
HFMA's Executive Survey: Value-Based Payment Readiness

Sponsored by Humana
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Executive Summary

In spring 2015, HFMA researchers surveyed 146 senior financial executives, ranging from chief financial officers to finance vice presidents to finance directors. The objective of the survey was to better understand views on readiness for value-based care. Of the respondents, 47 percent are from systems with more than two hospitals; 53 percent are from systems with two hospitals or less.

The survey focused on current needs as well as needs anticipated over the next three years. Respondents ranked organizational competencies in areas supporting value-based payment readiness based on where they are today and anticipated level of progress. In addition, they assessed ROI of efforts to date and rated a list of competencies based on the likelihood of enabling their organizations' value-based payment readiness.

Key findings:

- **Positive ROI:**
 - More than 50 percent of the respondents report that their systems have achieved positive ROI from value-based payment programs to date.
- **Significant Gaps in Interoperability**
 - Nearly 40 percent of respondents don't believe their organizations will have the capabilities needed within three years to succeed in risk-based value arrangements when it comes to interoperability, business intelligence, real-time data access, and effective chronic care management.
 - Interoperability is not only where organizations currently rank weakest but also where more than 70 percent of financial executives anticipate their organizations will need to be extremely capable in three years.
 - Such gaps are troubling when considering the respondents anticipate that 30-70 percent of their payments from payers will include value-based mechanisms within three years.
- **Data Analytics a Key Enabler**
 - Competencies around data use ranked highest in likelihood of enabling success under value-based payment. In particular, analytical support (business intelligence and actuarial), use of consistent care quality measures, and ability to monitor adherence to medically recommended regimens at the patient level ranked highest in enabling organizations to take on risk-based arrangements.

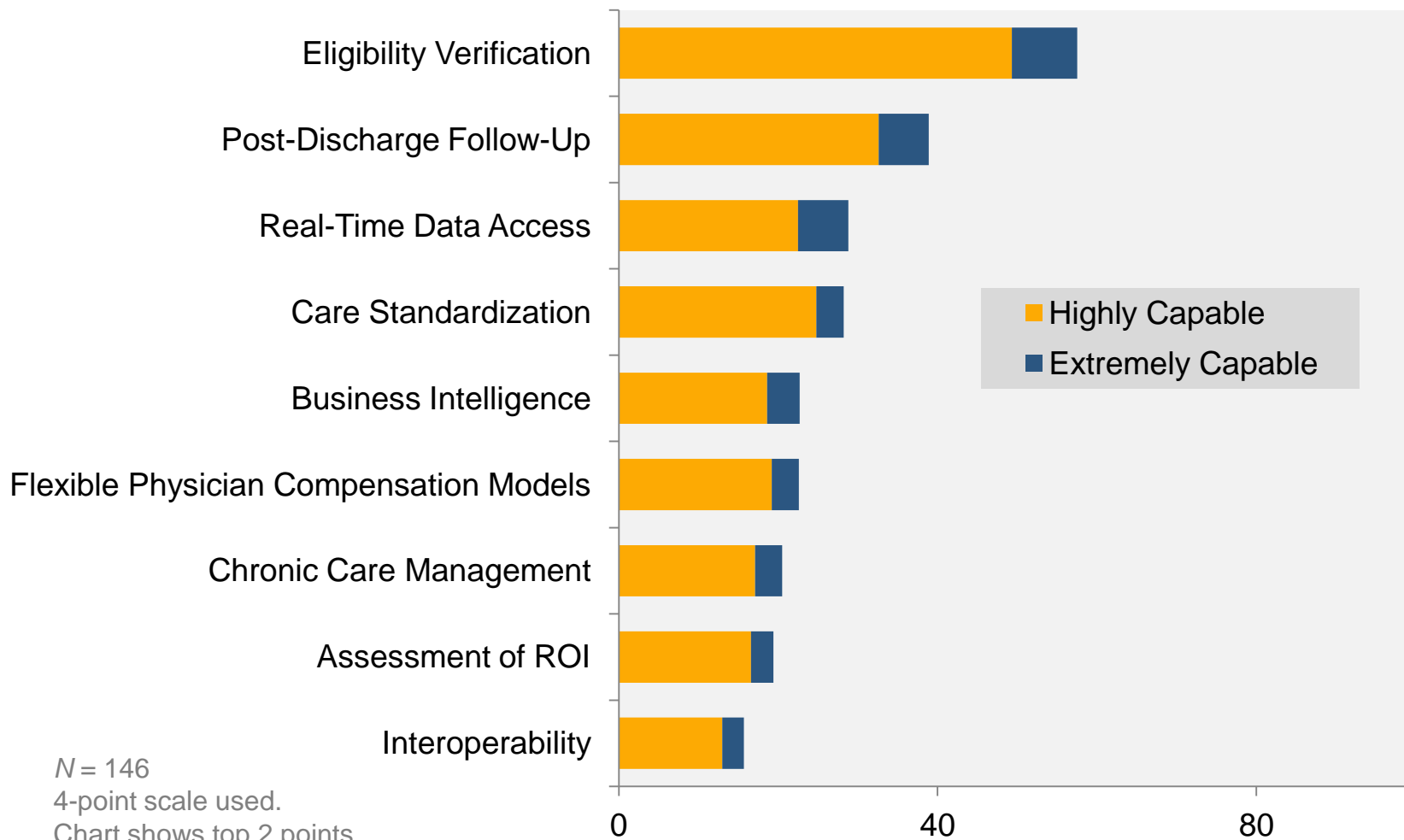
OVERVIEW

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- 3 Anticipated Gaps in Readiness
- 4 Anticipated Penetration
- 5 Financial Impact of Efforts to Date
- 6 Perceptions on Enabling Risk-Based Contracting

- Financial executives generally do not view their organizations as highly capable when it comes to many areas that support value-based payment.
- Interoperability is the area where they are least likely to report feeling highly or extremely capable.
- Only on verifying eligibility do they rate themselves as highly or extremely capable more than 50 percent of the time.

Current State

Please rate your organization's capabilities related to the areas below.



N = 146

4-point scale used.

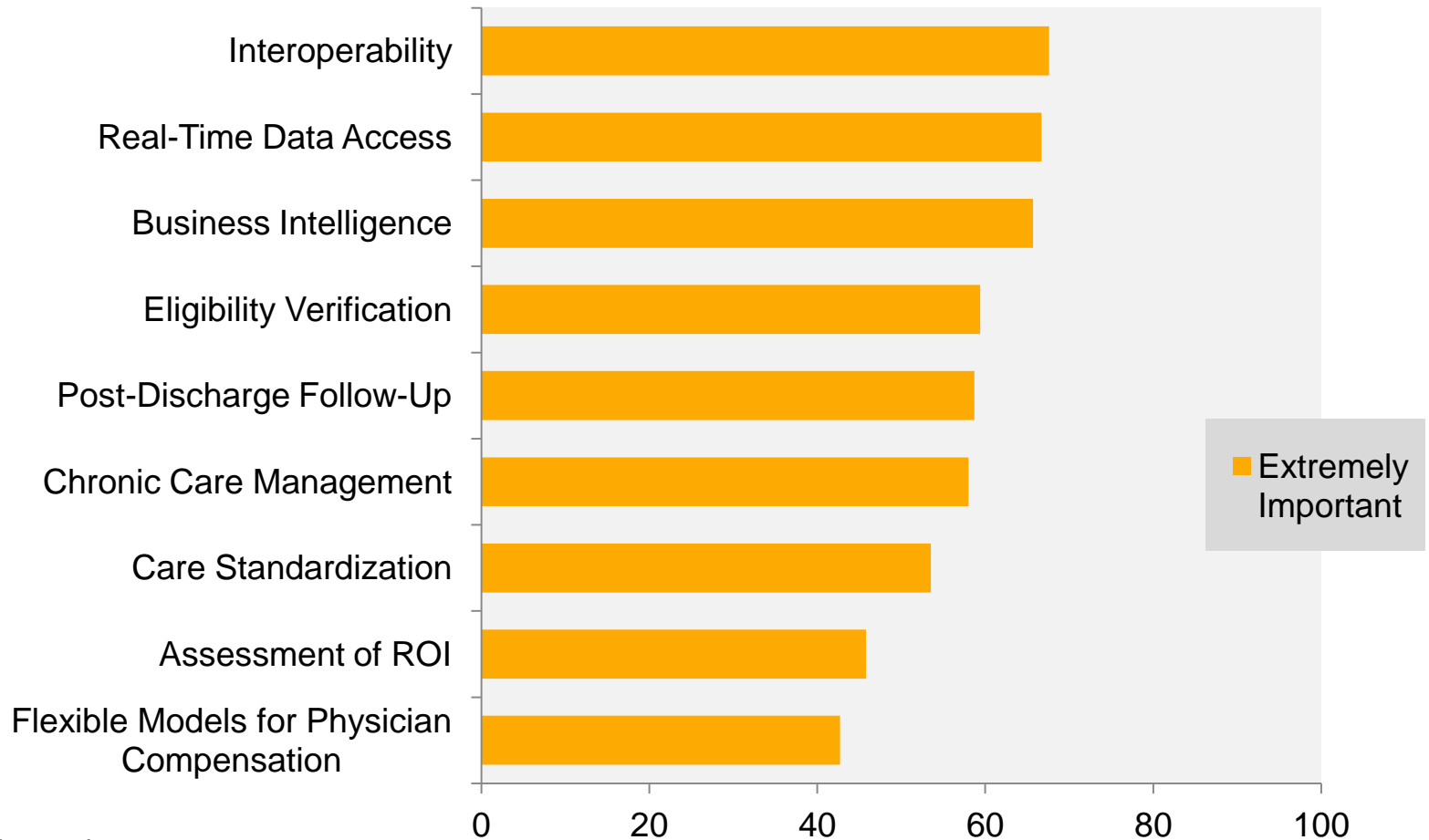
Chart shows top 2 points.



- Financial executives anticipate in three years that their organizations will need to be extremely capable when it comes to most of the areas that support value-based payment.
- Nearly 70 percent rank anticipated need for capabilities around interoperability at this level.

Projected Needs

Please rate the following capabilities on importance in three years.



N = 146

4-point scale used.

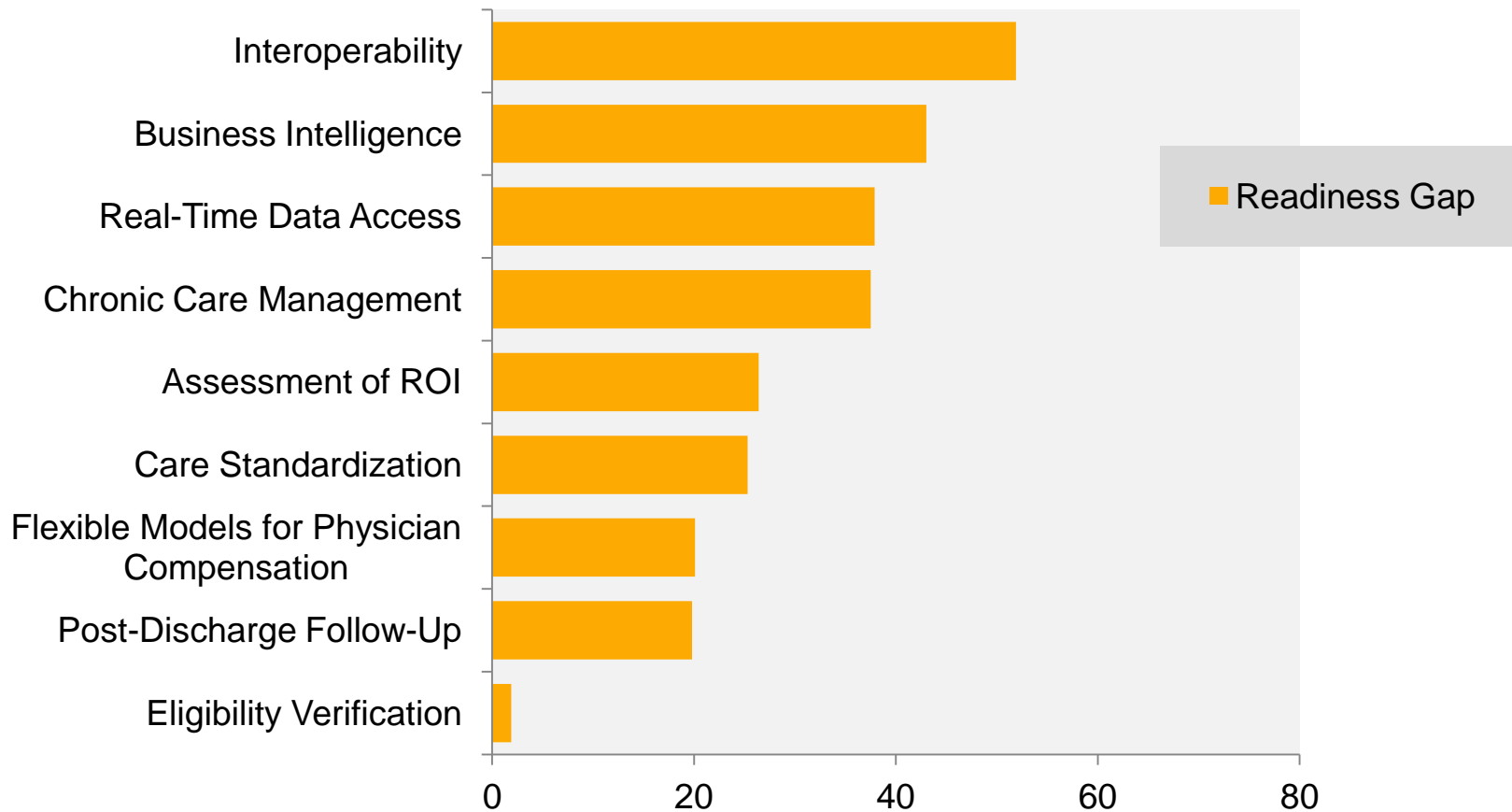
Chart shows top 2 points.



- Researchers define “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.
- Given capabilities today and expectations of future need, more than half of financial executives don’t expect their organizations will have the capabilities needed when it comes to interoperability.
- Other notable readiness gaps are in areas of business intelligence (ability to collect, analyze, and model data), clinician access to real-time data at the point of care, and systems to support effective chronic care management.

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.



When looking at median (middle level) experience, 12 percent of respondents' commercial payments currently incorporate value-based mechanisms.

This level is expected to be at 50 percent in three years.



Respondents expect in **three years** that

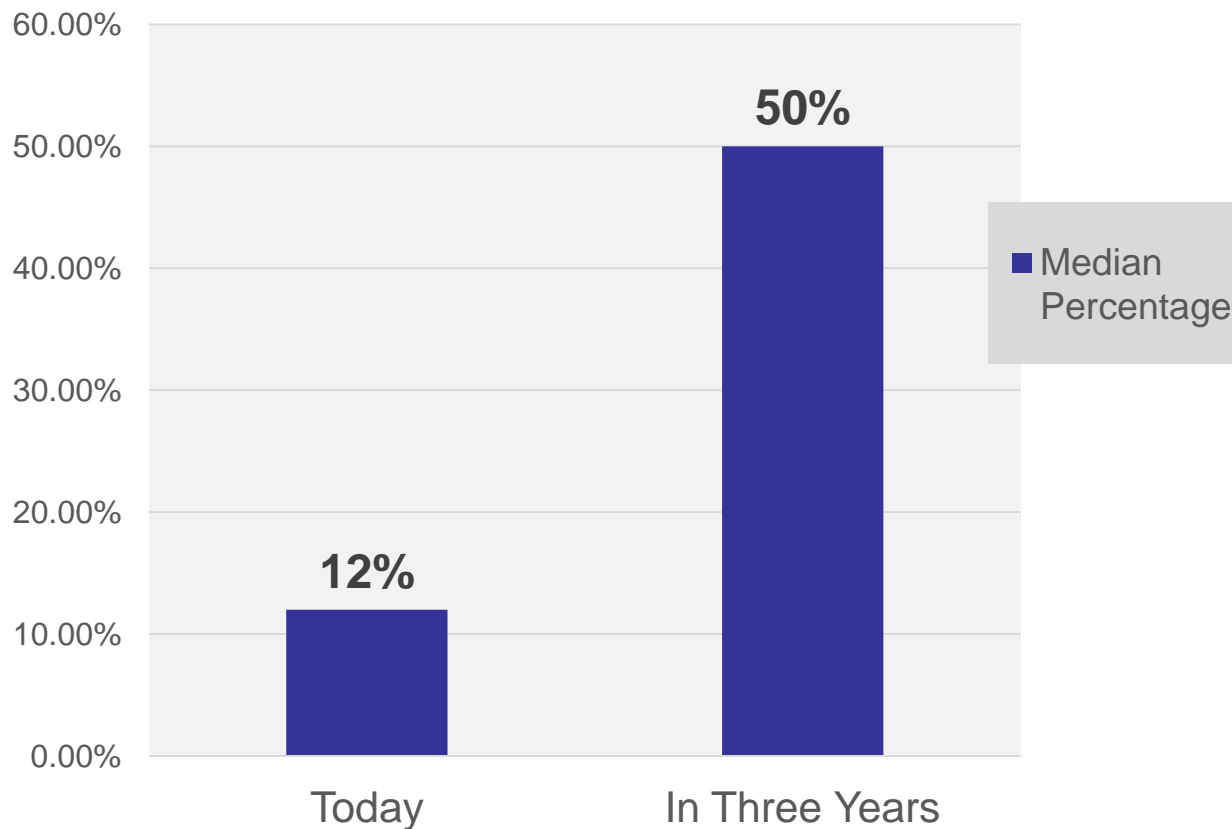
of their **COMMERCIAL PAYMENTS**

will incorporate **VALUE-BASED MECHANISMS**

30-70%

Anticipated Penetration of Value-Based Payment

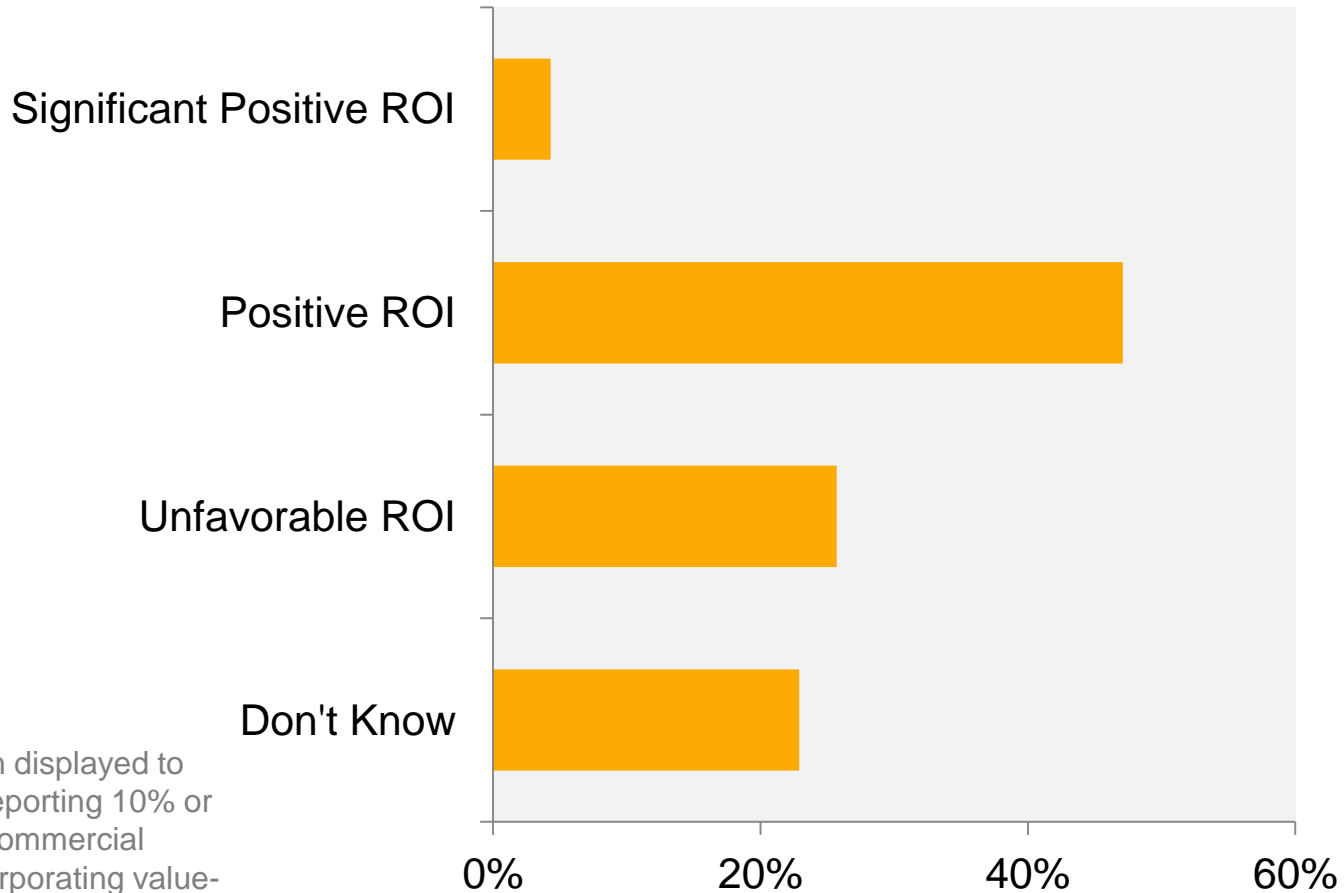
Please indicate overall percentage of your payments from commercial payers that incorporate value-based mechanisms today and likely percentage in three years.



- More than half of executives (51 percent) report their organizations have achieved positive ROI from value-based payment programs to date.
- About one-fourth (26 percent) are seeing unfavorable ROI.

Financial Impact of Efforts to Date

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



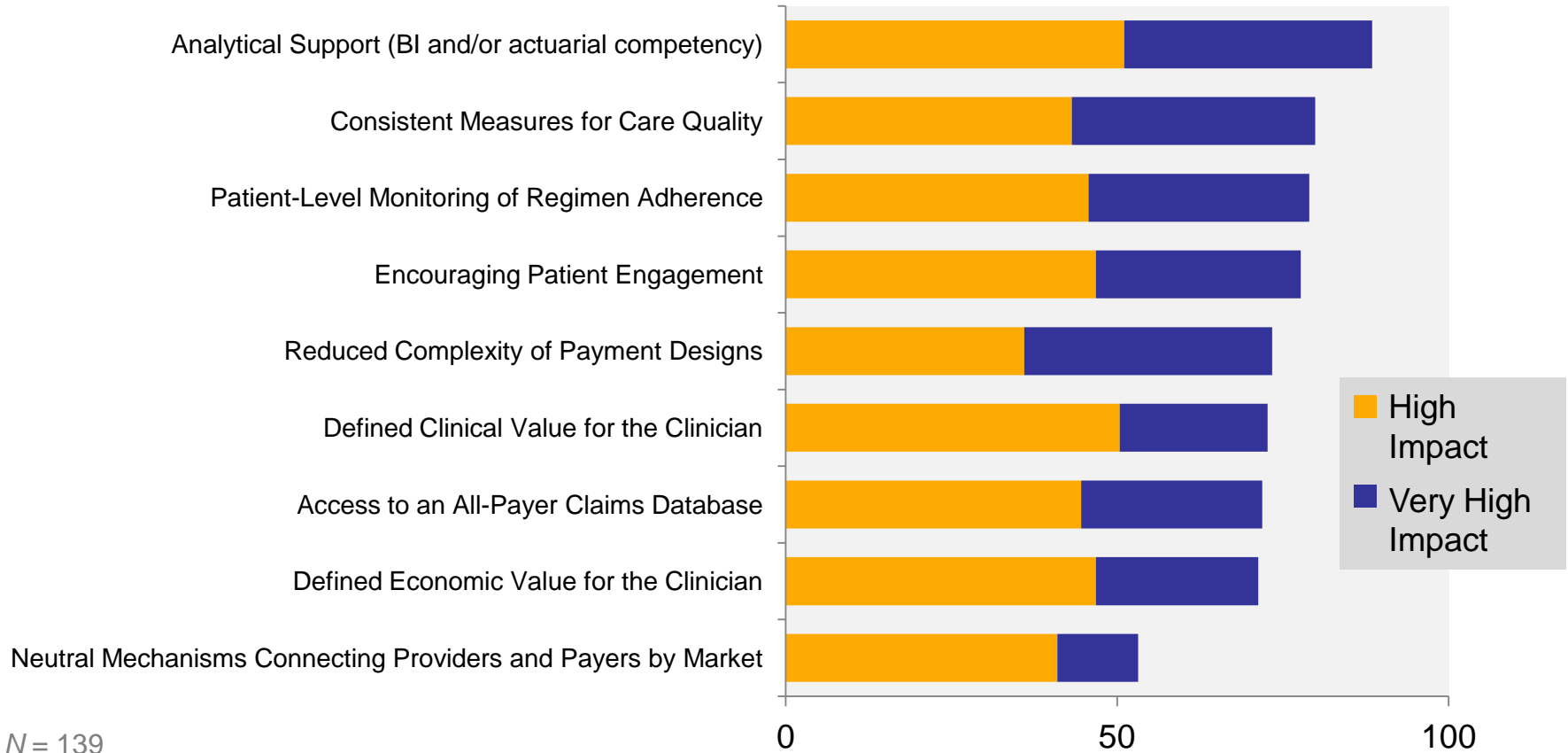
N = 70

Note: Question displayed to respondents reporting 10% or more of their commercial payments incorporating value-based mechanisms today.

- Analytical support was ranked first in having high or very high impact on an organization's ability to accept risk in a value-based contract.
- Closely following in importance were having consistent measures for care quality, monitoring adherence to medically recommended regimens at the patient level, and encouraging patient engagement.

Perceptions on Enabling Readiness

How could the following impact your organization's ability to accept risk in a value-based contract?



N = 139

4-point scale used.

Chart shows the top 2 points.

Additional Analysis

- Some variation in response was notable by size.
- Hospitals with 300 or more beds rated their capabilities much higher than smaller-sized peers when it came to chronic care management, assessing ROI, and interoperability.
- These “large” hospitals also placed greater importance than peers on having capabilities around interoperability, care standardization, access to business intelligence, and assessing ROI.
- “Large” hospitals also gave higher ranking than peers to the following enablers: adherence to medical recommendations at the patient level, ability to access analytic support, and ability to access an all-payer claims database.

Survey Procedures

- Survey participants were selected randomly from among HFMA members who are financial executives in hospitals and health systems.
- Findings are based on 146 responses received in February and March 2015. List size = 952; response rate = 15%.
- The survey instrument was designed jointly by HFMA and Humana staff.
- Analysis includes analysis of variance by size of hospital, size of associated system, and dominance of commercial carrier (data collected on survey itself).

Respondent Demographics

Level	Percentage
Executive (CFO, VP Finance, etc.)	90%
Director (Director of Finance)	10%

System Size	Percentage
1-2 Hospitals	53%
More than 2 Hospitals	47%

Bed Size	Percentage
Up to 99 Beds	40%
100–299 Beds	26%
300 or More Beds	34%

Definitions

- **Access to all-payer claims database:** Ability to access claims information regardless of payer affiliation
- **Analytical support:** Ability to adequately access business intelligence and/or actuarial and healthcare competencies to support program planning and administration
- **Assessment of ROI:** Ability to monitor value-based contracting revenue opportunities versus costs of implementation
- **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 effectively identify and screen patients participating under a value-based payment arrangement
- **Flexible models for physician compensation:** Flexibility of physician compensation program to accommodate both fee-for-service and value-based models

Definitions (contd.)

- **Interoperability:** Ability to aggregate clinical information across networks and between hospitals and physician practices
- **Percent at risk:** Overall percentage of payments from commercial payers that incorporates value-based mechanisms; commercial payers include traditional contracted payers as well as negotiated governmental contracts, such as Medicare Advantage and Medicaid managed care plans
- **Post-discharge follow-up:** Ability to effectively educate and monitor program participants regarding adherence to medical regimens after discharge from the facility (home health, patient follow-up)
- **Real-time data access:** Ability to provide meaningful data to care providers at the point of service

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