HEALTH PLAN READINESS TO OPERATIONALIZE VALUE-BASED PAYMENT MODELS

An Availity Research Study
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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.
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?

- **Reducing costs**
- **Expansion/growth**
- **Market alignment/competition**
- **Preparing for health care exchanges**
- **Provider enrollment/relations**
- **Customer service**

**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

**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
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.

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.

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.
**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**

**Manual 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

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

What phase of implementation is your health plan currently in?

Implementation Progress
- 53% Early
- 27% Mid
- 13% Late
- 7% 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
03 CURRENT SCOPE OF VALUE-BASED PAYMENT MODELS

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

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
- 0% Early
- 60% Mid
- 20% Late
- 20% 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.
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.