PROVIDER AND HEALTH PLAN READINESS TO SUPPORT VALUE-BASED PAYMENT MODELS

Implications, Recommendations and Research
SEPTEMBER, 2013
KEY FINDINGS

Availity’s health plan and provider readiness studies reveal a high risk for significant market disruption as the industry begins the migration to value-based payment models.

Significant revenue is expected to come from new payment models within three years.

Providers and health plans expect to be engaged simultaneously in multiple new payment models.

Respondents can’t yet support the automated information exchange critical to new payment model success.
MARKET IMPLICATIONS

The research findings reveal two major considerations:

1) the shift to value-based payment models has broad support and is expected to grow quickly over the next three years; and

2) health plans and providers are not prepared for the information exchange demands required to make these models successful.

Couple these together with the broad-reaching impacts of health care reform and the industry migration to ICD-10, and the risk for significant operational disruption is evident.

Early adopters of value-based programs, while encouraged by outcomes improvements, highlight concerns related to data access, exchange, and lack of automation. If providers and payers cannot simply and effectively share data (such as quality outcomes or notifications about patient admissions to the hospital), program scalability will be severely limited and the costs to continue operations will likely outweigh the benefits.

AVAILIITY RECOMMENDATIONS

Collaborate with your partners.
Health plans and providers need to engage each other. Learn what information is needed to support value-based payment models and determine the extent of each other’s information sharing capabilities.

Assess the impact of new information exchange needs on your current workflow processes.
Value-based programs must co-exist with fee-for-service, and this means workflow processes for data access and exchange need to be in harmony. Once you understand what new data is required in the program, determine whether you have easy and efficient access to it.

Get answers to these questions:

- Can the information I use in my current fee-for-service business help me transition to fee-for-value?
- For any truly ‘new’ data, where does it reside—with me or my partners?
- Is it useful for my traditional fee-for-service business?
- Can it be accessed easily and efficiently, or will I have to implement additional/ manual workflow processes to acquire it?
- What kind of additional resources and time will that require?
- How will that affect my overall business and operations?
- What about my partners? If they have to implement additional/manual processes, how does that affect the success of the program?

Evaluate existing market capabilities.
Once you understand what information is needed to support value-based programs, do some research to determine what solutions exist in the market today. Understanding your specific needs will help you filter through offerings that may tout value-based solutions, but do not truly meet your requirements.
AVAILITY RECOMMENDATIONS

- Be sure to assess the interoperability of all capabilities, to avoid creating silos of information that lead to information sharing problems.
- Develop a plan for acquiring the solutions you need to ensure minimal disruption to your business.

**Implement solutions that solve problems today and help you transition to value-based models.**

Studies of current value-based programs reveal data requirements, such as notification of inpatient admissions and patient clinical summary information, which are also meaningful for existing fee-for-service arrangements, particularly as it relates to care management. **Implementing solutions that address both types of reimbursement offers health plans and providers a sort of ‘two-for-one’ that brings even greater efficiency and value.** Examples include electronic medical attachments, real-time authorizations and referrals, data extracts from EMRs, and electronic reminders based on patient care gaps.

**Invest in training.**

Even the best solutions won’t bring value unless the people inside your organizations use them, and use them effectively. Know who your users are and engage them in the decision-making process affecting solution purchases. Getting their input up front will be invaluable to their engagement once the purchase has been made. Invest in training. This is critical to the successful adoption and utilization of any product, but especially when you need to realize results fast. End users need to understand how the selected solution(s) fit into their workflows and how they can use them to do their jobs more effectively and with greater ease. An outstanding user experience will pay big dividends in operational efficiency and overall program success.

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 measureable and meaningful organizational improvements, and enjoy the vitality of a healthy business.

For more information about Availity, please visit [www.availity.com](http://www.availity.com).
<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Health Plan Readiness to Operationalize Value-Based Payment Models</td>
</tr>
<tr>
<td></td>
<td>An Availity Research Study</td>
</tr>
<tr>
<td>7</td>
<td>Introduction</td>
</tr>
<tr>
<td>8</td>
<td>Definitions</td>
</tr>
<tr>
<td>9</td>
<td>Key Findings</td>
</tr>
<tr>
<td>11</td>
<td>Survey Results</td>
</tr>
<tr>
<td>01</td>
<td>Health Plan Priorities</td>
</tr>
<tr>
<td>02</td>
<td>Program Enablement/Operational Readiness</td>
</tr>
<tr>
<td>03</td>
<td>Current Scope of Value-Based Payment Models</td>
</tr>
<tr>
<td>19</td>
<td>Background and Methodology</td>
</tr>
<tr>
<td></td>
<td>Provider Readiness to Support Value-Based Payment Models</td>
</tr>
<tr>
<td></td>
<td>An Availity Research Study</td>
</tr>
<tr>
<td>21</td>
<td>Introduction</td>
</tr>
<tr>
<td>22</td>
<td>Definitions</td>
</tr>
<tr>
<td>23</td>
<td>Key Findings</td>
</tr>
<tr>
<td>25</td>
<td>Survey Results</td>
</tr>
<tr>
<td>01</td>
<td>Business Priorities &amp; Revenue Outlook</td>
</tr>
<tr>
<td>02</td>
<td>Information Needs &amp; Preparedness</td>
</tr>
<tr>
<td>03</td>
<td>Current Scope of Value-Based Payment Models</td>
</tr>
<tr>
<td>37</td>
<td>Background and Methodology</td>
</tr>
</tbody>
</table>
HEALTH PLAN READINESS TO OPERATIONALIZE VALUE-BASED PAYMENT MODELS

An Availity Research Study
INTRODUCTION

No matter where you go in health care, conversations about payment reform abound. The industry is fully engaged with discussions around structuring health plan payments based on ‘value’ versus ‘services rendered’. Pressure from the federal government to lower costs, coupled with employer and consumer frustration with the overall state of our health care system, make a shift to new payment structures highly likely. The message is clear: payments should be based on good care resulting in quality outcomes, not the volume of services rendered.

Over the past several years we have seen accountable care organizations (ACOs) begin to pepper the landscape. Pay for performance (P4P) and patient-centered medical home (PCMH) initiatives appear regularly in news releases and media conversations. Bundling payments continues to intrigue health plans, physicians, and patients. All carry great promise to make the transition from ‘fee for service’ to ‘fee for value.’ They likewise carry new risk profiles that by and large the industry is unprepared to broadly embrace.

For these reasons, many in the industry are asking, “How many of these new payment models are in place? How many health plans and providers have adopted them? When will we start to see the savings and cost containment these models predicted?”

To assess where the industry stands in terms of achieving the goals of value-based payment models (lower costs and better outcomes) requires us first to understand how well prepared health plans are to operationalize the models, and then how well enabled providers are to adopt them. Efficient operations that limit, or better yet, eliminate, labor-intensive processes are necessary for value-based payment models to work.

With the Health Plan Readiness to Operationalize Value-Based Payment Models study, Availity has gained critical insight into the significance of value-based payment models to health plans, projections for transitioning their business to them in the next three to five years, and the current levels of success health plans have achieved towards operationalizing the new models. These findings are presented here.
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.

**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

Value-based payment models are a priority for health plans, who forecast significant business impacts in transitioning to them.

- **82%** of respondents cite the development of new payment models as a ‘major priority’ for their organizations.
- **90%** expect value-based payment models to impact their top three (3) business objectives.
- **46%** expect a ‘major’ impact, while **44%** anticipate ‘some’ impact.

Value-based payment models support a small amount of health plan business today, but expectations for growth are high.

- Just **20%** of health plan respondents say value-based models support more than half of their businesses today.
- **40%** of health plans predict that in three years, value-based models will support more than half of their businesses.
- Nearly **60%** of respondents predict that in five years, value-based models will support more than half of their businesses.

Employer Group plans and Medicare plans are the leading focus for payment model migration.

- More than **75%** of respondents say they are focusing value-based payment efforts on their Employer Group plans.
- **54%** say Medicare plans are a priority for payment model transition.
- **46%** and **44%** cite Medicaid plans and Individual plans, respectively, as priority targets for value-based payment models.

**90%**
expect value-based payment models to impact their top three business objectives

**40%**
predict that in three years, value-based models will support more than half of their businesses

**75%**
focus value-based payment efforts on their Employer Group plans
Health plans resoundingly agree that value-based payment models require new types of information from providers, and the exchange of that information needs to be automated.

- 90% of health plans not only agree that value-based payment models will require different types of information, but also cite automating the exchange of that information as critical to program success.
- Nearly 75% of respondents plan to automate the exchange of information needed for value-based payment models within the next 12 to 18 months.
- The vast majority – 85% – believe that enabling real-time information exchange between health plans and physicians will provide the highest value relative to value-based payment program operations and objectives.

Few health plans have achieved the desired level of automation viewed as critical to the success of value-based payment models.

- 90% of health plans use a hybrid automated/manual process for information exchange.
- Less than 50% have real-time automation capabilities.

90% say automating the exchange of new information types is critical to program success.

<50% have real-time automation capabilities.
SURVEY RESULTS

01 Health Plan Priorities
02 Program Enablement/Operational Readiness
03 Current Scope of Value-Based Payment Models
01 HEALTH PLAN PRIORITIES

Value-Based Payments Touted as a Top Strategy to Achieving Health Plan Goals
Driving cost down and growing the business are the top priorities for health plans nationwide. Not surprisingly, doing so in a way that protects and improves their market positions and ability to compete comes in at a close third.

Value-based payment models top the list of most health plans (82%) as a means to achieving their business priorities, with nearly half forecasting a major impact from the models on their operating objectives.

Figure 1.1
Business priorities
Over the next 12–18 months, what would you identify as your health plan’s top 3 business initiatives?

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Figure 1.2
Priority of payment reform
Over the next 12–18 months, please rate the level of priority that payment reform or the development of new payment models represent to your health plan.

- 82% Major priority
- 15% Minor priority
- 3% Not a priority

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Figure 1.3
Impact of value-based payment models
Briefly describe the impact that value-based payment models will have on your health plan’s business lines, initiatives and objectives.

- 46% Major impact
- 44% Some impact
- 5% No impact
- 5% Unsure
**Health Plan Priorities**

**Tipping Point for New Payment Models Could Be Reached in as Few as Five Years**

While value-based payment models represent only a small amount of health plan business today, most plans expect that to change significantly over the next five years. Health plans report that 20% of their business is supported by value-based models today, but anticipate that figure rising to 60% by the end of 2017.

**Figure 1.4**

**Business supported by payment models**

How much of your business (by %) do you expect to be supported by value-based payment models over the follow time frames:

- Greater than 50%
- 26%–50%
- Less than 25%

**Employer Group Business is Primary Focus for New Payment Models**

The most popular target for implementation of value-based payment models is Employer Group business, at 77%, with Medicare plans following in second place at 54%. The focus is not surprising given the amount of business employer groups represent for most commercial and BlueCross BlueShield plans. Within those numbers, nearly 60% of health plans expect the new payment models to impact their high-deductible plans, which have grown in popularity with employer groups over the past several years.

**Figure 1.5**

**Consumer-driven health plan designs**

Do you expect value-based payment models to have an impact on your organization’s high-deductible and consumer-driven health plan designs?

- 59% Yes
- 33% No
- 8% Don’t know

**Figure 1.6**

**Business lines—focus for future development**

Over the next 12–18 months, which of the following business lines will your health plan focus the development of value-based payment models?
Automating Information Exchange Critical to Payment Model Success

For value-based payment models to work, 94% of health plans agree that they are going to have to exchange different types of information than under traditional fee-for-service arrangements. And that exchange needs to be automated to be effective (93%), with real-time automation delivering the highest value according to 85% of health plans.

Figure 2.1

‘New data’ sharing
The emerging value-based payment models discussed today will require different types of information to be exchanged between physicians and health plans.

- 69% Strongly agree
- 25% Agree
- 3% Neutral
- 3% Disagree
- 0% Strongly disagree

Figure 2.2

Importance of automation
Automating the information exchange/sharing between health plans and physicians is critical to cost-effective program operations and to successfully achieving program objectives.

- 59% Strongly agree
- 33% Agree
- 5% Neutral
- 3% Disagree
- 0% Strongly disagree

Figure 2.3

Value of real-time
Enabling real-time information exchange/sharing between health plans and physicians will provide the highest value relative to program operations and objectives.

- 49% Strongly agree
- 36% Agree
- 5% Neutral
- 10% Disagree
- 0% Strongly disagree
Manual Processes for Exchanging ‘New’ Information with Providers Still Prevalent

Though the focus is on automating information exchange in support of new payment models, most health plans (90%) report that their processes are a hybrid of manual and automated at best, with 74% focusing on more automation in the next 12–18 months. Nearly half have real-time capabilities in place, though the ability to use those capabilities to exchange new information types is unclear.

Figure 2.4
Manul vs. automated
Which of the following best describes the processes being utilized within your health plan to enable information exchange related to new payment models?

- 5% Fully automated
- 5% Fully manual
- 90% Both automated and manual

Figure 2.5
Real-time capabilities
Is the automation in place considered ‘real-time’?

- 46% Yes
- 49% No
- 5% Unsure

Figure 2.6
Automation plans for information exchange
Does your health plan have plans to automate the exchange of information needed for value-based payment models within the next 12–18 months?

- 74% Yes
- 13% No
- 13% Unsure
03 CURRENT SCOPE OF VALUE-BASED PAYMENT MODELS

Data Suggests ACOs Will Be Most Prevalent Value-Based Payment Model in Two Years

Of the six value-based payment models reviewed in this study, Patient Centered Medical Home (PCMH) is the most mature model today, with 62% of all respondents having implemented the model, with 19% more in some phase of implementation. And while only 47% of health plans report that they have implemented an Accountable Care Organization (ACO), another 40% state they are in the implementation process and expect those models to be fully operational in the next 12-18 months (raising that total to 87% if plans hold).

Figures 3.1 & 3.2
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
- 13% No plans
- 47% Currently implemented
- 40% Planning to implement

Implementation Progress
- 53% Early
- 27% Mid
- 13% Late
- 7% Unsure

Figures 3.3 & 3.4
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 P4P-like mechanism.

Implementation Plans
- 19% No plans
- 62% Currently implemented
- 19% Planning to implement

Implementation Progress
- 57% Early
- 43% Mid
- 0% Late
- 0% Unsure
03 CURRENT SCOPE OF VALUE-BASED PAYMENT MODELS

Figures 3.5 & 3.6
Payment for coordination
Payments are made to providers furnishing care coordination services that integrate care between providers.

Implementation Plans
- 34% No plans
- 46% Currently implemented
- 20% Planning to implement

What phase of implementation is your health plan currently in?

Implementation Progress
- 88% Early
- 0% Mid
- 0% Late
- 12% Unsure

Figures 3.7 & 3.8
Hospital pay-for-performance
Hospitals receive differential payments for meeting or missing performance benchmarks.

Implementation Plans
- 37% No plans
- 45% Currently implemented
- 18% Planning to implement

What phase of implementation is your health plan currently in?

Implementation Progress
- 57% Early
- 29% Mid
- 0% Late
- 14% Unsure
**Figures 3.9 & 3.10**

**Physician pay-for-performance**

Physicians receive differential payment for meeting or missing performance benchmarks.

**Implementation Plans**
- 23% No plans
- 67% Currently implemented
- 10% Planning to implement

**Implementation Progress**
- 0% Early
- 60% Mid
- 20% Late
- 20% Unsure

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**Figures 3.11 & 3.12**

**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**
- 42% No plans
- 24% Currently implemented
- 34% Planning to implement

**Implementation Progress**
- 43% Early
- 36% Mid
- 7% Late
- 14% Unsure
BACKGROUND AND METHODOLOGY

The Health Plan Readiness to Operationalize 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 fourth quarter of 2012. Porter Research completed interviews with qualified participants of 39 health plans who were knowledgeable about their organizations' value-based payment model plans and programs.

Target participants included Quality Management leadership, Medical Directors, and Chief Medical Officers.

All interviews were in-depth telephone interviews and respondents were made aware of Availity as the sponsor of the study.

Study results are considered directional or observational.
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.
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%

70% expect to support three or more different value-based models in the next three years

80% have implemented or are planning to implement a pay-for-performance model

40% of revenue expected from value-based programs in the next three years
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

90% agree that automating information exchange is critical to value-based program success.

99% agree that different types of information will need to be exchanged.

20% report having fully-automated information exchange capabilities.
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.
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?

12 months

24 months

36 months
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.

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.
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.

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.
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

Professional
- 19% Fully automated
- 7% Fully manual
- 74% Both automated and manual

Facility
- 20% Fully automated
- 8% Fully manual
- 68% Both automated and manual

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%
- 15%
- 15%

Facility
- 64%
- 15%
- 32%
**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?

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**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**
- 33% Yes
- 32% No
- 18% Unsure

**Facility**
- 40% Yes
- 28% No
- 19% Unsure
**Figure 2.11**

Clearinghouse satisfaction

Using a scale from 0-10, where zero = 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](chart)

- Mean: 6.15

### Professional

![Professional Satisfaction Chart](chart)

- Mean: 6.01

### Facility

![Facility Satisfaction Chart](chart)

- Mean: 6.28
03 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.

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.
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

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

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
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.