PHILIPS

Value-based care

National survey

Transforming healthcare: Results from a national survey of hospital executives on value-based payment models

Executive Summary

Background

While the future of healthcare legislation in the U.S. is constantly evolving, most experts believe that a trend towards value-based payment models has been set in motion and is likely to continue because the historical fee-for-service model is now regarded as a root cause of many ills within our healthcare system, such as high cost, fragmented and poor quality care and low patient satisfaction.

But the transition is a gradual process, which creates a conundrum for hospital executives as they have to succeed under today's fee-for-service system while preparing their organizations for the uncertain future of value-based payment. And they have to master this challenge in a low-margin and capital-intense industry that leaves little margin for error. In spite of the potentially far-reaching implications and difficulty of this transition, we know surprisingly little about how hospitals are reorienting in preparation for the new model today.

Technical approach

This report summarizes the findings from a national survey of 355 senior hospital executives on their current experience with value-based payment, their expectations for the future and the steps they are taking to prepare their organizations. The responses were statistically adjusted to bring results closer to being nationally representative, and multivariate regressions were used to generate rates that are statistically adjusted by hospital type, primary payer, ownership, bed size, geographic region, and current exposure to value-based payment models when applicable.

Results

Transition creates uncertainty and apprehension

Hospital executives have accepted that the transition to value-based payment will occur in a timeframe between two and five years, even though current exposure to value-based payment remains limited. As Figure ES-1 shows, only around 8% of revenue is "tied to value" based on CMS' broad definition and only about 3% actually at risk. Less than one-third of hospitals participate in any value-based payment model.

Even for hospitals that do participate, the stakes are limited with around 8% of revenue at risk. Exposure is higher for larger hospitals and in regions where value-based payment has become more common, like the Northeast, but the responses make clear that hospitals continue to operate in a fee-for-service world.

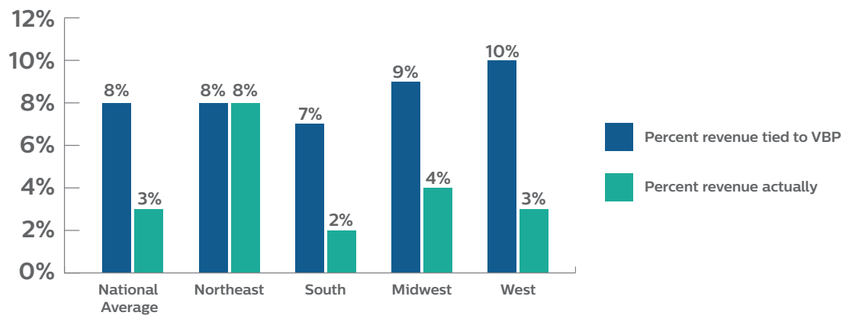

Figure ES-1: Share of hospital revenue affected by value-based payment, by region

The limited exposure is a logical consequence of the voluntary and experimental nature of value-based payment for now. Participation in ACOs and bundled payment pilots was voluntary until recently, and even the mandated Readmissions Reduction Program has limited consequences for many hospitals.

Despite the limited impact, less than 40% of respondents nationally perceive a positive impact of value-based payment on their business and only 6% believe it will improve margins.

Consolidation as defensive measure

A logical response to less forgiving environment is consolidation, which permits hospitals to realize economies of scale, improve negotiation leverage with health plans and spread necessary investments over a larger base. Nationally, 18% of hospitals had entered an affiliation with a larger entity and 26% were planning to do so in the next two years. Those changes were more common in the Northeast (36%) where value-based payment has become more prevalent. Almost half of respondents expect that both horizontal (44%) and vertical (48%) consolidation will continue over the next years.

Securing patient flows as transition strategy

The overarching theme to describe how hospital executives are managing this difficult transition is a focus on securing patient flows, as tying patients more closely to the organization serves a dual purpose. First, under the current fee-for-service model, it ensures a steady stream of patients to keep hospital beds full and surgical suites busy. Second, control of patient journey is a precondition to implement population health models under future value-based payment.

To this end, 64% and 71 % of hospitals have increased hiring of physicians and mid-level providers, respectively, in the last three years and close to half have added primary care practices (46%), as Figure ES-2 shows. Investments into telemedicine (56%) and patient portals (76%) as well as efforts to control "leakage", i.e., patients seeking care outside of a hospital's network, (33%) all aim at gaining greater control of patient journeys.

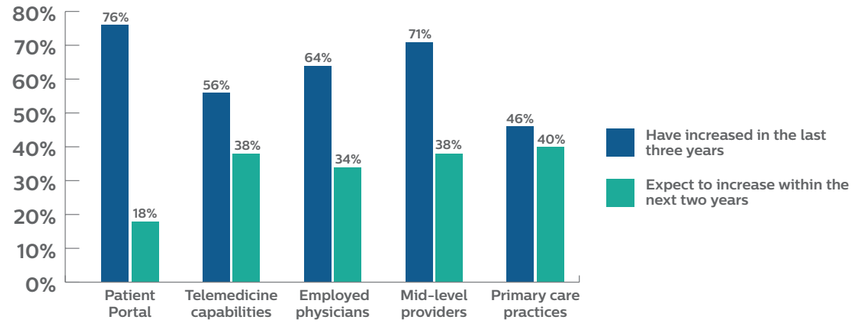

Figure ES-2: Investments aimed at increasing control of patient journey

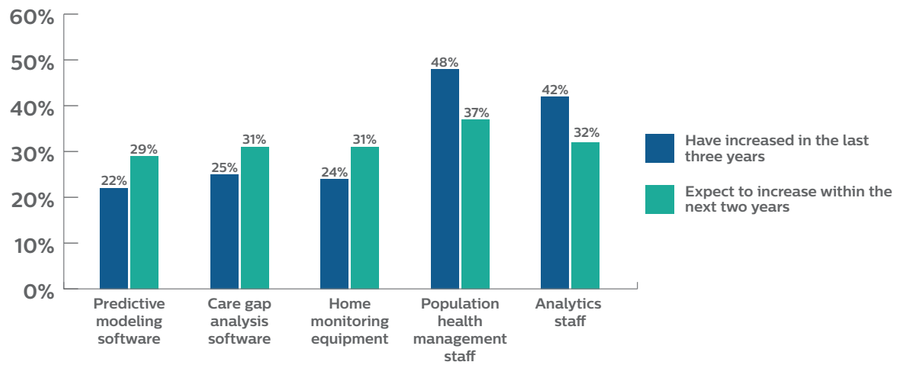

Figure ES-3: Investments aimed at adapting organization to value-based payment models

Cautious optimism - for the survivors

Going forward, around one-third of respondents (30%) expect that value-based payment will have a positive impact on their business and strengthen their competitive position. Larger hospitals and those in the Northeast where value-based payment has become more common are even more positive overall and more positive about the future impact of value-based payment than the past. Those responses suggest that executives expect value-based payment to trigger a period of consolidation and pressure on margins, but improved conditions for those who manage the transition successfully.

Summary

The emergence of value-based payment models implies a fundamental change in the operating environment for hospitals. Today's fee-for-service system creates incentives to maximize the number of transactions, such as admissions, tests and procedures, while value-based payment rewards population health objectives: Better health, better care and lower cost, the so-called Triple Aim.

The tension between today's prevailing incentives and expectations for the future create a conundrum for hospital executives as they need to start reorienting their complex organizations and make investments that may not have a financial return for many years. These decisions are made harder because of the limited operating margins of hospitals of around 5%[1] and because of restrictions that a hospital's unique role for its community imposes on business decisions.

The results of this survey illustrate that executives are managing this challenging transition by focusing on defensive measures. Vertical and horizontal consolidation increases the revenue base to afford future investments and improves bargaining power in negotiations with payers. Investments into capabilities to secure patient flows yield immediate returns in a fee-for-service environment and are at the same time a precondition to implement future population health models. In parallel, investments into technology to support population health management is picking up.

The data tell us that hospital executives have accepted that value-based payment is here to stay and are preparing their organizations for this new reality. They expect the transition to be painful and unforgiving with pressure on margins and consolidation. While challenging, taking the first steps towards the transition appears to be not only inevitable but also advantageous: Executives with current exposure the value-based payment models tend to have

1. http://www.aha.org/research/reports/tw/chartbook/2016/chart4-2.pdf

a more optimistic outlook, and most respondents agreed that those who manage the transition successfully will emerge in a stronger position.

Introduction

It has long been recognized that a payment system that ties payment to transactions, such as office visits, procedures and drugs dispensed, incentivizes healthcare providers to increase the number of transactions. This simple truth is seen as the root cause of many problems that plague the U.S. healthcare system, such as high cost, poor and inconsistent quality and patient experience, and obstacles to access to care.

Consequently, payers and policymakers have striven for many years to reform the payment system to value-based payment, i.e., to reward delivery of the so-called Triple Aim of better health, better care and lower cost, a trend that was accelerated by the passage of the Affordable Care Act (ACA). While the future of the ACA is now uncertain, most experts believe that the trend towards value-based payment will continue.

The trend has certainly picked up speed. In January 2015, the Obama Administration announced the goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, and 50 percent by 2018. In March of that year, the Centers for Medicare & Medicaid Services (CMS) announced that it had already hit its first target, 11 months ahead of schedule. Several commercial carriers have announced their intent to depart from fee-for-service payment as well.

But the transition is a gradual process. For example, CMS now considers all payments to hospitals for conditions that fall under the Readmission Reduction Program as "tied to value" even though hospitals are still paid based on their number of admissions and their actual exposure to penalties for readmissions may be limited.

Thus, the transition to value-based payment creates a conundrum for hospital executives as they have to continue to succeed under a fee-for-service system while preparing their organizations for the uncertain future of value-based payment. And they have to master this challenge in a low-margin and capital-intense industry that leaves little margin for error.

In spite of the potentially far-reaching implications and difficulty of this transition, we know surprisingly little about how hospitals are reorienting in preparation for the new model today. This gap in knowledge was the impetus behind a joint research venture between the Washington Post Brand Studio and Insights teams and Philips, with the hope of gaining insight on where hospitals are and where they expect to go as they begin this transformative journey.

Methods

Survey procedure

The survey text was drafted by two experts in health policy and payment reform, and underwent cognitive testing to finalize it. To this end, three hospital executives completed the survey, recorded their time and provided detailed feedback to the survey team on content, flow, and wording of items. Based on their input and additional tests for time needed to complete, a final version was developed.

The survey asked questions about hospital characteristics, such as size, ownership and payer mix, current exposure to value-based payment models, organizational changes and investments made in response to value-based payment models, and expectations for impact of these models on the organization. Appendix A has the final survey instrument.

The final text was formatted for printing and programmed into an online tool using the Qualtrics Survey Software. The survey was mailed in August 2016 to 5,881 senior hospital executives who were contained in a commercially available contact list. The list represents a convenience sample of executives representing all regions and hospital types, but not reflective of the national distribution. The original list was restricted to only one contact per institution.

The mailing included a cover letter introducing the survey and ensuring confidentiality of the responses, the actual survey instrument and a stamped return envelope. Respondents had the option of returning the completed survey in print or entering their answers online. Valid email addresses were available for 20% of the sample, who received reminder invitations by email.

Sample description

A total of 355 responses were received from 202 individual acute care hospitals (56.9%), 27 hospital chains (7.6%), 99 health systems (27.9%) and 27 integrated delivery systems, i.e., organizations that include a health plan (7.6%). Of the 202 individual hospitals, four were Academic Medical Centers and teaching hospitals (2%), 71 community hospitals (35.1%) and 123 rural hospitals (60.9%). ‘

As Figure 1 shows, almost four-fifths (78.3%) of the respondents represented not-for-profit organizations, followed by publicly owned hospitals (11.6%), and investor-owned (8.7%) and physician-owned (1.4%) for-profit hospitals.

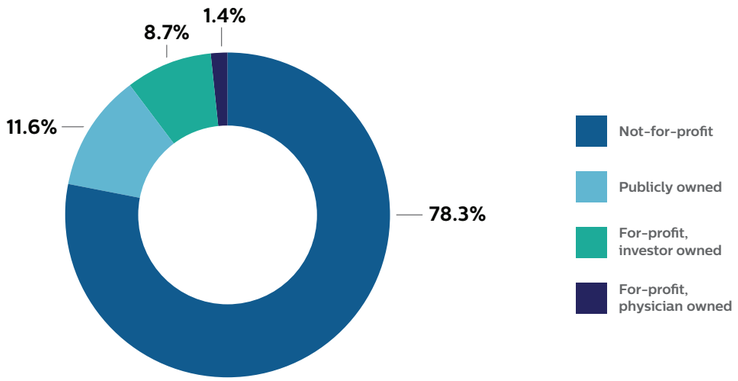

Figure 1: Ownership status of responding organizations

Table 1 summarizes the size of the responding hospitals in term of number of beds. About half of the sample represented small facilities with less than 50 beds, but facilities of all sizes contributed their data.

	Count	Percentage
Fewer than 50 beds	169	48
50 to 100 beds	50	14
101 to 200 beds	43	12
201 to 500 beds	45	13
501 to 1000 beds	23	6
More than 1000 beds	25	7
Total	**355**	**100**

Table 1: Size of responding organizations in terms of number of beds

Correspondingly, Table 2 depicts the distribution of the respondents by annual revenue with the majority of hospitals reporting revenue below $100 million.

	Count	Percentage
Less than $100 million	197	56
$101 to $250 million	51	14
$251 to $500 million	48	14
$501 to $750 million	11	3
$751 million to 1 billion	11	3
More than 1 billion	37	10
Total	**355**	**100**

Table 2: Size of responding organizations in terms of annual revenue

Table 3 shows the revenue contribution of different payers. Public payers (Medicare and Medicaid) account for around 60% of revenue and commercial insurance carriers for about 30%. Less than 8% comes from private pay or charity cases and a small proportion from other payers, such as Tricare. The payer mix is largely the same for hospitals of different sizes.

	Sample average	<50 beds	50-100 beds	101-200 beds	201-500 beds	501-1000 beds	>1000 beds
Commercial insurance	30.02	28.38	30.74	28.12	35.08	29.93	33.76
Public payers	60.70	61.45	60.69	62.76	57.86	60.55	57.39
Self-pay/charity	7.93	8.73	6.55	7.49	6.39	8.34	8.43
Other	1.35	1.43	2.02	1.63	.66	1.18	.42

Table 3: Revenue contribution of different payer types, overall and by number of beds (percentage)

Analytic approach

The raw responses were statistically adjusted in order to bring results closer to being nationally representative by using composite survey weights. Simply speaking, the method ensures that hospitals that are more typical for hospitals nationally in terms of size were given more weight in the final analysis. For example, small hospitals with less than 50 beds, which were overrepresented in the sample relative to their national frequency, were given less weight in the analysis.

In addition, multivariate regressions were used to generate rates statistically adjusted by hospital type, primary payer, ownership, bed size, geographic region, and current exposure to value-based payment models when applicable. This approach allows isolating the unique contribution of each characteristic to the responses. To illustrate, hospitals in the Northeast are generally more exposed to value-based payment. Thus, the unadjusted response rates for Northeastern hospitals to a given survey question reflect both regional differences and the greater exposure to value-based payment. Regression analysis decomposes those two effects and yields a predicted response rate for, say, a hospital in the Northeast, holding all other characteristics (e.g., size, ownership) constant.

Unless stated otherwise, all results presented in this report below are based on statistically adjusted rates.

Results

Current participation in value-based payment models

More than half of hospitals report no exposure to value-based payment as of 2016. About one-third (28%) are currently members of an Accountable Care Organization (ACO) and another 13% are planning to join one. ACO participation is more common in the Midwest and Northeast and least common in the South, as Figure 2 shows.

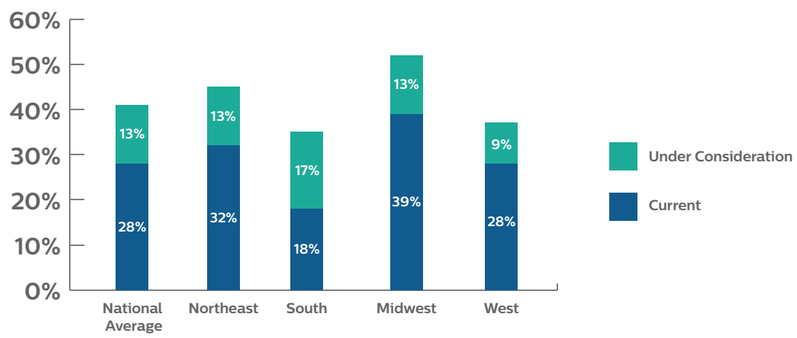

Figure 2: Participation in ACO, by region

illustrates that larger hospitals are more likely to be member of an ACO. Only 21% of hospitals with less than 50 beds but almost half (48%) of hospitals with 501 to 1,000 beds are members. Interestingly, there are no larger differences in stated intentions to join an ACO: 17% of hospitals with less than 50 beds and 18% of hospitals with more than 1,000 beds are considering it.

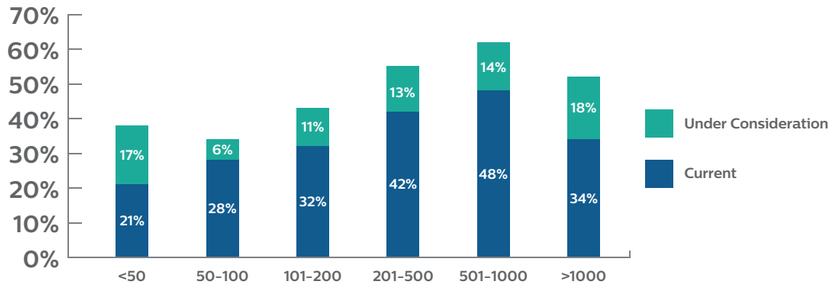

Figure 3: Participation in ACO, by number of beds

Around one-fifth of hospitals (21%) nationally are participating in bundled payment models, i.e., receive a flat fee for all hospital and physician services, including pre- and post-operative care, for major procedures, such as joint replacement or heart surgery. As depicted in Figure 4, bundled payment is currently more common in the Northeast and Midwest, whereas similar proportions of hospitals across the nation are considering using bundled payments.

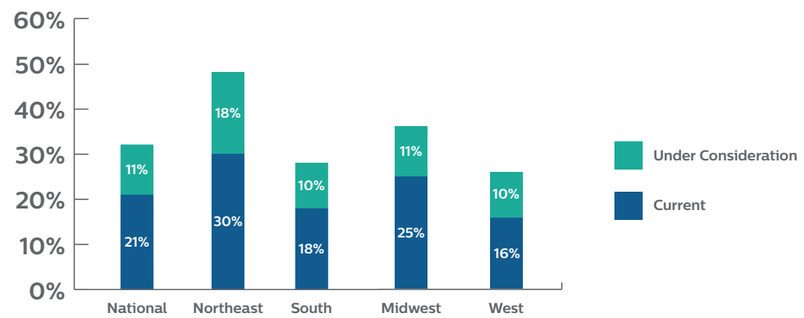

Figure 4: Participation in bundled payment models, by region

Figure 5 illustrates that larger hospitals with more than 200 beds are much more likely to be involved in bundled payment models. Around 70% of this group is either participating or considering to participate in those models. This is not surprising because bundled payment is most established for major surgical procedures, which are not commonly conducted in small facilities.

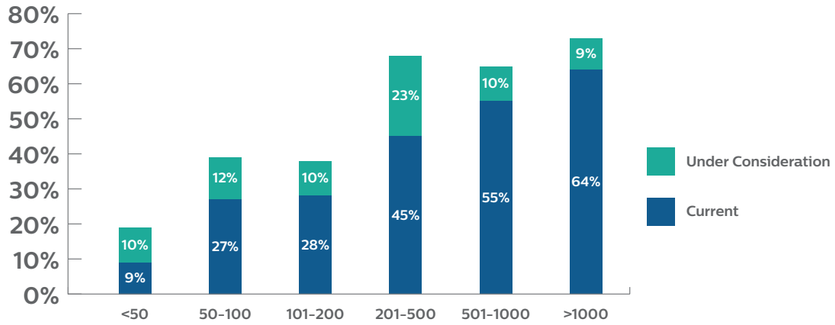

Figure 5: Participation in bundled payment models, by number of beds

On an unadjusted basis, 192 (55%) of respondents stated being held accountable for readmissions under value-based payment models, making it the most common criterion, followed by patient experience (51%), clinical quality of care (48%), patient outcomes (48%) and resource use (39%). This pattern is consistent with the rollout of the Readmission Reductions Program that – at least by CMS' definitions – states that all admissions for the included diagnoses fall under value-based payment. Similarly, patient experience, typically captured by the mandated Hospital Consumer Assessment of Healthcare Providers and System survey, is now commonly used for accountability purposes.

Around 37% of respondents reported that they participated in value-based payment programs voluntarily or because of federal requirements. Only 12% and 13% stated that they were participating because of requirements from their State or commercial insurers, and another 11% because of competitive considerations.

Current financial exposure to value-based payment models

Statistically adjusted, on average hospital executives reported that 8% of current revenue is "tied to value" based on the CMS definition, i.e., potentially affected by meeting targets for quality, patient experience or resource use (Figure 6), with no material differences by region. Hospitals in the Northeast, however, tend to have a larger share of their revenue actually at risk, i.e., actually as opposed to theoretically affected by value-based payment model.

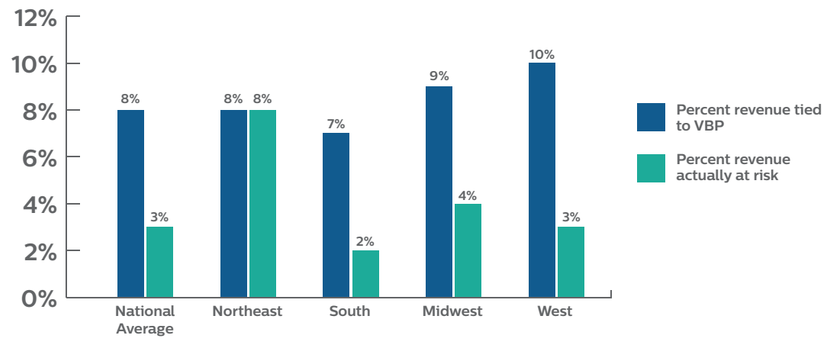

Figure 6: Share of hospital revenue affected by value-based payment, by region

Of note, these estimates reflect the fact that a substantial proportion (54%) of executives stated that they had no revenue tied to value-based payment at the moment. When looking at hospitals with non-zero revenue tied to value-based payment, executives report that 16% is tied to value based on CMS' definition and 8% actually at risk.

Following the patterns of participation in value-based payment models, larger hospitals have a greater share of revenue tied to value or actually at risk (Figure 7), but still far smaller shares than the 30% that CMS recently announced.

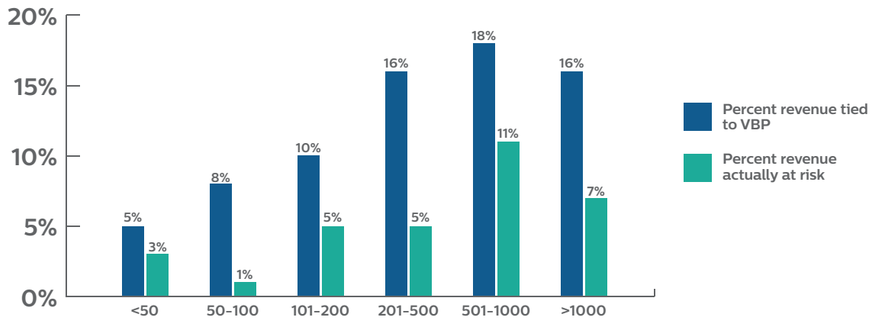

Figure 7: Share of hospital revenue affected by value-based payment, by number of beds

This seeming discrepancy is a consequence of the current reality of value-based payment models as well as the payer and service mix of hospitals. First, Medicare is the largest payer of hospital admissions but still only covers around 40%[2] of inpatient stays. Thus, more than half of hospital admissions are covered by other payers that may have less emphasis on value-based payment. Second, several Medicare programs, such as Bundled Payments for Care Improvement[3] and the Hospital Readmissions Reduction Program,[4] target inpatient care, whereas around 40%[5] of hospital revenue comes from outpatient care. Third, participation in value-based payment models is still predominately voluntary, and with many hospitals currently not participating, exposure is limited. Lastly, the bundled payment models, which are the most mature approach, tend to affect the major procedures that are mostly performed in larger facilities, explaining their great exposure.

The discrepancy between revenue tied to value-based payment and revenue actually at risk is a consequence of CMS' definition that considers any payment "tied" even if a provider is mostly paid fee-for-service. For example, an ACO receives fee-for-service payments with a potential 2% bonus for meeting quality and cost targets. CMS considers all payments "tied to value", while the actual financial exposure of the ACO is far lower. Similarly, CMS regards all payments for admissions under the readmission reductions program as "tied", but hospitals that have average readmission rates have a very limited risk of ever being exposed to penalties, as the penalties are based on having a statistically significantly higher rate of readmissions than predicted based on a hospital's case mix.

Perceived impact of value-based payment models

The majority of hospital executives view value-based payment as negative. Only 39% state that it had a positive impact on their business and 37% that it strengthened their competitive position (Table 4). Attitudes towards value-based payment tended to be more positive in the Northeast and Midwest than in the South and West. Hospitals with between 100 and 500 beds had the lowest agreement rates with both statements. Interestingly, the larger hospitals with more than 200 beds were more likely to agree or strongly agree with value-based payment strengthening their competitive position than with it having a positive impact on the business, whereas the pattern was reversed for the smaller organizations. The difference is particularly large for hospitals with over 1,000 beds. This response pattern appears to suggest that the overall impact of value-based payment is viewed as negative, but that larger hospitals believe that they will be in a better competitive position than their smaller counterparts.

	Value-based payment models had a positive impact on our business	Value-based payment has strengthened our competetive position
National Average	39%	37%
Northeast	43%	32%
South	28%	27%
Midwest	37%	38%
West	27%	23%
<50 beds	33%	24%
50-100 beds	36%	30%
101-200 beds	45%	37%
201-500 beds	23%	42%
501-1000 beds	20%	24%
>1000 beds	37%	52%

Table 4: Experience with value-based payment models: percentage of respondents that agreed or strongly agreed with the respective statement

2. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb180-Hospitalizations-United-States-2012.pdf | 3. https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps readmissions-reduction-program.html | 4. https://innovation.cms.gov/initiatives/bundled-payments/ | 5. http://www.aha.org/research/reports/tw/chartbook/2016/chapter4.pdf

Changes in response to value-based payment

Organizational changes

Table 5 displays organizational changes that respondents have made in the last three years or expect to make in the next two years in response to value-based payment models. Nationally, 18% had entered an affiliation with a larger organization and 26% were planning to do so in the next two years. Only 3% and 6% had been acquired or anticipated being acquired, respectively. These organizational changes were particularly common in the Northeast where twice as many hospitals as nationally (36%) had become affiliated with a larger organization and almost three times (17%) expected to be acquired. In contrast, only one percent of hospitals in the West had or expected to be acquired.

Predictably, smaller organizations were more likely to become affiliated or be acquired, and the share of revenue tied to value-based payment models appeared unrelated to those organizational changes.

	Affiliation with a larger organization (without being aquired)		Acquisition by another organization	
	Have made change in the last three years	Expect to make	Have made change in the last three years	Expect to make change within the next two years
National rate	18%	26%	3%	6%
Northeast	36%	27%	5%	17%
South	17%	27%	4%	7%
Midwest	18%	28%	4%	10%
West	11%	23%	1%	1%
<50	17%	27%	2%	7%
50-100	14%	35%	3%	3%
101-200	28%	17%	4%	7%
201-500	29%	37%	5%	7%
501-1000	7%	25%	4%	4%
>1000	17%	10%	9%	0%
0% revenue tied to VBP	19%	24%	5%	6%
<10% revenue tied to VBP	17%	38%	2%	6%
10-50% revenue tied to VBP	17%	24%	2%	6%
>50% revenue tied to VBP	15%	24%	2%	5%

Table 5: Organizational changes partially or fully in response to value-based payment models

Operational changes

Figure 8 shows which operational changes hospitals have undertaken or will undertake in response to value-based payment. The most common change was (33%) and is anticipated to be (36%) limiting referrals to providers outside of the organization, sometimes referred to as "leakage." Controlling such patient journeys is important for two reasons. First, it has the direct benefit of allowing a hospital to capture a greater share of a patient's healthcare spending, even under a fee-for-service system. Second, keeping a patient with the "walled garden" of the institution is a precondition for implementing population health management approaches under value-based payment. Improved care processes and better technology will only be financially viable, if rolled out to providers within an organization to allow value capture. In addition, ACO models are usually based on attribution, i.e., patients count towards the ACO's performance targets only if they receive the plurality of their care from that ACO's providers. It is therefore not surprising, as Table 6 shows in detail, that hospitals with more current exposure to value-based payment were more likely to control leakage.

The second most common change was increased incentives for providers, also more pronounced in hospitals with greater exposure to value-based payment, which is an important measure to align incentives with organizational objectives.

Another important observation is that hospitals report that they will be more likely to make those changes in the future than they have made them in the past. This is particularly marked for the elimination of high-cost or low-volume services, which only 16% of hospitals report having eliminated but 32% planning to do in the next two years.

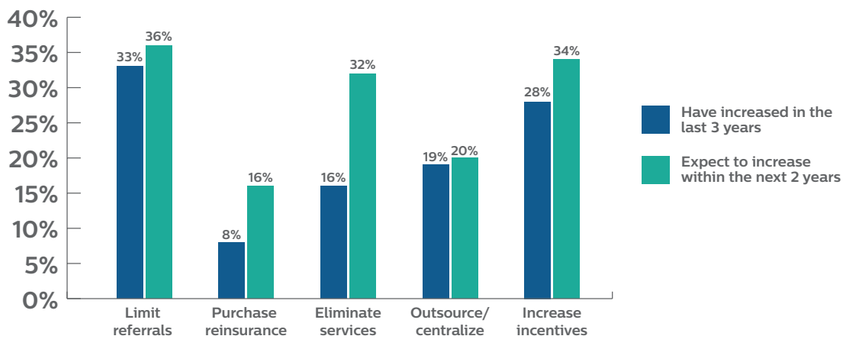

Figure 8: Operational changes in response to value-based payment

	Limit referrals outside organization		Purchase insurance or reinsurance		Eliminate services		Outsource/centralize admin activities		Increase incentives for providers	
National rate	33%	36%	8%	16%	16%	32%	19%	20%	28%	34%
Northeast	19%	32%	7%	13%	23%	26%	10%	26%	28%	19%
South	32%	25%	2%	14%	14%	35%	11%	22%	19%	27%
Midwest	20%	42%	4%	12%	11%	26%	9%	14%	17%	38%
West	23%	30%	4%	11%	5%	28%	19%	20%	22%	46%
<50	15%	30%	2%	11%	10%	31%	9%	18%	16%	35%
50-100	32%	24%	1%	15%	9%	24%	12%	14%	16%	22%
101-200	49%	46%	7%	9%	17%	34%	12%	27%	22%	38%
201-500	38%	42%	10%	15%	7%	35%	13%	16%	38%	27%
501-1000	19%	31%	8%	18%	11%	26%	13%	37%	20%	51%
>1000	26%	29%	6%	10%	38%	22%	17%	12%	21%	29%
0% revenue tied to VBP	17%	30%	2%	10%	11%	25%	11%	19%	15%	27%
<10% revenue tied to VBP	39%	32%	5%	16%	9%	40%	4%	19%	17%	44%
10-50% revenue tied to VBP	35%	38%	8%	18%	10%	31%	14%	17%	34%	40%
>50% revenue tied to VBP	42%	48%	9%	18%	29%	43%	37%	17%	57%	45%

Have increased | Will increase

Table 6: Operational changes in response to value-based payment, by region, size and exposure to value-based payment

Service provision

Figure 9 illustrates how hospitals have changed or are planning to change their service mix in response to value-based payment. The most obvious finding is that hospitals nationally are investing heavily in expanding outpatient care by adding primary and specialty care practices as well as outpatient procedures and diagnostics. Around one-third to half of hospitals have increased those services, and 20-40% are planning to increase them further. In contrast, less than 10% have added or plan to add inpatient beds, and the same goes for traditional adjacencies like inpatient rehab, home healthcare and outpatient pharmacies.

Of note, primary care is the business line with the largest expansion, which reflects its critical role for the future of hospitals. First, primary care is the conduit through which patients are tied to the institution, thus ensuring a steady stream of referrals for specialty care, procedures and admissions. In an increasingly competitive environment, such referrals are critical for a hospital to succeed under the still-dominant fee-for-service model. Second, future value-based payment models are designed to reward management of health and cost at the population level rather than transactional care. Having a robust primary care offering is a precondition for implementing population health approaches.

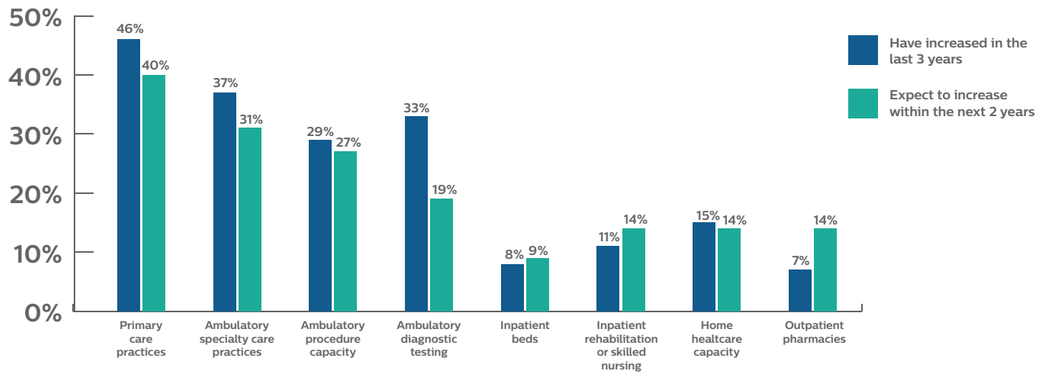

Figure 9: Changes to services in response to value-based payment

Table 7 provides a detailed breakdown of changes to services by region, number of beds and current exposure to value-based payment. Several interesting patterns emerge. As expected, larger hospitals, which are both more exposed to value-based payment today and more able to invest, increased capacity more than their smaller counterparts. For example, around two-thirds of hospitals with more than 200 beds but less than one-third of those with less than 50 beds have added primary care practices. But larger hospitals also increased the number of inpatient beds and traditional adjacencies considerably. For example, executives representing hospitals with more than 1,000 beds stated that 28% added inpatient beds, 36% inpatient rehab and 54% home healthcare capacity.

Hospitals that have a greater share of their revenue tied to value-based payment today are more likely to have invested in expanding outpatient services, both for primary and specialty care.

While the Northeast has the strongest exposure to value-based payment today, hospitals appear to lag other regions in expansion of services except for specialty care and diagnostics, but are more likely to have future expansion plans. Conversely, hospitals in the South and West report above-average expansion for almost all services.

	Primary care practices		Ambulatory specialty care practices		Ambulatory procedure capacity		Ambulatory diagnostic testing		Inpatient beds		Inpatient beds		Home Healthcare		Outpatient pharmacies	
National rate	46%	40%	37%	31%	29%	27%	33%	19%	8%	9%	11%	14%	15%	14%	7%	14%
Northeast	39%	43%	43%	29%	21%	27%	42%	18%	5%	9%	8%	20%	12%	18%	6%	22%
South	51%	36%	37%	28%	31%	27%	43%	19%	10%	10%	16%	17%	11%	11%	5%	20%
Midwest	42%	39%	39%	32%	29%	22%	28%	16%	8%	5%	8%	8%	20%	15%	9%	9%
West	48%	49%	30%	39%	30%	35%	21%	31%	8%	18%	11%	23%	20%	15%	12%	11%
<50	32%	43%	24%	35%	18%	30%	24%	22%	5%	6%	10%	16%	11%	14%	4%	15%
50-100	41%	37%	42%	28%	39%	19%	30%	16%	8%	7%	8%	16%	15%	17%	15%	13%
101-200	55%	38%	50%	24%	36%	21%	43%	11%	7%	7%	11%	10%	13%	9%	2%	14%
201-500	69%	40%	56%	30%	40%	32%	45%	22%	10%	15%	6%	8%	22%	10%	20%	16%
501-1000	68%	32%	49%	35%	44%	28%	63%	22%	39%	34%	20%	12%	16%	22%	25%	8%
>1000	67%	41%	65%	31%	55%	24%	50%	21%	28%	21%	36%	21%	54%	24%	26%	12%
0% revenue tied to VBP	37%	39%	27%	29%	21%	22%	25%	19%	8%	8%	8%	14%	11%	13%	7%	14%
<10% revenue tied to VBP	54%	47%	48%	52%	47%	47%	43%	36%	10%	15%	15%	16%	24%	21%	16%	16%
10-50% revenue tied to VBP	69%	39%	72%	27%	41%	27%	61%	8%	6%	6%	15%	23%	29%	17%	10%	16%
>50% revenue tied to VBP	57%	41%	38%	22%	45%	29%	37%	23%	13%	5%	30%	5%	20%	6%	2%	10%

Have increased Will increase

Table 7: Changes to services in response to value-based payment, by region, size and exposure to value-based payment

Staffing

Staffing changes reflect the aforementioned changes in service provision in response to value-based payment as Figure 10 shows. Physicians (64%) and mid-level providers (71%), such as physician assistants and nurse practitioners, were by far the most likely staff categories that hospitals expanded in the last three years, and they remain on top of the hiring priority for the near future. It is important to note that hospitals are seeking to employ physicians rather than increase the number of affiliated physicians in their efforts to secure control of patient flows.

But hiring patterns also reflect the shift to value-based models of care, as close to half of executives report having hired population health management staff (48%) and analytic staff (42%) as well as other clinicians (46%), such as social workers, dieticians and pharmacists, in the last three years. Hiring in those categories is expected to be on par with that of physicians and mid-level providers in the next two years. This trend suggests that hospitals are beefing up their capabilities to analyze their data and to manage care at the population level, which are essential steps for succeeding under value-based payment.

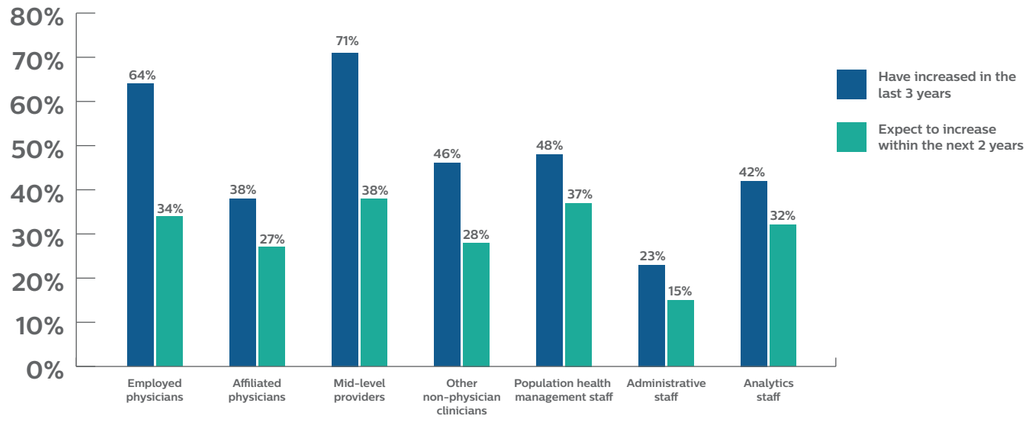

Figure 10: Expansion of different types of staff in response to value-based payment

	Employed physicians		Affiliated physicians		Mid-level providers		Other non-physician clinicians		Population health management staff		Admin staff		Analytics staff	
National rate	64%	34%	38%	27%	71%	38%	46%	28%	48%	37%	23%	15%	42%	32%
Northeast	74%	34%	42%	19%	73%	34%	62%	36%	54%	37%	20%	9%	48%	24%
South	73%	34%	36%	20%	77%	33%	49%	19%	40%	34%	20%	11%	32%	30%
Midwest	60%	28%	32%	25%	70%	32%	31%	23%	45%	30%	19%	9%	33%	29%
West	55%	35%	41%	29%	64%	51%	51%	33%	53%	41%	32%	31%	42%	34%
<50	58%	32%	31%	19%	60%	33%	35%	23%	41%	33%	19%	11%	25%	33%
50-100	51%	33%	31%	16%	80%	41%	41%	12%	42%	43%	8%	16%	30%	31%
101-200	72%	33%	31%	32%	79%	37%	52%	38%	56%	44%	30%	7%	55%	29%
201-500	80%	37%	46%	32%	84%	41%	57%	36%	51%	31%	36%	25%	57%	34%
501-1000	78%	26%	67%	26%	81%	33%	70%	37%	52%	24%	51%	12%	59%	12%
>1000	79%	28%	44%	42%	78%	41%	53%	20%	46%	22%	19%	9%	44%	21%
0% revenue tied to VBP	59%	32%	31%	24%	63%	38%	39%	26%	33%	31%	19%	13%	30%	28%
<10% revenue tied to VBP	59%	44%	41%	31%	78%	41%	56%	36%	56%	44%	22%	17%	37%	38%
10-50% revenue tied to VBP	87%	26%	48%	17%	89%	30%	46%	22%	66%	39%	31%	13%	48%	28%
>50% revenue tied to VBP	75%	24%	43%	14%	83%	26%	59%	8%	82%	33%	24%	3%	58%	28%

Have increased Will increase

Table 8: Expansion of different types of staff in response to value-based payment, by region, size and exposure to value-based payment

The detailed breakdown by region, size and current exposure to value-based payment in Table 8 shows how strongly the trends in hiring decisions are driven by the new payment reality. Hospitals in the Northeast, where value-based payment models have become more common, and hospitals with greater exposure to value-based payment regardless of region are the most likely to have expanded population health management, analytics and other clinical staff. Conversely, in the South, where value-based payment remains less prevalent, hospitals focus on hiring physicians and mid-level providers. Larger hospitals, regardless of location, are more likely to add employed and affiliated physicians, and all but the smallest hospitals hired more mid-level providers.

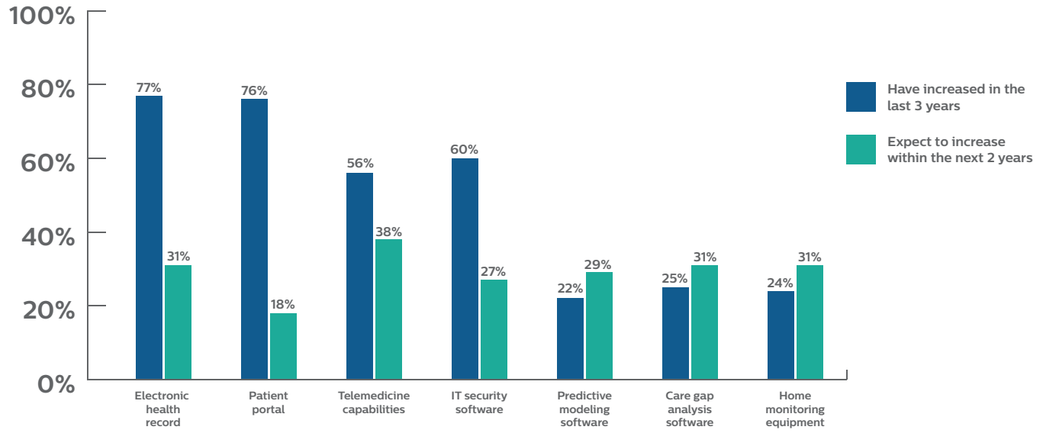

Figure 11: Investments into technology in response to value-based payment

Technology investments

Investments into new technology are detailed in Figure 11. The results suggest that hospitals have mostly reacted to external pressures in the last three years when making technology investments. First, more than three-quarters (77%) have installed or upgraded electronic health records, reflecting mandates and incentives at the federal level, and 60% have invested in IT security software, mostly likely in response to recent high-profile breaches. Second, 76% of respondents reported investment into patient portals and 56% into telemedicine capabilities. Both technologies facilitate patient engagement outside of the physical boundaries or the institution, and thus secure all-important patient flows.

At the same time, hospitals were less likely to invest into technology that would support population health management goals in the last three years. Less than a quarter have invested in predictive modeling software, which is used to proactively identify patients at risk for costly disease exacerbations, care gap analytics, which identifies unmet care needs, and home monitoring equipment.

Going forward, however, priorities appear to shift: Investment into "reactive" technologies is projected to decline, with the exception of telemedicine, while that into "proactive" technologies to increase. These finding imply that executives are beginning to orient their organizations towards value-based payment models.

Table 9 provides the detailed results by region, number of beds and current exposure to value-based payment. No clear patterns for differences in investment decisions emerge.

	Electronic health record		Patient Portal		Telemedicine capabilities		IT security software		Predictive modeling software		Care gap analysis software		Home monitoring equipment	
National rate	77%	31%	76%	18%	56%	38%	60%	27%	22%	29%	25%	31%	24%	31%
Northeast	83%	35%	69%	21%	58%	30%	78%	29%	14%	21%	28%	17%	29%	32%
South	84%	24%	89%	12%	59%	31%	63%	23%	13%	21%	12%	27%	17%	31%
Midwest	70%	27%	80%	12%	51%	44%	53%	29%	11%	23%	18%	22%	22%	23%
West	82%	29%	80%	25%	54%	37%	60%	20%	14%	43%	17%	43%	9%	41%
<50	81%	22%	85%	15%	52%	30%	63%	30%	6%	22%	9%	25%	12%	29%
50-100	79%	32%	79%	15%	56%	40%	53%	20%	14%	38%	17%	31%	18%	25%
101-200	83%	34%	85%	12%	65%	41%	64%	23%	22%	14%	25%	29%	35%	31%
201-500	73%	38%	87%	20%	54%	44%	50%	28%	31%	34%	34%	35%	25%	29%
501-1000	70%	27%	85%	13%	52%	56%	70%	24%	31%	27%	45%	21%	29%	29%
>1000	79%	27%	55%	8%	60%	36%	69%	9%	38%	29%	44%	19%	21%	40%
0% revenue tied to VBP	74%	26%	69%	14%	52%	33%	56%	25%	12%	21%	16%	22%	14%	24%
<10% revenue tied to VBP	83%	33%	95%	17%	50%	47%	63%	21%	14%	40%	11%	37%	14%	45%
10-50% revenue tied to VBP	90%	26%	98%	14%	65%	43%	68%	28%	11%	29%	31%	28%	41%	41%
>50% revenue tied to VBP	86%	28%	73%	18%	70%	31%	81%	31%	21%	29%	20%	47%	24%	26%

Have increased Will increase

Table 9: Investments into technology in response to value-based payment, by region, size and exposure to value-based payment

Expectations for future impact

Table 10 displays the responses to the question within which timeframe respondents expect value-based payment to have a meaningful impact on their business. One obvious finding is that only very few respondents (7%) expect no future impact and a plurality nationally (40%) expect the impact to occur within five years. But the assessment differs substantially by size and location. Larger hospitals, such as 82% of those with more than 1,000 beds, mostly state that they are seeing the impact already, whereas more than half (55%) of hospitals with less than 50 beds predict a timeframe of five years. Hospitals in the West perceive impact today (38%) or within two years (37%) even though value-based payment models are less prevalent there today compared to the Northeast, where almost half (47%) of hospitals assume a five-year timeframe.

	Already	Within 2 years	Within 5 years	Never
National Average	26%	28%	40%	7%
Northeast	15%	37%	47%	1%
South	19%	33%	46%	2%
Midwest	27%	21%	50%	2%
West	38%	37%	24%	2%
<50	10%	28%	55%	7%
50-100	21%	40%	34%	5%
101-200	53%	11%	34%	3%
201-500	37%	31%	30%	2%
501-1000	42%	17%	41%	0%
>1000	82%	15%	2%	1%

Table 10: Predicted timeframe within which value-based payment will have meaningful impact on respondents' business

Table 11 shows expectations for the future impact of value-based payment. Respondents were less likely to agree or strongly agree that value-based payment will have a positive impact on their business (30%) than that it has had a positive impact (36%, shown in Table 4). Abut about the same number of respondents believed that is will strengthen their competitive position in the future (36%) as in the past (37%). About half of executives in the Northeast, where value-based payment is most common, perceive a positive impact on business (50%) and competitive position (49%). Larger hospitals with more than 200 beds tend to be more optimistic about the effect on their competitive position than on their overall business.

	Value-based payment models will have a positive impact on our business	Value-based payment models will strengthen our competitive position
National Average	30%	36%
Northeast	50%	49%
South	26%	29%
Midwest	29%	41%
West	31%	32%
<50 beds	28%	25%
50-100 beds	26%	30%
101-200 beds	30%	44%
201-500 beds	34%	56%
501-1000 beds	40%	45%
>1000 beds	39%	70%

Table 11: Expectations for future impact of value-based payment models: percentage of respondents that agreed or strongly agreed with the respective statement

Hospitals that are currently part of an ACO are more positive about the future impact of value-based payment on their business (41% versus 26% for non-ACO members) and their competitive position (46% versus 31% for non-ACO members).

Figure 12 and Table 12 reflect expectations for changes that value-based payment will trigger. Very few hospital executives nationally (6%) expect a positive effect on margins, but 42% of executives in the Northeast believe so. Respondents in the Northeast and Midwest, both regions with higher current penetration of value-based payment, are more likely to expect vertical and horizontal consolidation than their colleagues in the West and South.

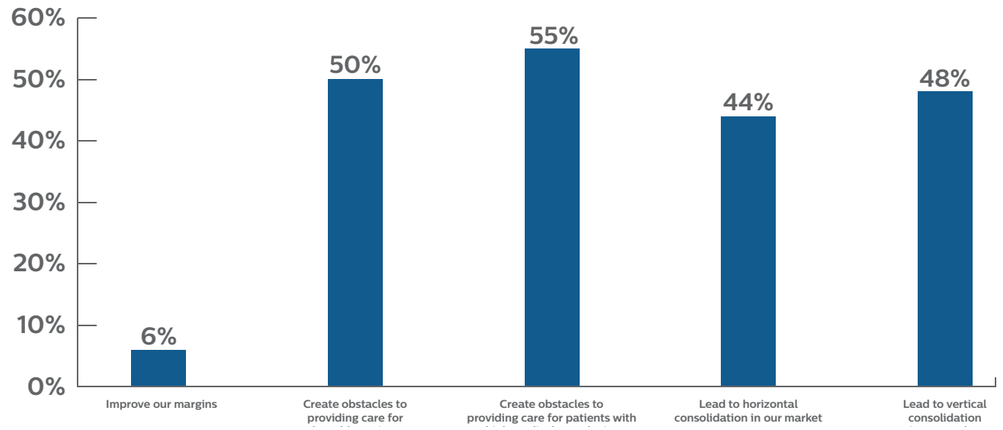

Figure 12: Expectations for impact of value-based payment models: percentage of respondents that agreed or strongly agreed with the respective statement

	Create obstacles to providing care for vulnerable patients	Create obstacles to providing care for patients with high medical complexity	Lead to horizontal consolidation in our market	Lead to vertical consolidation in our market	Improve our margins
National Rate	50%	55%	44%	48%	6%
Northeast	44%	49%	55%	63%	42%
South	54%	54%	41%	45%	4%
Midwest	47%	59%	52%	56%	4%
West	51%	51%	26%	31%	7%
<50	52%	55%	45%	42%	7%
50-100	48%	57%	30%	46%	5%
101-200	65%	62%	43%	52%	5%
201-500	35%	39%	59%	65%	4%
501-1000	33%	48%	34%	57%	16%
>1000	59%	70%	43%	54%	3%
Current ACO member	54%	60%	40%	47%	5%
Not current ACO member	41%	44%	51%	51%	10%

Table 12: Expectations for impact of value-based payment models: percentage of respondents that agreed or strongly agreed with the respective statement

The results in Table 13 show that around two-thirds of executives find their employed providers, but only 36% of affiliated and 26% of non-affiliated providers, ready to collaborate on value-based payment contracts. Larger hospitals are more likely to find all of their providers ready. Organizations that are not part of an ACO are more likely to find affiliated and non-affiliated providers prepared to collaborate that their ACO counterparts, where there were no differences for employed providers.

Our providers are prepared to collaborate with us on value-based payment contracts			
	Employed providers	Affiliated providers	Other providers
National rate	65%	36%	26%
Northeast	64%	39%	41%
South	63%	26%	17%
Midwest	70%	37%	28%
West	64%	53%	38%
<50 beds	55%	31%	21%
50-100 beds	65%	38%	22%
101-200 beds	73%	46%	31%
201-500 beds	80%	31%	35%
501-1000 beds	75%	48%	28%
>1000 beds	75%	49%	55%
Current ACO member	65%	31%	23%
Not current ACO member	65%	48%	35%

Table 13: Preparation of providers to collaborate on value-based payment contracts: percentage of respondents who strongly agreed or agreed

The view on impact of value-based payment on professional satisfaction is bleak as Table 14 summarizes. Only 5% and 4% of respondents agree or strongly agree that value-based payment will increase professional satisfaction of medical specialists and surgeons, respectively, with no meaningful differences by region, size and ACO membership. Even though it is assumed that mid-level providers will benefit from the shift to value-based payment, because they will gain greater responsibility and autonomy, only around a quarter of executives expect their satisfaction to improve.

In the next two years value-based payment models will increase professional satisfaction among our:			
	Medical subspecialists	Surgeons	Allied Professions
National rate	5%	4%	24%
Northeast	5%	4%	33%
South	4%	2%	21%
Midwest	8%	7%	22%
West	4%	2%	26%
<50 beds	7%	5%	27%
50-100 beds	5%	2%	21%
101-200 beds	3%		11%
201-500 beds	6%	4%	29%
501-1000 beds	3%	2%	21%
>1000 beds	5%	8%	25%
Current ACO member	4%	3%	21%
Not current ACO member	8%	4%	31%

Table 14: Expected impact of value-based payment on professional satisfaction, percentage of respondents who strongly agreed or agreed

Discussion of findings

Transition creates uncertainty and apprehension

The emergence of value-based payment models implies a fundamental change in the operating environment for hospitals. Today's fee-for-service system creates incentives to maximize the number of transactions, such as admissions, tests and procedures, while value-based payment rewards population health objectives: Better health, better care and lower cost, the so-called Triple Aim.

Hospital executives have accepted that this transition will occur in a timeframe between two and five years, even though current exposure to value-based payment remains limited. Only around 8% of revenue is "tied to value" based on CMS' broad definition and only about 3% actually at risk. Less than one-third of hospitals participate in any value-based payment model. Even for hospitals that do participate, the stakes are limited with around 8% of revenue at risk. Exposure is higher for larger hospitals and in regions where value-based payment has become more common, but the responses make clear that hospitals continue to operate in a fee-for-service world.

The limited exposure is a logical consequence of the voluntary and experimental nature of value-based payment for now. Participation in ACOs and bundled payment pilots was voluntary until recently, and even the mandated Readmissions Reduction Program has limited consequences for many hospitals.

The tension between today's prevailing incentives and expectations for the future create a conundrum for hospital executives as they need to start reorienting their complex organizations and make investments that may not have a financial return for many years. These decisions are made harder because of the limited operating margins of

hospitals of around 5% and because of restrictions that a hospital's unique role for its community imposes on business decisions.

It is therefore not surprising that less than 40% of respondents nationally perceive a positive impact of value-based payment on their business and only 6% believe it will improve margins, even though the actual impact remains limited so far.

Consolidation as defensive measure

A logical response to less forgiving environment is consolidation, which permits hospitals to realize economies of scale, improve negotiation leverage with health plans and spread necessary investments over a larger base. Nationally, 18% of hospitals had entered an affiliation with a larger entity and 26% were planning to do so in the next two years. Those changes were more common in the Northeast where value-based payment has become more prevalent. Almost half of respondents expect that both horizontal and vertical consolidation will continue over the next years.

Securing patient flows as transition strategy

The overarching theme to describe how hospital executives are managing this difficult transition is a focus on securing patient flows, as tying patients more closely to the organization serves a dual purpose. First, under the current fee-for-service model, it ensures a steady stream of patients to keep hospital beds full and surgical suites busy. Second, control of patient journey is a precondition to implement population health models under future value-based payment.

Additionally, 64% and 71 % of hospitals have increased hiring of physicians and mid-level providers, respectively, in the last three years and close to half have added primary care practices. Investments into telemedicine (56%) and patient portals (76%) as well as efforts to control "leakage" (33%) all aim at gaining greater control of patient journeys.

Initial steps towards transformation

In parallel to the transition strategy, executives are reshaping their organizations for the future. They have hired population health management staff (48%) and analysts (42%) and are investing into predictive modeling software (22%) and home monitoring equipment (24%). Investment into technology to support population health management is expected to increase in the next two years. This cautious shift reflects the fact that almost all respondents expect value-based payment to have a meaningful impact on their business within five years.

Cautious optimism – for the survivors

Going forward, around one-third of respondents expect that value-based payment will have a positive impact on their business and strengthen their competitive position. Larger hospitals and those in the Northeast where value-based payment has become more common are even more positive overall and more positive about the future impact of value-based payment than the past. Those responses suggest that executives expect value-based payment to trigger a period of consolidation and pressure on margins, but improved conditions for those who manage the transition successfully.

Summary

The results of this survey illustrate that executives are managing the challenging transition to value-based payment by focusing on defensive measures. Vertical and horizontal consolidation increases the revenue base to afford future investments and improves bargaining power in negotiations with payers. Investments into capabilities to secure patient flows yield immediate returns in a fee-for-service environment and are at the same time a precondition to implement future population health models. In parallel, investments into technology to support population health management is picking up.

The data tell us that hospital executives have accepted that value-based payment is here to stay and are preparing their organizations for this new reality. They expect the transition to be painful and unforgiving with pressure on margins and consolidation. While challenging, taking the first steps towards the transition appears to be not only inevitable but also advantageous: Executives with current exposure the value-based payment models tend to have a more optimistic outlook, and most respondents agreed that those who manage the transition successfully will emerge in a stronger position.

Appendix A

The Washington Post

Hospital C-Suite Survey on Value-Based Payment

Thank you very much for participating in this survey on how value-based payment has affected and will affect your organization. Please attempt to answer all questions and give your best estimate, if you are unsure of the exact answer.

We will treat your answers as confidential. Results will only be published in aggregate form and will never identify your organization or you personally without your permission. Summary findings will be published in a series of sponsored articles in the Washington Post and you will receive a detailed report on the findings as a token of our appreciation. If you have any questions regarding the survey, please contact our survey partner Benecit Research at benecit@verizon.net or (202) 468 5797.

A. How would you characterize your organization?

A.1 Which of these terms best describes your organization? (Please check *one* response)

- ☐1 Individual acute care hospital
- ☐2 Acute care hospital, part of larger organization containing other hospitals (but no other types of health care providers)
- ☐3 Health system (one or more hospitals, plus other types of health care providers, but no health plan)
- ☐4 Health system with health plan
- ☐5 Other, please describe: _____

A.2 How would you describe the ownership of your organization? (Please check *one* response)

- ☐1 For-profit, investor owned
- ☐2 For-profit, physician owned
- ☐3 Not-for-profit
- ☐4 Other, please describe

A.3 If you are a single acute care hospital, how would you characterize your hospital? (Please check *one* response, SKIP to A.4, if not an individual acute care hospital)

- ☐1 Academic Medical Center
- ☐2 Teaching hospital
- ☐3 Community hospital
- ☐4 Safety net hospital
- ☐5 Rural hospital
- ☐6 Other, please describe: _____

A.4 How many *acute inpatient* beds does your organization have in total?

- ☐1 Fewer than 50 beds
- ☐2 50 to 100 beds
- ☐3 101 to 200 beds
- ☐4 201 to 500 beds
- ☐5 501 to 1000 beds
- ☐5 More than 1000 beds

A.5 What was your organization's *patient care revenue* in the most recent fiscal year?

- ☐1 Less than $100 million
- ☐2 $101 to $250 million
- ☐3 $251 to $500 million
- ☐4 $501 to $750 million
- ☐5 $751 million to $1 billion
- ☐5 More than $1 billion

A.6 In the most recent fiscal year, approximately what percentages of your organization's *patient care revenue* came from the following sources? (Please give your best estimate)

a.	Commercial health plans (all types, including but not limited to HMOs and PPOs)	_____ % of total revenue
b.	Public payers (traditional Medicare, Medicare plans, Medicaid)	_____ % of total revenue
c.	Patient self-pay/charity care	_____ % of total revenue
d.	Other (specify): _____	_____ % of total revenue
		TOTAL =100 %

B. What is your organization's current exposure to value-based payment?

B.1 Is your organization participating in the following value-based payment models?

a.	Accountable Care Organization (ACO) demonstrations or contracts (specify): _____	☐1 No	☐2 Yes	☐3 Under consideration
b.	Bundled payment or episode-based payment demonstrations or contracts (specify): _____	☐1 No	☐2 Yes	☐3 Under consideration
c.	Other types of pilots, demonstrations, or new types of payment contracts (specify): _____	☐1 No	☐2 Yes	☐3 Under consideration

B.2 Which of the following criteria played a role in determining value-based payments to your organization in the most recent fiscal year? *(Please check all that apply)*

☐1 Adherence to evidence-based standards (process measures)	☐2 Patient outcomes (morbidity and mortality)
☐3 Patient experience or satisfaction	☐4 Readmissions
☐5 Resource use or cost	☐6 We don't participate in value-based payment models at the moment

B.3 In the most recent fiscal year, what proportion of payments for patient care was: *(Please give your best estimates)*

a. "tied to value" based on CMS' definition, i.e., *even partially paid under a value-based model*	_____ % of total revenue
b. At risk based on any value criteria *regardless of whether rewards or penalties actually occurred*	_____ % of total revenue
c. *Actually paid* based on any value criteria	_____ % of total revenue

B.4 Why is your organization participating in value-based payment models? *(Please check all that apply)*

☐1 Voluntary (e.g., initiated by your organization)	☐2 Triggered by competitive consideration (i.e., due to activities of your competitors)
☐3 Mandatory, due to federal laws or regulations	☐4 Mandatory, due to state laws or regulations
☐5 Mandatory, imposed by commercial payers	☐6 We don't participate in value-based payment models at the moment

B.5 Please indicate your agreement with the following statements about your experience with value-based payment models *over the last three years.* (Select N/A if you have no experience with value-based payment)

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	N/A
a. Value-based payment models had a positive impact on our business	☐1	☐2	☐3	☐4	☐5	☐6
b. Value-based payment has strengthened our competitive position	☐1	☐2	☐3	☐4	☐5	☐6

C. Which changes have you made or will you make in response to value-based payment?

C.1 Which of the following *organizational changes* has your organization *made or will make* partially or fully in response to value-based payment models? *(Please check all that apply)*

	Have made change in the last three years	Expect to make change within the next two years
Affiliation with a larger organization (without being acquired)	☐1	☐2
Acquisition by another organization	☐4	☐5

C.2 Which of the following *services* has your organization *increased or will increase* partially or fully in response to value-based payment models? (Please check all that apply)

	Have increased in the last three years	Expect to increase within the next two years
Primary care practices	☐1	☐2
Ambulatory specialty care practices	☐3	☐4
Ambulatory procedure capacity	☐5	☐6
Ambulatory diagnostic testing	☐7	☐8
Inpatient beds (new facilities or expansion of existing facilities)	☐9	☐10
Inpatient rehabilitation or skilled nursing facilities	☐11	☐12
Home healthcare capacity	☐13	☐14
Outpatient pharmacies	☐15	☐16

C.3 Which of the following *technology investments* has your organization made or will make partially or fully in response to value-based payment models?
(*Please check all that apply)*

	Have invested in the last three years	Expect to invest within the next two years
Electronic health record (new or upgraded	☐1	☐2
Patient portal	☐3	☐4
Predictive modeling software	☐5	☐6
Care gap analysis/disease management software	☐7	☐8
New/upgraded information *security* software	☐9	☐10
Home monitoring equipment	☐11	☐12
Telemedicine capabilities	☐13	☐14

C. 4 Which of the following *staff categories* has your organization expanded or will expand in response to value-based payment models? (*Please check all that apply)*

	Have expanded in the last three years	Expect to expand within the next two years
Employed physicians	☐1	☐2
Affiliated (non-employed) physicians	☐3	☐4
Mid-level providers (PA, NP, etc.)	☐5	☐6
Other non-physician clinicians (e.g., nurses, pharmacists, social workers)	☐7	☐8
Population health management staff (e.g., discharge coordinators, case managers)	☐9	☐10
Administrative (non-clinical) staff	☐11	☐12
Analytics staff (e.g., analysts, data scientists)	☐13	☐14

D.3 In the *next two years,* do you expect your organization will participate in the following types of pilots, demonstrations, or new types of payment contracts?

a.	Accountable Care Organization (ACO) demonstrations or contracts (specify): _____	☐1 No	☐2 Yes	☐3 Under consideration
b.	Bundled payment or episode-based payment demonstrations or contracts(specify): _____	☐1 No	☐2 Yes	☐3 Under consideration
c.	Other types of pilots, demonstrations, or new types of payment contracts (specify): _____	☐1 No	☐2 Yes	☐3 Under consideration

D.4 Please indicate how much you agree or disagree with the following statements about your expectations for the *next two years.*

		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
c.	Our employed providers are prepared to collaborate with us on value-based payment contracts	☐1	☐2	☐3	☐4	☐5
d.	Our affiliated providers (not employed) are prepared to collaborate with us on value-based payment contracts	☐1	☐2	☐3	☐4	☐5
e.	Other providers (not employed or affiliated with us) are prepared to collaborate with us on value-based payment contracts	☐1	☐2	☐3	☐4	☐5

D.5 In the *next two years* value-based payment models will:	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
a. improve our margins	☐1	☐2	☐3	☐4	☐5
b. create obstacles to providing care for vulnerable patients	☐1	☐2	☐3	☐4	☐5
c. create obstacles to providing care for patients with high medical complexity	☐1	☐2	☐3	☐4	☐5
d. lead to horizontal consolidation in our market	☐1	☐2	☐3	☐4	☐5
e. lead to vertical consolidation in our market	☐1	☐2	☐3	☐4	☐5

D.6 In the *next two years* value-based payment models will increase professional satisfaction among our:	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
a. medical subspecialists	☐1	☐2	☐3	☐4	☐5
b. surgeons	☐1	☐2	☐3	☐4	☐5
c. allied health providers (e.g., nurse practitioners, physician assistants)	☐1	☐2	☐3	☐4	☐5

E. Would you be willing to provide additional information?

a. Do you have any success stories to share that could qualify as best practices for other hospitals to follow?	☐1 No	☐2 Yes
b. Are you willing to be a case study resource for an article on organizations that made a successful transition to value-based payment?	☐1 No	☐2 Yes

If yes, how should we contact you?

Email: _____ Phone: _____

F. Are you interested in receiving a summary report of the data?

If yes, please give us an email to which we should send the report

Email: _____

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