TERRY Health

2023 Perspectives on Value-Based Care

Insights from Terry Health's Survey of Over 400 Providers and Payers

Research conducted by
Healthcare Financial Management Association (HFMA)

Table of Contents

Executive Summary

The shift to value-based care (VBC) is creating new challenges and opportunities for participants in the U.S. healthcare system. To better understand the rapidly evolving VBC landscape, Terry Health conducted a survey of over 400 providers, payers, and hybrid "pay-viders" in the spring of 2023. The survey paid particular attention to identifying areas in which the VBC experience of different types of healthcare organizations is aligned or at odds.

The Terry Health survey gives ample reasons for both hope and concern about the future of VBC.

The Terry Health survey gives ample reasons for both hope and concern about the future of VBC. The good news is that most respondents believe that VBC has the potential to deliver better health outcomes at a more affordable cost. The bad news is that the survey also reveals that there are significant obstacles to realizing VBC's full potential.

Among the most important findings are:

- Large majorities of respondents report that their VBC programs have been at least somewhat successful in improving patient/clinical outcomes, controlling/reducing costs, and improving patient experience. Only small minorities, however, think that they have been very successful in any of these areas.

- Healthcare system participants worry that significant obstacles are holding back VBC. Sixty-one percent of respondents say that reluctance to assume downside risk is a very significant factor in slowing VBC's growth, 51 percent say that the requirement to prove near-term ROI is, and 47 percent say that ongoing administrative costs are.

- Respondents also report that capability gaps in their organizations have negatively affected the performance of their VBC programs. Data availability is the most frequently cited capability gap, with 74 percent of respondents reporting that a gap in this area has had either a major or a minor negative effect on performance. Gaps in IT/digital capabilities (67 percent) and analytical capabilities (66 percent) are also high on the list of concerns.

- In addition to assessing capability gaps in their own organizations, respondents were asked whether they think the counterpart organizations in their VBC contracts have capability gaps. In every area, payers were much more likely to say that capability gaps have negatively affected the performance of providers than providers were to say that capability gaps have negatively affected the performance of payers.

- The survey revealed a worrisome difference of opinion about the fairness of VBC contracts. While payers tend to believe that VBC contract terms and conditions are neutral in the sense that they equally benefit both parties, many providers believe that they favor payers. When it comes to payment terms, 52 percent of providers believe this.

.....>

Executive Summary

- Contract terms aside, we also asked respondents to tell us more generally who they think benefits the most from VBC. Although there was no clear consensus among payers, providers and hybrids have little doubt that it is insurers.

While some of the survey findings merely confirm what will be common knowledge for most of our readers, we expect that others will be eye-opening. We hope that the insights the survey offers will help providers, payers, and hybrids alike navigate their VBC journeys more successfully. Understanding the challenges is at least as important as understanding the opportunities. And though the perspectives of healthcare system participants may differ, we all have the same goal: to deliver better health outcomes and a better healthcare experience at a more affordable cost.

Introducing the Terry Health Survey

As the industry shifts further into value-based care (VBC), U.S. healthcare organizations are dramatically reformulating their operations, business models, and risk arrangements.

> The Terry Health survey seeks to identify areas in which the VBC experience of providers, payers, and hybrids is aligned or at odds.

To better understand the challenges and opportunities that this shift creates, Terry Health conducted a survey of over 400 providers, payers, and hybrid "pay-viders" in the spring of 2023. While most previous VBC surveys have focused exclusively on either providers or payers, ours seeks to throw light on the perspectives of different types of participants in the healthcare system and to identify areas in which their experience is aligned or at odds. Our hope is that a better understanding of these perspectives will allow VBC to more fully achieve its potential to deliver better health outcomes at a more affordable cost.

The great majority of respondents are from healthcare organizations that are currently engaged in VBC. The survey, however, also includes some respondents from organizations that do not yet have VBC programs but are planning to launch them, as well as some from organizations that have no current plans to engage in VBC. Healthcare organizations of all sizes are represented, from relatively small to very large. So are organizations with VBC programs in all lines of business, including commercial, Medicare, and Medicaid.

The combined survey results for providers, payers, and hybrids are statistically significant, as are the results for providers alone. The numbers of payers and hybrids in the sample, when considered separately, are not large enough to meet standard tests of statistical significance. However, we believe that the results for these groups are sufficiently representative to allow at least tentative conclusions.*

The report is organized as follows. The next section discusses why healthcare organizations decide to become engaged in VBC, what respondents think the impact of their VBC programs has been, and how they assess VBC's potential to improve outcomes in the U.S. healthcare system as a whole. The following two sections turn to obstacles to VBC's long-term success, including factors that are impeding its more widespread adoption, capability gaps in organizations that already have VBC programs, and divergent views among different types of healthcare system participants about who benefits most from VBC. A conclusion then summarizes the report's findings.

* For technical details on the survey, including sample size, composition, and statistical significance, see the Technical Note at the end of the report.

Findings: Cautious *Optimism* about VBC's Impact

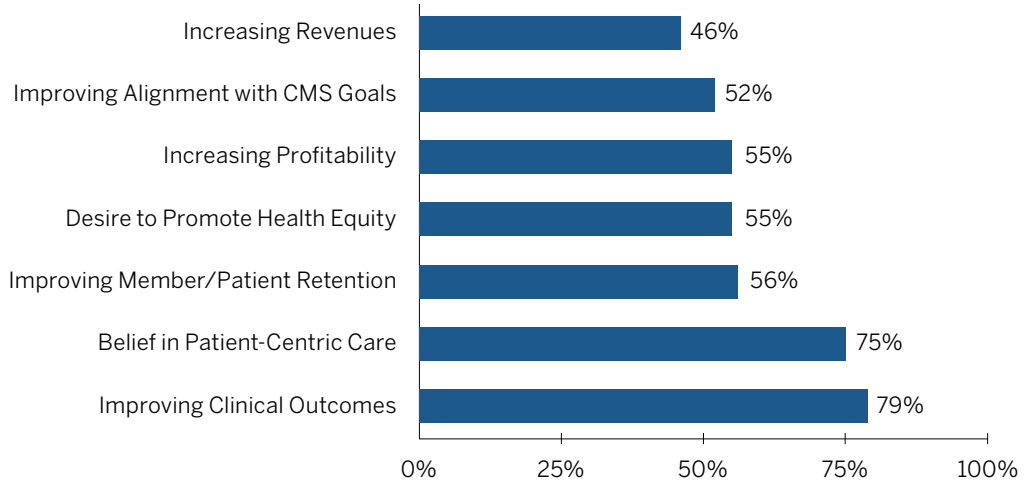
Bottom-line business interests clearly play an important role in persuading health-care organizations to become engaged in VBC. Roughly half of respondents from organizations that currently have or plan to have VBC programs report that increasing revenues, increasing profitability, improving member/patient retention, and improving alignment with CMS goals were very important considerations. Yet just as clearly, the decision to become engaged in VBC is also motivated by loftier goals. Slightly over half of respondents report that a desire to promote health equity was a very important consideration, fully three-quarters report that a belief in patient-centric care was, and four-fifths report that improving clinical outcomes was. (See figure 1.)

As we will see, there are some areas in which the perspectives of providers, payers, and hybrids diverge widely. The reasons for becoming engaged in VBC is not one of them. There are few striking differences in responses by organization type, except that payers are less likely to cite increasing revenues or profitability as very important, and more likely to cite improving alignment with CMS goals and a desire to promote health equity. Nor are there many striking differences by organization size, except that small and medium-sized organizations are more likely to cite increasing revenues and profitability, while very large ones are more likely to cite a belief in patient-centric care and a desire to promote health equity.

The views of healthcare system participants on the impact of VBC can best be described as cautiously optimistic. We asked those respondents whose organizations are currently engaged in VBC how successful they believe their programs have been in

Figure 1

Share of Respondents Saying That Various Considerations Were Very Important in Persuading Their Organizations to Become Engaged in VBC



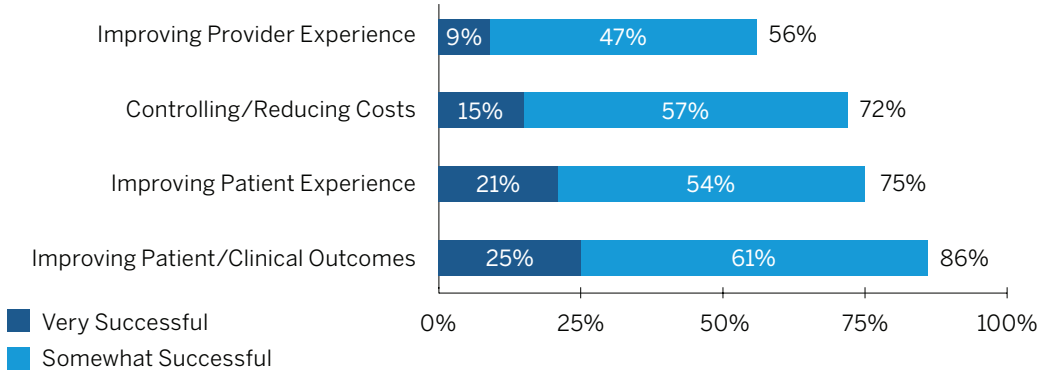
While a majority of respondents report that their VBC programs have been at least somewhat successful in improving outcomes across the four dimensions of the "quadruple aim," only a minority report that they have been very successful.

improving outcomes across the four dimensions of the so-called quadruple aim. Large majorities thought that they had been at least somewhat successful in improving patient/clinical outcomes, controlling/reducing costs, and improving patient experience, while a slight majority thought that they had been at least somewhat successful in improving provider experience. Only small minorities, however, thought that their VBC programs had been very successful in any of these areas. (See figure 2.) The views of providers, payers, and hybrids were generally aligned, except that payers and hybrids were more optimistic than providers about the impact of VBC on costs, while hybrids were more optimistic than either payers or providers about its impact on patient and provider experience.

We also asked all respondents, whether or not they are currently engaged in VBC, how

Figure 2

Share of Respondents Saying That Their VBC Programs Have Been Successful in Improving Outcomes across the Four Dimensions of the Quadruple Aim

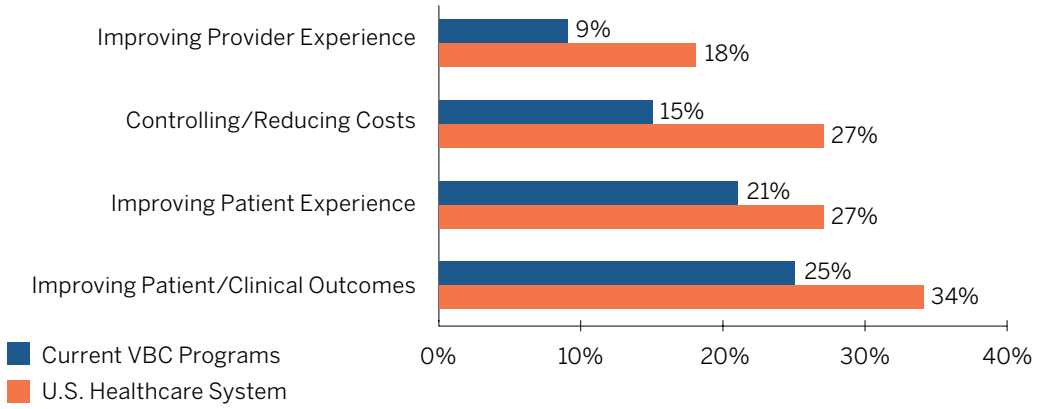


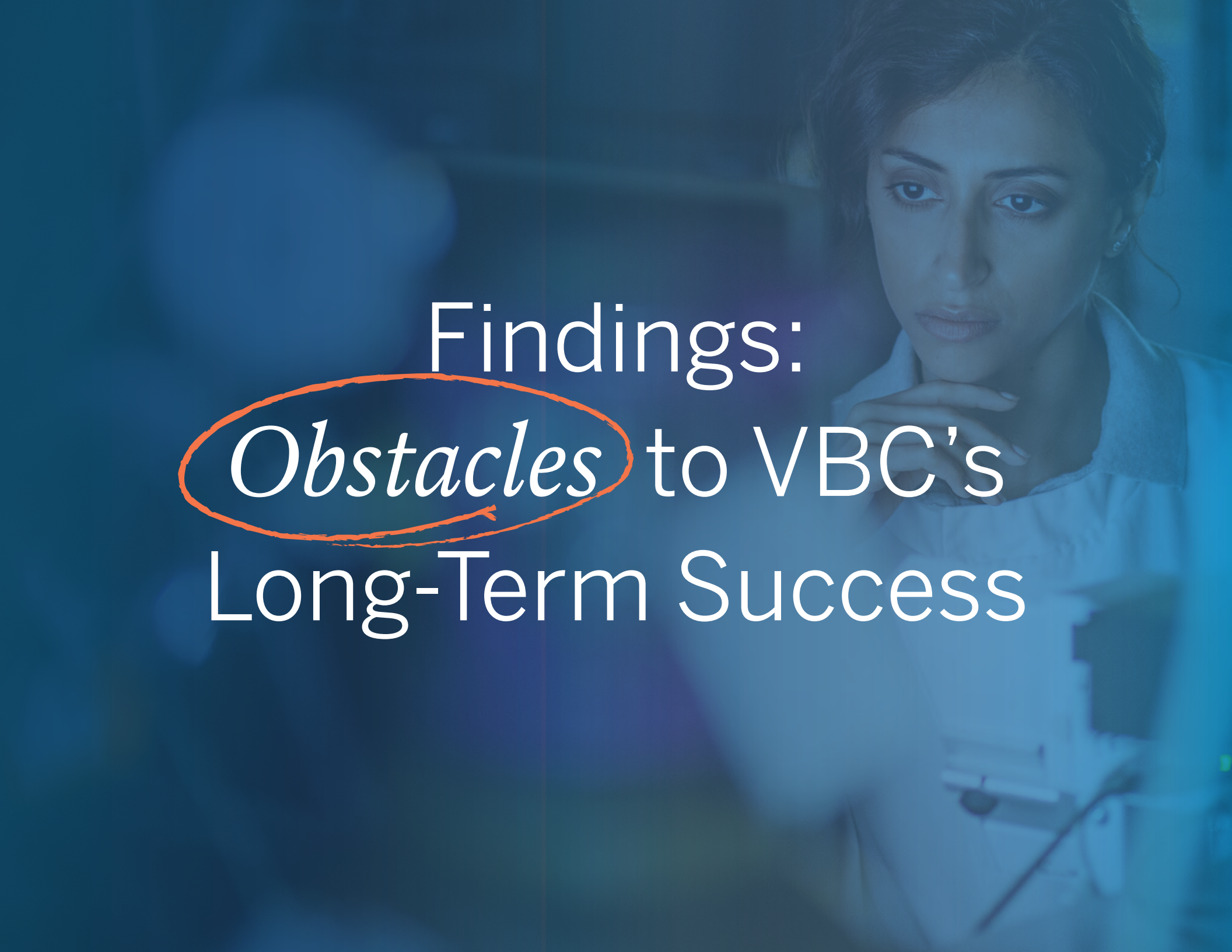
great a long-term potential they think VBC has to improve outcomes in the U.S. healthcare system as a whole. The shares of respondents saying that VBC has a great potential to improve systemwide outcomes were somewhat larger across all four dimensions of the quadruple aim than the shares saying that their own VBC programs have been very successful in improving outcomes. Yet these optimists still represented a minority of all respondents. (See figure 3.) Respondents from organizations planning to engage in VBC tended to be somewhat more pessimistic about VBC's long-term potential than those from organizations already engaged in VBC, while respondents from organizations with no current plans to engage in VBC tended to be considerably more pessimistic.

In recent years, healthcare system participants have become increasingly focused on reducing health disparities and improving health equity. With this in mind, we asked respondents how successful they believe the more widespread adoption of VBC would be in advancing these goals. Respondents were instructed to rate their answers on a scale of 1 to 5, with 1 being not at all successful and 5 being very successful. The average response for all respondents was an underwhelming 2.9. It may be that respondents believe that VBC is not particularly well adapted to the task of improving health equity. Or it may be that they believe no healthcare strategy is likely to have significant success absent broader economic and social reforms that address the root causes of health disparities.

Figure 3

Share of Respondents Saying That Their Current VBC Programs Have Been Very Successful in Improving Outcomes versus the Share Saying That VBC Has a Great Potential to Improve Outcomes in the U.S. Healthcare System as a Whole





Findings: *Obstacles* to VBC's Long-Term Success

Survey respondents believe that there are serious obstacles to VBC's long-term success, the most frequently cited being the reluctance of healthcare system participants to assume downside risk. When asked how significant various factors have been in slowing the growth of VBC in the U.S. healthcare system, 61 percent of respondents said that reluctance to assume downside risk was a very significant factor, while just 4 percent said that it was not at all significant. This reluctance seems to be reflected in the payment arrangements in respondents' own VBC programs. While 90 percent of respondents from organizations with commercial VBC contracts report that their programs include pay-for-performance, just 59 percent report that they include shared savings with downside risk and just 42 percent report that they include comprehensive population-based payment. The numbers for Medicare and Medicaid contracts are similar.

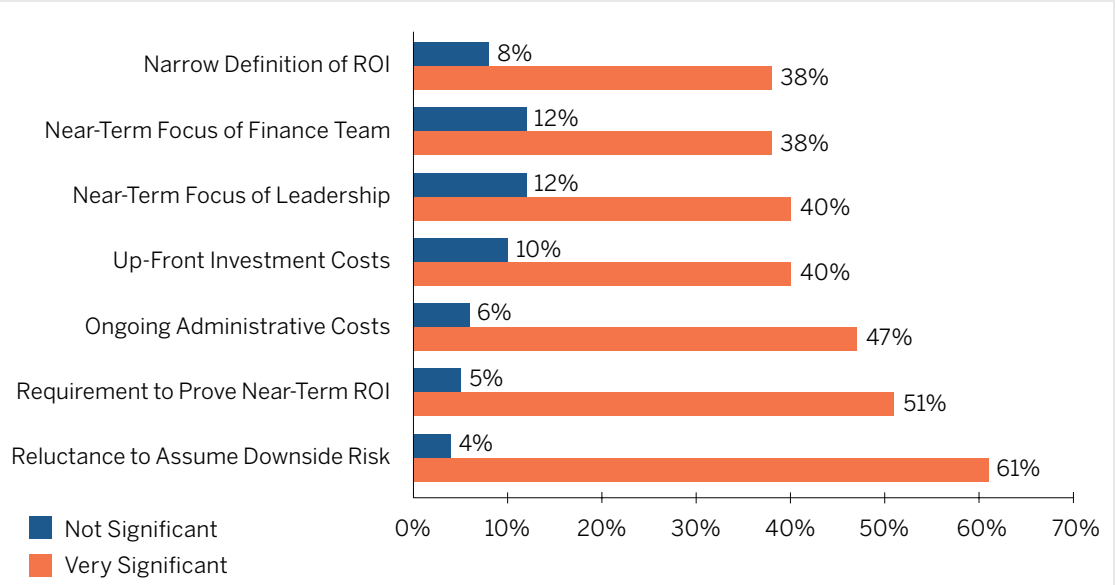
Three-fifths of respondents believe that reluctance to assume downside risk is a serious obstacle to VBC's success.

Yet if reluctance to assume downside risk is the most frequently cited obstacle to VBC's long-term success, it is by no means the only one. Roughly half of respondents think that ongoing administrative costs and the requirement to prove near-term ROI are very significant factors in slowing VBC's growth.

Smaller, but still substantial, shares think that up-front investment costs, a near-term focus of leadership and the finance team, and a narrow and purely financial definition of ROI are very significant factors. Very few respondents think that these factors are not at all significant. (See figure 4.)

Figure 4

Share of Respondents Saying That Various Factors Have Been Very Significant or Not Significant in Slowing the Growth of VBC in the U.S. Healthcare System



There are some interesting differences by organization type and size. Hybrids are more likely to think that the requirement to prove near-term ROI, the narrow definition of ROI, and ongoing administrative costs are very significant factors in slowing the growth of VBC. Providers are least concerned about the near-term focus of leadership or the finance team, while payers are most concerned. Not surprisingly, concerns about downside risk vary by organization size, with the share of respondents citing reluctance to assume it as a very significant factor in slowing the growth of VBC rising from 55 percent at very large organizations to 75 percent at small ones.

The buy-in of physicians is obviously critical to VBC's long-term success, yet physicians often express concerns about participating in VBC programs. Among the most commonly heard are that the data needed for physicians to perform effectively in VBC programs are often insufficient or inaccurate; that the requirements of VBC contracts may add to workload and/or negatively affect daily clinical care; that organizations often fail to align the physician compensation model with the requirements of VBC programs; and that organizations do not do enough to solicit physician input and feedback.

Large majorities of respondents report that gaps in data availability, IT/digital capabilities, and analytical capabilities have negatively affected the performance of their VBC programs.

We asked respondents which of these physician concerns they think need to be addressed in order to help ensure VBC's long-term success, and instructed them to choose the two that they believe are most important. Whether rightly or wrongly, very few respondents thought that doing more to solicit physician input and feedback is a priority, with just 10 percent including this concern in their top two. Beyond that, there was little consensus. Concerns about workload made the top-two list of 42 percent of respondents, concerns about the physician compensation model made the top-two list of 39 percent, and concerns about data availability made the top-two list of 33 percent. The relatively low priority given to physician concerns about data availability is surprising, since providers, payers, and hybrids all acknowledge that it constitutes a significant capability gap in their organizations.

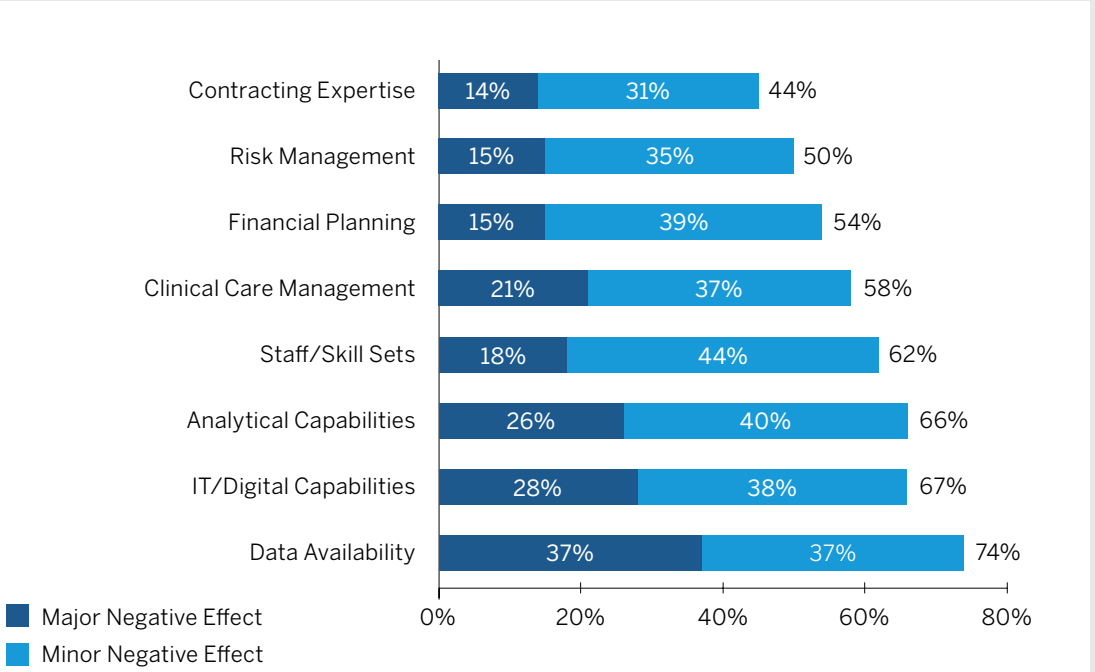
Even as obstacles like these are slowing VBC's growth, capability gaps in organizations that are already engaged in VBC may be undermining its effectiveness. We asked respondents whether gaps in a variety of areas have negatively affected the performance of their VBC programs. Data availability was the most frequently cited concern, with 74 percent of respondents reporting that a capability gap in this area has had either a major or a minor negative effect on performance. Gaps in IT/digital capabilities (67 percent) and analytical capabilities (66 percent) were also high on the list of concerns. Contracting expertise, where a much smaller 44 percent of respondents report having a capability gap, was at the bottom of the list. The shares of respondents reporting that capability gaps have had a major negative effect were considerably smaller than the shares reporting that they have had any negative effect at all.

But data availability, IT/digital capabilities, and analytical capabilities were still at the top of the list, while contracting expertise was still at the bottom. (See figure 5.)

We also asked respondents from organizations that are planning to become engaged in VBC whether they expect to have capability gaps in the same areas. Interestingly, the

Figure 5

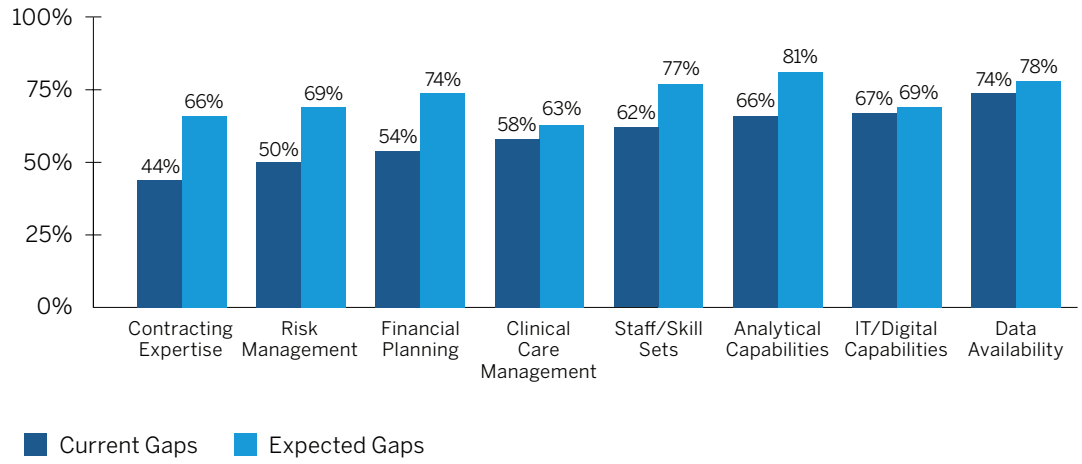
Share of Respondents Saying That Capability Gaps Have Had a Negative Effect on the Performance of Their VBC Programs



expected gaps are in every area larger than the actual gaps that respondents from organizations currently engaged in VBC report, and in some areas they are much larger. (See figure 6.) There are at least two plausible explanations. The first, and more pessimistic, is that earlier entrants to VBC tended to be industry leaders and are better prepared to manage its complexities than later entrants are. The second, and more optimistic, is that capability gaps tend to shrink over time as organizations "learn by doing."

Figure 6

Share of Respondents at Organizations with VBC Programs Reporting Capability Gaps versus Share of Respondents at Organizations That Plan to Engage in VBC Expecting to Have Capability Gaps

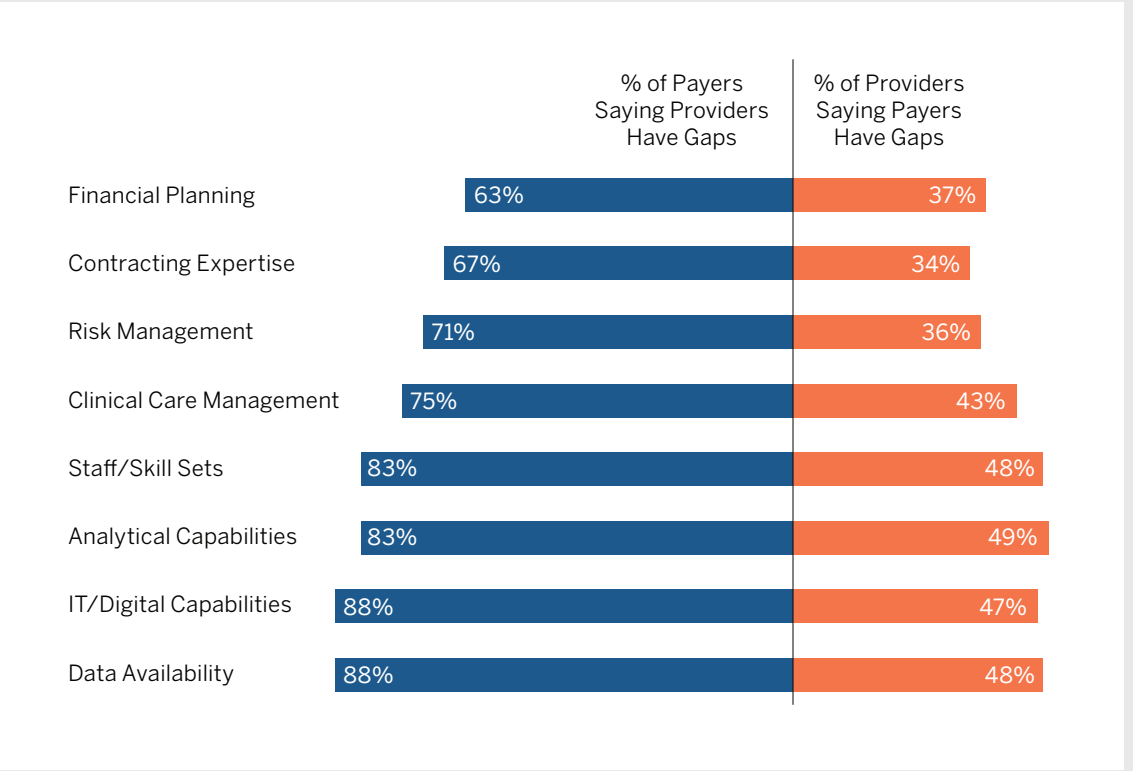


Providers appear to believe that payers are well equipped to succeed in a VBC world, while payers appear to doubt that providers are.

Perceptions about capability gaps in the organizations one does business with can sometimes be as revealing as perceptions about one's own capability gaps. To gauge these perceptions, we asked respondents from organizations that are currently engaged in VBC whether they think that capability gaps in the counterpart organizations with which they have contracts have negatively affected the performance of those organizations. The answers are eye-opening. In every area, payers were much more likely to say that their VBC counterparts have capability gaps than providers were. In other words, providers appear to believe that payers are well equipped to succeed in a VBC world, while payers appear to doubt that providers are. (See figure 7.) Hybrids were also more likely than providers to say that their VBC counterparts have capability gaps, but not as likely as payers were.

Figure 7

Share of Payers and Providers Saying That the Other Party to Their VBC Contracts Has Capability Gaps



Findings: Who Benefits Most from VBC

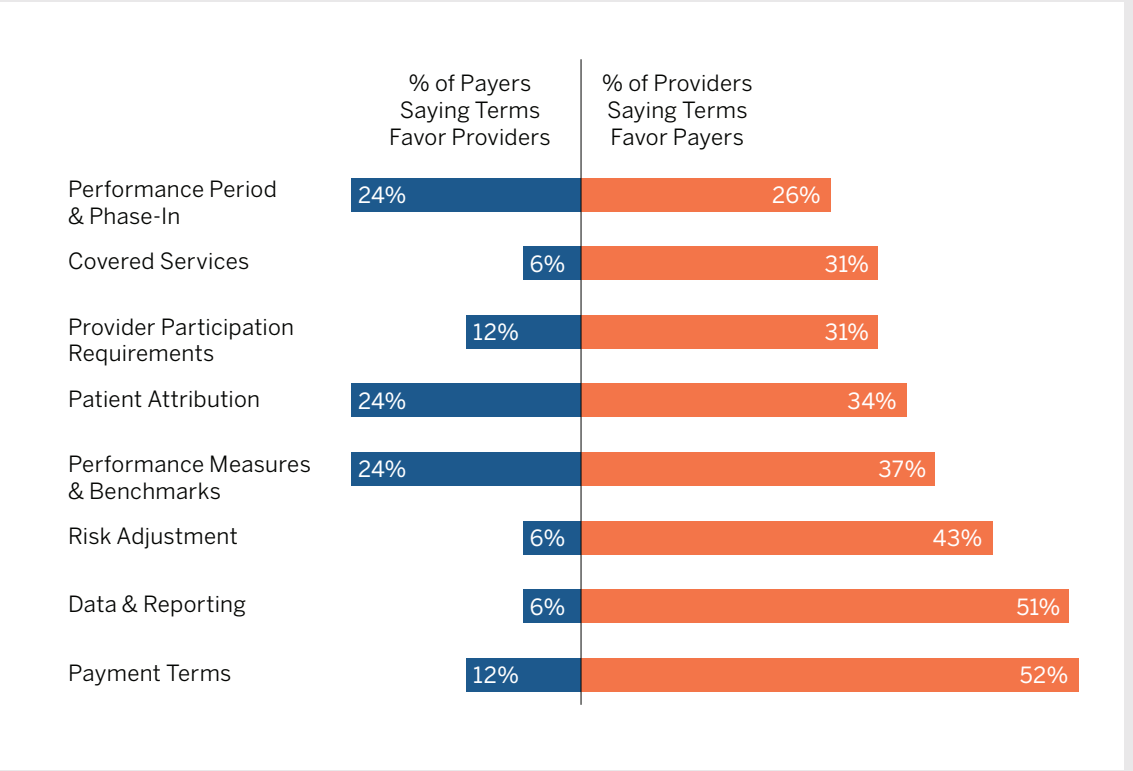
The survey reveals a worrisome difference of opinion about the fairness of VBC contracts. We asked respondents at organizations that are currently engaged in VBC whether the terms and conditions of their VBC contracts favor their own organization, the other party to the contract, or are neutral in the sense that they are fair and equally benefit both parties. In every contract area, from covered services to payment terms, providers were more likely than payers to believe that contracts favor the other party, and in some areas, including covered services, risk adjustment, data and reporting responsibilities, and payment terms, they were far more likely to believe this. (See figure 8.)

Fully one-half of providers believe that the payment terms in their VBC contracts favor their payer counterparts.

The perceptions of providers about the fairness of VBC contracts are striking enough in and of themselves. What makes them even more striking is that providers

Figure 8

Share of Payers and Providers Saying That the Terms of Their VBC Contracts Favor the Other Party

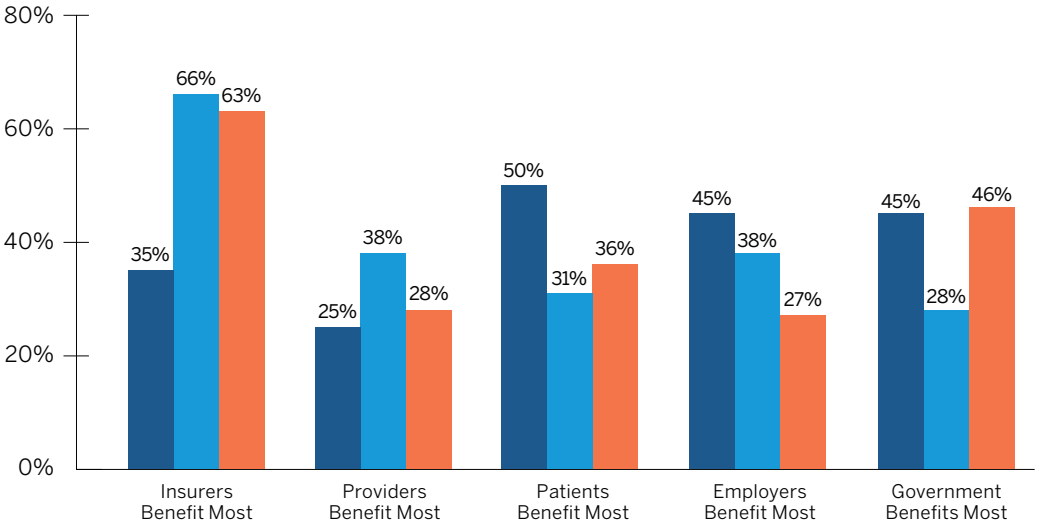


are no more likely than payers to say that a capability gap in their contracting expertise has negatively affected the performance of their VBC programs. There are several possible explanations for this seeming inconsistency in the survey results. Providers may be underestimating their capability gap in contracting expertise, they may be overstating the extent to which VBC contracts favor payers, or they may be doing both. Then again, they may be accurate in both assessments. If so, it would suggest that the balance of power in the relationship between payers and providers is so heavily tilted toward payers that it will be difficult to correct.

Contract terms aside, we also asked all respondents to tell us who they think benefits the most from VBC. Specifically, respondents were asked to rank insurers, providers, patients, employers (as plan sponsors), and the government (as Medicare and Medicaid payer) in order from benefits the most to benefits the least. The differences in responses by organization type are revealing. Although there is no clear consensus among payers about who benefits most, providers and hybrids have little doubt that it is insurers. (See figure 9.)

Figure 9

Share of Providers, Payers, and Hybrids Saying That Various Parties Benefit Most from VBC*



* Share of respondents ranking each party in first or second place.

Conclusion

The Terry Health survey gives ample reasons for both hope and concern about the future of VBC. On the hopeful side, large majorities of respondents report that their VBC programs have been at least somewhat successful in improving patient/clinical outcomes, controlling/reducing costs, and improving patient experience. Large majorities also believe that VBC has the potential to deliver these results in the U.S. healthcare system as a whole. Payers, providers, and hybrids, moreover, are all in broad agreement that this is the case.

It is true that only a slight majority of respondents report that their VBC programs have been at least somewhat successful in improving provider experience. But unlike the other three dimensions of the quadruple aim, this has never been one of VBC's core goals. It is also true that respondents see only a limited potential for VBC to improve health equity. But the causes of health disparities are complex and rooted in deeper economic and social inequities. It may be too much to expect that VBC alone can do much to move the needle.

Respondents seem to believe that VBC is having only a marginal impact on how the healthcare system works, not the transformative one that many of its architects and advocates hoped it would.

The real cause for concern is that only a minority of respondents believe that VBC has been or will be *very* successful in improving patient/clinical outcomes, controlling/reducing costs, or improving patient experience. Healthcare system participants are optimistic about VBC's potential, but only cautiously so. The impression one gets is that they believe the shift to VBC is having only a marginal impact on how the healthcare system works, not the transformative one that many of its architects and advocates hoped it would.

The survey suggests that this concern is well founded. There are the broad obstacles slowing the growth of VBC in the U.S. healthcare system, chief among them the reluctance of organizations to assume downside risk. Unless this changes, the underlying cost-plus incentives in healthcare financing and delivery will remain largely unchanged and the goal of delivering better health outcomes at a more affordable cost will prove elusive. Then there are the capability gaps in healthcare organizations engaged in VBC, especially in data availability, IT/digital capabilities, and analytical capabilities. Finally, there is the worrisome divergence in perspectives among providers, payers, and hybrids about who benefits most from VBC.

Addressing these challenges will be difficult, but not impossible. The government could make better use of both carrots and sticks to prod more healthcare organizations into VBC payment arrangements that include downside risk, or even full capitation. Healthcare organizations, especially small and medium-sized ones, could lean more heavily on external support to close the capability gaps that are undermining the performance of their VBC programs.

Conclusion

It may even be possible to find ways to level the VBC playing field, since in the end this would be in the interests of all concerned. While all types of healthcare organizations have a critical role to play in VBC, providers are the pivot on which the whole healthcare system turns. If significant numbers find that participating in VBC is not to their advantage, its long-term success could be doomed.

Technical Note

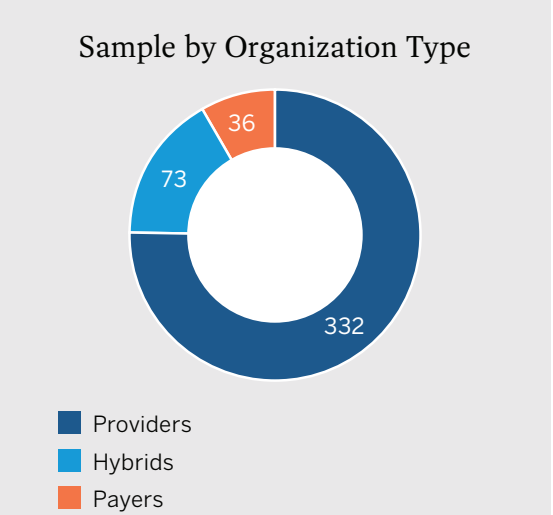
This technical note provides additional information about the Terry Health survey, including details on sample size and composition and the statistical significance of the results.

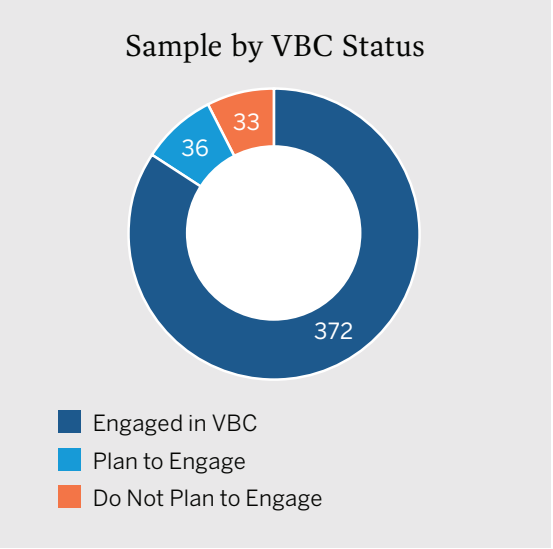
The survey was administered to a randomly selected sample of providers, payers, and hybrids in May 2023 using the Qualtrics online survey platform. The Healthcare Financial Management Association (HFMA) coded the survey, fielded it, and audited the raw data. Terry Health developed the survey instrument, analyzed the survey results, and wrote the report.

The survey sample consists of 441 respondents. Of these, 332 are from organizations that respondents identified as providers, 73 are from organizations that they identified as hybrids, and 36 are from organizations that they identified as payers. Participation in the survey was restricted to respondents at the director level or above. Respondents reported being responsible for a wide variety of functions within their organizations, the most common being finance or accounting (37 percent), operations or administration (29 percent), and revenue cycle or patient financial services (18 percent).

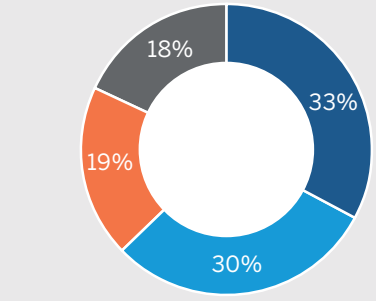
The great majority of respondents (372) are from organizations that are currently engaged in VBC. The sample, however, also includes some respondents from organizations that do not yet have VBC programs but are planning to launch them (36), as well as some from organizations that have no current plans to engage in VBC (33). Among respondents at organizations that are currently engaged in VBC, 85 percent report having commercial programs, 85 percent Medicare programs, and 67 percent Medicaid programs.

The sample includes healthcare organizations from all regions of the United States. It also includes organizations of all sizes. Organization size was determined as follows. Respondents were first asked to select one of four possible metrics for measuring size, then were asked to select a range for the metric they selected. The possible metrics were covered lives, patient panels, hospital beds, and net patient services revenue. In tabulating the survey results, we combined the corresponding size ranges for the four different metrics to derive overall counts for the number of small, medium-sized, large, and very large organizations.



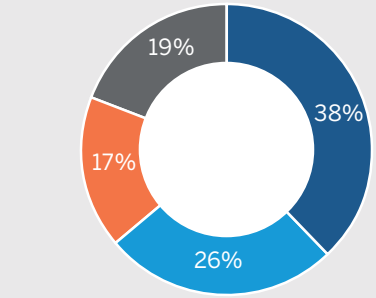


Distribution of Sample by Region*



*Excludes 80 records where location is not available and 12 records from Puerto Rico or elsewhere outside the fifty states.

Distribution of Sample by Organization Size*



*Excludes 43 records where size is not available.

Organization Size Metrics and Ranges

	Covered Lives	Hospital Beds
Small	Under 100,000	Under 26
Medium	100,000–500,000	26–100
Large	501,000–1,000,000	101–999
Very Large	Over 1,000,000	Over 999
	Patient Panels	**Net Patient Services Revenue**
Small	Under 1,200	Under $100 million
Medium	1,200–1,900	$100–$500 million
Large	1,901–2,300	$501 million–$1 billion
Very Large	Over 2,300	Over $1 billion

We calculate that the survey results for providers, payers, and hybrids combined are statistically significant at the 95 percent confidence interval with a margin of error of plus or minus 5 or 6 percent, depending on the question and whether level of agreement is taken into account. We also calculate that the results for providers alone are statistically significant at the 95 percent confidence interval with the same margin of error.*

The numbers of payers and hybrids in the sample, when considered separately, are not large enough to meet this test. However, the fact that members of each group were randomly selected, yet exhibit a considerable level of agreement on many questions, suggests that the results, while not statistically significant, are indicative enough to allow at least tentative conclusions.

* Our calculations are based on the latest data from the American Hospital Association on the number of U.S. hospitals and hospital systems and the latest data from the National Association of Insurance Commissioners on the number of U.S. health insurers. The calculations treat each hospital system as a single entity.

TERRY Health

About Terry Health

Terry Health, part of The Terry Group, is an interdisciplinary team of problem solvers who help organizations navigate the complexity of healthcare transformation. By mobilizing the unparalleled breadth and depth of our actuarial, clinical, and analytical expertise, we help our clients successfully meet and master the most complex challenges. Our services include VBC strategy, implementation, contracting, and analytics; risk adjustment analytics; population health, care management, and SDOH strategy and analytics; AI use case roadmapping and implementation; and product strategy and market assessment. Providers, insurers, employers, and healthcare innovators rely on us during times of change to provide critical intelligence and clear direction.

Acknowledgements

This report would not have been possible without the collaboration and dedication of many people. Dan Cox of Purpeller developed the survey concept and coordinated the project. The Terry Group's Richard Jackson and Munzoor Shaikh designed the survey instrument, analyzed the survey results, and wrote the project report. Basil Konbaz, also with The Terry Group, assisted with the statistical analysis, while The Terry Group's Carol Navin, Amy Qureshi, and Yi-Ling Lin provided valuable input. HFMA's Bill Voegeli coded the survey, fielded it, and audited the raw data, besides offering much helpful strategic advice. We are also grateful to the hundreds of healthcare industry leaders who took the time to share their perspectives.

For more information on Terry Health, contact us at insights@terrygroup.com.

terryhealth.com