characterize their readiness to participate in these models? To achieve success in the migration to these new models requires readiness by both health plan *and* provider. Further, where is the provider community going for guidance to ensure they can support these new models without disruption to their daily workflows and cash flow?

This study highlights the provider’s perspective on value-based payment models. Through research, Availity has gained critical insight into the importance of these emerging models to physician practices and hospitals, their expectations for transitioning to them in the next three years, and how well-prepared they are to support the evolving information requirements foundational to these models.

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DEFINITIONS

For the purpose of this study, Availity uses the following definitions:

**Automation**
As it pertains to the exchange of information between providers and health plans, automation means the ability to send and receive information electronically using a computer and software or the Internet.

**Provider**
Unless noted otherwise, the term ‘provider’ refers to both physician practices and hospitals.

**Real-time**
In terms of automated information exchange, real-time means the ability to send information immediately from one computer system to another. The submission takes mere seconds and the information is processed instantly by the receiving system.

**Value-based payment model**
Payment arrangements that reward physicians, hospitals, medical groups, and other health care providers based on measures including quality, efficiency, and positive patient experience.

Examples referenced in this study include:
- Accountable Care Organization
- Patient-Centered Medical Home
- Payment for Coordination
- Pay for Performance
- Bundled Payment
KEY FINDINGS

Payment reform and reimbursement is top of mind.
- Payment reform was rated 8.37 on a scale of 10 in terms of importance to providers.
- Payment reform and reimbursement were noted in the top five business priorities among physician practices and hospitals.
- Clinical quality and cost reduction took the top two spots in terms of overall importance.

Limited revenue expected from value-based payments over the next year, but a significant shift is expected.
- In three years, 78% of physician practices predict the revenue they receive from value-based models will be between 15 and 50%.
- In three years, 52% of hospitals expect 25-50% of their revenue from value-based programs, with 36% anticipating 51-100% of their revenue from these models.
- Nearly 70% of all respondents expect to support three or more different value-based models in the next three years.

Pay-for-Performance is the most broadly-implemented value-based model.
- Nearly 80% of respondents have implemented, or are planning to implement, a pay-for-performance model.
- Three other models show strong acceptance and support, with providers having implemented or planning to implement:
  - Patient-centered medical home—56%
  - Payment for coordination—48%
  - Accountable care organization—46%
KEY FINDINGS

Information exchange considered very important to program success.

• More than 90% of providers surveyed believe that automating the information exchange between providers and health plans is critical to value-based payment success.
• 67% of providers are focused on increased automation in the next 12-18 months.
• 99% of providers agree that different types of information will need to be exchanged between providers and health plans in support of value-based payment models.

Providers seek guidance from multiple sources.

• About 63% of physician practices are relying on their practice management system vendors. 44% look to professional associations for guidance.
• 60% of hospitals are working with health care analytic companies. 48% engage industry consultants.
• Only 33% report being highly confident in their clearinghouse’s ability to support value-based information exchange.

Largest provider organizations engaged in conversations with health plans.

• 80% of hospitals with more than 1,000 beds and 60% of practices with more than 100 physicians report they are in discussions with health plans regarding the information they need to share under value-based payment arrangements.
• 23% of hospitals with 401 – 1,000 beds* and 27% of practices with 11-99 physicians are having conversations with health plans.
• 40% of hospitals with 1-400 beds and zero percent of practices with 1-10 physicians are having conversations with health plans.

*40% were unsure
SURVEY RESULTS

01 Business Priorities & Revenue Outlook
02 Information Needs & Preparedness
03 Current Scope of Value-Based Payment Models
Payment Reform a “Top Three” Focus
Improving clinical quality and safety is the number one priority among providers. Complementing this top focus are equally strong commitments to reducing the cost of care delivery and underscoring the emphasis on quality by shifting to value-based forms of reimbursement.

When considering how to enable value-based payment models within their organizations, providers give high importance to systems integration and applications that allow stakeholders to access needed patient information.

Figure 1.1
Business initiatives
Over the next 12 to 18 months, what would you identify as your organization’s TOP 5 business initiatives?

Figure 1.2
Priority ratings
Using a scale from 0-10, where zero equals NOT A PRIORITY AT ALL and 10 equals a MAJOR PRIORITY, please rate the level of priority that each of the following will have on your organization over the next 12 to 18 months.

1 Clinical quality, safety
2 Cost reduction, process improvement
3 Patient experience
4 Payment reform, reimbursement (value based payment models, accountable care)
5 Technology (EMR, clinical technology)
Revenue from Value-Based Models Expected to Triple by 2016

While value-based payment models represent a small amount of provider revenue today, physicians and hospitals expect that figure to triple over the next three years, to around 38%. While hospitals expect more of their revenue will come from value-based programs on a faster timeline than physician practices, both clearly anticipate growth.

Similarly, both hospitals and physician practices also expect the number of value-based arrangements they support to grow, with 33% reporting they expect to participate in five or more models in the next three years.

Figure 1.4
Revenue expectations
How quickly do you expect emerging health plan models (value-based payment models) to have an impact on your revenue?

In X months, I’d expect Y% of our revenue to come from value-based payment models:
Figure 1.5
Number of value-based payment models
How many emerging health plan payment arrangements (value-based payment models) do you expect to support?

01 BUSINESS PRIORITIES & REVENUE OUTLOOK
Value-Based Models Require New Types of Information

More than 90% of providers surveyed agree that they will need to exchange different kinds of information under value-based models, as compared to traditional fee-for-service arrangements. More than 90% also agree that the information exchanged with health plans and other providers needs to be automated to achieve the highest value.

Figure 2.1
New information types, provider to provider
The emerging value-based payment models will require different types of information to be exchanged between my practice and other health care providers.

Overall

- 37% Strongly agree
- 62% Agree
- 0% Neutral
- 2% Disagree
- 0% Strongly disagree

Professional

- 67% 37%
- 29% 62%

Facility

- 56% 0%
- 44% 2%

Figure 2.2
New information types, provider to health plan
The emerging value-based payment models will require different types of information to be exchanged between my practice and health plans.

Overall

- 33% Strongly agree
- 60% Agree
- 6% Neutral
- 0% Disagree
- 2% Strongly disagree

Professional

- 69% 33%
- 6% 3%

Facility

- 56% 32%
- 32% 12%
02  INFORMATION NEEDS & PREPAREDNESS

Figure 2.3
Need for automation, provider to provider
Automating the information exchange/sharing between my practice and other health care providers is critical to cost effective program operations and to successfully achieving program objectives.

Figure 2.4
Need for automation, provider to health plan
Automating the information exchange/sharing between my practice and health plans is critical to cost effective program operations and to successfully achieving program objectives.
02 INFORMATION NEEDS & PREPAREDNESS

Figure 2.5
Importance of real-time, provider to provider
Enabling real-time information exchange/sharing between my practice and other health care providers will provide the highest value relative to program operations and objectives.

Overall

- 42% Strongly agree
- 44% Agree
- 10% Neutral
- 4% Disagree
- 0% Strongly disagree

Professional

- 35% Strongly agree
- 18% Agree
- 11% Neutral
- 4% Disagree
- 2% Strongly disagree

Facility

- 36% Strongly agree
- 18% Agree
- 6% Neutral
- 4% Disagree
- 2% Strongly disagree

Figure 2.6
Importance of real-time, provider to health plan
Enabling real-time information exchange/sharing between my practice and health plans will provide the highest value relative to program operations and objectives.

Overall

- 33% Strongly agree
- 60% Agree
- 6% Neutral
- 4% Disagree
- 2% Strongly disagree

Professional

- 26% Strongly agree
- 48% Agree
- 12% Neutral
- 4% Disagree
- 28% Strongly disagree

Facility

- 28% Strongly agree
- 56% Agree
- 12% Neutral
- 4% Disagree
- 4% Strongly disagree
02 INFORMATION NEEDS & PREPAREDNESS

Majority of Providers Plan to Increase Automated Information Sharing by End of 2014
While more than 70% of providers surveyed use a combination of manual and automated processes for sharing information with health plans and other providers today, 67% report plans to increase their levels of automated sharing in the next 12-18 months.

Figure 2.7
Process for information exchange: manual vs. automated
Which of the following best describes the processes being utilized within your practice to enable information exchange related to emerging health plan payment models (value-based payment models)?

Overall
19% Fully automated
8% Fully manual
71% Both automated and manual
2% Don’t know

Figure 2.8
Automation plans for information exchange
Does your practice have plans to automate the exchange of information needed for emerging health plan payment models (value-based payment models) within the next 12-18 months?

Overall
67% Yes
10% No
23% Unsure

Professional
70% Yes
15% No
15% Unsure

Facility
64% Yes
15% No
20% Unsure

02 INFORMATION NEEDS & PREPAREDNESS

Providers Engaging Multiple Sources for Value-Based Program Guidance

Hospitals are seeking guidance from health care analytic companies (60%) and industry consultants (48%) regarding information exchange needs for value-based payment models. In comparison, physician practices are looking to their practice management system vendors (63%) and professional associations (44%) for direction.

Only 33% were very satisfied that their clearinghouse vendor could support the exchange of information needed for value-based models to work.

Figure 2.9
Third party guidance
What types of partners/third party solution vendors are you working with—health care analytic companies or practice management system vendors

Figure 2.10
Health plan conversations
Is your organization currently in discussions/talks with any health plans about the exchange of information needed for emerging health plan payment models (value-based payment models)?

Overall
- 37% Yes
- 46% No
- 17% Unsure

Professional
- 63% No
- 28% Yes
- 5% Unsure

Facility
- 40% Yes
- 28% No
- 5% Unsure

Overall
- 28% Practice management system vendors
- 28% Health care analytics companies
- 23% Industry organizations or professional societies
- 18% Industry consultants
- 4% Other

Professional
- 40% Practice management system vendors
- 40% Health care analytics companies
- 15% Industry organizations or professional societies
- 17% Industry consultants
- 3% Other

Facility
- 37% Practice management system vendors
- 37% Health care analytics companies
- 15% Industry organizations or professional societies
- 17% Industry consultants
- 13% Other
Figure 2.11
Clearinghouse satisfaction
Using a scale from 0 to 10, where 0 = not satisfied and 10 = extremely satisfied, please rate your satisfaction with how prepared your clearinghouse is to deliver the solutions required to enable the information exchange/sharing needed to support your value-based payment programs.

Overall

![Overall satisfaction chart]

Professional

![Professional satisfaction chart]

Facility

![Facility satisfaction chart]
CURRENT SCOPE OF VALUE-BASED PAYMENT MODELS

While aggregate figures are represented here, it is important to note that the largest physician practices and hospitals report the highest propensity to implement each of the value-based models represented below. The general trend revealed the smaller the organization, the lower their expectation for participating in such models in the next few years.

Figure 3.1
ACO shared savings program
Groups of providers, known as accountable care organizations, which voluntarily assume responsibility for the care of a population of patients and share payer savings if they meet quality and cost performance benchmarks.

Implementation Plans
Overall
- 44% No plans
- 17% Currently implemented
- 29% Planning to implement
- 10% Other

Figures 3.2
Patient-centered medical home
A physician practice or other provider is eligible to receive additional payments if medical home criteria are met. Payment may include calculations based on quality and cost performance using a pay-for-performance-like mechanism.

Implementation Plans
Overall
- 40% No plans
- 27% Currently implemented
- 29% Planning to implement
- 4% Other

Professional
- 26% 7%
- 15% 52%
- 12% 32%
- 20% 36%

Facility
- 30% 44%
- 22% 32%
- 28% 36%
03 CURRENT SCOPE OF VALUE-BASED PAYMENT MODELS

Figure 3.3
Payment for coordination
Payments are made to providers furnishing care coordination services that integrate care between providers.

Implementation Plans
Overall
- 44% No plans
- 15% Currently implemented
- 33% Planning to implement
- 8% Other

Professional
- 30% No plans
- 22% Currently implemented
- 41% Planning to implement
- 7% Other

Facility
- 36% No plans
- 8% Currently implemented
- 48% Planning to implement

Figure 3.4
Pay-for-Performance
Health care providers receive differential payments for meeting or missing performance benchmarks.

Implementation Plans
Overall
- 17% No plans
- 48% Currently implemented
- 31% Planning to implement
- 4% Other

Professional
- 37% No plans
- 19% Currently implemented
- 24% Planning to implement
- 8% Other

Facility
- 36% No plans
- 8% Currently implemented
- 44% Planning to implement
- 16% Other

Figure 3.5
Bundled payment
A single “bundled” payment, which may include multiple providers in multiple care settings, is made for services delivered during an episode of care related to a medical condition or procedure.

Implementation Plans
Overall
- 54% No plans
- 15% Currently implemented
- 23% Planning to implement
- 8% Other

Professional
- 26% No plans
- 15% Currently implemented
- 59% Planning to implement
- 10% Other

Facility
- 16% No plans
- 16% Currently implemented
- 20% Planning to implement
- 48% Other
BACKGROUND AND METHODOLOGY

The Provider Readiness to Support Value-Based Payment Models study, sponsored by Availity, was conducted to obtain feedback on the challenges, needs, and trends related to payment reform initiatives. The study was administered by independent research firm Porter Research in the second quarter of 2013. Porter Research completed interviews with qualified participants of more than 50 physician practices and hospitals who were knowledgeable about their organizations’ value-based payment model plans and programs.

Target participants included leadership (C-suite and Vice Presidents) in Operations, Finance and/or Revenue Cycle Management.

All interviews were conducted online and respondents were made aware of Availity as the sponsor of the study.

Study results are considered directional or observational.
ABOUT AVAILITY

Availity delivers revenue cycle and related business solutions for health care professionals who want to build healthy, thriving organizations. Availity has the powerful tools, actionable insights and expansive network reach that medical businesses need to get an edge in an industry constantly redefined by change.

Whether health care professionals use Availity’s Advanced Clearinghouse, Revenue Cycle Management, Clinical Data Interchange or Web Portal services, they’ll be able to drive measurable and meaningful organizational improvements, and enjoy the vitality of a healthy business.

For more information about Availity, please visit www.availity.com.