



New Reimbursement Models to Eclipse Fee-for-Service by 2020

McKesson Study Measures Pace and Challenges of Payment Model Transformation

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SEATTLE--([BUSINESS WIRE](#))--**AHIP Institute 2014**—Healthcare is moving rapidly to incorporate measures of value into payment models, with more than two-thirds of payments expected to be based on value measurement in five years, up from just one-third today.

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That’s according to a new study, *The 2014 State of Value-Based Reimbursement*, a national research study of 464 payers and hospitals conducted by [ORC International](#), commissioned by [McKesson](#), and published this week at [AHIP’s Institute 2014 conference in Seattle, Wash.](#)

“This study found that 90% of payers and 81% of hospitals are already deploying some mix of value-based reimbursement combined with fee-for-service, and that’s adding complexity to a system that’s already overburdened,” said [Emad Rizk, M.D., President of McKesson Health Solutions](#). “We need to understand and address these dynamics for value-based care to successfully scale across markets. That’s why we have been investing in our technology to enable VBR transformation. As the research makes clear, payers and hospitals are aligned on the urgent need for these tools.”

For this study, McKesson commissioned ORC International to determine a baseline for the state of the industry's transition from volume (fee-for-service) to value (value-based reimbursement). The goal: to get an evidence-based understanding of how stakeholders are reacting to industry change and demands, what reimbursement models and technology they're using, how they're managing, what's working, what's not working, and where they expect to be in the next few years.

Key findings of *The 2014 State of Value-Based Reimbursement* study include:

- **Payers and hospitals are aligned on embracing payment with value measures.** Ninety percent of payers and 81% of hospitals now offer a mix of fee-for-service (FFS) and other reimbursement models. Those payers expect fee-for-service (FFS) to decrease from 56% today to 32% in five years. Hospitals using mixed models agree, projecting FFS will decline from 57% today to 34% in five years. Essentially, payers and hospitals anticipate two-thirds of payment will be based on complex reimbursement models with value measures by 2020.
- **Alignment with value-based reimbursement adoption varies depending on what the region looks like.** Collaborative regions, where one or two payers and hospitals are market leaders, are closer to value-based reimbursement. Fragmented regions, where there are multiple payers and hospitals and no clear market leaders, are closer to fee-for-service models.
- **Alignment is also influenced by the care delivery model.** Accountable Care Organizations (ACOs) are significantly closer to value-based reimbursement adoption than non-ACOs. Forty-five percent of hospitals surveyed are already part of an ACO. Among hospitals that are not part of an ACO, 59% anticipate joining an ACO within five years. Whether a provider is part of an ACO is important because it affects other factors, such as their alignment with value-based care systems.
- **Fee-for-service is expected to be largely replaced by Pay-for-Performance (P4P).** Payers say the proportion of their business that is aligned with P4P will increase from 10% today to 18% in five years. Hospitals agree, projecting their alignment with P4P will jump from 9% today to 21% in five years.
- **P4P is poised to take hold most strongly, but payers and hospitals say it is the most challenging to implement,** with 15% of

payers and 22% of hospitals characterizing P4P as “very difficult” or “extremely difficult.” They also cited Episode of Care/Bundled Payment (payers 9%, hospitals 15%) and others (e.g., Shared Savings; payers 15%, hospitals 22%) as “very difficult” or “extremely difficult.” Both payers and hospitals point to a lack of standards, analysis tools, and the need for better business IT infrastructure and systems as key reasons why P4P is tough to implement.

- **All key obstacles payers and hospitals “urgently need” to overcome are technology related**, led by the need to integrate internal, vendor, and collaborative IT systems (41% payers, 23% hospitals); and data collection, access, and analytics (22% payers, 20% hospitals).
- **Likewise, technology to catalyze clinician engagement will be crucial for VBR to succeed**, as 20% of payers and 17% of hospitals—the largest slices in both groups—say the primary challenge in getting to VBR is obtaining buy-in and engagement on the part of the clinicians.

“Healthcare is at a tipping point,” says Dana Benini, Vice President at ORC International. “If we look at where institutions fall on the continuum towards value-based reimbursement and how that’s evolving, we see that the pace of change is a lot faster than many believe. This is particularly apparent in the growth of accountable care. The number of ACOs has tripled in just two years. There are winners and losers emerging from this transition, and healthcare stakeholders are faced with adapting quickly to make sure they fall on the right side of that equation.”

According to Emad Rizk, M.D., “Exceptional collaboration paired with next-generation healthcare IT will be needed to tackle the unprecedented complexity of running complex reimbursement models at scale. We need to streamline the system by harnessing intelligence across markets. That’s the only way we can empower clinicians to provide patients with the right care at the right time at the right cost.”

The 2014 State of Value-Based Reimbursement study included 114 payers across a range of organization sizes, with 32% covering 100,000 to 500,000 lives, 42% covering 500,000 to two million lives, and 26% covering two million lives or more. Payers also encompassed multiple regions, with 30% operating in payer-centric regions, 11% in provider-centric regions, 28% in collaborative regions (where one or two payers and hospitals dominate the region), and 29% in fragmented regions (where there are no clear leaders among either payers or hospitals).

The study also included 350 hospitals representing a similar range of size and scope. From the sample of hospitals, 21% have fewer than 100 beds, 38% have between 101 and 250 beds, and 40% have more than 250 beds. As for region, 19% of hospitals are in payer-centric regions, 26% are in provider-centric regions, 23% are in collaborative regions, and 28% are in fragmented regions.

The complete research paper, *The 2014 State of Value-Based Reimbursement*, is available at no charge via McKesson Health Solutions' blog, [MHSdialog](#) and at [MHSvbrstudy.com](#). For more information on McKesson Health Solutions, please visit our [Web site](#), hear from our experts at [MHSdialogue](#) and follow us on Twitter at [@McKesson_MHS](#).

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