McKesson Health Solutions
The State of Value-Based Reimbursement and the Transition from Volume to Value in 2014

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This white paper uses the following definitions.

**Payer**
A health insurer/health plan that finances or reimburses the cost of health services.

**Provider**
A hospital or hospital system that provides healthcare services to patients. For clarity, this paper does not refer to clinicians (see below) as providers.

**Hospital**
Same as “provider.”

**Clinician**
A physician, nurse, or other healthcare professional who works directly with patients in a doctor's office, clinic, hospital, hospice, home setting, etc., as part of a provider network.

**Collaborative Region**
A region where one or two payers and hospitals are market leaders.

**Fragmented Region**
A region where there are multiple payers and hospitals and no clear market leaders.
We can now say with certainty that healthcare delivery is moving in one direction: towards value-based care. The affordability crisis is causing unprecedented changes in the healthcare landscape, the most significant of which is the transition from the current volume-based model to myriad models based on measures of value.

To remain relevant and competitive, payers, hospitals, health systems, and clinicians must respond now to integrate value-based models into their existing systems. However, most of these systems are already overburdened, inefficient, and poorly integrated (if they are integrated at all). Without the appropriate investments in contemporary healthcare IT that enables value-based care, existing systems will be pushed beyond the breaking point, and administration of these models will exceed the human capacity to fund and manage them.

The winners will be those who act and collaborate decisively. But good decisions require timely and accurate information. There is a strong need to benchmark and monitor the pace of change in the payer-provider landscape, understand how key stakeholders are reacting, and know, to the extent possible, how things will play out over the next several years. Indeed, this knowledge is critical to the long-term success of payers and providers and, most importantly, to improving care quality for patients and reducing healthcare costs for the nation.

Unfortunately, it hasn’t been clear what key stakeholders were (or were not) doing and how they were faring in this maelstrom of change. To address that, McKesson commissioned ORC International, a leading research and business intelligence firm with 15 offices worldwide and strong healthcare expertise, to study the issue. We wanted to answer questions such as these:

- How are payers and providers reacting to industry change and demands?
- How far along are they in this transition?
EXECUTIVE SUMMARY

• What reimbursement models are they using?
• What are their key obstacles and concerns in the face of complex and sweeping change?
• What attributes align an institution with value-based reimbursement?

ORC conducted a national baseline research study on the state of the transition from volume (fee-for-service) to value-based care. The study included a 20-minute online survey of high-level executives within 114 payer and 350 provider organizations, representing a range of sizes and regions.

Seven Major Trends
The results are in, and there can be no question as to healthcare’s embrace of value-based models. The bottom line: Most payers and providers expect value-based reimbursement to overtake fee-for-service by the year 2020, but they face daunting complexity in integrating complex reimbursement models, and say they have an urgent need for next-generation healthcare IT to successfully transition to value-based models. Overall, the research identified seven major trends:

1. Rapid adoption of VBR. The reimbursement landscape is changing faster than many had anticipated, with payers and providers decidedly aligned on embracing payment with value measures. Remarkably, 90% of payers and 81% of providers are already using some mix of value-based reimbursement (VBR) combined with fee-for-service (FFS). Stakeholders using mixed models are anticipating significant expansion in value-based care, projecting that payment with some form of value measurement will make up two-thirds of the market by 2020, up from one-third today. Providers using mixed models expect FFS to decrease from about 56% today to 34% five years from now.

2. Collaborative regions are more aligned with VBR. Collaborative regions, where one or two payers and providers stand out, are more aligned with VBR. Fragmented regions, where there are multiple payers and providers and no clear market leaders, are more aligned with FFS. Moreover, the larger the institution, the further along the continuum towards VBR it falls.
3. **Alignment with VBR is influenced by the care delivery model.** Accountable Care Organizations (ACOs) are significantly closer to VBR adoption than non-ACOs. Forty-five percent of providers surveyed are part of an ACO. These providers are significantly more likely to feel that the transition to VBR will have a positive financial impact on their organizations compared to those not in an ACO. That said, 59% of those not in an ACO anticipate joining one within five years.

4. **Pay-for-Performance leads the pack.** Of the existing value-based models, payers and providers project that the proportion of their total business (inclusive of commercial and Medicare) that is aligned with pay-for-performance (P4P) will experience the most growth. Payers using a mix of reimbursement models say the proportion of their business aligned with P4P will increase from 10% today to 18% in five years. Providers using a mix of reimbursement models project their alignment with P4P will jump from 9% today to 21% in five years.

5. **Existing healthcare IT systems are not aligned with VBR.** Though both payers and providers predict that P4P will be a critical part of their reimbursement model, 15% of payers and 22% of providers characterize P4P as "very difficult" or "extremely difficult" to implement. They also rated Episode of Care/Bundled Payment and others (e.g., Shared Savings) as very or extremely difficult. The key obstacles to implementing these value-based models, payers and providers agree, are a lack of standards, analytical tools, and the need for better business IT infrastructure and systems that support these models—all while taking action to reduce administrative burdens and costs to remain financially sound.

6. **The primary obstacles payers and providers “urgently need” to address in order to enable VBR are technology related.** This is led by the need to integrate internal, vendor, and collaborative IT systems (41% payers, 23% providers); and data collection, access, and analytics (22% payers, 20% providers).

7. **Technology to catalyze clinician engagement will be crucial to VBR’s success.** The largest proportion of payers and providers pointed to a lack of clinician buy-in and engagement with VBR as the number one challenge to its success (20% of payers and 17% of providers). This underscores a broader need within the industry for tools that enable clinician engagement with value-based models.
Seven Steps to Value-Based Care

McKesson’s research identified seven key trends (above) that are evident in the transformation from volume to value. Coincidentally, there are also seven key steps that payers and providers can take to facilitate movement towards value-based design, reimbursement, and care. These seven steps should be considered now because, as the 2014 State of Value-Based Reimbursement study documents, the industry is at a tipping point. The study data indicates an accelerating pace of change, and while FFS isn’t going away entirely, VBR is expected to eclipse FFS-only models by 2020. For stakeholders, it’s a matter of taking action now or risking being left behind, as dollars increasingly flow through value-based models. Here are seven steps you can take today to help avoid falling behind:

1. **Take the plunge together.** Value-based delivery changes depend on value-based payment changes. Who will make the first move? If payers decide to wait until the new care delivery system is in place, and if providers decide to wait until they know they’ll get paid for value-based care, neither will move forward. Instead, payers and providers need to collaborate or at least align with each other as they take steps towards adopting value-based payment models.

2. **Build a critical mass.** Multiple payers in a region are necessary to make it worthwhile for providers to participate in VBR in an efficient and automated fashion. Otherwise, it’s like launching a pilot program that is difficult to administer, inefficient, and not scalable. To this end:
   - *Find many local partners.* Align with other payers, hospital systems, and employers. This study shows that healthcare is evolving in a regional fashion and will continue to do so.
   - *Payers are well-positioned to take the lead,* bringing together multiple providers to talk about new types of reimbursement and what they’re trying to accomplish. Payers have the capital, infrastructure, and relationships (with employers, providers, and regulators) that allow them to invest in innovation and change through these partnerships.
   - *Find a neutral party.* Convening an open forum for stakeholders to talk freely about general ideas facilitated by a neutral party can be an effective approach. For example, the neutral party could be a local non-profit organization, or a state or county agency. In some cases, you could seek to participate in one of several federal initiatives, such as the CPCI program or through the State Innovation Models grants being awarded through CMS.
3. Reach out to employers. Employers are starting to embrace value-based care and payment arrangements, particularly episode-based reimbursement. Many companies are increasingly embracing health plan strategies that use financial incentives to hold providers accountable. That’s a big leap from where they used to be. There’s no time like the present to engage with employers in the discussion about value-based care and payment. Employers, providers, and payers all need to educate employees (i.e., patients) about value-based care so they understand it and can be part of the solution.

4. Find seed money. There has been a wave of grants to promote healthcare delivery reform. Look for federal, state, and foundation grants for pilot projects on delivery system design reform. In doing so, focus on one or two areas of reform to get value. Don’t try to do everything at once. You can’t boil the ocean. Land and expand instead. Conduct analytics to find out what your organization’s key pain points are, and focus only on the top one. For example, some organizations start by focusing on using episode of care for hip and knee replacements. Once they have that established, they target their next value-based innovation.

5. Have a five-year plan. This study shows that in five years, VBR will outpace FFS. Providers in particular tend to think in the short term, one pilot program at a time. But now you need to think longer term. Moving from pilot to standard operations requires scale. And technology can be an extremely effective enabler of scalability. Create a long term strategic road map that details where your organization needs to be in five years, and how it’s going to get there. Ensure the road map is flexible, however, because the environment is changing fast. Revisit the road map annually and rationalize the five-year plan against current industry trends.

6. Educate your people. Look for internal stakeholders within your organization, and together, get educated about marketplace trends identified in this study and be aware of what pilot studies are showing. Make sure you have benchmark data, because your people will need to be convinced that this is a real and crucial opportunity. Look for other health systems or plans that are ahead of you. Find champions in your organization (such as medical directors) who can lead, are highly respected, already have a key leadership role, and are diplomatic in building coalitions.

7. Adopt the new technology. Many believe the reason this change in healthcare delivery is happening now is simply because we finally have the technology that can make it
Value-based reimbursement models, especially when implemented as mixed reimbursement models—which is the current industry direction—are too complex and costly to design, administer, manage, measure, and scale without the right tools. When it comes to VBR, next-generation healthcare IT is crucial in four key areas: process reengineering and automation, connectivity, analytics, and decision support.

- **Process reengineering and automation** is critical to the success of VBR. The fast-growing mix of payment models is creating major complexity in the system. As the industry approaches 2020, this will intensify and trigger increased administrative costs that no organization can afford. To efficiently and effectively scale VBR, today's FFS processes must be reengineered, and hand-offs that might be manual must be automated.

- **Connectivity** is key to enabling payer and provider organizations to synchronize and streamline their own processes. It is also key to allowing effective communication with other stakeholders who are sharing information as well as the clinical and financial risk.

- **Analytics** help organizations support continual improvement by identifying problem areas and assessing trends inside the organization and in interactions with other stakeholders.

- **Decision support** helps payers, providers, clinicians, and even patients to use clinical evidence, as well as provider network and cost implications, to help make informed decisions at the point of care.

How does a payer, provider, clinician, or patient know what care is needed and when, let alone where it should be provided, what it will cost, and who should pay for it? It's not clear cut and it's not the same “patient-by-patient, plan-by-plan, send-me-a-fax” world. The only way to scale mixed reimbursement models across markets is to understand and use the new technology. By doing so, we can automate the complexity out of the human and organizational experience, and engineer better decisions across the board—all for better health in 2020.

Value-based reimbursement is not only here; it's here to stay. The vast majority of payers and providers in this study say that value-based models are not a fad. The choices for payers, providers, and clinicians are clear. And the time to act is now.
How Can McKesson Help?

At McKesson, we understand the challenges payers, providers, and clinicians face in the transition to value-based models. The only way to confidently scale today’s value-based reimbursement models is to automate the end-to-end process associated with them.

That’s why we’re investing in technology to enable VBR transformation, and it’s why our complete portfolio of products and services is focused on automating and transforming complex financial and clinical processes across healthcare to drive down costs and improve quality.

For more information on how McKesson can help your organization align with VBR, visit McKessonHS.com.

MHS Helps Automate & Transform Healthcare Reimbursement

Figure 1: McKesson Health Solution’s Comprehensive Reimbursement Technology Portfolio
As the healthcare industry transitions from a volume- to a value-based reimbursement approach, there have been enormous and rapid changes within the payer and provider landscape. The key players have had to be inventive and experimental in their efforts to improve the quality of care, while at the same time reducing their costs.

The government, and specifically the Affordable Care Act, has demanded innovation at a rapid-fire pace. But many reimbursement models and ideas put forth, although promising, are unproven and untested, and require technologies that are themselves untested on a larger scale.

**Background**

McKesson set out to determine the state of the industry’s transition from volume (fee-for-service) to value (value-based care). We wanted to go beyond the anecdotal evidence to gain a better understanding of how key stakeholders are reacting to the demands on them, how they are managing so far, what models and technology they are using, what is working, and what they expect to roll out in the next few years.

We decided to conduct a national study to explore these questions. The knowledge we gain is critical to informing the healthcare community—the payers, providers, and the vendors that serve them—and ultimately to the long-term success of payers and providers.
“The online survey of payers and providers represented a range of organization sizes and types.”

**Research Approach**

McKesson enlisted ORC International to conduct the national study on the transition to value-based care. The project had several phases, beginning with a 20-minute online survey of key stakeholders within both payer and provider organizations. ORC analysts poured over the results to identify key findings, trends, and themes that are pertinent to industry stakeholders.

**Survey Approach**

Survey design was built on the knowledge of population size and configuration in the payer and provider space in order to build statistically reliable research results. To optimize the breadth and representativeness of survey participants, respondents were recruited using large panels from an established panel supplier within the target functions of payers and providers.
Sample Designs: Payers
To include a wide range and representative sample of study participants, respondents were recruited using large panels from an established panel supplier within the target functions of payers and providers. All participants were executives performing at the director level and above and could speak to some of the overarching issues related to value-based reimbursement occurring in their organizations.

The online study included 114 payers, representing 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 or more lives. Payers encompassed a range of regions as well, with 30% operating in payer-centric regions, 11% in provider-centric regions, 28% in collaborative regions, and 29% in fragmented regions.

The distinction between collaborative and fragmented is that in a collaborative market there are one or two payers and one or two providers who are market leaders in the region. In a fragmented system, there are more than one or two payers and providers and no clear leaders.

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<table>
<thead>
<tr>
<th># Lives Covered</th>
<th>Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-500K</td>
<td>Payer-Centric</td>
</tr>
<tr>
<td></td>
<td>32%</td>
</tr>
<tr>
<td>500K-2M</td>
<td>Provider-Centric</td>
</tr>
<tr>
<td></td>
<td>42%</td>
</tr>
<tr>
<td>2M+</td>
<td>Collaboration</td>
</tr>
<tr>
<td></td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>Fragmented</td>
</tr>
<tr>
<td></td>
<td>29%</td>
</tr>
</tbody>
</table>

**Total Payers (N=114)**

Functions Recruited Into Study
- Medical Management
- Finance / Operations
- Network Management
- Technology

*Figure 2: Sample Design for Payers*
Sample Designs: Providers
McKesson also studied 350 providers, representing a similar range of size and scope. From the sample of providers, 21% have less than 100 beds, 38% have between 101 and 250 beds, and 40% have more than 250 beds.

As for region, 19% of providers are in payer-centric regions, 26% are in provider-centric regions, 23% are in collaborative regions, and 28% are in fragmented regions. It is important to note that 45% of providers are currently part of an ACO.

It was surprising to see that among those who are not part of an ACO, 59% of providers anticipate becoming part of an ACO within the next five years. Whether or not a provider is part of an ACO is important because it affects other factors, such as the provider’s alignment with value-based care systems.

We also found that 29% of providers have the availability of a health plan within the organization, and another 21% are part of a health plan offered to the general population. Similarly, 63% of providers are part of a health network or hospital system (vs. independent hospitals).

Figure 3: Sample Design for Providers
Figure 4: Sample Design for Providers

Availability of Health Plan in the Organization
- Health plan for employees only: 29%
- Health plan offered to general population: 21%
- Not a health plan: 48%
- I don’t know: 1%

Part of Health Network/Hospital System
- Yes: 63%
- No: 37%

Part of ACO
- Yes: 45%
- No: 55%

Anticipate Becoming Health Plan Within 5 Years?
- Yes: 23%
- No: 52%
- Don’t know: 26%

Anticipate Becoming ACO Within 5 Years?
- Yes: 59%
- No: 16%
- Don’t know: 25%
P4P Poised to Dominate but is Also the Most Challenging to Implement

The study demonstrated several dramatic themes in the transition occurring throughout healthcare delivery. We asked payers and providers many of the same questions, and found that in some instances, payers and providers are completely aligned in their expectations and experiences surrounding value-based reimbursement. They are also in agreement on some of the key issues that stakeholders face in the transition to value-based reimbursement.

Among the key findings, respondents project that pay-for-performance as a value-based model will experience the most growth and encompass a larger share of the reimbursement market.

It is important to note, however, that both payers and providers rate the pay-for-performance model with the highest level of difficulty to implement. In other words, the model that they predict will be a critical part of their reimbursement model is also the toughest to implement. They also rate a shared savings model as highly difficult to implement.
When asked what factors make these models difficult to implement, both providers and payers state that the key obstacles are technology related. They are concerned about not having the ability to measure and analyze, not having the infrastructure to support pay-for-performance, and a lack of systems to capture data.

Both payers and providers state that the tools they most urgently need to successfully implement value-based reimbursement are those that help clinicians understand and measure performance against quality and cost metrics.

Payers and providers are surprisingly aligned regarding the urgent need for these tools. In particular, both stakeholders believe the most critical tool to the success of value-based reimbursement is one that helps clinicians make decisions based on clinical evidence combined with member eligibility benefits and coverage information.
Value-Based Care Continuum – Current State

Payers and providers were asked to place themselves on a continuum of care, from FFS at one end and VBR at the other. We found that the larger the institution, the further along the continuum towards VBR they fall.

The data also shows that more collaborative regions are closer to VBR, whereas those in fragmented regions place themselves closer to FFS models. Similarly, ACOs are significantly closer to VBR than non-ACOs.

When asked how they feel they have fared in the transition to a value-based model, 64% of payers and 62% of providers feel they are on par with the rest of the industry, whereas 12% of payers and 16% of providers say they are behind. About a quarter of payers and providers say they are ahead.
“Large and more collaborative payers and providers are ahead of the curve in using value-based reimbursements.”
Payment Models Currently Implemented Among Payers

Payers are implementing a combination of payment models and the majority continue to use fee-for-service models.

Among value-based reimbursement models, the most widely used models are pay for performance (used by 65% of payers) and capitation, global payment, or total cost of care payment (used by 64% of payers).

Following close behind in popularity is episode of care/bundled payment, with 59% implementing these models. That’s followed by shared savings with upside, with 46% implementing. Shared savings with upside and downside is the least popular model, implemented by only 29%.

Payers in collaborative regions are significantly more likely to implement capitation/global payment compared to those in payer- and provider-centric regions. Larger payers are more likely to implement pay-for-performance models and shared savings with upside only.

“More than two-thirds of payers use pay-for-performance, capitation, global payment or total cost of payment value-based models of reimbursement.”

<table>
<thead>
<tr>
<th>Total Payers</th>
<th>Fee-for-service</th>
<th>Pay-for-performance (P4P)</th>
<th>Capitation, global payment, or total cost of care payment</th>
<th>Episode of care/bundled payment</th>
<th>Shared savings with upside</th>
<th>Shared savings with upside and downside</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>94%</td>
<td>65%</td>
<td>64%</td>
<td>59%</td>
<td>46%</td>
<td>29%</td>
</tr>
</tbody>
</table>

Figure 6: Payment Models Currently Implemented Among Payers

Letter indicates significant difference at 95% level of confidence.
“The majority of payers are encouraging patients to use higher value, lower cost providers or tiered provider pricing.”

Payer and Provider Use of Tiered Provider Pricing

More than two-thirds of payers are currently using tiered provider pricing, defined as a network structure geared toward encouraging patients to use higher value, lower cost providers. The majority of payers—68%—are currently doing this. Of payers who aren’t using tiered provider pricing, about half expect to be doing so in two to three years.

Among providers, fewer than half report participating in tiered pricing, and of those who aren’t, half expect to do so in the next two to three years. The fact that fewer providers than payers report participating in tiered pricing suggests that there is a subset of providers emerging as key partners for payers. In all likelihood, these providers are those who can demonstrate high quality, low cost care.
“This study found that 90% of payers and 81% of providers are already deploying some mix of value-based reimbursement combined with fee for service.”

**Mix of Payment Models: Payers**

Today, 90% of payers offer a mix of fee-for-service and other reimbursement models, and only 3% offer fee-for-service only. We asked payers who used mixed models to allocate the proportion of their total reimbursements among the models they use. On average, they allocate 56% to fee-for-service reimbursement, 17% to capitation, 10% to pay-for-performance, and smaller proportions to episode of care, global payment, and other models.

When projecting into the near future, however, participants expect the proportion of fee-for-service payments to decrease significantly, from 56% today to 32% five years from now. Much of that share will be taken up by the pay-for-performance model, which payers predict will increase from 10% today to 18% in five years.

Payers also predict that the share of payments through episode of care and bundled payment models will rise. Other models also show an increase, but payers predict that they will still make up a small proportion of total payments in five years.

There are some differences among the sample of payers. Those in collaborative regions currently have a higher proportion of pay-for-performance reimbursements than those in fragmented regions, and they expect to see more growth in pay-for-performance than those in fragmented regions. Similarly, the larger the payer, the more likely they are to expect pay-for-performance reimbursements to grow.
Figure 9: Payers’ Mix of Payment Models
“Providers are aligned with payers on embracing payment with value measures.”

Mix of Payment Models: Providers
Providers’ allocation of the proportion of reimbursements associated with different payment models is remarkably similar to that of payers. Providers allocate, on average, 57% for fee-for-service reimbursement but predict that the proportion will decrease dramatically to 34% in five years. They predict that pay-for-performance will jump from 9% today to 21% five years from now.

Smaller providers are more likely to report that fee-for-service makes up a higher proportion of their reimbursements. On the flip side, the larger the organization, the more likely it is to report that other models, particularly capitation and pay-for-performance, make up a higher proportion of its reimbursement. This finding underscores the role that institution size plays in VBR.

Likewise, if the institution is not part of an integrated delivery network or an ACO, it is more likely to state that a higher proportion of its reimbursement is fee-for-service. Those in collaborative regions are more likely to point to having shared savings as a part of their mix than those in fragmented regions.
Figure 10: Providers' Mix of Payment Models
“P4P is poised to dominate, but payers and providers agree that it is the most challenging to implement.”

**Comparison of Difficulty in Implementing Payment Models**

Both payers and providers state that although they expect pay-for-performance to be more common, they will have the most difficulty in implementing this model. They also rate the shared savings model as very or extremely difficult to implement.

Among respondents who have combined models, 15% of payers and 22% of providers rate the pay-for-performance model as very or extremely difficult to implement. The consistency in their answers is remarkable. Medium-sized providers are twice as likely as large providers to rate pay-for-performance models as very or extremely difficult to implement.

![Figure 11: Comparison of Difficulty in Implementing Payment Models](image)

(% rated extremely/very difficult – 9,10 on 10-pt scale)

<table>
<thead>
<tr>
<th>Payers who are other than fee-for-service only</th>
<th>Providers who are other than fee-for-service only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay for Performance</td>
<td>Pay for Performance</td>
</tr>
<tr>
<td>Episode of Care Payment/Bundled Payment</td>
<td>Episode of Care/Bundled Payment</td>
</tr>
<tr>
<td>Capitation</td>
<td>Capitation</td>
</tr>
<tr>
<td>Fee-for-Service only</td>
<td>Fee-for-Service only</td>
</tr>
<tr>
<td>Global Payment</td>
<td>Global Payment</td>
</tr>
<tr>
<td>Other (e.g. Shared Savings)</td>
<td>Other (e.g. Shared Savings)</td>
</tr>
</tbody>
</table>

Key Reasons
- Difficult to standardize
- Infrastructure/systems to capture data
- Allocation of payment / how to split
- Infrastructure/systems to capture data

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Key Drivers of Difficulty in Implementing Payment Models

Technology might be a major impediment to implementing payment models. When respondents rated a model as very difficult, they were asked to explain what factors made it hard to implement. Some key problems they cite include: It is difficult to standardize, difficult to measure/analyze, and they have a lack of infrastructure or systems to capture data.

Both payers and providers point to these technology issues as major obstacles. But providers are also struggling with how to allocate the payments among the various stakeholders, especially with episode of care and bundled payments.

“All key obstacles to implementing pay-for-performance are technology related, led by the need to integrate internal, vendor and collaborative IT systems.”

<table>
<thead>
<tr>
<th>Top Reasons find</th>
<th>Payers</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee-for-Service only to be difficult:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficult to get paid</td>
<td>14%</td>
<td>14%</td>
</tr>
<tr>
<td>Drives req. for constant inc. vol.</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>Difficult meet metrics/hit 100%</td>
<td>14</td>
<td>-</td>
</tr>
<tr>
<td>Complex system/must coordinate many pieces</td>
<td>24</td>
<td>-</td>
</tr>
<tr>
<td>Does not allow variation in Tx</td>
<td>14</td>
<td>-</td>
</tr>
<tr>
<td>Being phased out</td>
<td>-</td>
<td>14</td>
</tr>
<tr>
<td>Capitation to be difficult:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resistance from providers/CGs</td>
<td>21%</td>
<td>7%</td>
</tr>
<tr>
<td>Infrastructure/systems to capture data</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>Budget planning/staying within budget</td>
<td>-</td>
<td>11</td>
</tr>
<tr>
<td>Requires care integration/ coordinating all parties</td>
<td>-</td>
<td>11</td>
</tr>
<tr>
<td>Global Payment to be difficult:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allocation of pmnt/how to split</td>
<td>11%</td>
<td>19%</td>
</tr>
<tr>
<td>Complex system/must coordinate many pieces</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Resistance from providers/CGs</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Mandate/Medicare demanding</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Dependent on action of pt/CG/ out of provider's control</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Contract issues</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Episode of Care/Bundled Payment to be difficult:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allocation of pmnt/how to split</td>
<td>9%</td>
<td>27%</td>
</tr>
<tr>
<td>Difficult to control costs</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Contract issues</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Difficult to standardize</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Complex system/must coordinate many pieces</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>Requires care integration/ coordinating all parties</td>
<td>-</td>
<td>11</td>
</tr>
<tr>
<td>Pay for Performance to be difficult:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficult to standardize</td>
<td>24%</td>
<td>20%</td>
</tr>
<tr>
<td>Difficult to measure/analyze</td>
<td>20</td>
<td>11</td>
</tr>
<tr>
<td>Infrastructure/systems to capture data</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Difficult meet metrics/hit 100%</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>Difficult to implement</td>
<td>12</td>
<td>-</td>
</tr>
<tr>
<td>Dependent on action of pt/CG/ out of provider's control</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Other to be difficult:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficult to standardize infrastructure/systems to capture data</td>
<td>27%</td>
<td>6%</td>
</tr>
<tr>
<td>Allocation of pmnt/how to split</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td>Determining costs/uneven cost structures</td>
<td>-</td>
<td>17</td>
</tr>
<tr>
<td>Difficult to determine savings</td>
<td>-</td>
<td>17</td>
</tr>
<tr>
<td>Contract issues</td>
<td>-</td>
<td>11</td>
</tr>
</tbody>
</table>
Value-Based Metrics Measured in Provider Organizations

About three-quarters of providers are already implementing a number of value-based care metrics including patient experience, mortality measures, healthcare associated infection measures, clinical process of care measures, and patient safety measures.

“Only 37% of providers have implemented cost efficiency measures.”

However, a minority—only 37%—are measuring cost efficiency. Cost efficiency is a critical measure, and though it is uncommon today, 47% of providers not using these metrics expect to be implementing them within two to three years.

Current and Future Measures in Organization

<table>
<thead>
<tr>
<th></th>
<th>Today</th>
<th>2-3 years from now</th>
<th>Neither today nor 2-3 years from now</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Experience measures</td>
<td>79%</td>
<td>17%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Mortality measures</td>
<td>78%</td>
<td>3%</td>
<td>16%</td>
<td>9%</td>
</tr>
<tr>
<td>Healthcare Associated Infection measures</td>
<td>76%</td>
<td>18%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Clinical Process of Care measures</td>
<td>73%</td>
<td>22%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Patient Safety measures</td>
<td>71%</td>
<td>21%</td>
<td>4%</td>
<td>9%</td>
</tr>
<tr>
<td>Cost Efficiency measures</td>
<td>37%</td>
<td>47%</td>
<td>7%</td>
<td>9%</td>
</tr>
</tbody>
</table>
Perceived Financial Impact of a Transition to Value-Based Care

Payers and providers have different views on how value-based reimbursement models will impact the financial health of their organization. Nearly 60% of payers believe that making this transition to value-based reimbursement will have a positive impact on their organization financially.

Significantly fewer providers, only 35%, think that value-based models will have a positive financial impact on them. That difference is even greater among small providers (only 29% of whom said it will be a positive step, compared to 40% of large providers). This difference might reflect the notion that larger providers are more prepared for the transition and feel they can sail through it more easily.

“It’s also interesting to note that providers that are part of an ACO are significantly more likely to feel that this transition will have a positive financial impact than those not part of an ACO. This suggests that being part of an ACO makes a provider more aligned with the financial goals of the ACO.”
Payers are significantly more likely than providers to believe a transition to VBR will have a positive financial impact on the organization.

Providers who are not part of an ACO are the most likely to anticipate a negative financial impact.

**Perceived Financial Impact of a Transition to Value-Based Care**

<table>
<thead>
<tr>
<th>Impact on Profitability</th>
<th>Total Payers</th>
<th>Total Providers</th>
<th>&lt;100</th>
<th>101-250</th>
<th>&gt;250</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>59%</td>
<td>35%</td>
<td>29%</td>
<td>32%</td>
<td>40%</td>
<td>41%</td>
<td>30%</td>
</tr>
<tr>
<td>Negative</td>
<td>17%</td>
<td>45%</td>
<td>48%</td>
<td>49%</td>
<td>39%</td>
<td>37%</td>
<td>52%</td>
</tr>
</tbody>
</table>

It would have no significant impact: 25% 21% 23% 39% 21% 22% 20%

Letter indicates significant difference at 95% level of confidence.

**Figure 14: Perceived Financial Impact of a Transition to Value-Based Care**
**Reduction of Pricing to Payers**

In the current healthcare climate, some providers have been forced to reduce their pricing to payers. The study asked, “Have you had to reduce your pricing to payers by more than 20% in the last 12 months?” In fact, the study found that the majority—73%—have not reduced pricing by more than 20% in the last year.

But 15% say they had, and though not a majority, this still represents a significant number of providers. When those providers who have reduced pricing by 20% or more were asked what their institution was doing to remain financially sound, 44% say they are reducing costs, and 39% are streamlining and improving processes.

Technology plays a large role in both of these cost-saving approaches.

“A small but significant percentage of providers have been forced to reduce their pricing to payers by more than 20% in the last year.”

---

**Figure 15: Reduction of Pricing to Payers**

<table>
<thead>
<tr>
<th>Actions taken to be financially sound</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce costs</td>
<td>44%</td>
</tr>
<tr>
<td>Streamline/improve processes</td>
<td>39%</td>
</tr>
<tr>
<td>Increase volume of patients/Reduce readmissions</td>
<td>13%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>20%</td>
</tr>
</tbody>
</table>

---

**Reduction of Pricing to Payers by >20% in Last 12 months**

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>15%</td>
</tr>
<tr>
<td>No</td>
<td>73%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>11%</td>
</tr>
</tbody>
</table>
Top 3 Areas of Focus to Improve Overall Financial Performance

Providers were asked what their organizations’ top three areas of focus are to improve its overall financial performance. About two-thirds of the respondents rank revenue capture and clinical outcomes as their first or second top areas of focus. Administrative costs are ranked one or two by about 40% of providers. Consumer engagement is ranked first or second by only 28% of providers.

“Revenue capture tops providers’ lists to improve financial performance.”

Figure 16: Top 3 Areas of Focus to Improve Overall Financial Performance
Top Challenges to the Implementation and Success of Value–Based Reimbursement

To understand the biggest hurdles to implementing value-based reimbursement, payers and providers were provided with a list of issues and asked to rate how much of an obstacle each posed to success.

“Clinician engagement is a challenge that must be overcome for VBR to succeed.”

The single-most significant obstacle for both payers and providers is obtaining buy-in and engagement with value-based reimbursement on the part of the clinicians. However, in aggregate, more payers are likely to select integration issues as an obstacle, such as integration with providers’ various IT systems and integration of their own organizations’ systems with their providers’ EHR systems. Other highly ranked challenges are patient understanding of value-based reimbursement as well as payment within bundled and capitated models.
### % Provider Respondents Who Rated Issue the Highest (Most Significant Obstacle to the Success of VBR)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Total Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buy-in / engagement with VBR on the part of healthcare clinicians</td>
<td>17%</td>
</tr>
<tr>
<td>Patient engagement with/understanding of VBR benefit plan &amp; network</td>
<td>23%</td>
</tr>
<tr>
<td>Can pay other providers as part of bundle/capitated value based model</td>
<td>11%</td>
</tr>
<tr>
<td>Can reconcile &amp; adjust cost structure to implement new revenue models</td>
<td>10%</td>
</tr>
<tr>
<td>Interoperability of our EHR with internal and external systems</td>
<td>9%</td>
</tr>
<tr>
<td>Integration of my institution’s IT platforms w/our payers or other providers</td>
<td>8%</td>
</tr>
<tr>
<td>Access to the right data</td>
<td>8%</td>
</tr>
<tr>
<td>Performance analytics</td>
<td>6%</td>
</tr>
<tr>
<td>Ability to measure performance against value-based metrics</td>
<td>6%</td>
</tr>
<tr>
<td>Can share performance results w/payers, so can pay against those metrics</td>
<td>6%</td>
</tr>
<tr>
<td>Can differentiate my system/hospital within narrow networks of payers</td>
<td>5%</td>
</tr>
</tbody>
</table>

**Figure 18: Providers’ Top Challenges to the Implementation and Success of Value–Based Reimbursement**
“The vast majority of providers believe value-based reimbursement is not just a fad.”

Is VBR Here to Stay?

This is, of course, the big question. The vast majority of providers say that value-based models are here to stay and are not a fad.

Those who are less likely to think these models are permanent tend to be in smaller institutions or in fragmented regions.

About one-third of those in systems with under 100 beds say value-based models are just a fad.
About ORC International
ORC International is a research and business intelligence firm with 15 offices worldwide. The firm provides organizations with insight to support business growth and performance, specializing in the areas of Customer Equity, Employee Engagement, Marketing, and Strategy Development. ORC International’s aim is to engage, empower, and elevate clients’ market knowledge to become innovators in their fields, to capitalize on new opportunities, and to drive results, all through a unique, integrated approach—a combination of passionate researchers and industry experts paired with bespoke technology platforms and research science. For more information, please visit www.ORCInternational.com.

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