

2016 HIMSS Cost Accounting Survey

Executive Summary

March 2016



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Survey Background

In January 2015, U.S. Department of Health and Human Services (HHS) Secretary Sylvia Burwell announced that by the end of 2016, 30 percent of all Medicare payments made to hospitals and physicians would be based on “pay-for-value” payment models, and that by the end of 2018 that number would be increased to 50 percent. At the same time, Secretary Burwell also said that the remaining fee-for-service payment arrangements would be adjusted such that 85 percent of Medicare hospital payments would be tied to quality or value by the end of 2016, with an increase to 90 percent by the end of 2018.

During this initial stage of pay-for-value, it is expected that there will be a period of time during which provider revenues could decrease as payers and providers work to determine appropriate definitions of what should be included in a bundle, and what the appropriate pricing should be. At the same time, the healthcare market is experiencing a dramatic increase in patient financial responsibility, an area of revenue that has historically had a bad debt ratio of about fifty percent¹. It will be critical for providers to find a way to collect patient financial responsibilities as early in the revenue process as possible to help mitigate any disruptions caused by the changing payment methodology. This suggests the need to offer price transparency at the point of care so that conversations may be had early in the process regarding how much the patient will owe, and how and when they will pay.

With less than twelve months to reach HHS’s first goal, HIMSS wanted to ascertain how providers are progressing towards the HHS milestone. Do they believe they have the ability to accurately capture the cost of delivering care? Do they know what margin is necessary to maintain financial health? Are they confident in their ability to establish appropriate prices in this new environment? How automated are their cost accounting methods? Have they considered the potential revenue impact associated with the initial stages of the transition and considered the value of price transparency to help them increase collections of patient financial responsibility? What kind of assistance are they looking for from the industry? The findings of this survey are designed to determine the readiness of our provider community to move to pay-for-value and, identify those areas where HIMSS may be able to support their efforts.

¹ Citi analysis based on individual interviews with doctors and hospital administrators, conducted by Boundary Information Group (June 2013)

Key Survey Findings

The transition from fee-for-service to pay-for-value has been referred to as one of the greatest financial challenges the U.S. healthcare system currently faces.² Although this change is expected to happen over an extended period of time, CMS has announced aggressive goals for making the move with Medicare providers and hospitals. This requires healthcare providers to effectively navigate the challenges posed by a payment model that requires sharing and analyzing of data in ways that fee-for-service and its legacy revenue cycle management systems and business processes never contemplated. HIMSS's study examines the approach healthcare providers are pursuing as they manage the changing payment landscape. The findings provide important insights about where, in the months ahead, effort should be focused to assist organizations in moving to a pay-for-value system:

- While healthcare providers (especially those serving urban markets) demonstrate a willingness to move towards some form of a value-based payment system... few are comfortable with their current state of readiness for this transition.
- Only three percent of respondents believe their organization is highly prepared to make the transition from fee-for-service to pay-for-value.
- Many healthcare organizations have a formal process for determining healthcare costs, but only 39 percent regularly review those costs to ensure their information is current.
- Healthcare providers use an array of factors when determining service prices with *profit margin necessary to maintain financial health* and *actual cost to deliver the care* emerging as the most important factors. But, less than one-third of respondents have the ability to evaluate these costs in an automated fashion even though many have plans to expand the price transparency efforts.
- Provider organizations are looking for tools to share and track quality and financial information between providers and for consistent definitions and business practices that can be applied in all settings, regardless of who the payer may be.

About HIMSS

The Healthcare Information and Management Systems Society (HIMSS) is a global, cause-based, not-for-profit organization focused on better health through information technology (IT). In North America, HIMSS focuses on health IT thought leadership, education, events, market research, and media services. Founded in 1961, HIMSS North America encompasses more than 64,000 individuals, of which more than two-thirds work in healthcare provider, governmental, and not-for-profit organizations, plus over 640 corporations and 450 not-for-profit partner organizations, that share this cause.

² Brown, Bobbi and Jared Crapo. "The Key to Transitioning from Fee-for-Service to Value-Based Reimbursement." 2014. <https://healthcatalyst.com/hospital-transitioning-fee-for-service-value-based-reimbursements>

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